

Early Childbearing in Guatemala: A Continuing Challenge

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Key Points

- ∞ Guatemala has the third highest adolescent birthrate in Central America—114 births for every 1,000 women aged 15–19 each year.
- ∞ Only two-fifths of 20–24-year-old women have completed primary school. The proportion is one in four in rural areas and one in 10 among indigenous women.
- ∞ One-half of young women enter into a union (formal or consensual) before their 20th birthday. Three-quarters of those with no schooling do so, compared with one-quarter of those with a primary education or more.
- ∞ Forty-four percent of 20–24-year-olds were mothers by age 20; the proportion is highest among young women with no education (68%) and among indigenous women (54%).
- ∞ The great majority of 15–19-year-old women in union—83%, with little variation by residence or ethnicity—do not want to have a child in the next two years. However, only 18% are using an effective contraceptive.
- ∞ Although 70% of 15–24-year-olds who recently gave birth made at least one prenatal care visit, roughly half of the least educated and of indigenous women made none. Moreover, only half of 15–24-year-old mothers had professional medical care at their most recent delivery; the proportion is even lower among the least educated and indigenous women (one-quarter).

Early Childbearing in Guatemala:

A Continuing Challenge

Childbearing during adolescence is recognized worldwide as a factor with a profound impact on the well-being and reproductive health and rights of young women, and on a country's overall pace and direction of development.¹ In Guatemala, where limited resources shape the lives of many young people even without the added burden of parenthood, addressing the health and social consequences of high levels of adolescent childbearing is critical.

Understanding the context and consequences of adolescent sexual and reproductive behavior is important for several reasons. For instance, young people make up a very large proportion of Guatemala's population: An estimated one-quarter of Guatemalans are aged 10–19.² The consequences of the life choices that these young people make will resonate through Guatemalan society for many years to come. In addition, the timing of union formation and motherhood has lifelong implications for young women and consequences for the country's economic and social development. If young women in Guatemala are to play an active role in that development and prepare themselves adequately for their future, they need education and training—needs that often go unmet if, at an early age, they assume the responsibilities of being in a union and becoming a mother.

Each year, 114 of every 1,000 Guatemalan women aged 15–19 give birth.³ Although this rate represents a small decline from the 126 per 1,000 recorded in 1995,⁴ it is still the third highest in Central America, after the rates of Honduras (137)⁵ and Nicaragua (119⁶). Guatemala's rate exceeds those of El Salvador (104),⁷ Belize (95),⁸ Panama (89)⁹ and Costa Rica (78).¹⁰ As is true in many other countries, the birthrate among rural adolescents in Guatemala is far higher than that among urban adolescents (133 vs. 85 per 1,000¹¹). Furthermore, fertility among Guatemalan adolescents is declining at a slower pace than is overall fertility: The adolescent birthrate dropped by only 10% from 1995 to 2002, while the overall rate fell by 20%.¹²

New information from national surveys conducted in Guatemala makes it possible to look closely at the childbearing and related behaviors of Guatemalan adolescents* (FN A) (box). This report provides a picture of the sexual, union formation and childbearing experiences of Guatemalan young women, and explores the factors associated with the country's moderately high level of adolescent childbearing. It also looks at the associations between early childbearing and enduring disadvantage, and identifies the reproductive, health and educational services that Guatemalan women need to avoid early and often unplanned births.

The context of adolescent childbearing is key.

Giving birth at a young age can reduce a woman's long-term social and economic autonomy, derail her educational prospects and endanger both her health and that of her newborn. To address the issue effectively, it is important to understand the context in which early childbearing occurs. For example, women who give birth as adolescents are likely to be poor, and early childbearing can create further economic and social disadvantage. Women who start childbearing at a young age tend to have bigger families than those who postpone starting a family, and very young mothers and their children who start off impoverished are often unable to move out of poverty.¹³ In addition, early childbearing can severely restrict young women's educational opportunities and consequently limit their employment prospects.¹⁴ In contrast, because education has become increasingly linked to improving life prospects, women who delay their first birth until after adolescence may be able to go to school longer, which enables them to have a more direct role in determining their and their children's future.¹⁵

Furthermore, the potential for poor health outcomes of early childbearing may be heightened in areas where maternal and child health are poor. For instance, giving birth before complete physical maturity (i.e., at age 16 or younger) can endanger a young woman's health and may increase the risk that her child will be sick or die in infancy;¹⁶ these risks are compounded among poor adolescents, who are unlikely to have adequate nutrition and access to medical care.

Guatemala is a poor country with high fertility.

Guatemala is, by far, the most populous country in Central America; its estimated population of 13.2 million inhabitants is nearly double that of the second most populous country in the region, neighboring Honduras.¹⁷ It also stands out for being a largely rural country (54% of Guatemalans live in rural areas, compared with 31% of Central Americans overall¹⁸) and for having an exceptionally large and diverse indigenous population (indigenous peoples make up 43% of the total population¹⁹ and speak 22 languages).

The country, which is growing at an annual rate of 2.6%,²⁰ has one of the highest total fertility rates in all of Latin America—4.4 lifetime births per woman²¹—and one of the lowest rates of contraceptive use (43% of women of reproductive age who are in union).²² Guatemala also has one of the highest levels of social and economic inequity in the Americas. Although a “peace dividend” after nearly four decades of civil conflict that ended in 1996 has started to result in gradual reductions in poverty, the majority of Guatemalans—56% as of 2000—still subsist below the poverty line (i.e., do not have the resources to buy a basic package of goods and services).²³ The most vulnerable segment of the population—indigenous people—is even more destitute: Three-quarters of the indigenous population live in poverty, and one-quarter in abject poverty (i.e., cannot afford food alone).²⁴ Indigenous Guatemalans trail in all measures of socioeconomic development, health and education.

Guatemalan women suffer from poor reproductive health.

The Guatemalan population has a number of serious health problems, many of which are tied to poor reproductive health.

