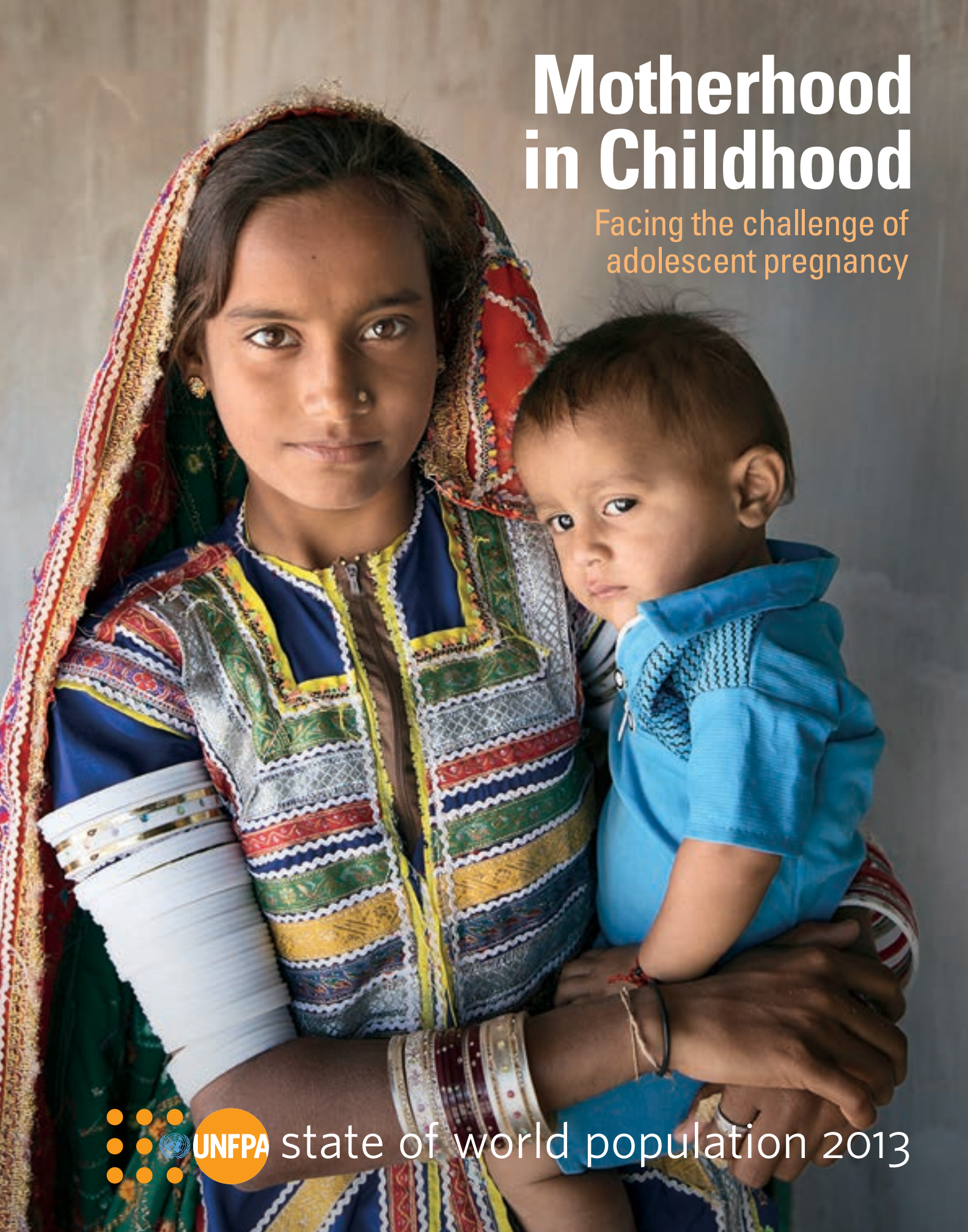

# Motherhood in Childhood

## Facing the challenge of adolescent pregnancy

UNFPA state of world population 2013

**The State of World Population 2013**

This report was produced by the Information and External Relations Division of UNFPA, the United Nations Population Fund.

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**MAPS AND DESIGNATIONS**
The designations employed and the presentation of material in maps in this report do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries. A dotted line approximately represents the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

UNFPA

Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled

UNFPA state of world population 2013

# Motherhood in Childhood

## Facing the challenge of adolescent pregnancy


Foreword page ii

Overview page iv

1 A global challenge page 1

2 The impact on girls' health, education and productivity page 17

3 Pressures from many directions page 31

4 Taking action page 57

5 Charting a way forward page 83

Indicators page 99

Bibliography page 111

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# Foreword

When a girl becomes pregnant, her present and future change radically, and rarely for the better. Her education may end, her job prospects evaporate, and her vulnerabilities to poverty, exclusion and dependency multiply.

Many countries have taken up the cause of preventing adolescent pregnancies, often through actions aimed at changing a girl's behaviour. Implicit in such interventions are a belief that the girl is responsible for preventing pregnancy and an assumption that if she does become pregnant, she is at fault.

Such approaches and thinking are misguided because they fail to account for the circumstances and societal pressures that conspire against adolescent girls and make motherhood a likely outcome of their transition from childhood to adulthood. When a young girl is forced into marriage, for example, she rarely has a say in whether, when or how often she will become pregnant. A pregnancy-prevention intervention, whether an advertising campaign or a condom distribution programme, is irrelevant to a girl who has no power to make any consequential decisions.

What is needed is a new way of thinking about the challenge of adolescent pregnancy. Instead of viewing the girl as the problem and changing her behaviour as the solution, governments, communities, families and schools should see poverty, gender inequality, discrimination, lack of access to services, and negative views about girls and women as the real challenges, and the pursuit of social justice, equitable development and the empowerment of girls as the true pathway to fewer adolescent pregnancies.

Efforts—and resources—to prevent adolescent pregnancy have typically focused on girls ages 15 to 19. Yet, the girls with the greatest vulnerabilities, and who face the greatest risk of complications and death from pregnancy and childbirth, are 14 or younger. This group of very young adolescents is typically overlooked by, or beyond the reach of, national health, education and development institutions, often because these girls are in forced marriages and are prevented from attending school or accessing sexual and reproductive health services. Their needs are immense, and governments, civil society, communities and the international community must do much more to protect them and support their safe and healthy transition from childhood and adolescence to adulthood. In addressing adolescent pregnancy, the real measure of success—or failure—of governments, development agencies, civil society and communities is how well or poorly we respond to the needs of this neglected group.

Adolescent pregnancy is intertwined with issues of human rights. A pregnant girl who is pressured or forced to leave school, for example, is denied her right to an education. A girl who is forbidden from accessing contraception or even information about preventing a pregnancy is denied her right

▲ *Dr Osotimehin with adolescent peer educators in South Africa.*
© UNFPA/Rayana Rassool

to health. Conversely, a girl who is able to enjoy her right to education and stays in school is less likely to become pregnant than her counterpart who drops out or is forced out. The enjoyment of one right thus puts her in a better position to enjoy others.

From a human rights perspective, a girl who becomes pregnant—regardless of the circumstances or reasons—is one whose rights are undermined.

Investments in human capital are critical to protecting these rights. Such investments not only help girls realize their full potential, but they are also part of a government's responsibility for protecting the rights of girls and complying with human rights treaties and instruments, such as the Convention on the Rights of the Child, and with international agreements, including the Programme of Action of the 1994 International Conference on Population and Development, which continues to guide the work of UNFPA today.

The international community is developing a new sustainable development agenda to succeed the Millennium Declaration and its associated Millennium Development Goals after 2015. Governments committed to reducing the number of adolescent pregnancies should also be committed to ensuring that the needs, challenges, aspirations, vulnerabilities and rights of adolescents, especially girls, are fully considered in this new development agenda.

There are 580 million adolescent girls in the world. Four out of five of them live in developing countries. Investing in them today will unleash their full potential to shape humanity's future.

**Dr Babatunde Osotimehin**
United Nations Under-Secretary-General
and Executive Director
UNFPA, the United Nations Population Fund

# Overview

Every day, 20,000 girls below age 18 give birth in developing countries. Births to girls also occur in developed countries but on a much smaller scale.

In every region of the world, impoverished, poorly educated and rural girls are more likely to become pregnant than their wealthier, urban, educated counterparts. Girls who are from an ethnic minority or marginalized group, who lack choices and opportunities in life, or who have limited or no access to sexual and reproductive health, including contraceptive information and services, are also more likely to become pregnant.

Most of the world's births to adolescents—95 per cent—occur in developing countries, and nine in 10 of these births occur within marriage or a union.

About 19 per cent of young women in developing countries become pregnant before age 18. Girls under 15 account for 2 million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries.

## Impact on health, education and productivity

A pregnancy can have immediate and lasting consequences for a girl's health, education and income-earning potential. And it often alters the course of her entire life. How it alters her life depends in part on how old—or young—she is.

*The risk of maternal death for mothers under 15 in low- and middle-income countries is double that of older females;* and this younger group faces

## FACING THE CHALLENGE OF ADOLESCENT PREGNANCY

- 20,000 girls giving birth every day
- Missed educational and other opportunities
- 70,000 adolescent deaths annually from complications from pregnancy, childbirth
- 3.2 million unsafe abortions among adolescents each year
- Perpetuation of poverty and exclusion
- Basic human rights denied
- Girls' potential going unfulfilled

significantly higher rates of obstetric fistulae than their older peers as well.

About 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth. Pregnancy and childbirth are a leading cause of death for older adolescent females in developing countries. Adolescents who become pregnant tend to be from lower-income households and be nutritionally depleted. Health problems are more likely if a girl becomes pregnant too soon after reaching puberty.

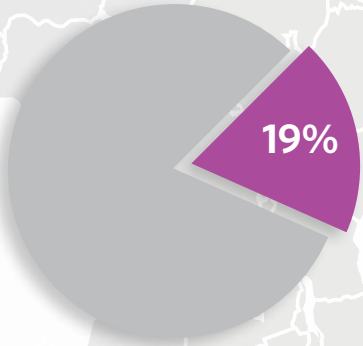
Girls who remain in school longer are less likely to become pregnant. Education

> "I was 14... My mom and her sisters began to prepare food, and my dad asked my brothers, sisters and me to wear our best clothes because we were about to have a party. Because I didn't know what was going on, I celebrated like everyone else. It was that day I learned that it was my wedding and that I had to join my husband. I tried to escape but was caught. So I found myself with a husband three times older than me.... This marriage was supposed to save me from debauchery. School was over, just like that. Ten months later, I found myself with a baby in my arms. One day I decided to run away, but I agreed to come back to my husband if he would let me go back to school. I returned to school, have three children and am in seventh grade."
>
> *Clarisse, 17, Chad*

## UNDERLYING CAUSES

- Child marriage
- Gender inequality
- Obstacles to human rights
- Poverty
- Sexual violence and coercion
- National policies restricting access to contraception, age-appropriate sexuality education
- Lack of access to education and reproductive health services
- Underinvestment in adolescent girls' human capital

### PREGNANCY BEFORE AGE 18




About 19 per cent of young women in developing countries become pregnant before age 18

prepares girls for jobs and livelihoods, raises their self-esteem and their status in their households and communities, and gives them more say in decisions that affect their lives. Education also reduces the likelihood of child marriage and delays childbearing, leading eventually to healthier birth outcomes. Leaving school—because of pregnancy or any other reason—can jeopardize a girl's future economic prospects and exclude her from other opportunities in life.

## Many forces conspiring against adolescent girls

An "ecological" approach to adolescent pregnancy is one that takes into account the full range of complex drivers of adolescent pregnancy and the interplay of these forces. It can help governments, policymakers and stakeholders understand the challenges and craft more effective interventions that will not only reduce the number of pregnancies but that will also help tear down the many barriers to girls' empowerment so that pregnancy is no longer the likely outcome.

One such ecological model, developed by Robert Blum at the Johns Hopkins Bloomberg School of Public Health, sheds light on the constellation of forces that conspire against the adolescent girl and increase the likelihood that she will become pregnant. While these forces are numerous and multi-layered, they all, in one way or another, interfere with a girl's ability to enjoy or exercise rights and empower her to shape her own future. The model accounts for forces at the national level—such as policies regarding adolescents' access to contraception or lack of enforcement of laws banning child marriage—all the way to the level of the individual, such as a girl's socialization and the way it shapes her beliefs about pregnancy.

Most of the determinants in this model operate at more than one level. For example, *national-level* policies may restrict adolescents'

## PRESSURES FROM MANY DIRECTIONS AND LEVELS

An "ecological" approach to adolescent pregnancy is one that takes into account the full range of complex drivers of adolescent pregnancy and the interplay of these forces.

Pressures from all levels conspire against girls and lead to pregnancies, intended or otherwise. National laws may prevent a girl from accessing contraception. Community norms and attitudes may block her access to sexual and reproductive health services or condone violence against her if she manages to access services anyway. Family members may force her into marriage where she has little or no power to say "no" to having children. Schools may not offer sexuality education, so she must rely on information (often inaccurate) from peers about sexuality, pregnancy and contraception. Her partner may refuse to use a condom or may forbid her from using contraception of any sort.

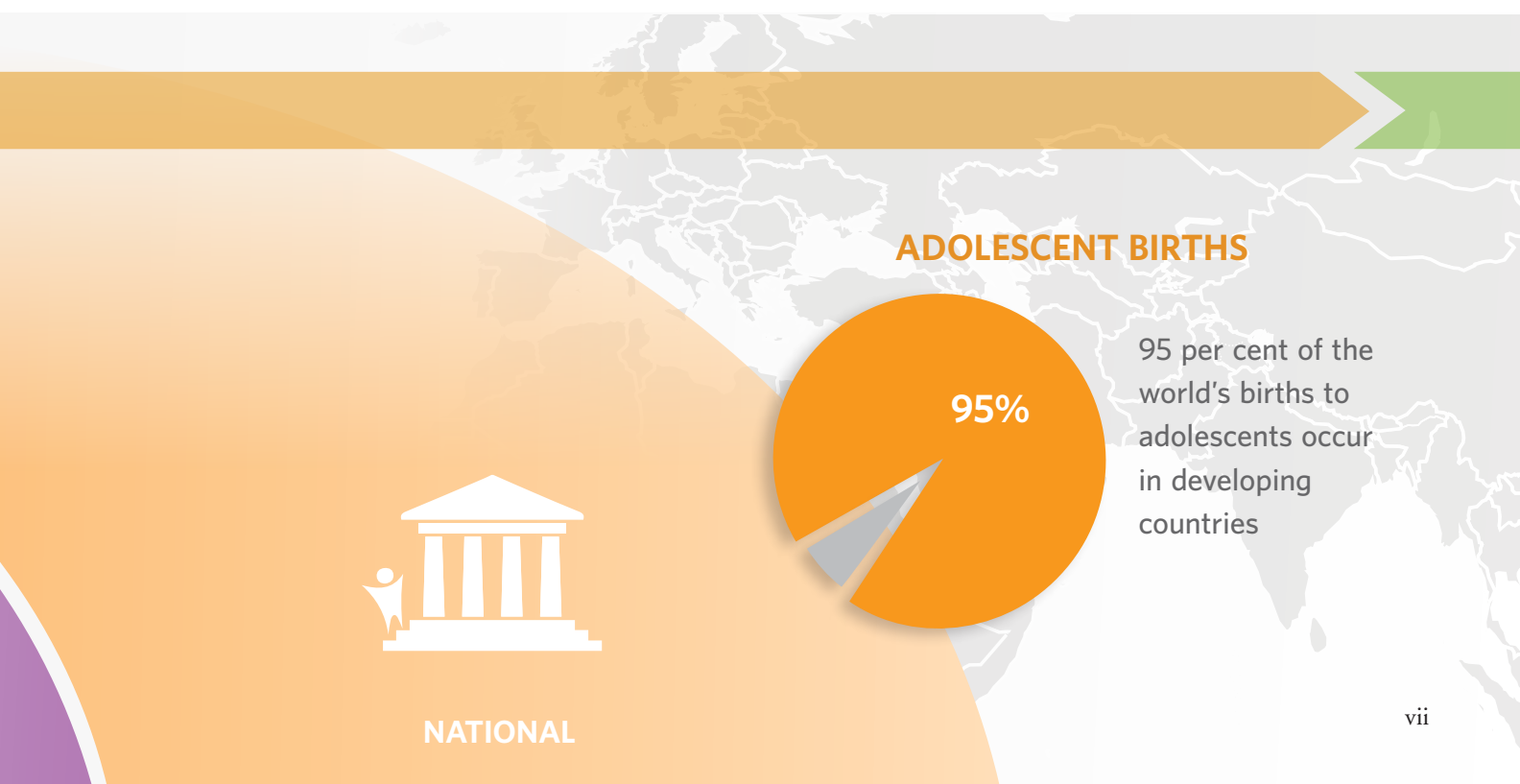
access to sexual and reproductive health services, including contraception, while the *community* or *family* may oppose girls' accessing comprehensive sexuality education or other information about how to prevent a pregnancy.

This model shows that adolescent pregnancies do not occur in a vacuum but are the consequence of an interlocking set of factors such as widespread poverty, communities' and families' acceptance of child marriage, and inadequate efforts to keep girls in school.

For most adolescents below age 18, and especially for those younger than 15, pregnancies are not the result of a deliberate choice. To the contrary, pregnancies are generally the result of an *absence of choices* and of circumstances beyond a girl's control. Early pregnancies reflect powerlessness, poverty and pressures—from partners, peers, families and communities. And in too many instances, they are the result of sexual violence or coercion. Girls who have little autonomy—particularly those in forced marriages—have little say about whether or when they become pregnant.

Adolescent pregnancy is both a cause and consequence of rights violations. Pregnancy undermines a girl's possibilities for exercising the rights to education, health and autonomy, as guaranteed in international treaties such as the Convention on the Rights of the Child. Conversely, when a girl is unable to enjoy basic rights, such as the right to education, she becomes more vulnerable to becoming pregnant. According to the Convention on the Rights of the Child, anyone under the age of 18 is considered a child. For nearly 200 adolescent girls every day, early pregnancy results in the ultimate rights violation—death.

Girls' rights are already protected—on paper—by an international, normative framework that requires governments to take steps that will make it possible for girls to enjoy their rights to an



education, to health and to live free from violence and coercion. Children have the same human rights as adults, but they are also granted special protections to address the inequities that come with their age.

Upholding the rights that girls are entitled to can help eliminate many of the conditions that contribute to adolescent pregnancy and help mitigate many of the consequences to the girl, her household and her community.

Addressing these challenges through measures that protect human rights is key to ending a vicious cycle of rights infringements, poverty, inequality, exclusion and adolescent pregnancy.

A human rights approach to adolescent pregnancy means working with governments to remove obstacles to girls' enjoyment of rights. This means addressing underlying causes, such as child marriage, sexual violence and coercion, lack of access to education and sexual and reproductive health, including contraception and information. Governments, however, cannot do this alone. Other stakeholders and duty-bearers, such as teachers, parents, and community leaders, also play an important role.

## Addressing underlying causes

Because adolescent pregnancy is the result of diverse underlying societal, economic and other forces, preventing it requires multidimensional strategies that are oriented towards girls' empowerment and tailored to particular populations of girls, especially those who are marginalized and most vulnerable.

Many of the actions by governments and civil society that have reduced adolescent fertility were designed to achieve *other* objectives, such as keeping girls in school, preventing HIV infection, or ending child marriage. These actions can also build human capital, impart information or skills to empower girls to make decisions in life and uphold or protect girls' basic human rights.

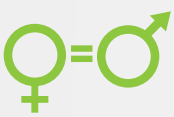
# FOUNDATIONS FOR PROGRESS

### EMPOWER GIRLS

Building girls' agency, enabling them to make decisions in life

### RESPECT HUMAN RIGHTS FOR ALL

Upholding rights can eliminate conditions that contribute to adolescent pregnancy



### RECTIFY GENDER INEQUALITY

Put girls and boys on equal footing

### REDUCE POVERTY

In developing and developed countries, poverty drives adolescent pregnancy

Research shows that addressing unintended pregnancy among adolescents requires holistic approaches, and because the challenges are great and complex, no single sector or organization can face them on its own. Only by working in partnership, across sectors, and in collaboration with adolescents themselves, can constraints on their progress be removed.

Keeping adolescent girls on healthy, safe and affirming life trajectories requires comprehensive, strategic, and targeted investments that address the multiple sources of their vulnerabilities, which vary by age, abilities, income group, place of residence and many other factors. It also requires deliberate efforts to recognize the diverse circumstances of adolescents and identify girls at greatest risk of adolescent pregnancy and poor reproductive health outcomes. Such multi-sectoral programmes are needed to build girls' assets across the board—in health, education and livelihoods—but also to empower girls through social support networks and increase their status at home, in the family, in the community and in relationships. Less complex but strategic interventions may also make a difference. These could include the provision of conditional cash transfers to girls to enable them to remain in school.

