Clarifying the interpretation of declining adolescent pregnancy trends: Implications for child protection and service provision

To the Editor: We read with considerable interest the article by Barron *et al*.[1] on adolescent pregnancy trends in South Africa (SA), published in the *South African Medical Journal*. The use of national public-sector data, the inclusion of termination of pregnancy (TOP) figures and the disaggregation of adolescents into the 10 - 14 and 15 - 19-year age cohorts represent important methodological strengths.[2,3] The article provides valuable national-level data for tracking trends in adolescent reproductive outcomes, particularly in the period following the COVID-19 pandemic.

In addition to the interpretive cautions identified by Barron *et al*., we highlight further considerations relevant to child protection and service provision. While the observed downward trends are epidemiologically noteworthy, Barron *et al*. note that the data are descriptive and do not, on their own, explain the underlying drivers of these declines. Building on this, the observed reductions should therefore be interpreted in the context of still-elevated rates. Adolescent pregnancy in SA presents a persistent public health, social and rights-based concern, particularly when assessed against regional and international benchmarks.

In the *SAMJ* analysis, pregnancies in early adolescence are described as being 'most likely to reflect sexual violence and coercion'. While this framing underscores the heightened vulnerability associated with this age group, it should not be assumed that all such pregnancies arise from unlawful or coercive sexual conduct, particularly in the context of age-proximate peer relationships. However, in the SA legal context, sexual activity involving children below the age of consent is tightly regulated, and may trigger mandatory reporting and child-protection responses irrespective of partner proximity in age. Nonetheless, pregnancy among children below the age of consent cannot be understood solely as a reproductive health outcome; in the SA context, it often serves as a sentinel indicator of serious sexual harm.[4] Trends affecting this age group therefore require interpretation that is explicitly informed by child-protection considerations, rather than fertility metrics alone.

Patterns in recorded births or TOPs among 10 - 14-year-olds – including short-term increases followed by a reversion to levels observed in earlier years – do not necessarily indicate a corresponding reduction in sexual violence against children.[4] Such patterns may reflect shifts in reporting practices, access constraints, underutilisation of formal health services, increased stigma or fear of disclosure, or the concealment of sexual harm, particularly where engagement with health services may trigger investigation or mandatory reporting. Health-system data are therefore especially sensitive to distortion in younger adolescents, and should be interpreted cautiously. This limitation underscores the importance of interpreting pregnancy trends alongside other indicators of adolescent sexual exposure and harm.

Sexual violence against children does not invariably result in pregnancy.[5] Many forms of sexual harm and unlawful sexual conduct – including non-vaginal acts, same-sex violence, coercive sexual activity without conception, or ongoing exploitative conduct mitigated by the use of contraception – are not captured by pregnancy-based indicators. Reliance on pregnancy outcomes alone therefore risks substantial under-ascertainment of the true burden of sexual harm. Health-system indicators focused exclusively on pregnancy are thus an insufficient proxy for assessing progress in the prevention of sexual violence against children.

The interpretation of declining adolescent pregnancy rates would accordingly be strengthened by triangulation with additional indicators of sexual exposure and harm. Patterns of sexually transmitted infection (STI) incidence, testing and treatment among adolescents – particularly younger adolescents – may provide complementary insight into sexual activity and exploitation that do not culminate in pregnancy. While STI data are themselves affected by under-diagnosis, access inequities and gendered testing practices, their inclusion would help contextualise pregnancy trends and mitigate the risk of over-interpretation.

Declining trends should also not be used to justify the reduction, suspension, or reprioritisation of adolescent-focused sexual and reproductive health services, violence-prevention programmes, or child-protection interventions. In the absence of clear evidence explaining the observed declines, any rollback of services would be premature. Teenage pregnancy, irrespective of whether rates are increasing or decreasing, remains associated with substantial adverse health, educational, social and economic consequences for adolescents and their children.

From a policy perspective, declining adolescent pregnancy rates – particularly in a context where absolute rates remain high and causal pathways are uncertain – should be interpreted as a mandate to sustain and strengthen, rather than scale back, adolescent sexual and reproductive health services and child-protection interventions. Consistent with the authors' call for a strengthened and co-ordinated national response, these findings highlight the importance of continued investment in both prevention and support systems.

Our concern is not with the accuracy or value of the descriptive data presented in the article. Rather, it is with the risk that declining aggregate figures – particularly among children below the age of consent – may be interpreted as signalling that the underlying drivers of adolescent pregnancy and sexual harm are diminishing, or have been adequately addressed. Without explicit acknowledgment of the persistent burden, uncertainty regarding causation and the limitations of pregnancy-based indicators, such inferences risk undermining appropriate policy responses.[5]

We offer these reflections in a constructive spirit. The authors' work provides important trend data, and its public value will be maximised by ensuring that observed declines are carefully contextualised alongside persistently high rates, unknown causal pathways and the continuing need for robust health, prevention and child-protection systems. Clear differentiation between fertility trends among older adolescents and indicators of sexual harm among younger children remains essential to ensure that improvements in measurement do not inadvertently obscure ongoing vulnerability.

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The authors of the original article did not have anything to add when offered the opportunity to comment.