- Low rates of prenatal care, the overall precarious health status of poor women and low rates of attended births all contribute to the current maternal mortality ratio of 153 maternal deaths per 100,000 live births, one of the highest in the region.²⁵ Indigenous women suffer disproportionately, as their ratio is nearly

three times that of nonindigenous women (211 vs. 70). The ratio for adolescent women in 2000 was 110 maternal deaths per 100,000 live births.

- The 2002 infant mortality rate of 39 infant deaths per 1,000 live births is among the highest in Central America.²⁶

- Induced abortion is illegal in Guatemala except to save a pregnant woman's life,²⁷ but an estimated 27,000 women are hospitalized each year for treatment of postabortion complications.²⁸ Although these are complications from both spontaneous and induced abortions, most postabortion patients in Latin American who claim to have had a miscarriage in reality have undergone an unsafe induced abortion.²⁹ According to the limited information available on the characteristics of women hospitalized for such complications, one-fifth are aged 15–19, which suggests that a substantial number of Guatemalan adolescents resort to unsafe abortion each year.³⁰

Educational levels among female adolescents are very low.

Young women's reproductive and overall health tends to improve with increased levels of schooling. Unfortunately, the goal of achieving universal primary education for Guatemalan women remains a long way off. Although the overall proportion of women aged 20–24 who had completed at least seven years of schooling rose dramatically from 1995 to 2002—from 27% to 39% (Table 1, row 1)—primary school completion remains rare among indigenous women (11%) and among women in rural areas (24%).

Educational attainment varies widely by ethnicity and area of residence (Figure 1). For example, the rate of primary school completion is nearly five times as high among nonindigenous as among indigenous young women (51% vs. 11%), and 2.5 times as high among urban as among rural adolescents (62% vs. 24%). Poverty is the overriding reason for these differentials, but it is compounded by the fact that whereas one-third of the indigenous population speak only an indigenous language,³¹ instruction is offered only in Spanish, and by the difficulty of filling low-paying teaching jobs in hard-to-reach rural areas. All of these factors reduce indigenous and rural parents' motivation to send their children to school, especially their daughters, who are often needed at home.

Union formation and sexual initiation occur early.

Early unions continue to be a prevailing norm. One-quarter of 20–24-year-old women in 2002 had entered into a formal or consensual union before their 17th birthday (Figure 2), and one-half had done so before their 20th birthday. (Guatemalan adolescents are more likely to enter into consensual unions than formal ones. In 2002, 11% of 15–19-year-olds were in a consensual union, whereas 7% were in a formal union.³²) The rate at which adolescents enter unions has declined little in recent years—just 10% from 1995 to 2002 (Table 1, row 2).

As is the case in much of the world, education is one of the most important factors associated with age at first union: One-quarter of women with at least seven years of schooling have entered into a union by age 20, compared with three-quarters of those with no schooling (Table 1, row 2). This differential is far greater than that by area of residence or by ethnicity.

Not all adolescent sexual activity occurs within a union, however, and although such activity outside union is still heavily sanctioned, its prevalence has increased moderately in recent years. Whereas 14% of 20–24-year-old women in 1995 had had premarital sexual relations as teenagers, 18% of those in 2002 had done so, a 25% increase over the seven-year period (Table 1, row 3).

Although Guatemala is predominantly a socially conservative society, it is not immune to the influences of the rapidly changing modern world. The level of premarital sexual activity has increased among nearly every subgroup of women, with the notable exception of those with no schooling, among whom it has decreased (Table 1, row 3). As these increases in premarital sex combine with the incipient trend toward postponing union formation, the period of exposure to the risk of unintended pregnancy may lengthen, and young women's risk of resorting to unsafe abortion could rise as a result.

One-fifth of all Guatemalan women aged 20–24 had sexual intercourse before age 16, two-fifths before age 18 and nearly three-fifths before age 20 (Figure 2). Unless sexually active teenage women use contraceptive protection, many are at risk of pregnancy.

Childbearing during adolescence is very common in Guatemala.

In Guatemala, as in much of the developing world, when women form unions early, they also tend to start childbearing at a young age. Overall, 44% of 20–24-year women in 2002 had had a baby before age 20; this proportion had declined just 7% since 1995 (Table 1, row 5). However, the already low proportion giving birth before age 15 fell by one-third between 1995 and 2002, from 4% to less than 3% (Table 1, row 7).

The proportion of women who were teenage mothers has been essentially stable since the mid-1990s in nearly every subgroup examined; the minor overall decline thus appears to have resulted primarily from the drop among rural adolescents (from 55% in 1995 to 49% in 2002). Again, the largest gap in outcome is associated with education: The proportion of women who gave birth as adolescents is three times as high among uneducated 20–24-year-olds as among those who completed primary school (68% vs. 22%—Figure 3). Although it is hard to tease out cause and effect, we know that giving birth before age 20 is strongly associated with a reduced likelihood of completing primary school: Only 20% of 20–24-year-olds who were teenage mothers had completed primary school, compared with 55% of young women who postponed having children until age 20 or older.³³

These basic childbearing patterns apply across all eight of Guatemala's geographic regions;* (FN B) both the differences by education and the rate of adolescent childbearing reach their highest levels in the sparsely populated, underdeveloped and indigenous region of Petén. Overall, the proportion who give birth as a teenager is highest in Petén (66%) and lowest in Metropolitana (33%).³⁴

Poverty, which goes hand in hand with too little schooling, is another important determinant of adolescent childbearing. The proportion of 20–24-year-old women who were teenage mothers declines steadily with increasing socioeconomic status (Table 2). Sixty-two percent of the least well-off women gave birth as teenagers, compared with 52% of those in the middle income range and 27% of the most affluent. Since indigenous and rural women are especially likely to be poor, they run the greatest risk of giving birth at a very young age. Indeed, indigenous women aged 20–24 are far more likely than their

nonindigenous peers to have been adolescent mothers (54% vs. 39%—Figure 3), and rural women are more likely than urban women to have given birth before age 20 (49% vs. 35%).