## The way forward

Many countries have taken action aimed at *preventing* adolescent pregnancy, and in some cases, to support girls who have become pregnant. But many of the measures to date have been primarily about changing the behaviour of *the girl,* failing to address underlying determinants and drivers, including gender inequality, poverty, sexual violence and coercion, child marriage, social pressures, exclusion from educational and job opportunities and negative attitudes and stereotypes about adolescent girls, as well as neglecting to take into account the role of boys and men.

## EIGHT WAYS TO GET THERE

**1 Girls 10 to 14**
Preventive interventions for young adolescents

**2 Child marriage**
Stop marriage under 18, prevent sexual violence and coercion

**3 Multilevel approaches**
Build girls' assets across the board; keep girls on healthy, safe life trajectories

**4 Human rights**
Protect rights to health, education, security and freedom from poverty

**5 Education**
Get girls in school and enable them to stay enrolled longer

**6 Engage men and boys**
Help them be part of the solution

**7 Sexuality education and access to services**
Expand age-appropriate information, provide health services used by adolescents

**8 Equitable development**
Build a post-MDG framework based on human rights, equality, sustainability

"The reality is that people are very judgmental, and that's how human beings are. To hear that even after all your accomplishments... all the stuff you've gone through to pass these hurdles, to become a better person... people can be very unforgiving because they are going to remember 'Oh, she had a baby when she was 15'."

*Tonette, 31, pregnant at 15, Jamaica*

Experience from effective programmes suggests that what is needed is a transformative shift away from narrowly focused interventions targeted *at* girls or at preventing pregnancy, towards broad-based approaches that build girls' human capital, focus on their agency to make decisions about their lives (including matters of sexual and reproductive health), and present real opportunities for girls so that motherhood is not seen as their only destiny. This new paradigm must target the circumstances, conditions, norms, values and structural forces that perpetuate adolescent pregnancies on the one hand and that isolate and marginalize pregnant girls on the other. Girls need both access to sexual and reproductive health services and information and to be unburdened from the economic and social pressures that too often translate into a pregnancy and the poverty, poor health and unrealized human potential that come with it.

## THE BENEFITS

HEALTH

### BETTER MATERNAL AND CHILD HEALTH

Later pregnancies reduce health risks to girls and to their children.

EDUCATIONAL

### MORE GIRLS COMPLETING THEIR EDUCATION

This reduces the likelihood of child marriage and delays childbearing, leading eventually to healthier birth outcomes. Also builds skills, raises girls' status.

EQUALITY

### EQUAL RIGHTS AND OPPORTUNITY

Preventing pregnancy helps ensure girls enjoy all basic human rights.

Additional efforts must be made to reach girls under age 15, whose needs and vulnerabilities are especially great. Efforts to prevent pregnancies among girls older than 15 or to support older adolescents who are pregnant or who have given birth may be unsuitable or irrelevant to very young adolescents. Very young adolescents have special vulnerabilities, and too little has been done to understand and respond to the daunting challenges they face.

Girls who have become pregnant need support, not stigma. Governments, international organizations, civil society, communities, families, religious leaders and adolescents themselves all have an important role in effecting change. All will gain by nurturing the vast possibilities that these young girls, brimming with life and hope, represent.

## UNFPA, RIGHTS AND ADOLESCENT PREGNANCY

For UNFPA, which is guided by the Programme of Action of the International Conference on Population and Development (ICPD), respecting, protecting and fulfilling adolescents' human rights, including their right to sexual and reproductive health and their reproductive rights:

- Reduces vulnerabilities, especially among those who are the most marginalized, by focusing on their particular needs;
- Increases and strengthens the participation of civil society, the community and adolescents themselves;
- Empowers adolescents to continue their education and lead productive and satisfying lives;
- Increases transparency and accountability; and
- Leads to sustained social change as human rights-based programmes have an impact on norms and values, structures, policy and practice.

ECONOMIC

### INCREASED ECONOMIC PRODUCTIVITY AND EMPLOYMENT

Investments that empower girls improve income-earning prospects.

POTENTIAL

### ADOLESCENT GIRLS' POTENTIAL FULLY REALIZED

Prospects are brighter for a girl who is healthy, educated and able to enjoy rights.

©Mark Tuschman

# 1 A global challenge

Every year in developing countries, 7.3 million girls under the age of 18 give birth.

© Mark Tuschman/AMMD

"I was 16 and never missed a day of school. I liked studying so much, I would much rather spend time with my books than watch TV! I dreamt of going to college and then getting a good job so that I could take my parents away from the dingy house we lived in.

Then one day, I was told that I had to leave it all, as my parents bartered me for a girl my elder brother was to marry. Such exchange marriages are called *atta-satta* in my community. I was sad and angry. I pleaded with my mother, but my father had made up his mind.

My only hope was that my husband would let me complete my studies. But he got me pregnant even before I turned 17. Since then, I have hardly ever been allowed to step out of the house. Everyone goes out shopping and for movies and neighbourhood functions, but not me. Sometimes, when the others are not at home, I read my old school books, and hold my baby and cry. She is such an adorable little girl, but I am blamed for not having a son.

But things are gradually changing. Hopefully, customs like *atta-satta* and child marriage will be totally gone by the time my daughter grows up, and she will get to complete her education and marry only when she wants to."

*Komal, 18, India*

Every year in developing countries, 7.3 million girls under the age of 18 give birth (UNFPA, 2013). The number of pregnancies is even higher.

Adolescent pregnancies occur with varying frequency across regions and countries, within countries and across age and income groups. What is common to every region, however, is that girls who are poor, live in rural or remote areas and who are illiterate or have little education are more likely to become pregnant than their wealthier, urban, educated counterparts.

Girls who are from an ethnic minority or marginalized group, who lack choices and opportunities in life, or who have limited or no access to sexual and reproductive health, including contraceptive information and services, are also more likely to become pregnant.

Worldwide, a girl is more likely to become pregnant under circumstances of social exclusion, poverty, marginalization and gender inequality, where she is unable to fully enjoy or exercise her basic human

rights, or where access to health care, schooling, information, services and economic opportunities is limited.

Most births to adolescents—95 per cent—occur in developing countries, and nine in 10 of these births occur within marriage or a union (World Health Organization, 2008).

## Births to girls under age 18

About 19 per cent of young women in developing countries become pregnant before age 18 (UNFPA, 2013).

According to estimates for 2010, 36.4 million women in developing countries between ages 20 and 24 report having had a birth before age 18. Of that total, 17.4 million are in South Asia.

Among developing regions, West and Central Africa have the largest percentage (28 per cent) of women between the ages of 20 and 24 who reported a birth before age 18.

According to estimates for 2010, 36.4 million women in developing countries between ages 20 and 24 report having had a birth before age 18.

Data gathered in 54 countries through two sets of demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS) carried out between 1990 and 2008 and between 1997 and 2011 show a slight decline in the percentage of women between the ages of 20 and 24 who reported a birth before age 18: from about 23 per cent to about 20 per cent.

◀ Abriendo Oportunidades *offers safe spaces, mentoring, educational opportunities and solidarity for adolescent Mayan girls. It also introduces new possibilities into their lives.*

© Mark Tuschman/UNFPA

The 54 countries covered by these surveys are home to 72 per cent of the total population of developing countries, excluding China.

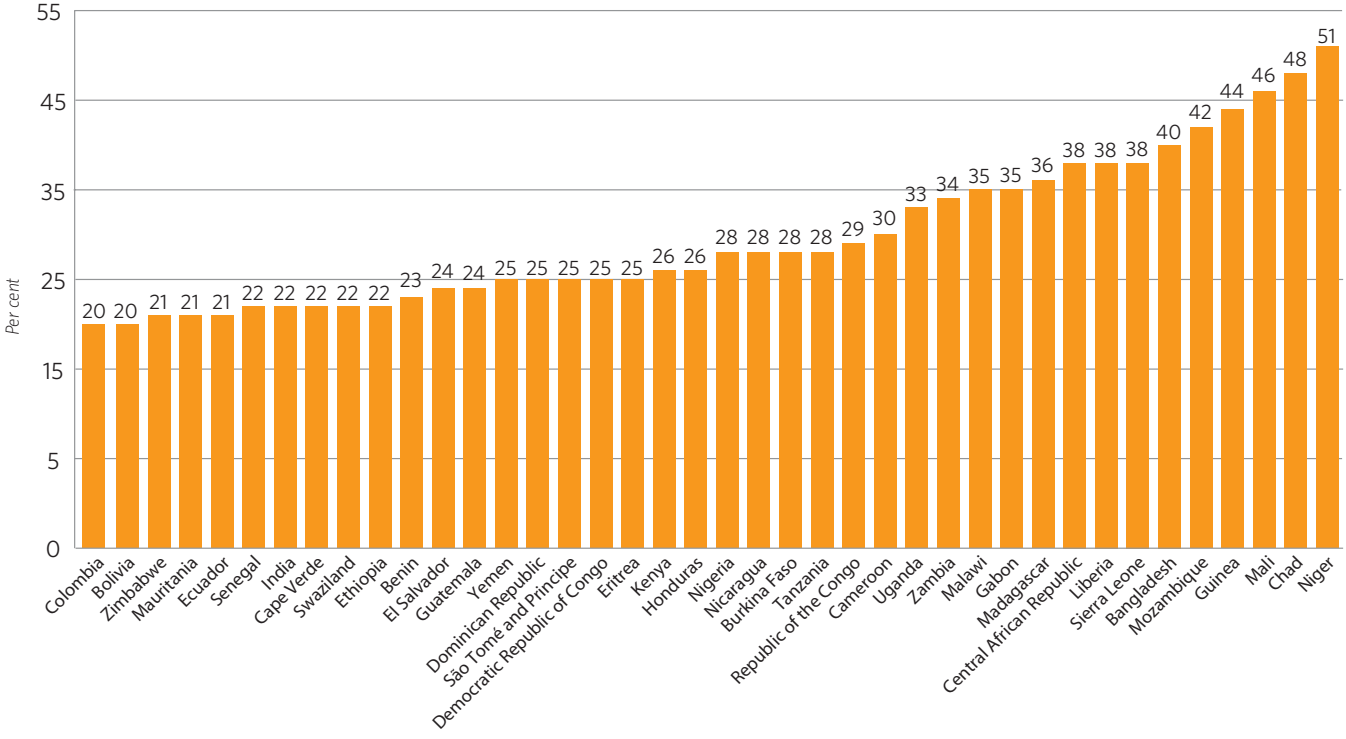
Of the 15 countries with a "high" prevalence (30 per cent or greater) of adolescent pregnancy, eight have seen a reduction, when comparing findings from DHS and MICS surveys (1997–2008 and 2001–2011). The six countries that saw increases were all in sub-Saharan Africa.

Under the Convention on the Rights of the Child, anyone under age 18 is considered a "child." Girls who become pregnant before 18 are often unable to enjoy or exercise their rights, such as their right to an education, to health and an adequate standard of living, and thus are denied these basic rights. Millions of girls under 18 become pregnant in marriage or in a union. The Human Rights Committee has joined other rights-monitoring bodies in recommending legal reform to eliminate child marriage.

## Births to girls under age 15

Girls under age 15 account for 2 million of the 7.3 million births to girls under 18 every year in developing countries.

### COUNTRIES WITH 20 PER CENT OR MORE OF WOMEN AGES 20 TO 24 REPORTING A BIRTH BEFORE AGE 18




*Source:* www.devinfo.org/mdg5b

According to DHS and MICS surveys, 3 per cent of young women in developing countries say they gave birth before age 15 (UNFPA, 2013).

Among developing regions, West and Central Africa account for the largest percentage (6 per cent) of reported births before age 15, while Eastern Europe and Central Asia account for the smallest percentage (0.2 per cent).

Data gathered in 54 countries through two sets of DHS and MICS surveys carried out between 1990 and 2008 and between 1997 and 2011 show a decline in the percentage of women between the ages of 20 and 24 who reported a birth before age 15, from 4 per cent to 3 per cent. The decline, which has been rapid in some countries, is attributed largely to a decrease in very early arranged marriages (World Health Organization, 2011b). Still, one girl in 10 has a child before the age of 15 in Bangladesh, Chad, Guinea, Mali, Mozambique and Niger, countries where child marriage is common.

Latin America and the Caribbean is the only region where births to girls under age 15 rose. In this region, such births are projected to rise slightly through 2030.

In sub-Saharan Africa, births to girls under age 15 are projected to nearly double in the next 17 years. By 2030, the number of mothers under age 15 in sub-Saharan Africa is expected to equal those in South Asia.

First-hand and qualitative data on this group of very young adolescents—between the ages of 10 and 14—are scarce, incomplete or non-existent for many countries, rendering these girls and the challenges they face invisible to policymakers.

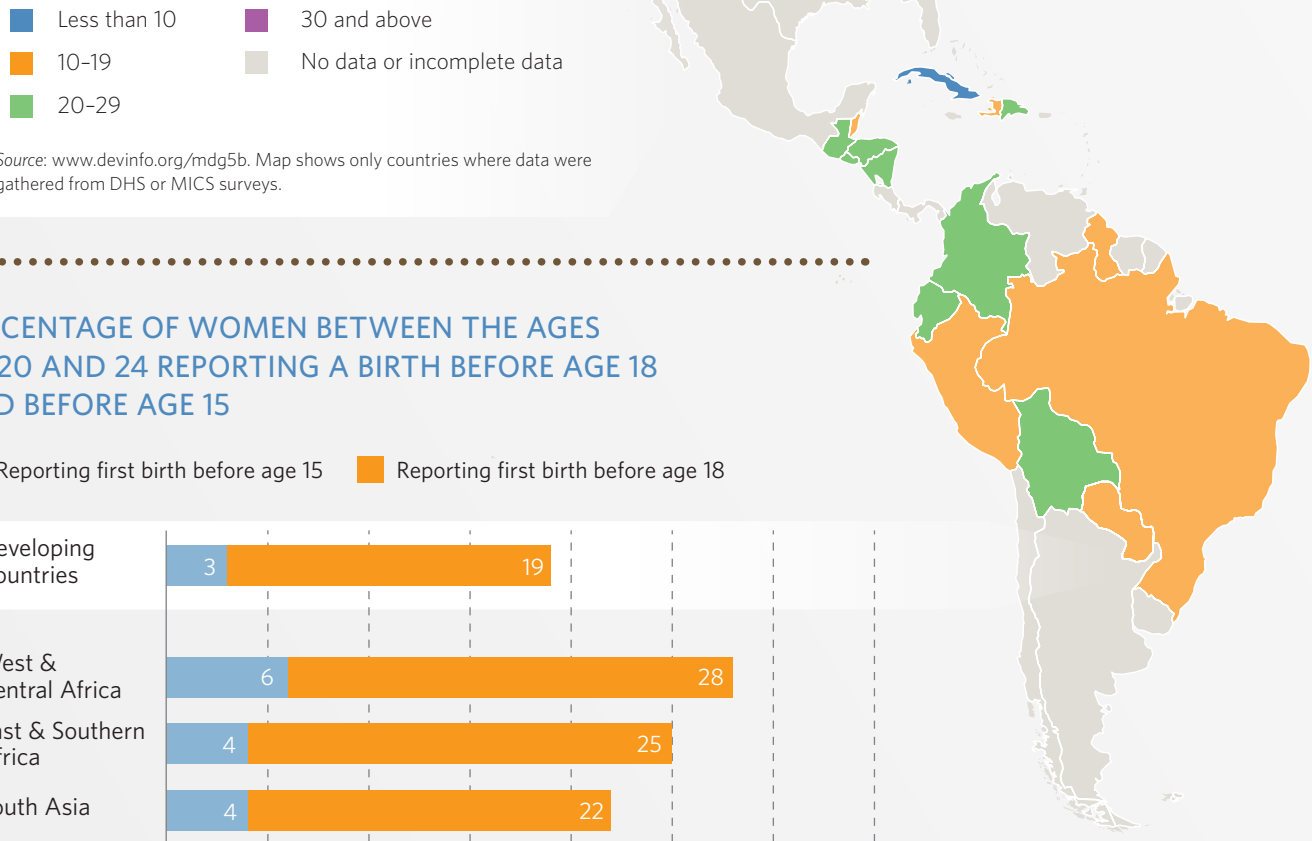
"I was going out with my boyfriend for a year and he used to give me money and clothes. I got pregnant when I was 13. I was still in school. My parents asked my boyfriend to stay at our place. He promised them that he would take care of me. After that, he left. He stopped calling and I had no contact with him. After I delivered my baby my parents took care of me and taught me how to take care of him. All I want is...to go back to school. After school I will be able to have a profession like being a teacher and have a driver's license."

*Ilda, 15, Mozambique*

The main reason for the paucity of reliable, complete data is that 15-year-olds are typically the youngest adolescents included in national DHS surveys, the primary source of information about adolescent pregnancies. This is so because there are ethical challenges in collecting data from this group, especially about sensitive issues of sexuality and pregnancies. Therefore, most data about those under age 15 are obtained retrospectively—that is,

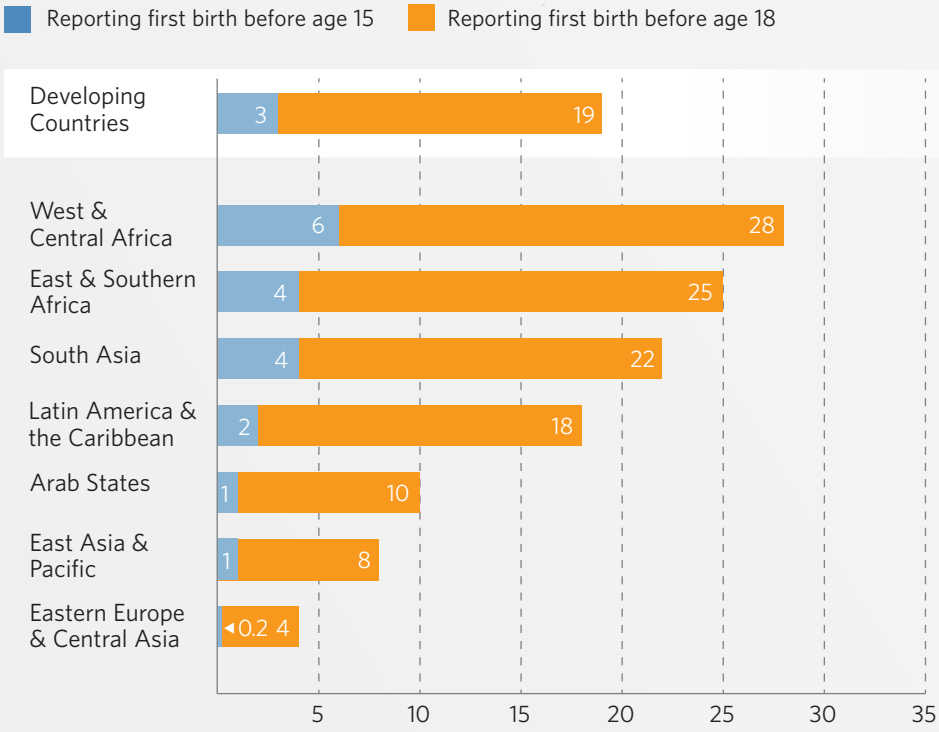
# FACING THE CHALLENGE OF ADOLESCENT PREGNANCY

## PERCENTAGE OF WOMEN AGES 20 TO 24 WHO REPORTED GIVING BIRTH BY AGE 18
(MOST RECENT DATA FROM DEVELOPING COUNTRIES, 1996-2011)

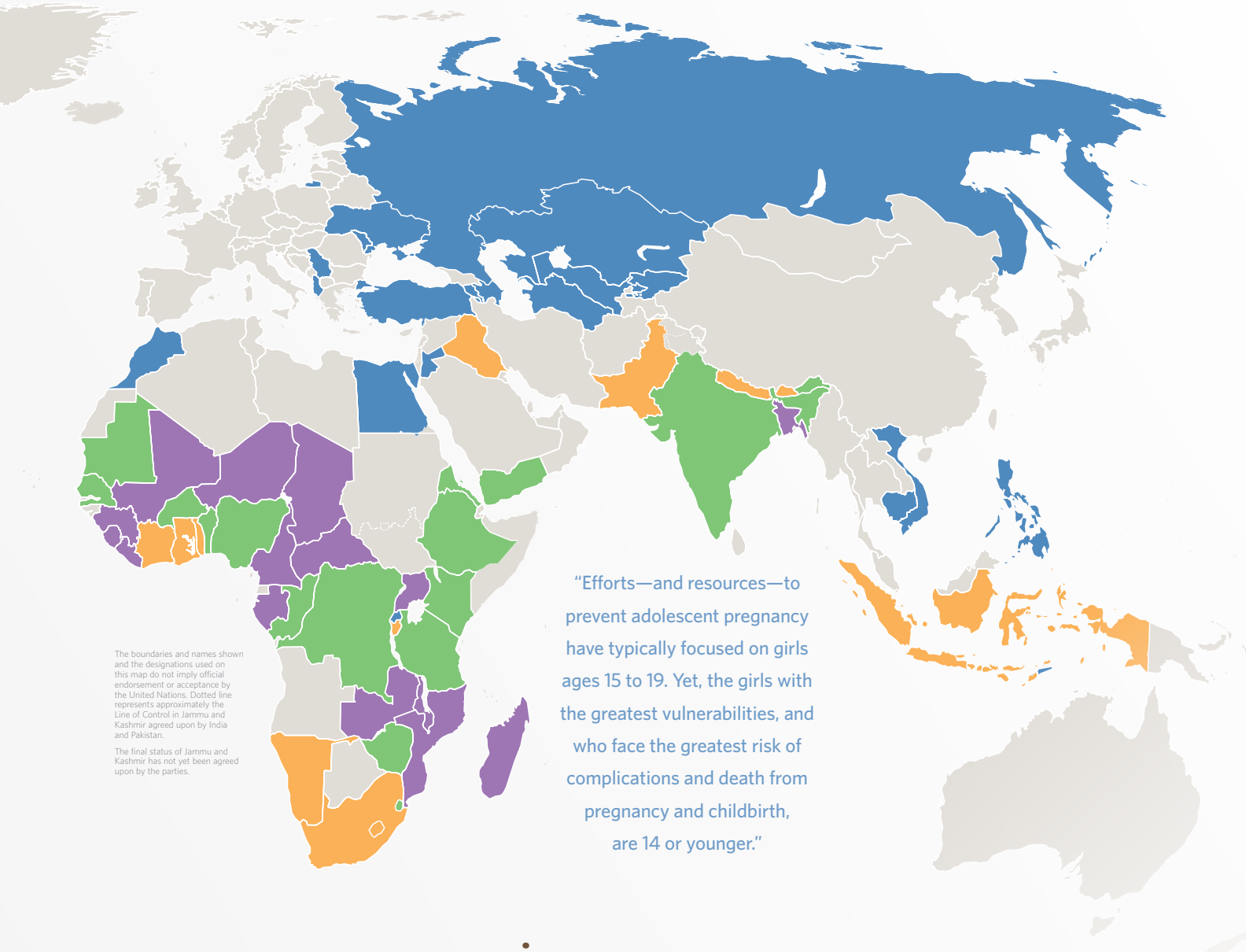



*Source*: www.devinfo.org/mdg5b. Map shows only countries where data were gathered from DHS or MICS surveys.