Similar disparities are evident in the proportions of women who gave birth even earlier—before age 18 (Table 1, row 6) or before age 15 (Table 1, row 7). The educational disparity in very early childbearing—before age 15, an age that carries the highest risk of adverse consequences—is especially startling: Six percent of nonschooled 20–24-year-old women had a child before their 15th birthday, compared with 1% of those who had at least completed primary school. Overall, 19% of today’s 15–19-year-olds have given birth or are pregnant (Table 1, row 8); the proportion is as high as 36% among those who have never been to school.

The birthrate among adolescents has declined over the past decades (although not as much as the birthrate among all women); nevertheless, the number of young women who give birth as teenagers keeps rising, because of the population momentum built in to Guatemala’s very young population. Whereas an estimated 57,000 births in 1987 were to 15–19-year-olds, that number had climbed to 72,000 by 2002 (Table 3). Moreover, adolescents accounted for roughly the same proportion of all births in 2002 as they did in 1987, about one-fifth.

Childbearing outside union is infrequent.

By and large, adolescent childbearing in Guatemala occurs within union. As the country modernizes, however, this is likely to change, and then the hardships of single motherhood may exacerbate the burden of too-early childbearing. Indeed, out-of-wedlock childbearing has become more common among teenagers: The proportion of 20–24-year-olds who gave birth outside union doubled between 1995 and 2002, from less than 2% to almost 4% (Table 1, row 4). It varies little across subgroups, and this uniformity speaks to the generalized effects of modernization in the country.

Even so, the strong stigma surrounding single motherhood persists throughout Guatemalan society and may motivate some sexually active women who are not in a union to practice contraception. It

is also possible that in the case of an unexpected pregnancy, young single women may enter a union to legitimate the pregnancy, underreport the resulting birth or turn to unsafe abortion.

Many women view early union and childbearing as inevitable.

Comparing the proportions of 20–24-year-old women who were in union by age 20 and who had had a child by that age shows how closely the two behaviors are linked (Table 1, rows 2 and 5). For most adolescent women, even the most educated (i.e., those who have at least completed primary school), union formation is closely followed by childbearing.

To what extent is early childbearing seen as an inevitable part not just of being in a union but of life? In many communities, adolescent unions, pregnancy and childbearing may not be perceived as limiting or negative. Many areas present few educational or work opportunities for women, and given that Guatemalan cultural norms strongly support early childbearing, young women may see entering a union and becoming a mother as their best option, since they have few prospects for other life directions. Further, in many insular indigenous and rural communities, early union formation and childbearing are often a young woman's only option, especially given indigenous women's lack of autonomy and their belief that women are predestined to have a certain number of children.³⁵

Although clear majorities of adolescents do not want a child any time soon, few practice contraception.

A very high and virtually unchanging proportion of 15–19-year-olds in union say that they do not want to have a child in the next two years—84% in 1995 and 83% in 2002 (Table 1, row 11). Yet, a far smaller proportion of these women—18%—are using a modern method of contraception* (FN C) to prevent that from happening (Table 1, row 15). This level of use, although low, represents a 75% increase since 1995.

The rise in the prevalence of modern method use between 1995 and 2002 was nothing less than astonishing among rural adolescents (from 4% to 13%), uneducated adolescents (1% to 8%) and indigenous adolescents (1% to 8%). These increases say as much about the changing situation in the

country as about the extraordinarily low starting point, however. And clearly illustrating the widespread cultural expectations that young women start their families soon after entering a union, very few adolescents in union practice contraception before they have had a child: Three percent without a child use a modern method, compared with 25% of those who have already had a child.³⁶

Despite the uniformly high proportion of adolescents in union who do not want a child soon, as expected, relatively advantaged young women are far more likely to act on that preference than are their disadvantaged peers. For example, the proportion using a modern method is more than twice as high among urban as rural women (31% vs. 13%), three times as high among nonindigenous as indigenous adolescents (26% vs. 8%) and five times as high among the most as the least educated women (40%* (FN D) vs. 8%). These disparities reflect poor access to care, the scarcity of public-sector services in rural areas and resistance to modern contraceptives, which is fueled by myths that they are dangerous.

As the previous paragraphs suggest, although unmet need for contraception has declined in almost every subgroup of women, it is still unacceptably high. Among sexually active adolescents—i.e., all those in union, along with those not in union who have had intercourse in the past three months—more than five in 10 who do not want to have a child soon are not using an effective contraceptive method (Table 1, row 17). It is, however, encouraging that among groups for which we have reliable data, unmet need declined by 6–19% among every subgroup of women but one. Unfortunately, indigenous women, who have the highest level of unmet need (67%) and thus are at greatest risk of unintended pregnancy, experienced virtually no change over the period.

What proportion of births to adolescent women are unplanned?

When need for contraception goes unmet, unplanned births inevitably result. Although most births to 15–19-year-old women in Guatemala are planned, a rising proportion are either mistimed (wanted but at a later date) or not wanted at all. Overall, 29% of recent births (within the past five years) to 15–19-year-olds in 2002 were unplanned, an increase from the 24% reported in 1995 (Table 1, row 9). Tellingly, this upward trend reflects increases among the more disadvantaged subgroups: The proportions unplanned

rose among rural, less educated and indigenous adolescents from quite low levels in 1995 (14–19%) to close to average levels in 2002 (25–30%). Levels of unplanned childbearing declined among urban adolescents (from 33% to 27%) and those with a primary education (from 44% to 29%).

These trends in unplanned childbearing partly reflect gaps in knowledge of the effective contraceptives that enable women to act on their reproductive preferences. The proportion of 15–19-year-olds who know of any modern contraceptive method grew between 1995 and 2002 (Table 1, row 13), and is now fairly high (85%) overall. However, it is considerably lower among uneducated and indigenous women (60% and 70%, respectively). Lack of essential knowledge about modern contraceptives endangers the health of Guatemalan adolescents, as it elevates their risk of both unintended pregnancy and sexually transmitted infections (STIs), including HIV. Indeed, the quality and coverage of sexuality education are woefully inadequate: Only one in four 15–24-year-old Guatemalan women have received any instruction on contraception through talks or courses; moreover, fewer than three in 10 have learned about any of seven reproductive health topics—including menstruation and HIV/AIDS.³⁷

Prenatal and delivery care are inadequate among adolescents.

Whatever a pregnancy's planning status, adolescents need quality care to see them safely through pregnancy and childbirth. For a wide range of reasons, including pervasive poverty, an inadequate health infrastructure, geographic inaccessibility and cultural preferences for traditional birth attendants, not all adolescents get the comprehensive prenatal and delivery care they need to avoid complications and have healthy babies.

Overall, 70% of pregnant women aged 15–24* (FN E) receive any professional prenatal care (Table 1, row 20). The proportion who make at least one prenatal visit reaches at least eight in 10 among the most educated and nonindigenous young women, but is only about one-half among the least educated and indigenous adolescents. (Although we lack the more relevant information on the number of visits made, the norms under the National Reproductive Health Program recommend a minimum of four, including two during the last month of pregnancy.³⁸) The rates of minimal coverage among the subgroups

of women with the greatest need for improved prenatal care, although low, nonetheless reflect excellent recent progress—roughly 50% increases since 1995.

Even lower proportions of Guatemalan young mothers give birth at a medical facility than receive any prenatal care. Overall, one-half of pregnant 15–24-year-olds have a professional attend their delivery at a public or private medical facility (Table 1, row 21). Uneducated and indigenous young women are particularly unlikely to have a medically attended delivery (25% and 23%, respectively), and are thus likely to give birth at home (where 54% of maternal deaths occur³⁹). Clearly, although the most disadvantaged young women are the most likely to become pregnant, they are also the most likely to lack access to the care that their pregnancy requires.

Long-standing reasons, beyond lack of geographic and economic access to medical facilities, help explain why indigenous young women might default to the cultural familiarity of *comadronas tradicionales* (traditional midwives) and home-based births. For instance, they may distrust the mainly nonindigenous, male medical establishment, which is often perceived as insensitive and insulting, and their husbands and families might prefer that they not go to male physicians because of prevailing standards of modesty.⁴⁰

Nonetheless, much progress has been achieved in the use of professional delivery care, especially among the populations with the greatest need (Table 1, row 21): Between 1995 and 2002, the proportion of births that were medically attended increased by 60% among rural women (from 25% to 40%) and uneducated women (from 16% to 25%), and it nearly doubled among indigenous women (from 12% to 23%).

Youth policies are in place but are not yet fully in force.

Guatemala has a lot of catching up to do in terms of adolescent sexual and reproductive health. The good news is that the past decade has seen a great deal of activity. The 1996 peace accords started the positive trend with their blueprint for comprehensive social, economic and political action (including the directive that education campaigns aimed at preventing STIs be conducted among adolescents⁴¹). The accords were

followed by the 1999 Plan Nacional de Atención Integral de los y las Adolescentes; however, although the plan has adolescent sexual and reproductive health as a thematic focus, it does not propose specific steps or programs to achieve it. Such a program was finally articulated in 2001, in the landmark Social Development Law, which, among many other provisions, created the country's Reproductive Health Program and its Policy and Program in Social Development and Population.⁴²

The Reproductive Health Program's adolescent component directs public-sector entities, such as the Ministerio de Salud Pública y Asistencia Social (MSPAS) and the Instituto Guatemalteco de Seguridad Social, to provide separate, specialized services geared to adolescents, including services to space pregnancies and to provide prenatal and delivery care, and services for the prevention and treatment of STIs; moreover, the law calls for sexuality education "in all the country's educational centers and at all levels" to help prevent unintended pregnancies and STIs among adolescents, and states that adolescents cannot be expelled from formal or informal educational institutions because of pregnancy.

Unfortunately, despite these laudable goals, very few adolescent programs are operating on the ground. Only two nongovernmental organizations—the Asociación Pro-Bienestar de la Familia (APROFAM) and the Asociación Guatemalteca de Educación Sexual (AGES)—provide adolescent-friendly reproductive health services and supplies, and the Ministry of Health runs just four clinics whose services are oriented toward adolescents.⁴³ Such specialized care or, at a minimum, training for providers on how to offer services for adolescents, is essential in a country where the stigma associated with nonmarital sexual relations makes adolescents especially reluctant to use adult-oriented facilities or purchase contraceptives openly in pharmacies. Adolescents' fear of judgmental treatment raises their likelihood of unprotected sex and its negative consequences.

After a stormy beginning, including a presidential veto, a congressional override and a ruling by the Constitutional Court, the Ley de Acceso Universal y Equitativo a los Servicios de Planificación Familiar was passed by Congress in April 2006.⁴⁴ The law makes access to contraception universal and free of charge for the first time, and provides for a dedicated line for contraceptives in the MSPAS budget. In addition to mentioning adolescents as one of several high-need target populations, the law

contains two articles that are devoted entirely to adolescents: Article 9 calls for coordinating strategies between ministries to provide specialized services, and article 10 specifies that beginning in the last two years of primary school, age-appropriate school-based sexuality education curricula should include content on “individuals’ rights and responsibilities in maintaining and promoting their health; sexuality; and too early and unwanted pregnancies as risk factors for poor maternal and child health outcomes.”⁴⁵

The low level of education, especially among females, is a major hindrance.

The necessity of improving the educational attainment of Guatemalan young women cannot be emphasized enough. The country is far from reaching the second Millennium Development Goal, universal primary education. Innovative programs are needed to impress the importance of educating girls upon families whose daughters are needed to work at home and who believe that female education is not worth investing in, since girls’ future will likely be one of being in a union and bearing children.⁴⁶

It is important to remember that adolescent motherhood within union is widely accepted in Guatemala and that only a minority of births to adolescents—29%, with little variation across subgroups—are classified as having been unplanned at the time. The many possible reasons that early childbearing is so common include cultural and social norms, pervasive poverty, exceptionally low educational levels (particularly among indigenous girls), limited or no job prospects, a sense of fatalism, and entrenched gender roles that encourage young women to prove their femininity—and young men their masculinity—by starting a family early.