## PERCENTAGE OF WOMEN BETWEEN THE AGES OF 20 AND 24 REPORTING A BIRTH BEFORE AGE 18 AND BEFORE AGE 15



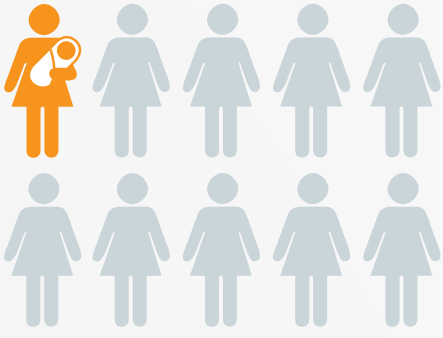

*Source:* UNFPA, 2013. Calculations based on data for 81 countries, representing more than 83 per cent of the population covered in these regions, using data collected between 1995 and 2011.



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan.

The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

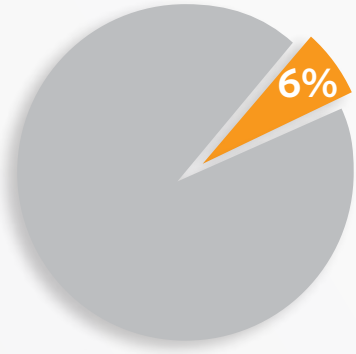
"Efforts—and resources—to prevent adolescent pregnancy have typically focused on girls ages 15 to 19. Yet, the girls with the greatest vulnerabilities, and who face the greatest risk of complications and death from pregnancy and childbirth, are 14 or younger."



# ONE GIRL IN 10

has a child before the age of 15 in Bangladesh, Chad, Guinea, Mali, Mozambique and Niger

## BIRTHS BEFORE AGE 15




Among developing countries, West and Central Africa account for the largest percentage (6 per cent) of reported births before age 15.

"I was 12 years old when a man came to ask my parents for my hand in marriage. They told me to marry him and after some time I fell in love with him. I have two older brothers. Both of them went to school, but my parents never let me. I don't know why, maybe because I am a girl and they knew that I was going to get married later on. I had my first child when I was 13 years old. It is not normal but it just happened. I had problems giving birth but everything went well. I have three girls and I am pregnant for the fourth time."

*Marielle, 25, pregnant at 13, Madagascar*

researchers ask women who are between 20 and 24 to report the age at which they married and had their first pregnancy or birth.

Maintaining high ethical standards is crucial in conducting information-gathering activities. Children and adolescents require special protections, both because they are vulnerable to exploitation, abuse, and other harmful outcomes, and because they have less power than adults. Information about schooling and general well-being has long been collected on young adolescents, but most researchers have shied away from covering sensitive topics, either because of social norms concerning age-appropriate behaviours, ethical concerns regarding potentially harmful effects of the research, or doubts about the validity of young adolescents' responses (Chong et al., 2006).

In a report on DHS data concerning adolescents between the ages of 10 and 14, the Population Council emphasized the need for research about important markers of the transition from childhood to adolescence: "In reviewing these DHS data on very young adolescents, what we mainly know is that we don't know very much." (Blum et al., 2013)

Some researchers question whether very young adolescents have the cognitive ability to answer questions requiring a thoughtful assessment of the barriers they face or of potential consequences of future actions. Others believe that the stigma surrounding premarital sexual activity for girls is too high to obtain accurate information (Chong et al., 2006).

## Birth rates vary within countries

Adolescent birth rates often vary within a country, depending on a number of variables, such as poverty or the local prevalence of child marriage. Niger, for example, has the world's highest adolescent birth rate and the highest child marriage rate overall, but girls in the country's Zinder region are more than three times as likely to give birth before age 18 than their counterparts in the nation's capital, Niamey. Zinder is a poor, predominantly rural region, where malnutrition is common and access to health care is limited.

A review of data gathered through DHS and MICS surveys in 79 developing countries between 1998 and 2011 shows that adolescent birth rates are higher in rural areas, among

adolescents with no education and in the poorest 20 per cent of households.

Variations within a country may result not only from differences in incomes, but also from inequitable access to education and sexual and reproductive health services, including contraceptives, the prevalence of child marriage, local customs and social pressures, and inadequate or poorly enforced laws and policies.

Understanding these differences can help policymakers develop interventions that are tailored to the diverse needs of communities across a country.

## Pregnancies and births among married children

Despite near-universal commitments to end child marriage, one in three girls in developing countries (not including China) is married before age 18 (UNFPA, 2012).

Most of these girls are poor, less-educated and live in rural areas. In the next decade, an estimated 14 million child marriages will occur annually in developing countries.

Adolescent birth rates are highest where child marriage is most prevalent, and child marriages are generally more frequent where poverty is extreme. The prevalence of child marriage

*Sixteen-year-old Usha Yadab, class leader for Choose Your Future, a UNFPA-supported programme in Nepal that teaches girls about health issues and encourages the development of basic life skills.*

©William Ryan/UNFPA

"All of a sudden the world became a lonely place. I felt excluded from my family and the community. I no longer fitted in as a young person, nor did I fit in as a woman."

*Tarisai, 20, pregnant at 16, Zimbabwe*

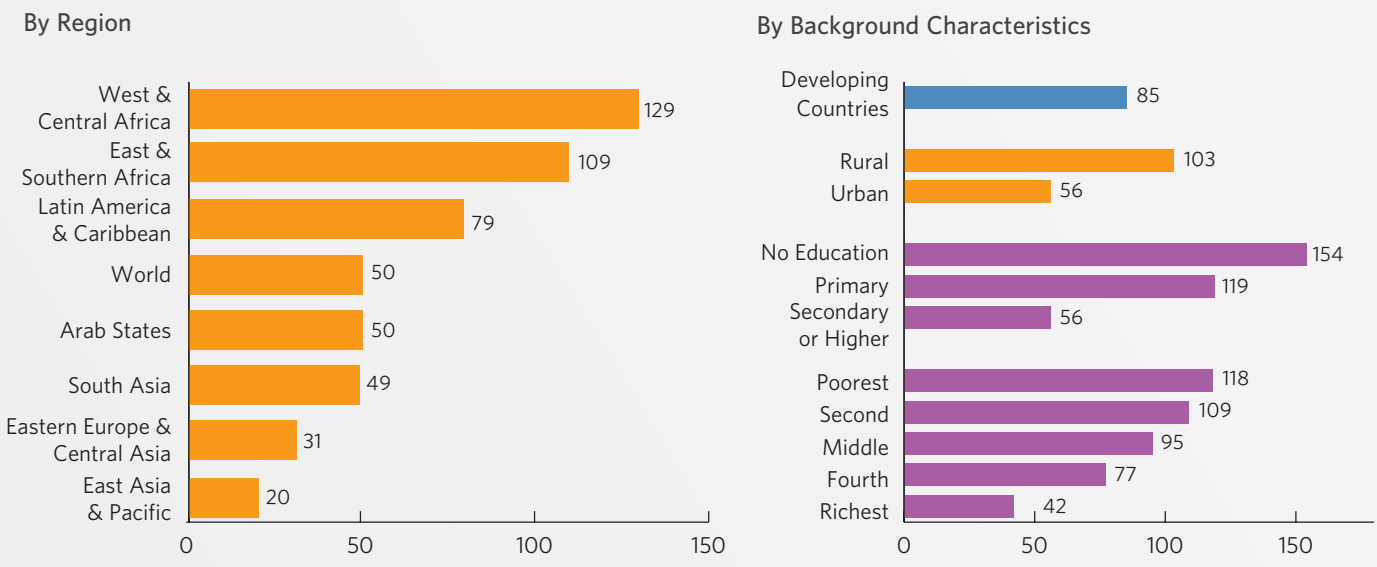
varies substantially across countries, ranging from 2 per cent in Algeria to 75 per cent in Niger, which has the world's fifth-lowest per capita gross national income (World Bank, 2013).

While child marriages are declining among girls under age 15, 50 million girls could still be at risk of being married before their 15th birthday in this decade.

Today, one in nine girls in developing countries is forced into marriage before age 15. In Bangladesh, Chad and Niger, more than one in three girls is married before her 15th birthday. In Ethiopia, one in six girls is married by age 15.

Age differences within unions or marriages also influence adolescent pregnancy rates.

## ADOLESCENT BIRTH RATES (DATA FROM 79 COUNTRIES)



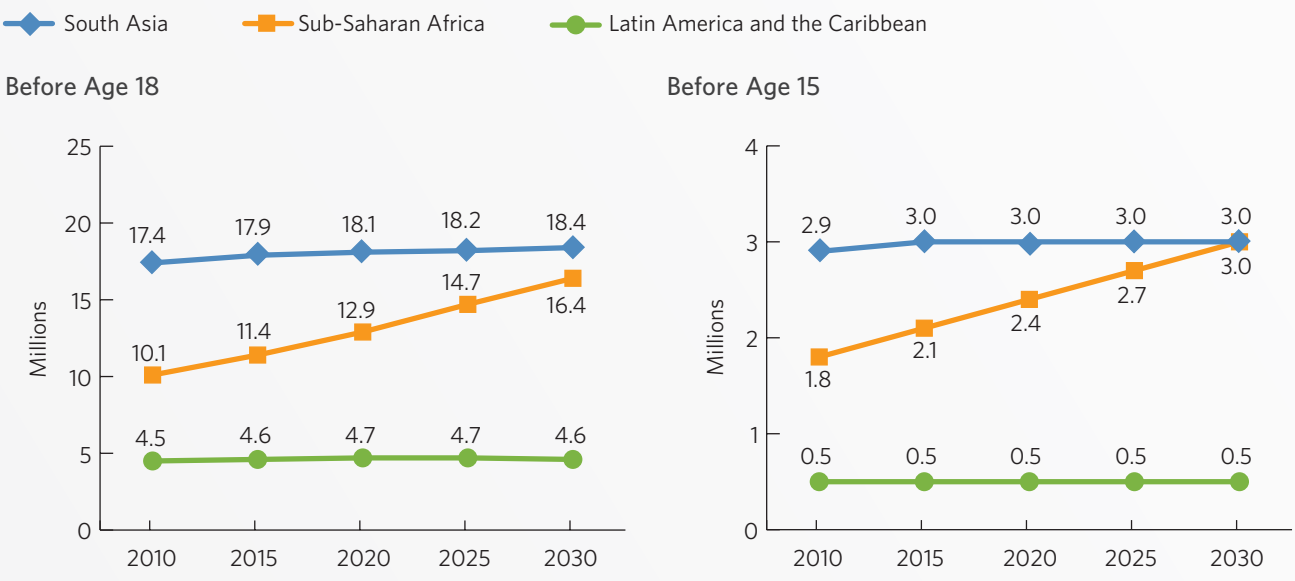

*Source:* UNFPA, 2013.

A UNFPA review of four countries found that the greater the age difference, the greater the chances are that the girl will become pregnant before age 18 (United Nations, 2011a).

In countries where women tend to marry at young ages, the differences between the singulate mean age at marriage, or SMAM, between males and females are generally large. The three countries with the lowest female SMAMs as of 2008 were Niger (17.6 years), Mali (17.8 years) and Chad (18.3 years). All had age differences between male and female SMAMs of at least six years. SMAM is the average length of single life among persons between ages 15 and 49 (United Nations, 2011a).

> "I was given to my husband when I was little and I don't even remember when I was given because I was so little. It's my husband who brought me up."
>
> *Kanas, 18, Ethiopia*

## WOMEN BETWEEN THE AGES OF 20 AND 24 REPORTING A BIRTH BEFORE AGE 18 AND BEFORE AGE 15, 2010 AND PROJECTIONS THROUGH 2030




*Source:* www.devinfo.org/mdg5b

## PER CENT OF ADOLESCENT GIRLS IN MARRIAGES AND ADOLESCENT BIRTH RATES

| Developing Regions | Girls, ages 15–19 | |
|---|---|---|
| | Currently married (%) | Adolescent birth rate |
| Arab States | 12 | 50 |
| Asia and Pacific | 15 | 80 |
| East Asia and Pacific | 5 | 50 |
| South Asia | 25 | 88 |
| Eastern Europe and Central Asia | 9 | 31 |
| Latin America and Caribbean | 12 | 84 |
| Sub-Saharan Africa | 24 | 120 |
| East and Southern Africa | 19 | 112 |
| West and Central Africa | 28 | 129 |
| Developing countries | 16 | 85 |

Source: www.devinfo.org/mdg5b

## PER CENT OF WOMEN REPORTING A FIRST BIRTH BEFORE AGE 18, BY AGE DIFFERENCE BETWEEN PARTNERS

| Age differences between female and male partners | Niger | Burkina Faso | Bolivia | India |
|---|---|---|---|---|
| Female is older than male partner or up to 4 years younger | 39.9 | 21.5 | 29.7 | 21.6 |
| Female is between 5 and 9 years younger than male partner | 60.1 | 34.4 | 41.5 | 32.3 |
| Female is at least 10 years younger than male partner | 59.0 | 38.5 | 45.8 | 39.1 |
| Total | 56.8 | 33.4 | 34.7 | 28.5 |

Source: United Nations, 2011a.

## Developed countries face challenges too

Adolescent pregnancy occurs in both developed and developing countries. The levels differ greatly, although the determinants are similar.

Of the annual 13.1 million births to girls ages 15 to 19 worldwide, 680,000 occur in developed countries (United Nations, 2013). Among developed countries, the United States has the highest adolescent birth rate. According to the United States Centers for Disease Control and Prevention, 329,772 births were recorded among adolescents between 15 and 19 in 2011.

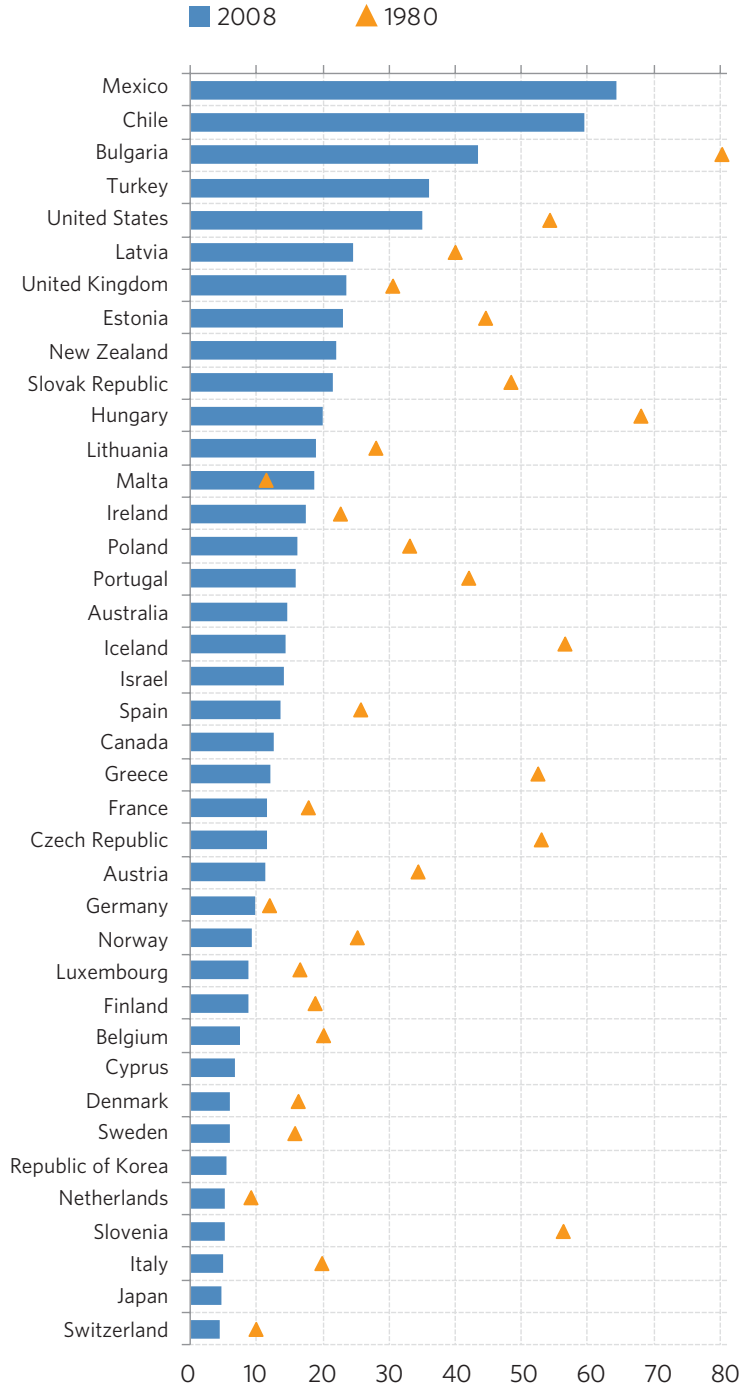
Among member States of the Organisation for Economic Co-operation and Development, which includes a number of middle-income countries, Mexico has the highest birth rate (64.2 per 1,000 births) among adolescents between 15 and 19 while Switzerland ranks the lowest, with 4.3. All but one OECD member, Malta, saw a decrease in adolescent pregnancy rates between 1980 and 2008.

## Conclusion

Most adolescent pregnancies occur in developing countries.

Evidence from 54 developing countries suggests that adolescent pregnancies are occurring with less frequency, mainly among girls under 15, but the decrease in recent years has been slow. In some regions, the total number of girls giving birth is projected to rise. In sub-Saharan Africa, for example, if current trends continue, the number of girls under 15 who give birth is expected to rise from 2 million a year today to about 3 million a year in 2030.

### ADOLESCENT FERTILITY RATES IN OECD COUNTRIES, 1980 AND 2008




*Source:* http://www.oecd.org/social/soc/oecdfamilydatabase.htm

## ADOLESCENTS AND CHILDREN: DEFINITIONS AND TRENDS

Although the United Nations defines "adolescent" as anyone between the ages of 10 and 19, most of the internationally comparable statistics and estimates that are available on adolescent pregnancies or births cover only part of the cohort: ages 15 to 19. Far less information is available for the segment of the adolescent population between the ages of 10 and 14, yet it is this younger group whose needs and vulnerabilities may be the greatest.

According to the Convention on the Rights of the Child, anyone under the age of 18 is considered a "child." This report focuses on pregnancies and births among *children* but must often rely on data on pregnancies and births for the larger cohort of *adolescents*. Data on *children* (younger than 18) who become pregnant are more limited, covering a little more than one third of the world's countries.

## LARGE AND GROWING ADOLESCENT POPULATIONS

In 2010, the worldwide number of adolescents was estimated to be 1.2 billion, the largest adolescent cohort in human history. Adolescents make up about 18 per cent of the world's population. Eighty-eight per cent of all adolescents live in developing countries. About half (49 per cent) of adolescent girls live in just six countries: China, India, Indonesia, Nigeria, Pakistan and the United States.

If current population growth trends continue, by 2030 almost one in four adolescent girls will live in sub-Saharan Africa where the total number of adolescent mothers under 18 is projected to rise from 10.1 million in 2010 to 16.4 million in 2030.

In developing and developed countries, adolescent pregnancies are more likely to occur among girls from lower-income households, those with lower levels of education and those living in rural areas.

Retrospective data on pregnancies are available for adolescent girls ages 10 to 14 as well as those 15 to 19, but much more is known about the latter group because household surveys reach them directly.

Data about pregnancies or births outside of marriage are especially scarce. But these data are crucial to understanding the determinants of pregnancies among this group, their challenges and vulnerabilities, the impact on their lives, and on actions that governments, communities and families might take to help them prevent pregnancies or support those who have already become pregnant or given birth.

The life trajectories of each pregnant girl depends, however, not only on how young she is, but also where she lives, how empowered she is through rights and opportunities and how much access she has to health care, schooling and economic resources. The impact of a pregnancy on a married 14-year-old girl in a rural area, for example, is very different from that of an 18-year-old who is single, lives in a city or has access to family support and financial resources.

More in-depth data and contextual information on patterns, trends and the circumstances of pregnancy among girls under 18 (and especially the cohort of adolescents ages 10 to 14) would help lay the groundwork for the targeting of interventions, the formulation of policies and for a deeper understanding of causes and consequences, which are complex, multidimensional and extend far beyond the

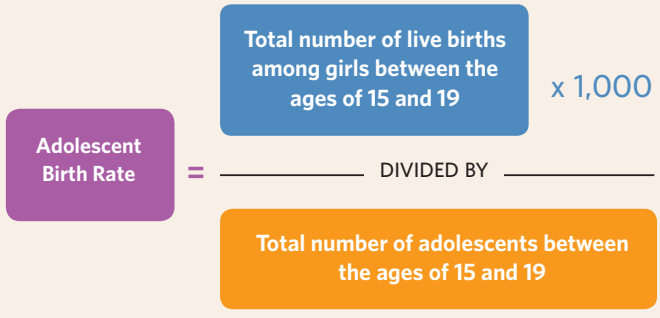
## ESTIMATING ADOLESCENT PREGNANCY AND BIRTH RATES

Precise data on adolescent pregnancies are scarce. Vital registration systems collect information on *births*, not pregnancies. Unlike births, pregnancies are generally not reported and aggregated upward to national statistical institutions. Some pregnancies fail very early, before a woman or girl is aware she is pregnant. Pregnancies may go undocumented in developing countries because adolescents often do not—or cannot—access antenatal care and thus do not come to the attention of health care providers. Pregnancies that end in miscarriage or abortion (often performed illegally and clandestinely) are also absent from most national databases.

Most countries, therefore, rely on information about *births*, as a proxy for data on the prevalence of adolescent *pregnancy*. Estimates of birth rates are invariably lower than pregnancy rates. For example, according to a 2008 study, the pregnancy rate among adolescents age 15 to age 19 in the United States was 68/1,000 while the birth rate was 40/1,000 (Kost and Henshaw, 2013). Pregnancy rates include miscarriages, abortions, stillbirths, and pregnancies carried to term, while the birth rate includes only live births.

The proxy data that demographers rely on is gathered in two ways:

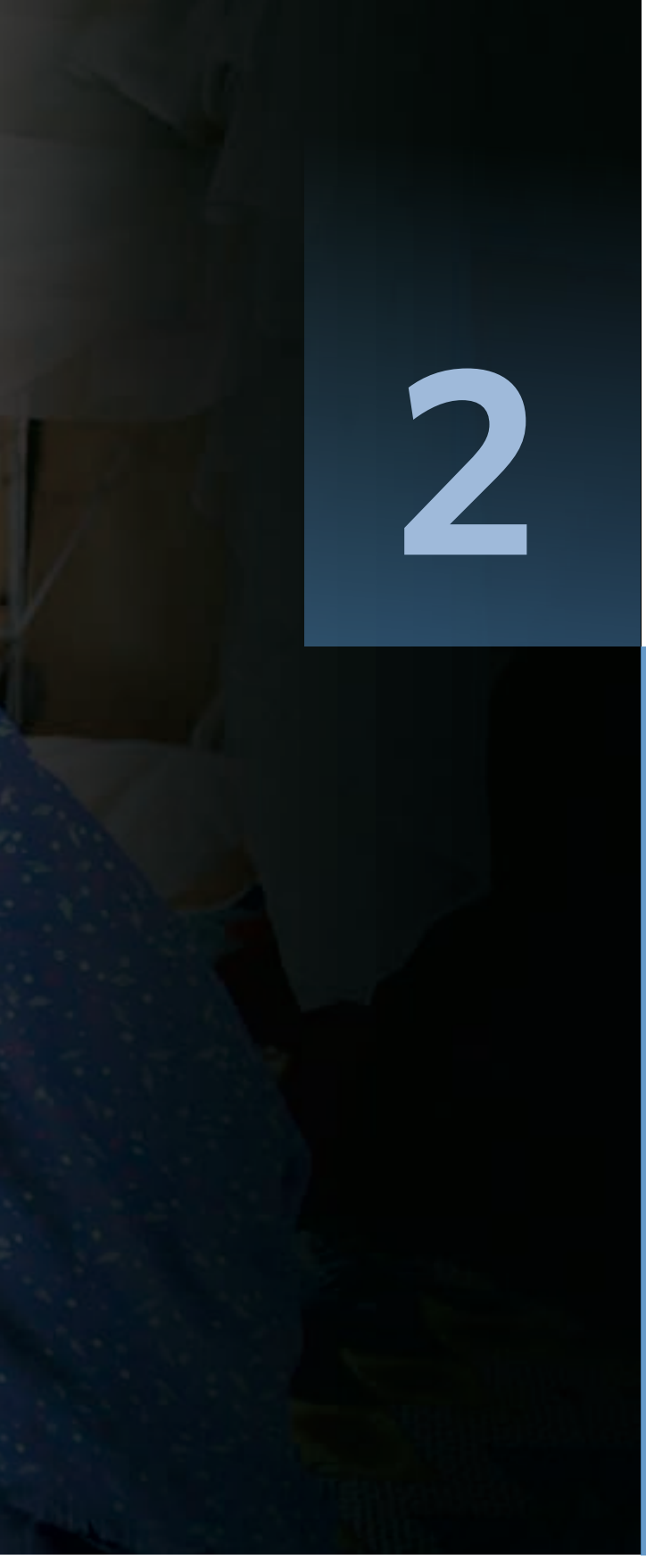
- Through a retrospective approach, which asks women between the ages of 20 and 24 if they had had a child at an earlier age, usually before age 18. Data used in the retrospective approach and cited in this report come from demographic and health surveys, or DHS, and multiple indicator cluster surveys, or MICS, which have been carried out in 81 developing countries.
- By *calculating* the adolescent birth rate:




The retrospective approach yields insights into births to girls before the age of 18, but can also provide insights into births to girls younger than 15. The adolescent birth rate, however, includes only live births to girls between the ages of 15 and 19.

sphere of a pregnant girl. But just as important—and just as limited—are data and insights about the men and boys who father the children of adolescent girls.

Adolescent pregnancies are not the sole concern of developing countries. Hundreds of thousands of them are reported each year in high- and middle-income countries, too. But some of the patterns found in developing countries are also relevant in developed ones: girls who live in low-income households, are rural, have less education or have dropped out of school, or who are ethnic minorities, immigrants, or marginalized sub-populations are more likely to become pregnant. In developing countries, most adolescent pregnancies occur within marriages, while in developed countries, they increasingly occur outside of marriage.



# 2

# The impact on girls' health, education and productivity

When a girl becomes pregnant or has a child, her health, education, earning potential and her entire future may be in jeopardy, trapping her in a lifetime of poverty, exclusion and powerlessness.

◀ *A 13-year-old fistula patient at a VVF centre in Nigeria.*
© UNFPA/Akintunde Akinleye

When a girl becomes pregnant or has a child, her health, education, earning potential and her entire future may be in jeopardy, trapping her in a lifetime of poverty, exclusion and powerlessness.

The impact on a young mother is often passed down to her child, who starts life at a disadvantage, perpetuating an intergenerational cycle of marginalization, exclusion and poverty.

And the costs of early pregnancy and childbirth extend beyond the girl's immediate sphere, taking a toll on her family, the community, the economy and the development and growth of her nation.

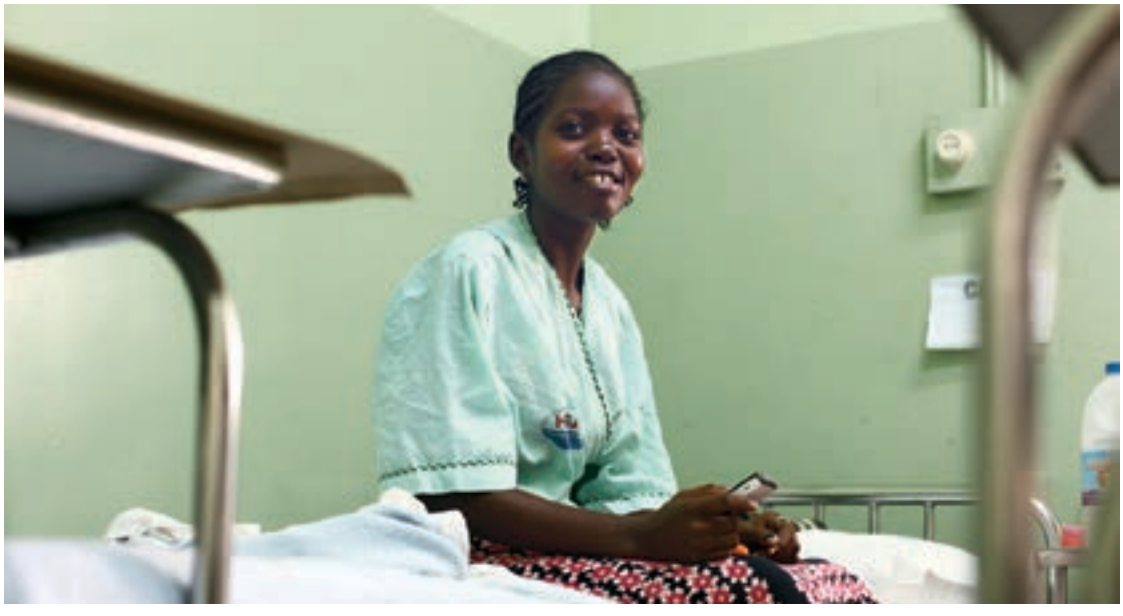
While pregnancy can affect a girl's life in numerous and profound ways, most quantitative research has focused on the effects on health, education and economic productivity:

- *The health impact* includes risks of maternal death, illness and disability, including obstetric fistula, complications of unsafe abortion, sexually transmitted infections, including HIV, and health risks to infants.
- *The educational impact* includes the interruption or termination of formal education and the accompanying lost opportunities to realize one's full potential.
- The *economic impact* is closely linked to the educational impact and includes the exclusion from paid employment or livelihoods, additional costs to the health sector and the loss of human capital.

## Health impact

About 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth (UNICEF, 2008). Complications of pregnancy and childbirth are a leading cause of death for older adolescent females (World Health Organization, 2012).

Adolescents who become pregnant tend to be from lower-income households and be nutritionally depleted. Although rates vary by region, overall, approximately one in two girls in developing countries has nutritional anaemia, which



*Hortência, 25, developed an obstetric fistula at 17, during a complicated delivery.*
© UNFPA/Pedro Sá da Bandeira

can increase the risk of miscarriage, stillbirth, premature birth and maternal death (Pathfinder International, 1998; Balarajan et al., 2011; Ransom and Elder, 2003).

A number of factors directly contribute to maternal death, illness and disability among adolescents. These include the girl's age, her physical immaturity, complications from unsafe abortion and lack of access to routine and emergency obstetric care from skilled providers. Other contributing factors include poverty, malnutrition, lack of education, child marriage and the low status of girls and women (World Health Organization, 2012b).

Health problems are more likely if a girl becomes pregnant within two years of menarche or when her pelvis and birth canal are still growing (World Health Organization, 2004).

### Obstetric fistula

Physically immature first-time mothers are particularly vulnerable to prolonged, obstructed labour, which may result in obstetric fistula, especially if an emergency Caesarean section is unavailable or inaccessible. Although fistula can occur to women at any reproductive age, studies in Ethiopia, Malawi, Niger and Nigeria show that about one in three women living with obstetric fistula reported developing it as an adolescent (Muleta et al., 2010; Tahzib, 1983; Hilton and Ward, 1998; Kelly and Kwast, 1993; Ibrahim et al., 2000; Rijken and Chilopora, 2007).

Obstetric fistula is a debilitating condition that renders a woman incontinent and, in most cases, results in a stillbirth or the death of the baby within the first week of life.

Between 2 million and 3.5 million women and girls in developing countries are thought to be living with the condition. In many instances, a

## OBSTETRIC FISTULA: ANOTHER BLIGHT ON THE CHILD BRIDE

It was personal experience that turned Gul Bano and her cleric husband, Ahmed Khan, into ambassadors against early marriage and its worst corollary—obstetric fistula.

As is the custom in the remote mountain village of Kohadast in the Khuzdar district of Balochistan province in Pakistan, Bano was married off as soon as she reached adolescence, at 15, and was pregnant the following year.

There being no healthcare facility near Kohadast, Bano did not receive antenatal care and no one thought there would be complications. But, events were to prove different. After an extended labour lasting three days, Bano delivered a dead baby. "I never saw the colour of my son's eyes or his hair. I never held him once to my bosom," recalls Bano, now 20.

Her troubles had only begun. A week later, Bano realized she was always wet with urine and reeking of fecal matter. "I was passing urine and stools together."

Unable to handle the prolonged labour, Bano's young body had developed an obstetric fistula caused by the baby's head pressing hard against the lining of the birth canal and tearing into the walls of her rectum and the bladder.

Obstetric fistula is now generally acknowledged to be another burden on the girl child, deprived of basic education and forced into marriage—for which she is neither physically nor mentally prepared.

Khan stood by his young wife and sought medical help. He discovered a hospital in Karachi specializing in treating fistula and other conditions related to reproductive health. Koohi Goth Women's Hospital, where fistula victims are treated free, was started by Dr. Shershah Syed, one of Pakistan's first gynaecologists to train in repairing the painful and socially embarrassing condition.

"It's been almost three years and she [Bano] has gone through six operations," says Dr. Sajjad Ahmed, who worked at Koohi Goth as manager of UNFPA's fistula project from June 2006 to February 2010.

Today Bano and Khan have become vocal advocates of the campaign against fistula. They travel across Pakistan, spreading the word about how to prevent the injury and what to do about it. "Khan is a cleric and yet he does not conform to the stereotype of a religious person," said Syed. "He tells parents that fistula can be avoided if they stop marrying off their daughters at a very early age." Bano shares her story and tells married women about the importance of birth spacing, antenatal checkups and timely access to emergency obstetric care.

*—Zofeen Ebrahim, Inter Press Service*

woman—or girl—living with obstetric fistula is ostracized from her home and her community and is at risk of poverty and marginalization.

The persistence of obstetric fistula is a reflection of chronic health inequities and health-care system constraints, as well as wider challenges, such as gender and socio-economic inequality, child marriage and early child bearing, all of which can undermine the lives of women and girls and interfere with their enjoyment of their basic human rights.

In most cases, fistula can be repaired through surgery, but few actually undergo the procedure, mainly because services are not widely available or accessible, especially in poor countries lacking quality medical services and infrastructure, or because the surgery, which can cost as little as $400, is prohibitively expensive for most women and girls in developing countries. Of the 50,000 to 100,000 new cases per year, only about 14,000 undergo surgery, so the total number of women living with the condition rises every year.

While a skilled birth attendant and emergency Caesarean section can help an adolescent avert obstetric fistula, the best way to protect a girl from the condition is to help her delay pregnancy until she is older and her body matures. Often this means protecting her from early marriage.

### ESTIMATES OF UNSAFE ABORTIONS AND UNSAFE ABORTION RATES FOR GIRLS, AGES 15 TO 19, 2008

| Developing regions | Annual number of unsafe abortions to girls 15–19 | Unsafe abortion rate (per 1,000 girls 15–19) |
|---|---|---|
| Developing countries | 3,200,000 | 16 |
| Africa | 1,400,000 | 26 |
| Asia excluding East Asia | 1,100,000 | 9 |
| Latin America and the Caribbean | 670,000 | 25 |

*Source*: Shah and Ahman, 2012.

## Unsafe abortion

Unsafe abortions account for almost half of all abortions (Sedgh et al., 2012; Shah and Ahman, 2012). According to the World Health Organization, an unsafe abortion is "a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both" (World Health Organization, 2012c). Almost all (98 per cent) of the unsafe abortions take place in developing countries, where abortion is often illegal. Even where abortion is legal, adolescents may find it difficult to access services.

Data on abortions, safe or unsafe, for girls between the ages of 10 and 14 in developing countries are scarce but rough estimates have been made for the 15 to 19 age group, which accounts for about 3.2 million unsafe abortions in developing countries each year (Shah and Ahman, 2012).

This study covers Africa, Asia (excluding East Asia) and Latin America and the Caribbean (Shah and Ahman, 2012). Rates of unsafe abortions per 1,000 are similar for sub-Saharan Africa and Latin America and the Caribbean: 26 versus 25, respectively; however, the total number of unsafe abortions in sub-Saharan Africa is more than double that of Latin America and the Caribbean, because of the former's larger population size. Sub-Saharan Africa accounts for 44 per cent of all unsafe abortions among adolescents between the ages of 15 and 19 in the developing world (excluding East Asia), while Latin America and the Caribbean account for 23 per cent.

In sub-Saharan Africa, an estimated 36,000 women and girls die each year from unsafe abortion, and millions more suffer long-term illness or disability (UN Radio, 2010).

Compared to adults who have unsafe abortions, adolescents are more likely to experience complications such as haemorrhage, septicaemia, internal organ damage, tetanus, sterility and even death (International Sexual and Reproductive Rights Coalition, 2002). Some explanations for worse health outcomes for adolescents are that they are more likely to delay seeking and having an abortion, resort to unskilled persons to perform it, use dangerous methods and delay seeking care when complications arise.

Adolescents make up a large proportion of patients hospitalized for complications of unsafe abortions. In some developing countries, hospital records suggest that between 38 per cent and 68 per cent of those treated for complications of abortion are adolescents (International Sexual and Reproductive Rights Coalition, 2002).

"I have accepted my HIV status because when something has happened, it has happened."

*Neo, 15, Botswana*

### PERCENTAGE OF GIRLS, AGES 15 TO 19, WHO EVER HAD SEXUAL INTERCOURSE AND REPORTED AN STI OR SYMPTOMS IN THE PAST 12 MONTHS

*(COUNTRIES WITH 20 PER CENT OR MORE)*

| | |
|---|---|
| Guinea | 35 per cent |
| Ghana | 29 per cent |
| Congo, Republic of | 29 per cent |
| Nicaragua | 26 per cent |
| Côte d'Ivoire | 25 per cent |
| Dominican Republic | 21 per cent |
| Uganda | 21 per cent |

*Source*: Kothari et al., 2012.

## Sexually transmitted infections

Worldwide each year, there are 340 million new sexually transmitted infections, or STIs. Youth between the ages of 15 and 24 have the highest rates of STIs. Although STIs are not a consequence of adolescent pregnancy, they *are* a consequence of sexual behaviour—non-use or incorrect use of condoms—that may lead to adolescent pregnancy. If untreated, STIs can cause infertility, pelvic inflammatory disease, ectopic pregnancy, cancer, and debilitating pelvic pain for women and girls. They may also lead to low birth-weight babies, premature deliveries and life-long physical and neurological conditions for children born to mothers living with STIs.

In seven of 35 countries covered in a recent review of demographic and health surveys, at least one in five female adolescents between the ages of 15 and 19 who ever had sexual intercourse indicated that they had an STI or symptoms of one in the past 12 months (Kothari et al., 2012).

Demographic and health surveys show that, in general, the percentage of females between the ages of 15 and 19 who ever had sex and who reported STIs or symptoms in the past 12 months is higher than that reported by males who ever had sex in that same age group. In Côte d'Ivoire, for example, 25 per cent of females between 15 and 19 and who had ever had sex reported an STI or symptoms of one compared to 14 per cent of males in the same age group.

Other studies of STIs and adolescents also show that girls are more frequently affected than boys (Dehne and Riedner, 2005). STIs are common among sexually assaulted adolescents and abused children.