All elements of Guatemalan society likely support actions to ensure and protect the health of young mothers and their babies. To that end, the government needs to better educate all adolescents, but especially rural and indigenous adolescents, about the importance of quality prenatal and delivery care. Successful programs to train *comadronas tradicionales* in recognizing obstetric emergencies and referring women for appropriate care should be expanded;⁴⁷ at the same time, nonindigenous providers need to be better sensitized to the needs of pregnant indigenous adolescents. Moreover, adolescents need better access to effective contraceptives to adequately space their planned births.

Confronting early childbearing will require coordination on many fronts.

Positive changes in broad health and social indicators in Guatemalan society are occurring rapidly. Much can be done to harness that momentum and work toward even better outcomes for adolescent women in the near future.

- At the very least, the existing laws and policies geared to adolescents need to be better linked to programs—run either by the government or by local or international nongovernmental organizations—to assure that the objectives articulated in those policies have a chance at realization.
- Education officials and policymakers need to step up efforts to encourage adolescents of both genders to stay in school for as long as possible. The push is especially needed in the most impoverished communities, since poverty status is even more important than ethnicity or gender in explaining female Guatemalan adolescents' low levels of school enrollment and educational attainment.⁴⁸
- The high proportion of young women with an unmet need for modern contraception—52% of all those who are sexually active, whether they are in union or not—highlights the inability of existing services to reach this population. Adolescent-friendly services are crucial in Guatemala; the few programs catering to adolescents' needs have to be better funded and replicated, and providers in general should be educated about adolescents' needs.
- Since the bulk of adolescent childbearing in Guatemala occurs within union, the husbands and partners of young mothers need to be involved in efforts to limit the social and health consequences of very early motherhood. Even among adolescents in union, there is value in providing comprehensive education on contraception, communication skills and the importance of birthspacing to avert the potentially more severe health, social and economic effects of having a second birth during adolescence.
- The government needs to better educate young women about the importance of professional prenatal and delivery care. It also needs to ensure that these services are accessible in underserved areas and that they are culturally acceptable to indigenous populations.

- Adolescents' need for family planning overlaps with their need for services to prevent the spread of STIs, including HIV. Although the prevalence of HIV infection is far lower in Guatemala than in neighboring Honduras and Belize, the size of Guatemala's population means that it has the greatest absolute numbers of annual infections in the region.⁴⁹ How many of these infections are among adolescents is not known, but given that levels of nonmarital sexual activity are on the rise, that condom use among adolescents is rare⁵⁰ and that 75% of Guatemala's HIV cases are transmitted through heterosexual behavior,⁵¹ immediate action is warranted.
- As the mass media continue to reach more Guatemalans each year, they should be called upon to supplement school-based sexuality education to spread prevention messages and information about newly available services to adolescents, especially those who have dropped out or have not enrolled in school. Culturally appropriate, indigenous-language messages need to be developed for hard-to-reach communities.
- Finally, the government needs to commit more resources to implementing the letter and spirit of existing policies that aim to protect the health of Guatemala's future—its adolescents.

Footnotes

FN A

*Because of constraints on data availability, in this report we define adolescence as ages 15–19. Many experts, however, define it as ages 10–19.

FN B

*The eight regions are Central, Metropolitana (which contains the capital, Guatemala City, and is the most urbanized region), Nor-Occidente, Nor-Oriente, Norte, Sur-Occidente, Sur-Oriente and Petén.

FN C

*Modern methods are the pill, implants, male and female sterilization, the IUD, the diaphragm, spermicides, the condom and the sponge.

FN D

*Although this proportion is based on 41 unweighted cases, the very large absolute difference by education suggests that socioeconomic advantage conferred by education is related to increased contraceptive use.

FN E

*We included data on 20–24-year-olds who have given birth to ensure a large enough sample; nonetheless, we expect that any issues of access to care would be the same for adolescents as for women in their early 20s.

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Data Sources

Data presented in this report came mainly from two national-level reproductive health surveys in Guatemala—the 1995¹ and the 2002² Encuestas Nacionales de Salud Materno Infantil (ENSMI), which were conducted by the Ministerio de Salud Pública y Asistencia Social and the Instituto Nacional de Estadística, with other national and international organizations. For the 1995 survey, 12,403 women of childbearing age (15–49), both in and not in union, were interviewed; for the 2002 ENSMI, the sample was 9,155 such women. Both surveys obtained information on sexual activity, partner characteristics, reproductive preferences, fertility experiences, contraceptive use, and maternal and child health. These surveys have large enough samples to permit analyses among adolescents by urban or rural residence, level of education, ethnicity and socioeconomic status. This report also draws on an earlier national survey, the 1987 ENSMI.³ Population estimates come from the United Nations Population Division.

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Table 1. Selected Demographic and Reproductive Measures