Adolescent girls are also more likely than boys to be living with HIV. Young women are more vulnerable to HIV infection because of biological factors, having older sex partners, lack of access to information and services and social norms and values that undermine their ability to protect themselves. Their vulnerability may increase during humanitarian crises and emergencies when economic hardship can lead to increased risk of exploitation, such as trafficking, and increased reproductive health risks related to the exchange of sex for money and other necessities (World Health Organization, 2009a).

## HIV PREVALENCE AMONG ADOLESCENTS AGES 15 TO 19, BY SEX, IN SELECTED SUB-SAHARAN AFRICAN COUNTRIES, 2001–2007

*Source:* World Health Organization, 2009a.

### Health risks to infants and children

The health risks to the infants and children of adolescent mothers have been well documented. Stillbirths and newborn deaths are 50 per cent higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29 (World Health Organization, 2012a). About 1 million children born to adolescent mothers do not make it to their first birthday. Infants who survive are more likely to be of low birth weight and be premature than those born to women in their 20s. In addition, without a mother's access to treatment, there is a higher risk of mother-to-child transmission of HIV.

## ADOLESCENTS, AGES 10 TO 19, LIVING WITH HIV, 2009

| Region | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | Estimate | (low estimate - high estimate) | Estimate | (low estimate - high estimate) | Estimate | (low estimate - high estimate) |
| East and Southern Africa | 760,000 | (670,000 - 910,000) | 430,000 | (370,000 - 510,000) | 1,200,000 | (1,000,000 - 1,400,000) |
| Western and Central Africa | 330,000 | (270,000 - 440,000) | 190,000 | (140,000 - 240,000) | 520,000 | (390,000 - 680,000) |
| Middle East and North Africa | 22,000 | (17,000 - 30,000) | 9,700 | (7,800 - 12,000) | 32,000 | (25,000 - 40,000) |
| South Asia | 50,000 | (44,000 - 57,000) | 54,000 | (47,000 - 66,000) | 100,000 | (90,000 - 130,000) |
| East Asia and the Pacific | 27,000 | (15,000 - 30,000) | 23,000 | (14,000 - 34,000) | 50,000 | (29,000 - 73,000) |
| Latin America and the Caribbean | 44,000 | (34,000 - 55,000) | 44,000 | (31,000 - 82,000) | 88,000 | (62,000 - 160,000) |
| CEE/CIS | 9,000 | (7,700 - 10,000) | 3,900 | (3,400 - 4,500) | 13,000 | (11,000 - 15,000) |
| World | 1,300,000 | (1,100,000 - 1,500,000) | 780,000 | (670,000 - 900,000) | 2,000,000 | (1,800,000 - 2,400,000) |

*Source:* UNICEF, 2011.

### Health risks to girls giving birth before age 15

Research indicates that very young adolescents in low- and middle-income countries have double the risk for maternal death and obstetric fistula than older women (including older teens), especially in sub-Saharan Africa and South Asia (Blum et al., 2013).

As young people transition from the early to late adolescent years, sexual and reproductive behaviours contribute to diverging mortality and morbidity patterns by gender, with younger adolescent girls facing an increased risk of sexual coercion, sexually transmitted infections, including HIV, as well as the gender-specific consequences of unintended pregnancies and psychological trauma (Blum et al., 2013).

Neal et al. (2012) also show that girls who are 15 or younger are at markedly higher odds for conditions such as eclampsia, anaemia, postpartum haemorrhage and puerperal endometritis than older adolescents. Evidence also suggests that the adverse neonatal outcomes associated with adolescent pregnancies are greater for younger adolescents.

Many countries with high levels of early adolescent motherhood are also those with very high maternal mortality ratios (Neal et al., 2012).

A study by the World Health Organization shows that girls who become pregnant at 14 or younger are more likely to experience premature delivery, low infant birth weight, perinatal mortality and health problems in newborns (World Health Organization, 2011). The risks

▲ *Marielle, 25, gave birth when she was 13.*
© UNFPA/ Berge, Borghild

to very young mothers and their newborns are exacerbated for girls who are malnourished. A pregnancy can compromise a mother's status even further and disrupt normal growth patterns, while their babies are more likely to be underweight and die.

Girls under 15 are not physically ready for sexual intercourse or childbearing and lack the cognitive capacities and power to make safe, informed or voluntary decisions (Dixon-Mueller, 2008). Still, in more than 30 countries, 10 per cent of adolescents have had sexual intercourse by age 15, with rates as high as 26 per cent in Niger. Research shows that in some countries, many girls' first sexual encounters are non-consensual, and the incidence of forced sex is higher among very young adolescents (Erulkar, 2013).

## Psychosocial impact

Millions of girls are forced into marriage every year, and an estimated 90 per cent of adolescents who give birth are married. This means millions move from being a child to being a married mother with adult responsibilities with little time in between. One day, they are under a parent's authority. The next, they are under a partner's or husband's authority, perpetuating and reinforcing a cycle of gender inequality, dependence and powerlessness.

In the transition from childhood to forced marriage and motherhood, a girl may experience stress or depression because she is not psychologically prepared for marriage, sex or pregnancy, and especially when sex is coerced or non-consensual. Depending on her home and

community environments, she may feel stigmatized by an early pregnancy (especially if it is outside of marriage) and seek an abortion, even in settings where abortions are illegal and unsafe, often accepting the risk of a disastrous health outcome.

## Impact on girls' education

Girls who remain in school longer are less likely to become pregnant. Education prepares girls for jobs and livelihoods, raises their self-esteem and their status in their households and communities, and gives them more say in decisions that affect their lives. Education also reduces the likelihood of child marriage and delays childbearing, leading to healthier eventual birth outcomes.

A new survey of countries to assess their progress in implementing the Programme of Action of the 1994 International Conference on Population and Development confirms that higher literacy rates among women between ages 15 and 19 are associated with significantly lower adolescent birth rates (UNFPA, 2013a).

A recent analysis of 39 countries found that—with the exceptions of Benin and Mali—unmarried girls (ages 15 to 17) who attend school are considerably less likely to have had premarital sex, as compared to their out-of-school peers (Biddlecom et al., 2008; Lloyd, 2010). These findings underscore the protective effects that an education may confer against adolescent pregnancy and its adverse outcomes.

The social and economic benefits to a girl who stays in school are great, but so are the costs to a girl who leaves school early—or is forced out because of a pregnancy.

The causal relationship, however, between adolescent pregnancies and early school-leaving can be difficult to disentangle (UNFPA, 2012a). Girls who become pregnant may have already dropped out of school before the pregnancy or were never in school to begin with. One study of francophone African countries showed that only between 5 per cent and 10 per cent of girls leave school—or are expelled—because of pregnancy (Lloyd and Mensch, 2008). Instead, the study found that "union formation"—first marriage or cohabitation—is more likely to be the reason.

Still, for many adolescents who become mothers, their formal education comes to a permanent halt, either because of individual circumstances,

### MARRIED, AND BACK IN SCHOOL

Filesia is a free-spirited, bubbly 15-year-old, chatting and giggling among her friends. She is enjoying her life as a Standard 8 primary school student in Malawi and says she cannot wait to get to secondary school within the year.

But Filesia is not quite like all the other students in her class. Her parents forced her to drop out of school and get married after she became pregnant at the age of 13.

"My boyfriend, who was 18 at the time, enticed me to have sex with him. He told me that I was too young to get pregnant and I believed him," said Filesia. She became pregnant after having sex twice. "I knew nothing about contraceptives so we did not use any protection."

"My parents said they could no longer keep me in their house after they discovered I was pregnant. They handed me over to my boyfriend's family and we started living together after conducting a traditional wedding," Filesia said.

Filesia stayed married for two years after giving birth to a baby boy, but she has now returned to school, rescued from life as an underage bride by the Community Victim Support Unit, supported by the United Nations Joint Programme on Adolescent Girls led by UNFPA.

"I now know about contraceptives through the youth club I joined. I do not intend to indulge in sex again until I finish school because I lived under a lot of poverty when I got married," said Filesia. Filesia says she wants to be a policewoman. "I want to be rescuing other girls who are forced into early marriages."

such as child marriage or family or community pressures, or because schools forbid pregnant girls from attending or forbid their return once they have had a baby (Panday et al., 2009). And even in countries where laws allow girls to return, a minority of girls actually resumes education. In South Africa, for example, the Constitution and the Schools Act of 1996 state that girls who become pregnant should not be denied access to education, but one review found that only about one in three adolescents who left school because of a pregnancy ever returned. A study in Chile found that being a mother reduces a girl's likelihood of attending and completing high school by between 24 per cent and 37 per cent (Kruger et al., 2009).

The problem of truncated education for adolescent mothers is not unique to developing countries. In the United States, for example, 329,772 children were born to adolescents between the ages of 15 and 19 in 2011. Only about half of the girls who become pregnant as teenagers manage to complete their high school education by age 22. In contrast, nine tenths of girls who do not become pregnant as teenagers obtain their high school diploma by age 22 (Perper et al., 2010).

The longer girls are out of school, the less likely they are to return.

For girls to be able to return to school, supportive policies are necessary but often insufficient: new mothers are also likely to need financial assistance, child care and one-on-one counselling to help them deal with the challenges, including stigma, of adolescent motherhood.

"I was happy and sad at the same time. Happy because I gave birth to a precious baby boy... But my parents have to support me and my baby now... I dropped out of school, and since then I have to find a job to support my child... I'm a single mom. I have to do everything for my baby."

*Thoko, South Africa (no age given)*

## Economic impact

When a girl has the power to delay a pregnancy, she may also be empowered socially to stay in school, and then economically to secure a more lucrative job or pursue other income-earning opportunities, according to a World Bank study (Chaaban and Cunningham, 2012). Investments that empower girls are beneficial to the economy; conversely, the costs of not investing in them are high. The lifetime opportunity cost related to adolescent pregnancy—measured by the mother's foregone annual income over her lifetime—ranges from 1 per cent of annual GDP in China to 30 per cent of annual GDP in Uganda. The opportunity cost is a measure of "what could have been" if only the additional investment had been made in girls.

The World Bank study illustrates the opportunity costs associated with adolescent pregnancy and dropping out of school. If all 1.6 million adolescent girls in Kenya, for example, completed secondary school, and if the 220,098 adolescent mothers there were employed instead of having become pregnant, the cumulative

effect could have added $3.4 billion to Kenya's gross income every year. This is equivalent to the entire Kenyan construction sector. Similarly, Brazil would have greater productivity equal to more than $3.5 billion if teenage girls delayed pregnancy until their early twenties, while India's productivity would be $7.7 billion higher.

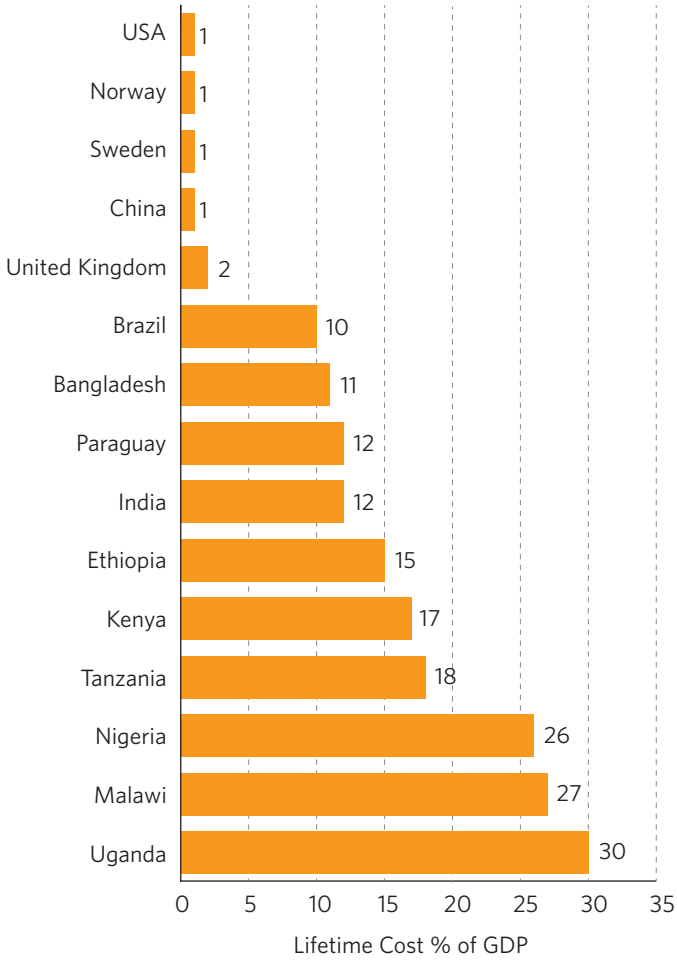
Since most adolescent pregnancies occur at a time when girls are of secondary-school age, dropping out of *secondary* school results in higher costs to the economy than dropping out of primary school. Because the number of affected girls is much greater among secondary school populations than among primary school populations, the negative impact on returns on investment in secondary education is much higher than the negative impact on primary school education.

The World Bank study states that this analysis underestimates the true cost of not investing in girls. The costs computed are only economic ones and should be seen as lower than the true social costs. The study looks only at lost productivity in the labour market and thus does not estimate costs incurred to women's health, the possible implications for the child's future productivity as indicated by studies that show that children of adolescent mothers have lower school attainment rates, and the social costs of unwed adolescent mothers.

The true costs, which include lower health status of the children of these girls, lower life expectancy, skill obsolescence of jobless girls, less social empowerment, and so forth would increase the cost estimates many-fold (Cunningham et al., 2008).

When policy failures or other pressures on adolescent girls result in large numbers of pregnancies, the economic costs may extend beyond the individual to the community and the nation.

## LIFETIME COST OF ADOLESCENT PREGNANCY OF THE CURRENT COHORT OF GIRLS 15 TO 19 YEARS OLD, AS SHARE OF ANNUAL GDP




*Source:* Chaaban and Cunningham, 2011.

Some costs may arise, for example, through increased demand on already overstretched health care systems for the management of complications from unsafe abortions to adolescents. According to the International Sexual and Reproductive Rights Coalition (2002), "In many developing countries, hospital records

## THE HUMAN RIGHTS DIMENSION

Rights violations are often an underlying cause and frequently a consequence of adolescent pregnancy.

Girls who become pregnant are often not able to enjoy or exercise their rights as guaranteed in international treaties such as the Convention on the Rights of the Child. Similarly, when a girl is unable to enjoy basic rights such as her right to an education, she becomes more vulnerable to becoming pregnant before adulthood.

If an adolescent becomes pregnant as a result of forced or coerced sex, her rights are further undermined. If that same girl is unable to attend school because she is pregnant or responsible for taking care of her children, her rights are again denied. If she cannot attend school, her income-earning potential in life is blunted, and her chances of spending the rest of her life in poverty increase dramatically.

Last year, the Office of the High Commissioner for Human Rights issued a groundbreaking report, which framed the United Nations Human Rights Council's numerous resolutions on maternal mortality and morbidity as human rights violations and identified some of the underlying causes of adolescent pregnancy:

*The first step is to analyse not only why adolescent girls suffer from high rates of maternal morbidity and death, but also why they are becoming pregnant. A human rights-based approach defines the problem and addresses it in terms of both the immediate and underlying causes of maternal mortality and morbidity, given that they determine the possibilities for resolving concrete problems at the local level. Amidst many other factors, adolescent pregnancy might be due to a lack of comprehensive sexuality education; gender norms that reinforce early pregnancy; early marriage; high levels of sexual violence and/or transactional sex; a lack of youth-friendly health services; lack of affordable and accessible contraception; or a combination of the above.* (Office of the High Commissioner for Human Rights, 2012, paragraph 59).

Intersecting forms of inequality compound the situation. Adolescent girls living in poverty or in rural areas, or who are also disabled, or indigenous, face additional barriers to accessing sexual and reproductive health information and services, and in some cases, are more likely to be subject to sexual violence.

Addressing adolescent pregnancy through human rights protections builds on an international, normative framework that requires governments to take steps that will make it possible for girls to enjoy their rights to an education, to health and to live free from violence. Children have the same human rights as adults but they are also granted special protections to address the inequities that come with their age.

Upholding rights, therefore, can help eliminate many of the conditions that contribute to adolescent pregnancy and help mitigate many of the consequences to the girl, her household and her community. Addressing these challenges through human rights protections is key to ending a vicious cycle of rights infringements, poverty, inequality, exclusion and adolescent pregnancy.

At the International Conference on Population and Development (ICPD) in 1994, 179 governments acknowledged the connections among early marriage, adolescent childbearing and elevated rates of adolescent maternal mortality. The ICPD Programme of Action highlighted the critical role that education can play in preventing these harms (ICPD Programme of Action, Principle 4 and paragraph 7.41). Governments agreed to protect and promote adolescents' rights to reproductive health education and information and to guarantee universal access to comprehensive and factual information on reproductive health.

Since the ICPD, United Nations treaty-monitoring bodies, which interpret and monitor governments' compliance with human rights treaties, have recognized the need to empower adolescents to make informed decisions about their lives and have asserted that *adolescents have the same human rights, including reproductive rights, as adults have.* The Convention on the Rights of the Child, the most ratified human rights treaty in the world, expressly recognizes children as rights holders. However, lacking the legal capacity to act on their own behalf, in many cases children as rights-holders are not given the ability or choice to claim their rights. This lack of autonomy in decision-making, combined with their low social and economic status and their physical vulnerability, make it more difficult for them to enjoy and exercise those rights.

suggest that between 38 per cent and 68 per cent of women treated for complications of abortion are below 20 years of age." In Ethiopia, in 2008, "an estimated 52,600 women received care in a health facility for complications of unsafe abortion" (Guttmacher Institute, 2010). Given that women seeking abortion in Ethiopia have a mean age of 23, it is safe to say that a significant proportion of those treated for abortion complications in Ethiopia are adolescents (Guttmacher Institute, 2010). A recent paper (Abdella et al., 2013) estimated that the direct cost to the national health system in Ethiopia for treating post-abortion complications was between $6.5 million and $8.9 million per year. In some countries in Latin America, hospitals are crowded with adolescents needing treatment for complications from pregnancy, childbirth, or abortion.

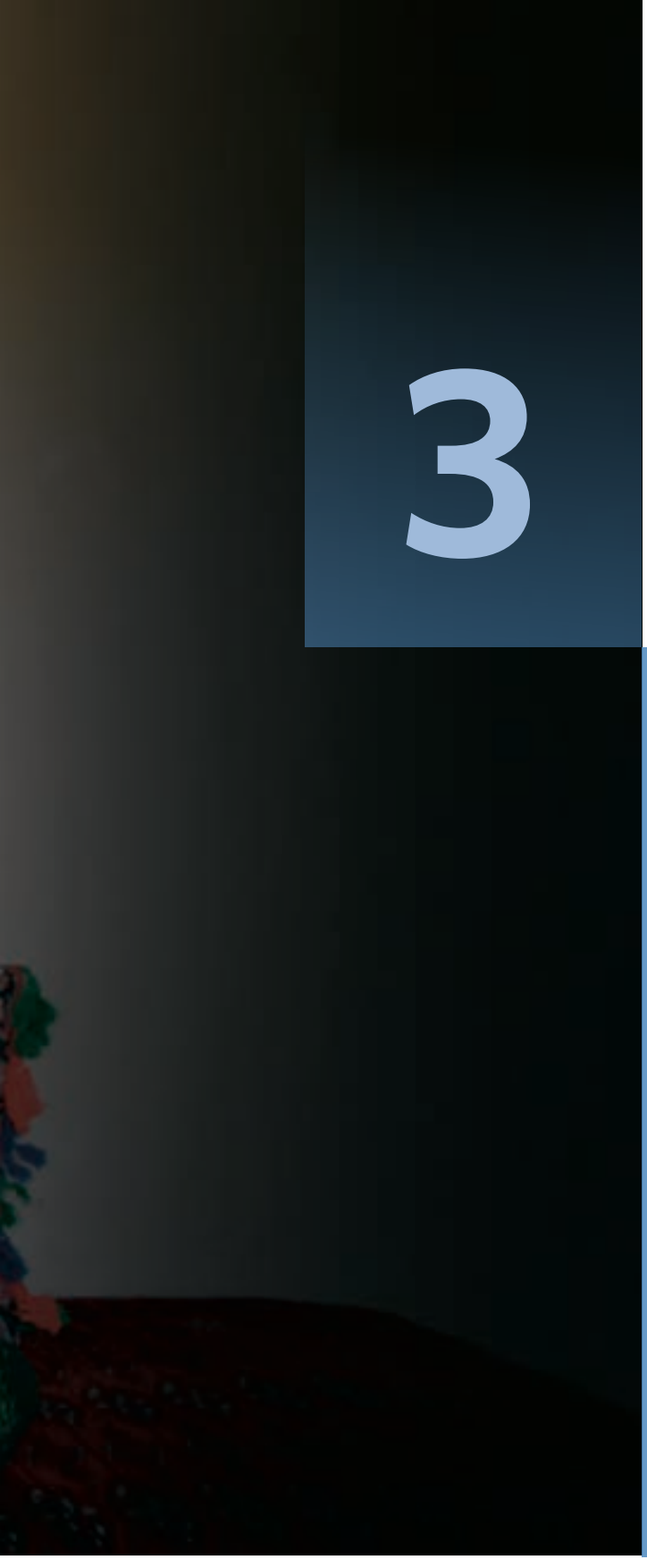
The costs are not limited to abortion complications nor are they limited to developing countries: "In 2008 [in the United States], teen pregnancy and childbirth accounted for nearly $11 billion per year in costs to United States taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents and lost tax revenue because of lower educational attainment and income among teen mothers" (National Campaign to Prevent Teen and Unplanned Pregnancy, 2011).

> "It is taboo to talk about sex. Sometimes, there are programmes about contraception on TV but young people do not pay enough attention. We discuss sex among ourselves, but we do not address the issue with our parents. Most often, it is the girls who ask the boys to use condoms. The boys do not think to ask the girls to take the pill or another method of contraception."
>
> *Ngimana, 17, Senegal*

## Conclusion

Adolescent pregnancy and childbirth can have negative consequences for girls' physical and mental health and social well-being, their educational attainment, and their income-earning potential. These impacts are rooted largely in persistent gender inequality and discrimination in legal, social and economic structures, which result in stigma and marginalization and violate fundamental human rights. When girls are denied the information and services they need to prevent pregnancy, their autonomy is undermined. When they become pregnant and are forced from school, their rights are violated. When they are forced to marry or are subjected to sexual violence or coercion, their rights are additionally violated.

When their human rights are respected, girls are less likely to be stigmatized and marginalized and are free to develop and maintain healthy relationships with friends and peers. They have access to sexual and reproductive health services and are able to get an education, regardless of their situation. They are better able to become healthy, productive and empowered citizens who can participate as equal members of their households, communities and nations.



# 3

# Pressures from many directions

Adolescent pregnancies do not occur in a vacuum but are the consequence of inter-locking factors, such as widespread poverty, communities' and families' acceptance of child marriage and inadequate efforts to keep girls in school.

◀ *Faiz, 40, and Ghulam, 11, at home prior to their wedding, Afghanistan.*

© Stephanie Sinclair/VII/Tooyoungtowed.org (2005)

One hundred seventy-nine governments agreed in 1994 at the International Conference on Population and Development (ICPD) on the need to "promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies." (ICPD Programme of Action, paragraph 7.46).

Yet many of the actions—before and since 1994—to achieve the objectives of reducing the number of adolescent pregnancies have been narrowly focused, targeting girls as the problem and aiming to change their behaviour as the solution.

Such actions generally fail to reduce adolescent pregnancies because they neglect the underlying economic, social, legal and other circumstances, structures, systems, norms and rights violations that drive adolescent pregnancy around the world. Another shortcoming of these approaches is their failure to take into account the role of men and boys in perpetuating and preventing adolescent pregnancy.

An "ecological" approach to adolescent pregnancy is one that takes into account the full range of complex drivers of adolescent pregnancy and the interplay of these forces. It can help governments, policymakers and stakeholders understand the challenges, and craft more effective interventions that will not only reduce the number of pregnancies but will also take steps that can tear down the many barriers to girls' empowerment so that pregnancy is no longer the likely outcome.

One such ecological model sheds light on the constellation of forces that conspire against the adolescent girl and increase the likelihood that she will become pregnant (Blum and Johns Hopkins, 2013). While these forces are numerous and multi-layered, they are all in one way or another about a girl's inability to enjoy or exercise rights and about the lack of power to shape her own future.

Most of the determinants in this model operate at more than one level. For example, *national-level* policies may restrict adolescents' access to sexual and reproductive health services, including family planning, while the *community* or *family* may oppose girls' accessing comprehensive sexuality education or other information about how to prevent a pregnancy.

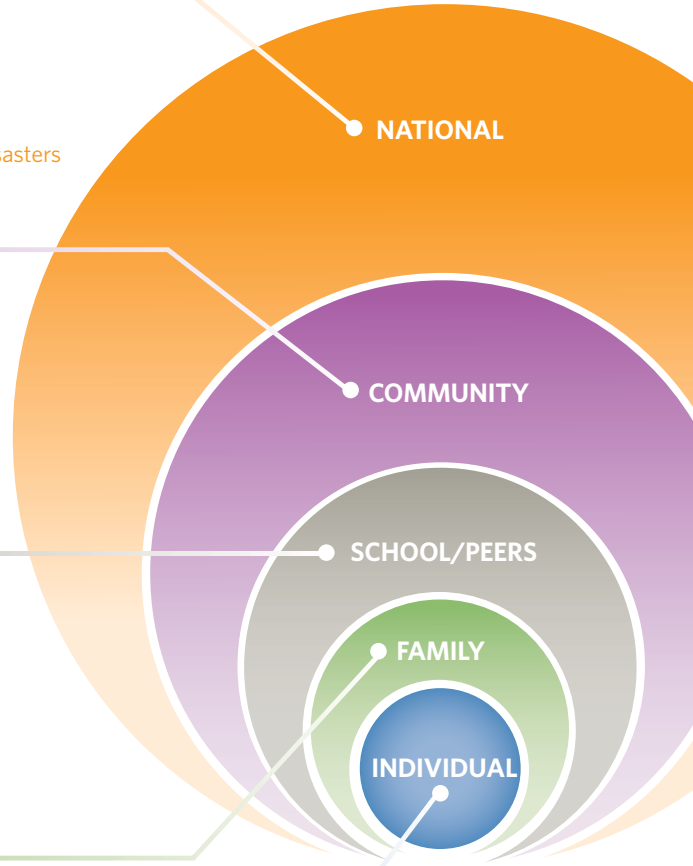
This model shows that adolescent pregnancies do not occur in a vacuum but are the consequence of an interlocking set of factors such as widespread poverty, communities' and families' acceptance of child marriage, and inadequate efforts to keep girls in school.

In technical guidance on applying rights-based approaches to reduce maternal mortality in 2012, the Office of the High Commissioner for Human Rights called on States to address the diverse, multidimensional drivers of adolescent pregnancy by eliminating "immediate and underlying causes." (Human Rights Council, 2012). Gender norms that reinforce early pregnancy, child marriage, sexual violence and other such underlying causes cited by the Office of the High Commissioner for Human Rights also feature in this ecological model.

## National-level determinants

National laws and policies, the level of government commitment to meeting obligations under human rights instruments and treaties, the extent of poverty or deprivation, and political stability can all influence whether a girl becomes pregnant. These determinants are beyond an adolescent's—or any individual's—control,

## DETERMINANTS OF ADOLESCENT PREGNANCY: AN ECOLOGICAL MODEL




- Laws limiting access to contraception
- Unenforced laws against child marriage
- Economic decline, poverty
- Underinvestment in girls' human capital
- Political instability, humanitarian crises and disasters

- Negative attitudes about girls' autonomy
- Negative attitudes about adolescent sexuality and access to contraception
- Limited availability of youth-friendly services
- Absence of antenatal and postnatal care for young mothers
- Climate of sexual coercion and violence

- Obstacles to girls' attending or staying enrolled in school
- Lack of information or no access to quality comprehensive sexuality education
- Pressure from peers
- Partners' negative gender attitudes and risk-taking behaviours

- Negative expectations for daughters
- Little value on education, especially for girls
- Favourable attitudes to child marriage

- Age of puberty and sexual debut
- Socialization of girls to pursue motherhood as only option in life
- Internalized gender-inequitable values
- Lack of recognition of evolving capacities

yet they can have a tremendous impact on how much power a girl has to shape her own future and realize her potential.

For example, if they are enforced, national laws that ban child marriage can help eliminate one of girls' main vulnerabilities to pregnancy.

At the national level, adolescents' access to contraception may be blocked because of laws that prohibit anyone under age 18 from accessing sexual and reproductive health services, including family planning, without parental or spousal consent, thereby preventing sexually active girls and their partners from obtaining and using contraception. Many countries also ban emergency contraception or forbid adolescents' access to it.

In some countries, there is a disconnect between age of consent to sexual activity and the minimum age to access sexual and reproductive health services, including contraception and information. As a result, adolescents may be constrained by requirements for parental consent to access services or they may have to rely on health providers to deem them capable or eligible for services. Health care providers may be reluctant to grant access in fear of reprisals from parents or guardians who may not want their children to obtain contraception or other sexual and reproductive health services.

*Prenatal care at Tan Ux'il centre in Guatemala.*

© Mark Tuschman/ Planned Parenthood Global

The major national-level determinant of adolescent pregnancy is an overall under-investment in girls' human capital development, especially education and health, including sexual and reproductive health. Less than two cents of every dollar spent on international development is directed specifically toward adolescent girls (International Planned Parenthood Federation, n.d.).

Adolescent pregnancies tend to occur more frequently among indigenous populations or ethnic minorities for a variety of reasons, including discrimination and exclusion, lack of access to sexual and reproductive health services, poverty or the practice of child marriage. In Serbia, for example, the adolescent birth rate among the Roma minority is 158, more than six times the national average of 23.9 and higher than the rate in many of the least developed countries (Statistical Office of the Republic of Serbia and UNICEF, 2011). In Bulgaria, more than 50 per cent of Roma adolescent girls give birth to a child before turning 18, and in Albania, the average age of Roma mothers at the birth of their first child is 16.9 years (UNDP, 2011; UNFPA, 2012c). The high adolescent birth rates among Roma populations are linked to limited access to sexual and reproductive health services, including family planning, child marriage,

social and economic exclusion from mainstream society and pressures within their communities (Colombini et al., 2011).

Poverty and economic stagnation are other national-level forces that can deny adolescents opportunities in life. With few prospects for jobs, livelihoods, self-sufficiency, a decent standard of living and all that comes with it, a girl becomes more vulnerable to early marriage and pregnancy because she or her family may see these as her only options or destiny. In addition, poor adolescents are less likely to complete their schooling and consequently often have less access to school-based comprehensive sexuality education or information about sexual and reproductive health and about preventing a pregnancy (World Health Organization, 2011).

In many emergency, conflict and crisis settings, adolescent girls are often separated from family and cut off from protective social structures. They are therefore at increased risk of rape, sexual exploitation and abuse, further increasing their vulnerability to pregnancy (Save the Children and UNFPA, 2009). To provide for themselves or the needs of their families in crisis settings (as well as in conditions of extreme poverty), adolescent girls may feel compelled to engage in sex work, exacerbating vulnerabilities to violence, sexually transmitted infections and pregnancy. Meanwhile, because of service disruptions, damaged infrastructure, lack of security or because providers may be overwhelmed by a surge in demand for services, access to sexual and reproductive health care, including family planning, may be limited. Similarly, schools, often the main provider of comprehensive sexuality education, may be shuttered, and other sources of accurate and complete information about how to prevent a pregnancy or a sexually transmitted infection, including HIV, may be scarce or non-existent. In some crisis settings, parents may force their girls into marriage with the aim of reducing economic hardship or with the expectation that the arrangement will help protect their daughters from harm in environments where sexual violence is common.

> "...I was in the first year of junior high when it happened. One night, I went to fetch water...he took me... he raped me. I was scared, but I was still a kid of 15, I could not think or imagine that I was going to get pregnant. I knew it after."
>
> *Léocadie, 16, Burundi*

## Community-level determinants

Each community has its own norms, beliefs and attitudes that determine how much autonomy and mobility a girl has, how easily she is able to enjoy and exercise her rights, whether she is safe from violence, whether she is forced into marriage, how likely she is to become pregnant, or whether she can resume her education after having had a child.

Community-level forces are especially important in determining whether there is a climate of sexual coercion, whether young people have

a voice in the life of the community, whether youth-friendly sexual and reproductive health services and contraception are available and accessible, and how well maternal health services are equipped and staffed to support a girl during her pregnancy and childbirth and then help her avoid a second pregnancy.

> "I went to a hotel where I met my boyfriend. He told me 'let's have sex without a condom.' I told him 'no, *with* condom.' He said 'if you get pregnant, I will take care of the child,' and that is how I got this girl."
>
> *Whitney, 16, Suriname*

## Access to contraception and sexual and reproductive health services

Complications from pregnancy and childbirth are a leading cause of death for female adolescents, and obstetric fistula (resulting from prolonged, difficult deliveries) is a major source of morbidity (Patton et al., 2009; Abu Zahr, C., 2003). Contraceptives, including male and female condoms, can help prevent pregnancy and sexually transmitted infections and eliminate many of the associated health risks. Yet adolescents' unmet need for contraceptives, information and services remains great, despite international commitments to remove barriers to family planning.

The consequence is that a segment of the largest generation of adolescents in history is unable to fully exercise their reproductive rights and prevent unintended pregnancies and protect themselves from sexually transmitted infections, including HIV (UNFPA 2012a).

In sub-Saharan Africa and South Central and Southeast Asia, more than 60 per cent of adolescents who wish to avoid pregnancy have an unmet need for modern contraception. These adolescents who do not use modern contraception or rely instead on a traditional method of family planning account for more than 80 per cent of unintended pregnancies in this age group (UNFPA 2012a).

### *Attitudes, beliefs and access to contraception*

At the community level, access to contraception may be impeded by norms, mores, attitudes and beliefs that adolescents *should not* be sexually active and that they therefore do not need contraception. This gap between adult attitudes and adolescent realities is a recipe for early pregnancy. Gender norms—in the community or nationally—can also determine whether an adolescent gains access to contraception. In some societies, girls are expected to marry young or prove their fertility before unions are formalized. Expectations for boys may include gaining sexual experience as well as proving their fertility (World Health Organization, 2012b).

The impact of the community-level sociocultural context on young women's reproductive behaviour cannot be overstated (Goicolea 2009). In parts of sub-Saharan Africa and South Asia, as well as in low-income communities in high-income countries, motherhood may be

seen as "what girls are for," and their social value comes from their capacity to produce children (Presler-Marshall and Jones, 2012; Edin and Kefalas, n.d.).

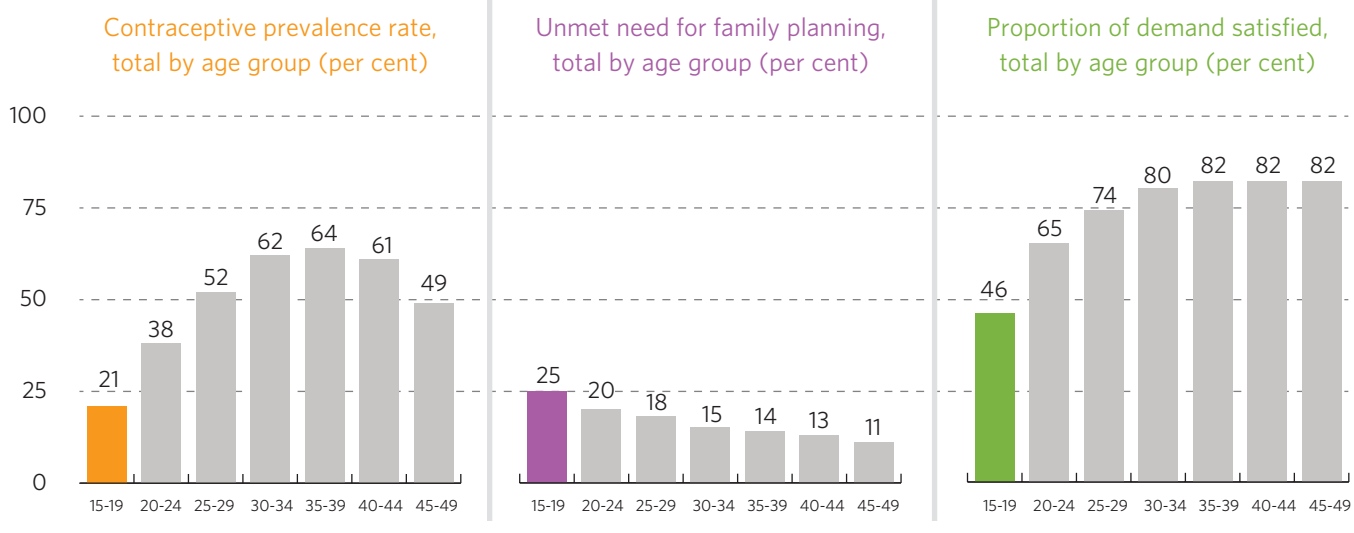
About one in four women between the ages of 15 and 49 in developing countries has never been married. This unmarried group consists mostly of adolescents and young women between the ages of 15 and 24. There has been a steady, long-term trend towards increased levels of sexual activity among these unmarried girls and young women because of a combination of factors: the global decline in the age of menarche, the rising age at marriage and changing societal values (Singh and Darroch, 2012). When they become sexually active, never-married adolescent girls and young women face much greater difficulties in obtaining contraceptives than do married women, in large part because of the stigma attached to being sexually active before marriage.

> "I knew about condoms, but could not ask my husband to use one. I was only 16 when I got married and felt he would get angry, as I was less educated than him. "
>
> *Pinki, 19, India*

### *Access and demand among married adolescents*

Excluding China, approximately one in three adolescent girls under age 18 in developing countries is married or in a union (UNFPA, 2012b). Within this group, 23 per cent are using a modern or traditional method of contraception; 23 per cent have an unmet need for it;

## LEVELS OF CONTRACEPTIVE USE AND DEMAND BY SEVEN AGE GROUPS, MOST RECENT DATA




*Source:* UNFPA, 2013.

and 54 per cent have no need for contraception because they indicate they wanted their latest birth. According to the World Health Organization (2008), 75 per cent of adolescent births are categorized as "intended."

Compared to other age groups, adolescents who are married or in a union have both the lowest use of contraception and the highest levels of unmet need, hence, the lowest levels of demand satisfied for contraception. Lack of knowledge and fear or experience of side effects are major reasons for non-use or discontinuation.

In countries with a high prevalence of child marriage and a strong preference for sons, married girls face pressures to forego contraception until they give birth to a boy (Filmer et al., 2008). This analysis of 5 million births in 65 countries found evidence of preference for sons affecting fertility in South Asia, Eastern Europe, and Central Asia.

*Participants in the Comprehensive Empowerment Programme for the Reduction of Unplanned Pregnancies Among Adolescent Mothers, sponsored by Women Across Differences and UNFPA.*

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### *Gender-specific attitudes and behaviours*

Rigid ideals about appropriate attitudes and behaviours of girls, boys, women and men are learned and socially constructed norms that vary across local contexts and interact with sociocultural factors such as class or caste. These social and gender norms are carried out and reinforced on multiple levels, among individuals in peer groups and families and through community attitudes and practices (UNFPA, 2012a).

Differential treatment of boys and girls as they grow up begins early, and it continues throughout their lives. The result is that everyone—boys, girls, men and women—absorbs messages about how they ought or ought not to behave or think, and early on, begin to establish divergent expectations of themselves and other females and males. Often, these expectations can translate into practices and risk-taking that can have negative sexual and reproductive health outcomes, including adolescent pregnancy (UNFPA, 2012a). In many countries, boys and men are culturally validated for having multiple partners or having sex without a condom.

Many girls and young women say they do not use contraception—even when they know it is available and even though they have a right to it—because their male partners oppose it or view contraception negatively (Presler-Marshall and Jones, 2012). The risks of ignoring male opposition to contraception may be particularly serious for adolescent girls who are married or in a union. If married girls secretly use contraception, they may face beatings, divorce or other forms of punishment if they are caught or fail to produce children (Presler-Marshall and Jones, 2012). Where male attitudes are the prevailing or mainstream ones, girls may internalize these same attitudes and express similarly negative views to contraception.

### *Youth-friendly services*

Youth-friendly sexual and reproductive health services are those that are conveniently located, have opening hours that are aligned with young people's routines, provide a welcoming, non-judgmental atmosphere and maintain confidentiality. Lack of confidentiality, or the perception of it, forms a major barrier to girls' accessing contraception (Presler-Marshall and Jones, 2012). The effectiveness of stand-alone or parallel youth-friendly services in reducing adolescent pregnancy has not yet, however, been fully evaluated.

### *Services for girls who are pregnant*

Fewer than half the pregnant adolescents in Chad, Ethiopia, Mali, Niger and Nigeria have received any antenatal care from a skilled provider (Kothari et al., 2012). In these same five countries, even fewer delivered with the help of a skilled attendant. Meanwhile, a DHS analysis (Reynolds, et al., 2006) found that in some countries, including Brazil, Bangladesh, India and Indonesia, adolescents were less likely than women to obtain skilled care before, during and after childbirth.

Young first-time mothers are more likely than older mothers to experience delays in recognizing complications and seeking care, reaching an appropriate health care facility and receiving quality care at a facility (UNFPA, 2007). If an adolescent is unmarried, she may have the extra burden of being unfavourably judged by health-care providers and her community and family.