Guatemalan women's experiences often vary with their residence, level of schooling and ethnicity.																
Measure	All		Residence				Years of education						Ethnicity			
			Urban		Rural		0		1-6		≥7		Indigenous		Nonindigenous	
	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002
Unweighted Ns																
Women 15-19	2,949	1,601	917	533	2,032	1,068	660	259	1,610	914	679	428	1,282	704	1,653	897
Women 20-24	2,272	1,757	689	548	1,583	1,209	678	455	1,157	873	437	429	945	753	1,314	1,003
(1) % aged 20-24 who have ≥7 years of education	27.3	39.4	47.3	61.8	12.6	24.4	na	na	na	na	na	na	5.1	11.0	37.6	51.3
(2) % aged 20-24 in union before age 20*	56.1	50.3	47.2	40.8	62.7	56.8	74.5	77.1	61.9	61.1	29.5	26.3	67.6	63.7	50.8	44.7
(3) % aged 20-24 who had premarital sex before age 20	14.4	17.7	16.5	19.3	13.0	16.7	15.7	12.5	15.1	19.0	12.2	18.9	11.1	13.9	16.0	19.4
(4) % aged 20-24 who had a premarital birth before age 20	1.5	3.9	1.3	4.8	1.7	3.4	1.3	3.7	1.8	4.3	1.1	3.7	1.1	4.4	1.7	3.8
% aged 20-24 who gave birth before specific age																
(5) Age 20	46.7	43.5	35.6	35.0	55.0	49.2	64.6	67.9	52.0	53.3	21.2	21.7	56.4	54.3	42.2	39.0
(6) Age 18	26.4	24.4	19.6	18.6	31.4	28.3	42.1	42.8	28.9	30.5	7.7	9.2	35.5	33.7	22.1	20.5
(7) Age 15	4.0	2.6	1.5	1.7	5.9	3.3	10.5	6.1	2.9	2.8	0.2	0.9	6.7	4.4	2.8	1.9
(8) % aged 15-19 who have given birth or are pregnant	21.1	19.2	14.7	14.7	26.1	22.3	35.9	36.4	24.7	24.2	7.7	6.6	26.0	21.9	18.5	17.8
(9) % of adolescent births that were unplanned†	23.6	29.3	33.4	26.6	18.8	30.4	17.8	26.0	22.9	30.9	43.7	29.2	13.9	25.4	30.0	31.6
% aged 15-19 and sexually active‡ who do not want a child soon§																
(10) All	84.8	84.4	86.5	83.2	83.9	84.7	82.2	76.5	84.2	86.9	95.4	87.5**	83.2	83.5	86.2	85.0
(11) In union	84.4	83.3	85.6	80.3	83.9	84.2	81.7	76.2	83.6	86.1	96.6	83.7**	83.0	82.6	85.6	83.8
(12) Not in union	92.7**	††	††	††	††	††	††	††	††	††	††	††	††	††	††	††
(13) % aged 15-19 who know of any modern method of contraception††	67.5	84.8	80.5	90.1	57.3	81.1	34.2	59.9	61.4	81.2	94.8	98.0	41.9	69.5	80.3	92.5
% aged 15-19 and sexually active using a modern method																
(14) All	10.4	18.2	25.3	29.4	4.1	12.8	1.0	7.8	11.6	19.5	32.3	32.1**	1.1	7.6	17.3	25.6
(15) In union	10.2	18.3	25.4	30.8	4.2	13.3	1.0	7.9	10.9	19.0	35.6	39.5**	1.1	8.1	17.6	25.5

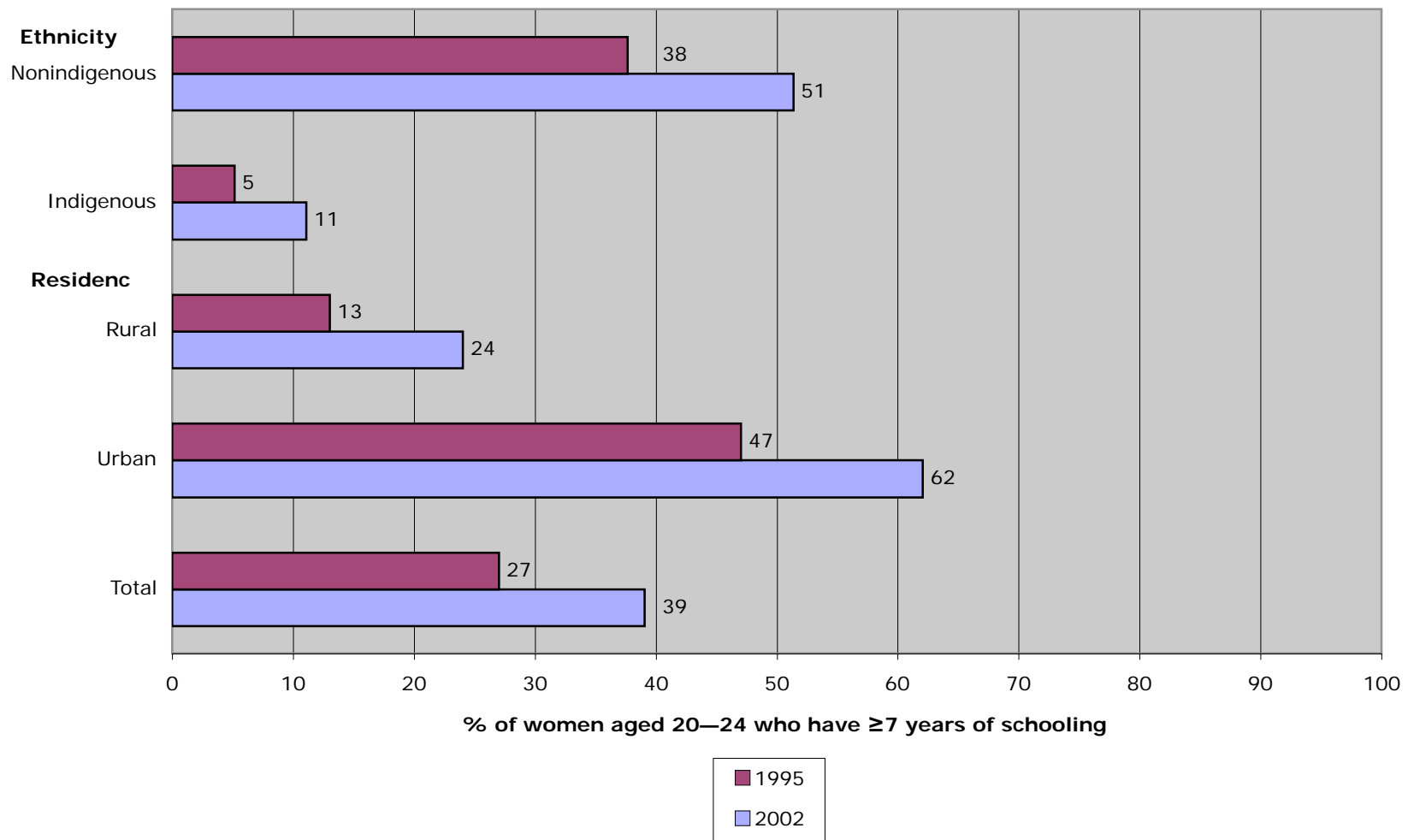
Measure	All		Residence				Years of education						Ethnicity				
	1995	2002	Urban		Rural		0		1-6		≥7		Indigenous		Nonindigenous		
			1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	1995	2002	
(16) Not in union	13.6**	††	††	††	††	††	††	††	††	††	††	††	††	††	††	††	††
% aged 15-19 and sexually active who have an unmet need for effective contraception§§																	
(17) All	57.9	51.9	50.0	41.2	61.2	57.1	64.9	55.3	56.3	51.7	45.5	46.4**	66.3	66.7	52.2	42.1	
(18) In union	57.0	50.0	47.4	35.0	60.6	56.1	64.5	55.4	55.7	50.4	40.7	34.1**	66.1	65.2	50.0	39.6	
(19) Not in union	76.3**	††	††	††	††	††	††	††	††	††	††	††	††	††	††	††	
(20) % aged 15-24 who received professional prenatal care***	52.8	69.9	70.6	81.0	42.8	64.0	30.1	50.6	57.1	72.4	82.7	86.1	35.8	54.0	63.1	79.2	
(21) % aged 15-24 who received professional delivery care***	39.0	50.9	63.8	72.1	25.0	39.5	15.9	25.4	40.3	48.2	80.1	86.5	12.4	23.3	55.0	66.9	