Antenatal and postnatal care are not only essential for the health of the girl and her pregnancy, but they also present opportunities to provide information and contraception that may help an adolescent prevent or delay a second pregnancy.

> "I started dating so that we could have food... ended up pregnant."
>
> *Malebogo, 19, Botswana*

## Sexual violence and coercion

The social and physical consequences of sexual violence among adolescents are dire, with immediate and enduring rights, health and social development implications (Jejeebhoy et al., 2005; Garcia-Moreno et al., 2005). Forced sex and intimate partner violence increase girls' vulnerabilities to pregnancy.

Young age is a known risk factor for a woman's likelihood of experiencing violence at the hands of an intimate partner (World Health Organization, 2010; Krug et al., 2002).

The World Health Organization defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim" (Krug et al., 2002: 149).

The World Health Organization, which characterizes sexual violence as a violation of human rights, estimates that some 150 million adolescent girls experienced forced sex or other forms of sexual violence in a single year, 2002 (Andrews, 2004). The first sexual experience of many young women is forced (Krug et al., 2002; Garcia-Moreno et al., 2005; UNFPA and Population Council, 2009).

Analysis of DHS surveys from 14 countries shows that the proportion of young women between 15 and 24 years old whose first sexual experience—within or before marriage—was non-consensual ranged widely from 2 per cent in Azerbaijan to 64 per cent in the Democratic Republic of the Congo (UNFPA and Population Council, 2009).

Likewise, a World Health Organization multi-country study in 10 countries found that the share of women reporting forced first sex ranged from about 1 per cent in Japan and Serbia to about 30 per cent in Bangladesh (Garcia-Moreno et al., 2005).

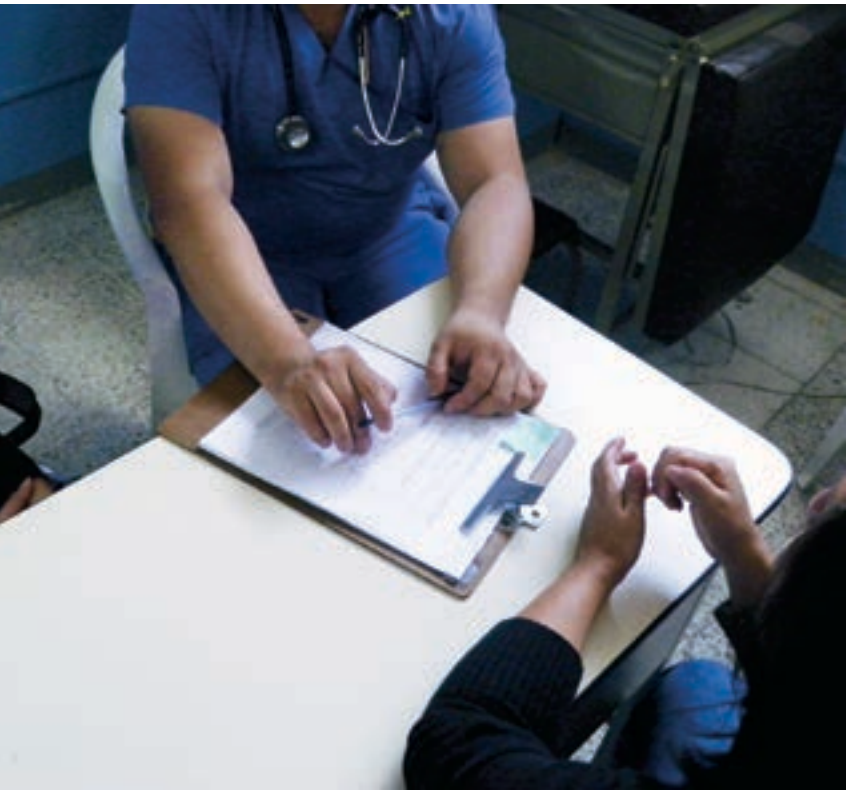
Forced sex also occurs within marriage. For example, an analysis of DHS surveys from 27 countries found that the proportion of young women, ages 15 to 24, who reported sexual violence perpetrated by their husbands ranged from 1 per cent in Nigeria to 33 per cent in the Democratic Republic of the Congo (UNFPA and Population Council, 2009).

Indeed, as a study in Nyeri, Kenya, among married and unmarried young women between the ages of 10 and 24 showed, married females were at even higher risk of experiencing sexual coercion than their unmarried, sexually active counterparts (Erulkar, 2004).

Contrary to popular belief, perpetrators of sexual violence are typically boys and men known to their adolescent victims: husbands, intimate partners, acquaintances or those in positions of authority. This finding is observed across all regions of the world (Jejeebhoy and Bott, 2005; Jejeebhoy et al., 2005; Bott et al., 2012; Erulkar, 2004).

An estimated one in five adolescent girls experiences abuse during pregnancy (World Health Organization, 2007; Parker et al., 1994). Twenty-one per cent of adolescents experience intimate-partner violence within three months of delivery. Physical abuse and violence during pregnancy have been recognized as important risk factors for poor health in both mothers and infants (World Health Organization, 2007; Newberger et al., 1992).

Coerced sex is "the act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will" (Heise et al., 1995). Several national and sub-national studies suggest that between 15 per cent and 45 per cent of young women who had engaged in premarital sex reported at least one coercive experience.



*Guatemala's Survivors Foundation counsels girls and women who have been sexually assaulted.*
© UNFPA Guatemala

▲ *Young people in Ecuador participate in a march organized to mark adolescent pregnancy prevention week.* ©UNFPA/Jeannina Crespo

An adolescent girl whose sexual partner is considerably older is at greater risk of coerced sex, sexually transmitted infections, including HIV, and pregnancy. When a partner is significantly older, the power differential in the relationship is especially unfavourable for the girl, making it more difficult for her to negotiate the use of contraception, especially condoms, for protection against pregnancy and sexually transmitted infections. In five of 26 countries covered by a recent study (Kothari et al., 2012), at least 10 per cent of adolescent girls (ages 15 to 19) reported having had sex in the preceding year with a man who was at least 10 years older: Dominican Republic (10 per cent), the Republic of the Congo (11 per cent), Armenia and Zimbabwe (15 per cent) and Ethiopia (21 per cent).

Unmarried girls may face an additional form of sexual coercion that makes them vulnerable to pregnancy: pressures from transactional sex. One study in Zimbabwe found, for example, that of 1,313 men surveyed, 126 of them (10.4 per cent) reported having traded money or gifts for sex with an adolescent girl in the preceding six months (Wyrod et al., 2011). These "gifts" are "imbued with power differentials and offered to girls who have little voice to say 'no'" (Presler-Marshall and Jones, 2012).

Human rights bodies condemn sexual violence against women and adolescent girls in all its forms, whether it occurs in times of peace or in times of conflict by State actors or by private persons, whether it occurs in the home, schools, the workplace, or in health care facilities, or whether it results in a pregnancy or not. The rights to be free from violence, ill treatment, and torture, as well as the rights to life, health, and non-discrimination create a government duty to protect women and adolescent girls from

violence, regardless of the perpetrator (Center for Reproductive Rights, 2009).

The ICPD Programme of Action recognizes that one of the cornerstones of population and development-related programmes is eliminating all forms of violence against women, including sexual abuse and violence against children and adolescents (ICPD, Principles 4 and 11).

## School, peers, partners

### *School*

The longer girls stay in school, the more likely they are to use contraception and prevent pregnancy and the less likely they are to marry young (Lloyd, 2006; UNICEF, 2006; Lloyd and Young, 2009). Girls who are not in school are more likely to get pregnant than those remaining in school, whether or not they are married.

▼ *Girls in Rajasthan, India learning to read.*
© Mark Tuschman/ Educate Girls India

The Secretariat of the 65th World Health Assembly in 2012 called education "a major protective factor for early pregnancy: the more years of schooling the fewer early pregnancies," adding that "birth rates among women with low education are higher than those with secondary or tertiary education."

While the correlation between educational attainment and lower rates of adolescent pregnancy is well documented, the direction of causality and the sequencing are still the subject of some debate, as noted in the previous chapter. In many countries, early school-leaving is attributed to adolescent pregnancy; however, pregnancy and early marriage are more likely to be consequences rather than causes of early school leaving. Once girls have left school, pregnancy and/or marriage are likely to follow in short order (Lloyd and Young, 2009).

Educational attainment and sexual and reproductive transitions are closely related in that a pregnancy or an early marriage can derail a girl's schooling. As boys typically marry later than girls and do not face the same risks and responsibilities associated with pregnancy, their sexual maturation and behaviour do not have the potential to interfere with their school progress in the same way (Lloyd and Young, 2009).

A 2012 study provides evidence that interventions that encourage school attendance are effective in reducing overall adolescent fertility, making a case for expanding educational opportunities for girls and creating incentives for school continuation (McQueston et al., 2012). Enabling or encouraging girls to attend

and stay in school, however, may require breaking down economic barriers to access education by, for example, waiving fees for girls from poorer households. It may also require mitigating risks to girls' health and safety by, for example, adequately protecting girls from sexual abuse or violence in school and on their way to and from school, and providing a culturally sensitive school environment.

> "I started living with my partner at age 14. My plans were to have a stable relationship, to keep on with school and to become a professional. However I got pregnant at 15. At first I didn't even know how to take care of a newborn. I had to quit school."
>
> *Marcela, 18, El Salvador*

*Age-appropriate, comprehensive sexuality education*

Few young people receive adequate preparation for their sexual and reproductive lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections, including HIV. Many young people approach adulthood faced with conflicting and inaccurate information and messages about sexuality. This is often exacerbated by embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers, at a time when it is most needed.

In many instances, adolescents have inaccurate or incomplete information about sexuality, reproduction and contraception (Presler-Marshall and Jones, 2012). A study in Uganda, for example, found that one in three adolescent males and one in two females did not know that condoms should be used only once (Presler-Marshall and Jones, 2012; Bankole et al., 2007). A study in Central America found that one in three adolescents did not know a pregnancy could occur the first time a girl had sex (Presler-Marshall and Jones, 2012; Remez et al., 2008). And a study in one area in Ethiopia showed that although nearly all adolescents knew that unprotected sex could result in HIV infection, less than half realized it could also result in pregnancy (Presler-Marshall and Jones, 2012; Beta Development Consulting, 2012).

Comprehensive sexuality education is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills.

The Programme of Action of the ICPD recognized that providing adolescents with information is the first step towards reducing adolescent pregnancies and unsafe abortions and empowering adolescents to make

## PROPORTION OF ADOLESCENTS SURVEYED AGES 12-14, BY SEX AND COUNTRY, ACCORDING TO THEIR ATTITUDES REGARDING PROVISION OF SEXUALITY EDUCATION FOR YOUNG PEOPLE, 2004

| Sex/country | It is important that sex education be taught in school | 12-14 year olds should be taught about using condoms to avoid AIDS | Providing sexuality education to young people does not encourage them to have sex |
|---|---|---|---|
| Females | | | |
| Burkina Faso | 78 | 73 | 63 |
| Ghana | 91 | 49 | 68 |
| Malawi | 67 | 76 | 68 |
| Uganda | 82 | 76 | 49 |
| Males | | | |
| Burkina Faso | 81 | 78 | 59 |
| Ghana | 89 | 63 | 62 |
| Malawi | 73 | 73 | 68 |
| Uganda | 78 | 76 | 52 |

*Source:* Bankole and Malarcher, 2010.

conscious and informed decisions (paragraphs 7.44 and 11.9). Human rights treaty-monitoring bodies have called on governments to meet obligations to provide access to sexuality education and information.

By reaching adolescents early in puberty, school settings can provide young people with the information and skills they will need to make responsible decisions about their future sexual lives (Kirby, 2011).

Through school-based comprehensive sexuality education programmes, educators have an opportunity to encourage adolescents to delay sexual activity and encourage them to behave responsibly when they eventually engage in consensual sexual activity, particularly by using condoms and other modern methods of contraception (Kirby, 2011).

Sexuality education is more likely to have a positive impact when it is comprehensive and implemented by trained educators who are knowledgeable about human sexuality, understand behavioural training and are comfortable interacting with adolescents and young people on sensitive topics. The curriculum should focus on clear reproductive health goals, such as preventing unintended pregnancy, and on specific risk behaviours and protective behaviours that lead directly to the achievement of those health goals (Kirby, 2011).

Curriculum-based programmes are more effective if they also develop life skills, address contextual factors, and focus on the emerging feelings and experiences that accompany sexual and reproductive maturity. To be effective in preventing pregnancy and sexually transmitted infections, sexuality education should be linked with reproductive health services, including contraceptive services (Chandra-Mouli et al., 2013).

Parents and educators sometimes fear that sexuality education will encourage adolescents to have sex. But research shows that sexuality education does not hasten the initiation of or increase sexual activity (UNESCO, 2009). A review of 36 sexuality education programmes in the United States concluded, for example, that when information about abstinence and contraception is provided, adolescents do not become more sexually active or have an earlier sexual debut (Advocates for Youth, 2012).

A study covering four African countries shows that adolescents generally welcome sexuality education in schools. The majority of the girls and boys surveyed also said that sexuality education in schools did not encourage them to have sex (Bankole and Malarcher, 2010).

For girls and boys to benefit from a school-based sexuality-education curriculum, they of course need to be *in school*. In some countries, two-thirds of the girls between the ages of 12 and 14 are not in school. That means that school-based sexuality education misses the majority of that cohort (Biddlecom, et al., 2007) and underscores a need to reach those who are not in school.

In countries where large numbers of young people are not enrolled in secondary school, sexuality education programmes and those aimed at reducing the incidence of sexually transmitted infections can also be implemented in clinics, through radio programmes, and in community settings that attract young people.

But the availability of comprehensive sexuality education alone does not guarantee impact. Quality, tone, content and delivery are also important. Teachers who feel awkward with the subject matter or who are judgmental about adolescent sexuality may impart information that is inaccurate, confusing or incomplete. Comprehensive sexuality education that is offered to boys and girls in the same classroom may result in low attendance by girls in some settings (Pattman and Chege, 2003; Presler-Marshall and Jones, 2012).

The Children's Rights Committee has also noted that "consistent with their obligations to ensure the right to life, survival and development of the child (article 6), States parties [to the Convention on the Rights of the Child] must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality" (Committee on the Rights of the Child, 2003a).

International human rights bodies have noted that the rights to health, life, non-discrimination, information and education require States to both remove barriers to adolescent access to sexual and reproductive health information and to provide comprehensive and accurate sexuality education, both in and out of schools. Treaty-monitoring bodies have also recommended

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that sexual and reproductive health education be made a compulsory and robust component of the official curricula in primary and secondary schools, including vocational schools (Center for Reproductive Rights, 2008a; See also ICPD, paragraph 11.9).

### Peers

Peers can influence how adolescents view becoming pregnant, as well as their attitudes towards preventing pregnancy, dropping out of school or staying enrolled until graduation. Peer pressure can thus discourage early sexual debut and marriage, or it can reinforce the likelihood of early and unprotected sexual activity (Chandra-Mouli et al., 2013).

> "I didn't know he intended to impregnate me this time, I remember our plan was when I turn 18... I was not ready to have a baby yet, which made me think of not going through with my pregnancy, but my friends insisted I should since my partner and I were already living together... But I knew I was not really ready yet."
>
> *K.C., 18, pregnant at 17, the Philippines*

### Partners

Another influence is a girl's sexual partner or spouse, including his age and his views on marriage, sex, gender roles, contraception, pregnancy and childbearing.

Research on the early sexual activity of adolescent males shows that unhealthy perceptions about sex, including seeing women as sexual objects, viewing sex as performance-oriented and using pressure or force to obtain sex, begin in adolescence and may continue into adulthood. Perceptions of masculinity among young men and adolescent boys are a driving force for male risk-taking behaviour, including unsafe sexual practices.

#### *Men and boys: partners in the process*

Strengthening opportunities for boys and young men to participate in supporting gender-equality efforts can have an impact not only on women and girls but also on their own lives (UNFPA 2013b).

Boys and men are often socialized to believe that the enjoyment of sexual relations is viewed as their prerogative, and they are taught to take the lead in their sexual relationships, creating significant pressure (and insecurity). Traditional views of what it means to be a man can encourage men to seek out multiple sexual partnerships and to take sexual risks (UNFPA, 2012).

Though women more consistently suffer the negative effects of harmful gender norms across their lifetimes, societies also socialize their men, male adolescents and boys in ways that drive poor sexual and reproductive health outcomes. In many societies, men are encouraged to assert their manhood by taking risks, asserting their toughness, enduring pain, being independent providers, and having multiple sex partners. The roles and

responsibilities of breadwinner and head of the household are inculcated into boys and men; fulfilling these behaviours and roles are dominant ways to affirm one's manhood.

Gender norms as a rule establish and reinforce women's subordination to men and drive poor sexual and reproductive health outcomes for both men and women. Women are often prevented from learning about their rights and from obtaining the resources that could help them plan their lives and families, sustain their advancement in school, and support their participation in the formal economy (Greene and Levack, 2010). Men are often not offered most sources of sexual and reproductive health information and services and may develop the sense that planning families is not their domain, but rather is women's responsibility.

In the context of sexual and reproductive health and reproductive rights, there is growing recognition among the international community that addressing gender inequities in health, promoting sexual and reproductive health and reproductive rights, and preventing HIV and gender-based violence at all levels in society is not possible without efforts to directly engage men and boys as partners in these processes (International Planned Parenthood Federation, 2010).

### EXCERPTS FROM THE ICPD PROGRAMME OF ACTION ON GENDER EQUALITY

The objectives are to achieve equality and equity based on harmonious partnership between men and women and enable women to realize their full potential; to ensure the enhancement of women's contributions to sustainable development through their full involvement in policy- and decision-making processes at all stages...; to ensure that all women, as well as men, are provided with the education necessary for them to meet their basic human needs and to exercise their human rights.

Countries should act to empower women and should take steps to eliminate inequalities between men and women as soon as possible by establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life; promoting the fulfilment of women's potential through education, skill development and employment, giving paramount importance to the elimination of poverty, illiteracy and ill health among women; eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health... (Programme of Action, paragraphs 4.1–4.4)

## Family-level determinants

Unless a girl lives in a child-headed household or is homeless, she is going to be influenced by her family or guardian. Family-level determinants include the stability and cohesiveness of the family; the degree to which there is conflict or violence in the home; the extent of household poverty or wealth; the presence of role models; and the reproductive history of parents, especially whether the mother and father married as children or whether the mother became pregnant as an adolescent. Other family-level determinants include the education level of adults and their expectations for their children, the level of communication within the household, the intensity of cultural and religious values, and the views of family decision makers on gender roles and child marriage.

### Child marriage

The prevalence of child marriage depends in part on national policies and laws and their enforcement, on community-level norms and on the extent of poverty in a country, but it is at the level of the family where decisions are made about forcing a child into a marriage or union.

By definition, child marriage occurs when at least one of the partners is under age 18. Every

day, 39,000 girls are married. Once a girl marries, she is usually expected to have a baby. About 90 per cent of adolescent pregnancies in developing countries are within marriage.

About 16 per cent of girls in developing countries (excluding China) marry before age 18, compared with 3 per cent of boys. *One out of nine girls is married before age 15.* Adolescent birth rates are highest where child marriage is most prevalent; and independent of the overall wealth of a nation, girls in the lowest income quintile are more likely to have a baby as an adolescent than their higher income peers.

Child marriage persists for reasons including local traditions or parents' beliefs that it can safeguard their daughter's future. But more often than not, child marriage is the consequence of limited choices. Girls who miss out or drop out of school are especially vulnerable—while the more exposure a girl has to formal education and the better-off her family is, the more likely marriage is to be postponed. Simply stated, when girls have life choices, they marry later (UNFPA, 2012).

Married girls are often under pressure to become pregnant immediately or soon after marriage, although they are still children themselves and know little about sex or reproduction. A pregnancy too early in life before a girl's body is fully mature is a risk to both mother and baby.

In 146 countries, State or customary laws allow girls younger than 18 to marry with the consent of parents or other authorities; in 52 countries, girls under age 15 can marry with parental consent. In contrast, 18 is the legal age for marriage without consent among males in 180 countries. The lack of gender equality in the legal age of marriage reinforces the social norm that it is acceptable for girls to marry earlier than boys.

Men exercise disproportionate power in nearly every aspect of life, which restricts women's and girls' exercise of their rights and denies them an equal role in their households and communities. Unequal gender norms tend to place a higher value on boys and men than on girls and women. When girls from birth lack the same perceived value as boys, families and communities may discount the benefits of educating and investing in their daughters' development.

In addition, girls' perceived value may shift once they reach puberty. Child marriage is often seen as a safeguard against premarital sex, and the duty to protect the girl from sexual harassment and violence is transferred from father to husband.

Customary requirements such as dowries or bride prices may also enter into families' considerations, especially in communities where families can pay a lower dowry for younger brides.