*All measures referring to union status include formal and consensual unions. †Denominator is all births to women younger than 20 in the five years before the interview. ‡All women in union, as well as women not in union who have had intercourse in the past three months. §Want no children or want to wait two or more years before their next birth. **Unweighted N is small (25-49). ††Suppressed because the unweighted N is less than 25. ‡‡The pill, injectables, implants, male and female sterilization, the IUD, the diaphragm, spermicides, the condom and the sponge. §§Women are considered to have an unmet need if they are sexually active, do not want a birth in the next two years and are not using an effective method. ***Refers to most recent birth within the last five years. Professional care is care provided by doctors and nurses at private- and public-sector hospitals and clinics. Note: na=not applicable. Sources: 1995 and 2002 ENSMI.

Table 2. Childbearing and Socioeconomic Status	
Teenage childbearing is most common among the least advantaged.	
Household socioeconomic level	% of women 20–24 who gave birth before age 20
Low	62.4
Middle	52.2
High	27.1
<i>Note:</i> Socioeconomic status is based on an index of household amenities and characteristics. <i>Source:</i> 2002 ENSMI.	

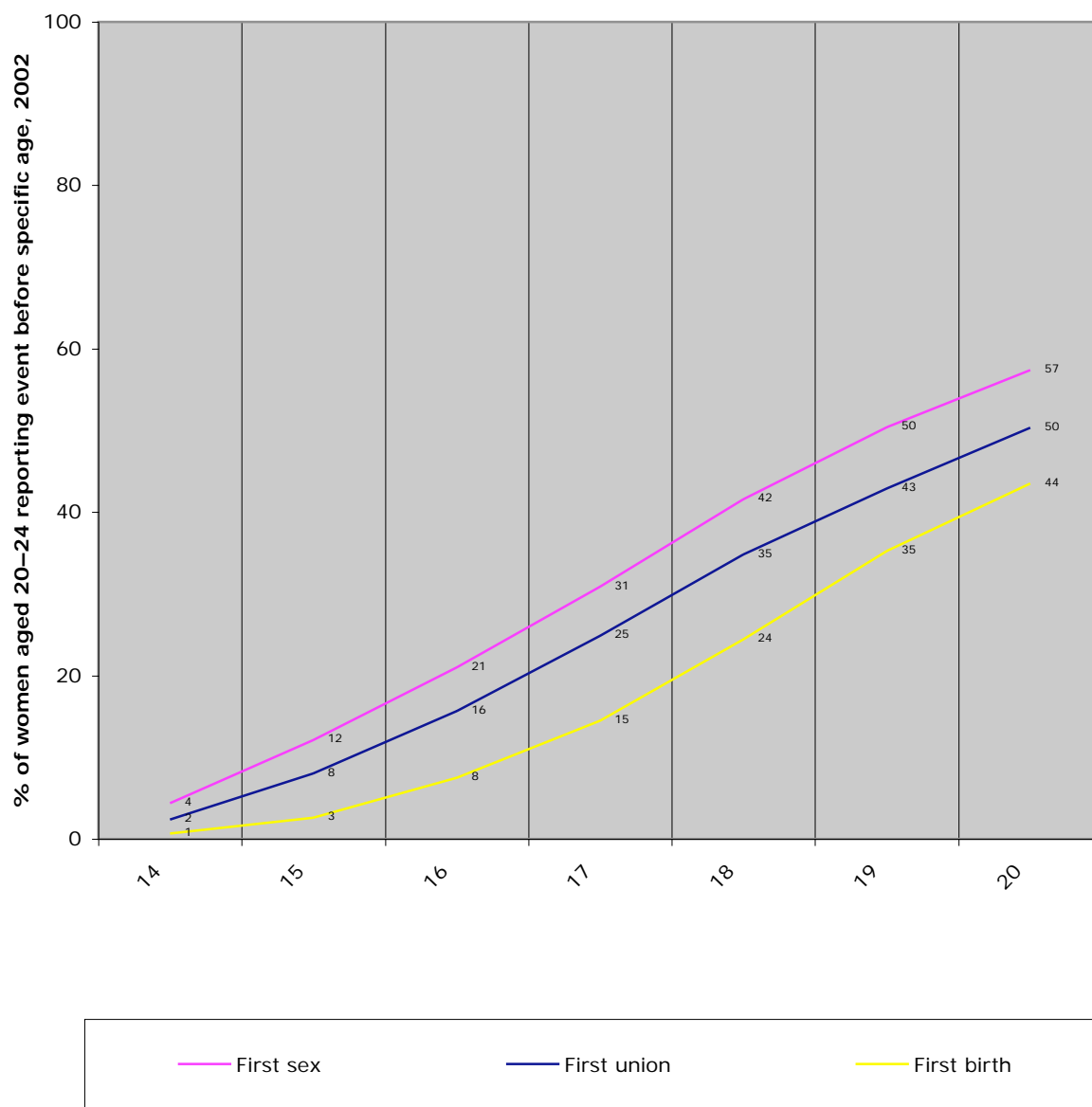
Table 3. Teenage Childbearing Trends				
The birthrate among women aged 15–19 has declined consistently since the late 1980s.				
Year	Birthrate (births per 1,000 women 15-19)	Annual no. of births (in 000s)	No. of women (in 000s)	% of all births that are to adolescents
1987	139*	57	407	18.5
1995	126†	69	550	18.8
2002	114†	72	635	18.6
<p>*Annual rate, based on births that occurred in the two years before the survey. †Annual rate, based on births that occurred in the three years before the survey. <i>Sources:</i> Birthrate—1987, 1995 and 2002 ENSMI. Number of women—United Nations (UN), <i>World Population Prospects: The 2004 Revision</i>, New York: UN, 2005, Vols. I and II.</p>				

Figure 1. Schooling
Educational levels among young women are rising slowly, but remain low.



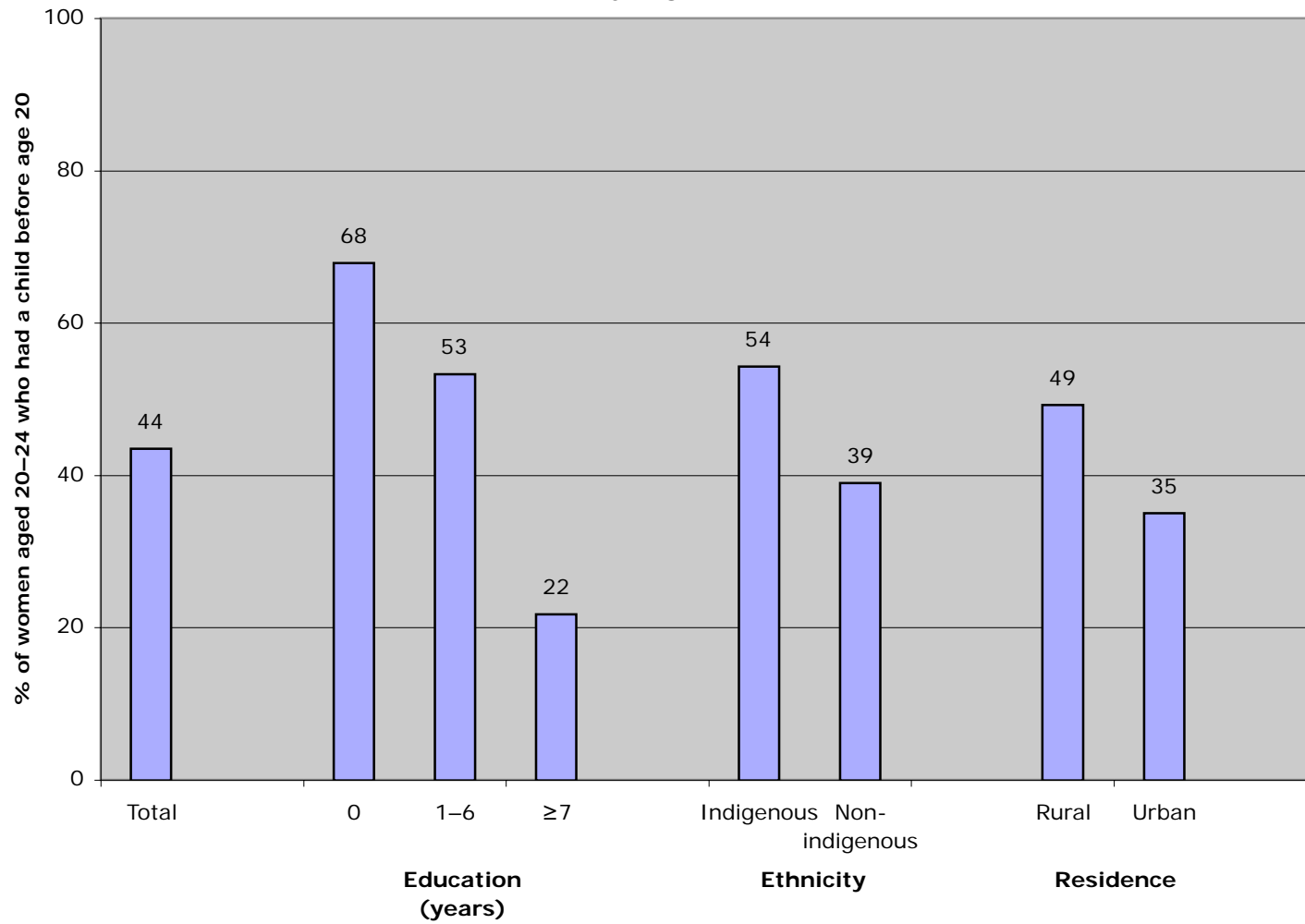
Sources: 1995 and 2002 ENSMI.

Figure 2. Transitions to Adulthood
First sex, first union and first birth occur early
among Guatemalan women.



Source: 2002 ENSMI.

Figure 3. Early Motherhood
Rural, indigenous and less educated women are especially likely to give birth as adolescents.



Source: 2002 ENSMI.

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