Families, particularly those who are poor, may want to secure a daughter's future where there are few opportunities for girls to be economically productive. Families may want to build or strengthen alliances, pay off debts, or settle disputes. They may want to be sure that their children have enough children to support them in old age. They may want to divest themselves of the burden of having a girl. In extreme cases, they may want to earn money by selling the girl.

Families may also see child marriage as an alternative to education, which they fear might make a girl unsuitable for responsibilities as wife and mother. They may share the social norms and marriage patterns of their neighbours and community or the historical patterns within their family. Or they may fear that the girl will bring dishonour to the family if she has a child outside marriage or chooses an inappropriate husband.

Child marriage does not always lead to immediate sexual relations, however. In some cultures, a girl may marry very young but not live with her husband for some time. For example, in Nepal and Ethiopia, delayed consummation of marriage is common among young brides, especially in rural areas.

While they are often viewed as adults in the eyes of the law or by custom (when children are married, they are often emancipated under national laws and lose protections as children), child brides need particular attention and support, due to their exceptional vulnerability (Committee on the Rights of the Child, 2003). Compared to older women, child brides are generally more vulnerable to domestic violence, sexually transmitted infections and unintended pregnancy due to power imbalances, including those that may result from age differences (Guttmacher Institute and International Planned Parenthood Federation, 2013).

International human rights standards condemn child marriage. The Universal Declaration of Human Rights, the foundational human rights instrument, declares that "marriage shall be entered into only with the free and full consent of the intending spouses." The Committee on Economic, Social, and Cultural Rights and the Committee on the Elimination of Discrimination Against Women have repeatedly condemned the practice of child marriage. The Human Rights Committee has joined other treaty bodies in recommending legal reform to eliminate child marriage (Center for Reproductive Rights, 2008), and the Convention on the Rights of the Child and its corresponding committee require States parties to "take measures to abolish traditional practices that are harmful to children's health."

## WHEN CHILDREN GIVE BIRTH TO CHILDREN

Radhika Thapa was just 16 years old when she married a 21-year-old man three years ago. Now, she is expecting a baby and is well into the last months of her pregnancy. This is not the first time she has been with child. Her first two pregnancies ended in miscarriages.

"The first time I conceived I was just 16, I didn't know much about having babies, nobody told me what to do," Thapa says, while assisting customers at the vegetable store she runs with her husband in the small town of Champi, some 12 kilometres from Nepal's capital, Kathmandu. "The second time I wasn't ready either, but my husband wanted a baby so I gave in," she admitted. After the second miscarriage, Thapa's doctors urged her to wait a few years before trying again, but she was under immense pressure from her in-laws, who threatened to "find another woman for her husband if she kept losing her babies."

According to the 2011 Nepal Demographic and Health Survey, 17 per cent of married adolescent girls between ages 15 and 19 are either pregnant or are mothers already. The survey also shows that 86 per cent of married adolescents do not use any form of contraception, meaning that few girls are able to space their births.

"You are talking about a child giving birth to another child," says Giulia Vallese, Nepal's representative for the United Nations Population Fund (UNFPA).

"When girls get pregnant their education stops, which means a lack of employment opportunities and poverty," says Bhogedra Raj Dotel of the Government's family planning and adolescent sexual reproductive health division.

Menuka Bista, 35, is a local female community health volunteer in Champi, assisting about 55 households in her area. Bista has been advising Thapa, to ensure that the girl has a safe pregnancy. "Radhika...knows she needs to go to the doctor and eat nutritious food for her baby to be safe, but she doesn't make decisions about her body: her husband and in-laws do," Bista said.

This observation is echoed in research carried out by various experts: according to Dotel, husbands and in-laws make all the major decisions about a woman's reproductive health, from what hospital she visits to where she will deliver her child. For this reason, Vallese believes it is important to train husbands and family members on reproductive health and rights.

*—Malika Aryal, Inter Press Service*

### Parents

Parents play central roles, both directly and indirectly in determining the future of their adolescent daughters. As role models, parents have the power to reinforce and perpetuate gender inequality or instil beliefs that boys and girls should enjoy the same rights and opportunities in life. They may impart information about sexuality and prevention of pregnancy or they may withhold vital information. They may place a value on education for both their daughters and sons, or they may socialize girls to believe that their only destiny is marriage and having children. They may help develop girls' life skills and encourage them to be autonomous, or they may succumb to economic and community pressures and force their girls into marriage and a lifetime of dependency.

## Individual-level determinants

Adolescence is a critical developmental transition between childhood and young adulthood, a period in which important individual, behavioural and health trajectories are established—and a period in which problematic or harmful patterns can also be prevented or ameliorated, and positive patterns enhanced.

A pivotal moment in adolescence is puberty. On average, girls enter puberty 18 to 24 months before boys, whose physical development is slower and can continue through late adolescence. For girls, many of the developmental changes associated with adult reproductive capabilities are often complete before intellectual and decision-making capacities fully mature. Puberty is a time when specific gender roles and expectations are reinforced.

*Girls attend class in rural Rajasthan, India.*

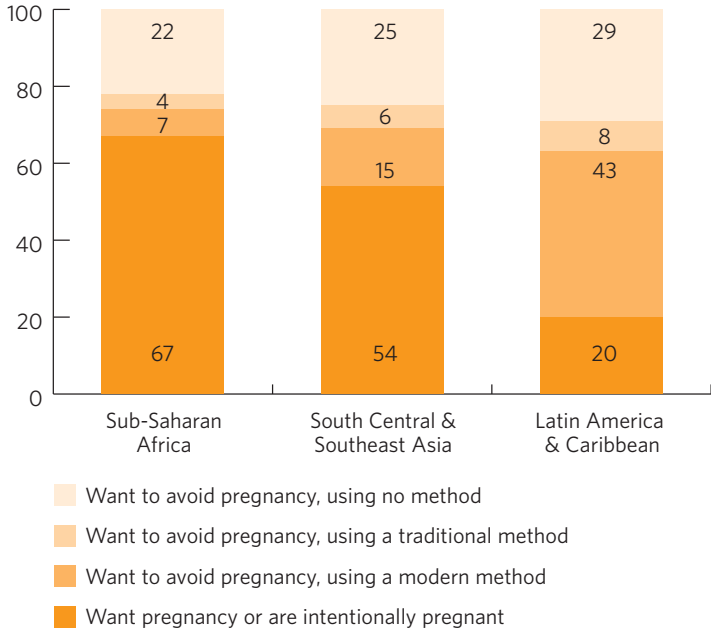
© Mark Tuschman/ Educate Girls India

In much of Europe and North America, female puberty is generally completed between ages 12 and 13, and across the world the age of puberty is declining, especially in middle- and high-income countries. It is not uncommon in some developed countries for girls today to enter puberty as early as age eight or nine. Factors associated with age of puberty include nutrition and sanitation. As the health status of populations improves, the age of menarche declines. Boys generally go through puberty between the ages of 14 and 17.

Data from Scandinavian countries, for example, show that the average age of menarche has declined from between 15 and 17 years in the mid-1800s to between 12 and 13 years today. Data from the Gambia, India, Kuwait, Malaysia, Mexico and Saudi Arabia also show declines in the age at menarche. The mean age of menarche in Bangladesh is 15.8 and that for Senegal is 16.1, with menarche in other developing countries being a year or two earlier (Thomas et al., 2001).

## PREGNANCY DESIRES AND CONTRACEPTIVE USE

The proportion of married adolescents who are or wish to become pregnant varies widely by region




*Source:* Guttmacher Institute, 2010.

### Socialization and expectations

Research suggests that some adolescent girls desire to become pregnant. One study showed that 67 per cent of married adolescents in sub-Saharan African want to be pregnant or are intentionally pregnant (Guttmacher Institute, 2010). In places where the culture generally idealizes motherhood, pregnancy may be seen by an adolescent as a means of gaining status or becoming an adult. It may also be perceived by girls as a means for escaping abusive families (Presler-Marshall and Jones, 2012). Helping girls see themselves as more than potential mothers—and helping communities do the same—is key to reducing the number of adolescent pregnancies (Presler-Marshall and Jones, 2012).

As noted by Singh (1998), "From the perspective of the adolescent herself, and her family, the meaning and the consequences of childbearing during the teenage years range widely. These consequences vary from the positive—the fulfilment of an expected progression from childhood to the adult status conferred by marriage and motherhood and the joy and rewards of having a baby—to the negative—the assumption of the burden of carrying for and bringing up a child before the mother is emotionally or physically prepared to do so."

Most research on motivations towards pregnancy, however, has focused on adolescents in *developed* countries, often from low-income households or who are members of a

disadvantaged minority. This research suggests that some girls may want a baby to love (and to love them). They may believe that a baby will strengthen their ties to their partner. If their peers have babies, they may want one too. They may want to demonstrate that they are responsible and mature enough to be a mother. If they feel they have no other options, they may feel they have nothing to lose and possibly a few things to gain (a baby, a relationship, status).

A qualitative study in Taung, South Africa (Kanku and Mash, 2010) drew on findings from focus groups of pregnant adolescent girls, young women who had had an adolescent pregnancy, and adolescent boys. It concluded, "Most teenagers perceived falling pregnant as a negative event with consequences such as unemployment, loss of a boyfriend, blame from friends and family members, feeling guilty, difficulty at school, complications during pregnancy or delivery, risk of HIV, secondary infertility if an abortion is done and not being prepared for motherhood. A number of teenagers, however, perceived some benefits and saw that it could be a positive event depending on the circumstances." The study concluded, "Multifaceted and intersectoral approaches are required, and it is likely that strategies to reduce teenage pregnancy will also impact on HIV and other sexually transmitted infections."

"I decided to have a child because I wanted to feel like an adult... Now I have to make it work. For the sake of my son, I need to go back to school and get a proper education. I now know that my destiny is not to change diapers. I want to be a lawyer and change the world. For my son."

*Jipara, 17, Kyrgyzstan*

## Adolescents' evolving capacities

The Committee on the Rights of the Child, at its 33rd session in 2003, called adolescence "a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviours and roles involving new responsibilities requiring new knowledge and skills" (Committee on the Rights of the Child, 2003).

With adolescence, the Committee stated, come "new challenges to health and development owing to their relative vulnerability and pressure from society, including peers, to adopt risky health behaviour. These challenges include developing an individual identity and dealing with one's sexuality. The dynamic transition period to adulthood is also generally a period of positive changes, prompted by the significant capacity of adolescents to learn rapidly, to experience new and diverse situations, to develop and use critical thinking, to familiarize themselves with freedom, to be creative and to socialize."

The Convention on the Rights of the Child acknowledges minors' "evolving capacities," or their acquisition of sufficient maturity and understanding to make informed decisions on matters of importance, including on sexual and reproductive health services. It also recognizes that some minors are more mature than others (Article 5; Committee on the Rights of the

Child, 2003; CEDAW, 1999; CRPD, Article 7) and calls on States to ensure that appropriate services are made available to them independent of parental or guardian authorization (Committee on the Rights of the Child, 2003; CEDAW, 1999).

Nine years earlier, the Programme of Action of the International Conference on Population and Development, which continues to be the basis for the work of UNFPA today, also acknowledged adolescents' evolving capacities and called on governments and families to make information and services available to them, taking into account the rights and responsibilities of parents (paragraph 7.45). The 179 governments that endorsed the Programme of Action also agreed that the "response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. In particular, information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies…. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction" (Programme of Action, paragraph 7.41).

> "Sometimes I think my pregnancy and motherhood in those years made me stronger. I am more prepared to face all of life's problems. But, on the other hand, I believe that being a mother at that age complicated my life... I have not gone through all the steps of growing up as my peers did. I did not have all the advantages of being a young person, and I did not have equal opportunities for success."
>
> *Zeljka, 27, pregnant at 17, Bosnia-Herzegovina*

### Other individual-level determinants

Factors that place individuals at risk for early pregnancy do not start only with the onset of puberty; rather, many of the risk factors they experience have their origins in early childhood or even generations before they were born. In high-income countries, for example, girls who become pregnant at an early age are significantly more likely than their non-pregnant peers to have had a mother who had an early pregnancy. Another influence is maternal nutrition, which affects birth weights and can have life-long consequences. In 1995, physician and researcher David Barker hypothesized that newborns with low birth weights (often the case with babies born to poor adolescent girls) went on as adults to be at significantly greater risk than average for a host of non-communicable diseases (Barker, 1995).

## The special vulnerabilities of girls ages 10 to 14

Very young adolescents, ages 10 to 14, undergo tremendous physical, emotional, social, and intellectual changes. During this period, many very young adolescents go through puberty, have their first sexual experiences, and in the case of girls, may be married as children.

The onset of puberty brings substantial physical changes, as well as vulnerabilities to boys and, especially, to girls. Puberty for girls begins on average two years earlier than for boys. This fact, combined with very restrictive gender norms and limited assets, often leaves many girls with only their physical bodies as a core reliable asset. This asset can be potentially exploited for non-consensual, unprotected, and underage sexual relations; and it may also subject girls to marriage against their rights and will, with the expectation that they will bear children as soon as possible.

For most children, early adolescence is marked by good health and stable family circumstances, but it can also be a period of vulnerability because of intense and rapid transitions to new roles and responsibilities as caretakers, workers, spouses, and parents. In many countries, the impact of HIV, poverty, and political and social conflict on families and communities has eroded traditional safety nets and increased the vulnerability of young adolescents (UNFPA and the Population Council, n.d.).

When children of this age are neither living with their parents nor attending school, there is a good chance that they are not receiving familial or peer support to properly deal with the challenges they face and are not being given adequate opportunity to develop into productive members of society. In some settings, young female adolescents are domestic workers, migrants from rural communities in search of work and an education, or are fleeing a forced marriage. Others may already be child brides and are now living with their spouse and, possibly, his family. These youth are among the least likely to seek out and receive social services and therefore require a proactive set of prescriptions to minimize their vulnerability to exploitation.

DHS data from 26 sub-Saharan African countries show that up to 41 per cent of girls between the ages of 10 and 14 were not living with either parent (although some may been living with other relatives). Somewhat smaller shares of girls in that age group were not living with either parent in Latin America and the Caribbean. The lowest proportions were in Asia (World Health Organization, 2011b).

"When I went into labour, they brought the traditional *daya* midwife. She didn't pay attention to the size or the position of the fetus. The whole day, I was in pain, holding onto the rope until I had no energy left in me. I thought I was going to die. Then they took me to the hospital, which was over two hours away. The moment I reached there I lost consciousness. And when I woke up, they told me my baby had died."

*Awatif, 33, pregnant at 14, Sudan*

Young people who are not living with one or both parents are also at a higher risk of participating in illegal and unsafe work. An estimated 30 per cent of girls 10 to 14 were working in sub-Saharan Africa, compared with 26 per cent and 27 per cent, respectively, in Asia and the Pacific, and 17 per cent and 5 per cent, respectively, in Latin America and the Caribbean (World Health Organization, 2011b).

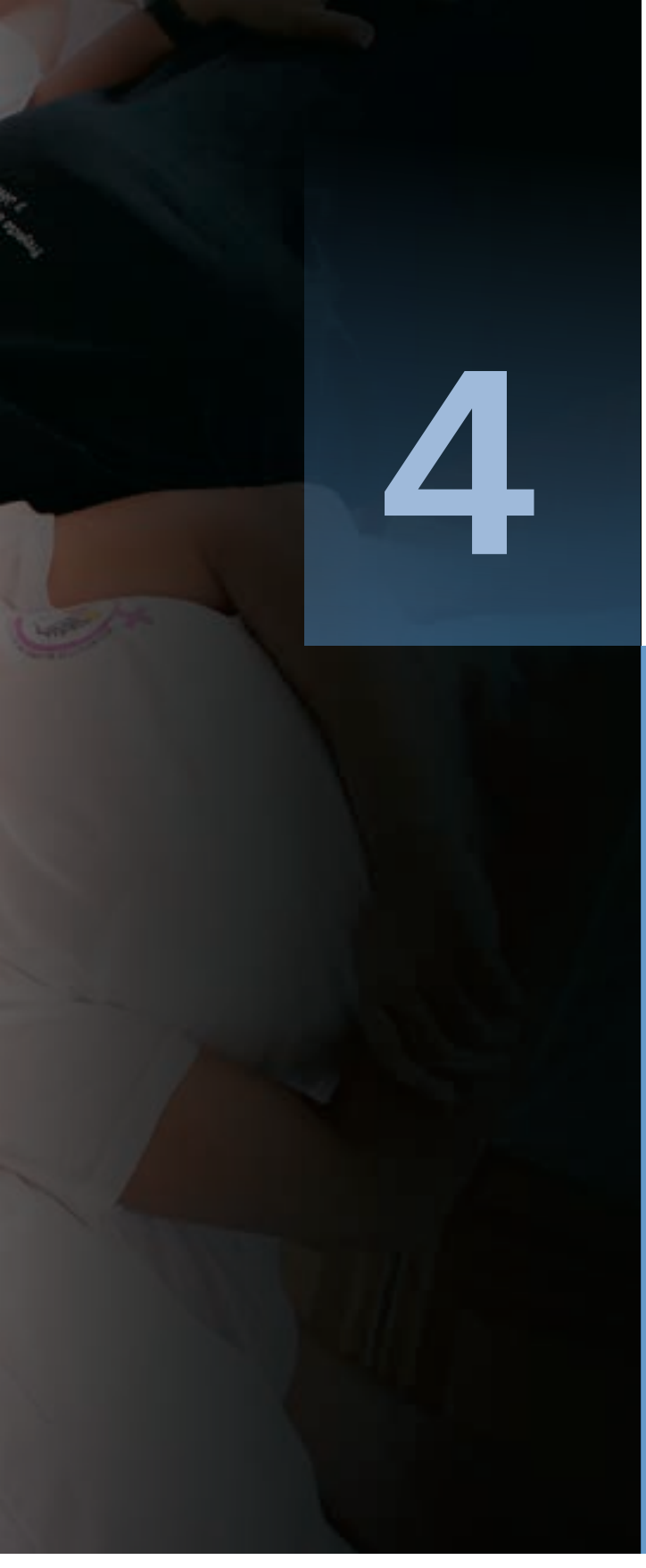
Also, most comprehensive sexuality education is delivered through school-based curricula. However, not all adolescents attend school and not all remain in school until they initiate sex. Married girls between the ages of 10 and 14 and who are not in school have virtually no access to sexuality education, further increasing their vulnerability to pregnancy.

> "I was 14 years old and was in high school when I had to stop going to school because my family did not have money to pay my school fees. My mother used to send my sister and me to the market to beg for something to bring home to eat. One day, we begged two gentlemen for some money. They gave 2,000 Congolese Francs [about $2] to my sister to buy food to take home. Once my sister left, they took me to a pub and bought me a sweet drink, but it had something in it that put me to sleep. I woke up in a health center, where nurses told me that I had been raped. I became pregnant."
>
> *Chada, 16, Democratic Republic of the Congo*

## Conclusion

The determinants of adolescent pregnancy are complex, multidirectional, multidimensional and vary significantly across regions, countries, age and income groups, families and communities.

Pressures from all levels conspire against girls and lead to pregnancies, intended or otherwise. National laws may prevent a girl from accessing contraception. Community norms and attitudes may block her access to sexual and reproductive health services or condone violence against her if she manages to access services anyway. Family members may force her into marriage where she has little or no power to say "no" to having children. Schools may not offer sexuality education, so she must rely on information (often inaccurate) from peers about sexuality, pregnancy and contraception. Her partner may refuse to use a condom or may forbid her from using contraception of any sort. And menarche may be wrongly seen by her family or older husband as readiness for childbearing. No matter how much a girl wishes to claim her childhood, go to school and reach her full potential, the forces working against her can be overwhelming.



# 4

# Taking action

Multilevel interventions that aim to develop girls' human capital, focus on their agency to make decisions about their reproductive health, and promote gender equality and respect for human rights have had documentable impact on preventing pregnancies.

◀ *Youth peer providers from the AMNLAE teen programme in Nicaragua.*

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Sexual and reproductive health and full enjoyment of rights are central to adolescents' transition into adulthood and are vital to adolescents' identity, health, well-being and personal growth, development and fulfillment of their potential in life.

Fully engaged, educated, healthy, informed and productive adolescents can help break multigenerational poverty and can contribute to the strengthening of their communities and nations. Countries with a large share of their populations who are adolescents or young people have an opportunity to reap a substantial demographic bonus for their nations' economies, development, resilience and productivity. This requires investing in adolescents' and young people's human capital and expanding the range of choices and opportunities available to them. But many adolescents, especially girls, are denied the investments and opportunities that would enable them to realize their full potential. For example, 26 per cent of the world's adolescent girls and 17 per cent of boys between the ages of 11 and 15 are not in school.

Adolescent pregnancy is a symptom of underinvestment in girls' human capital and the societal pressures and structural inequities that prevent girls from making decisions about their health, sexual behaviour, relationships, marriage and childbearing and that critically influence whether they will be able to take full advantage of opportunities for education, employment and political participation (UNFPA, 2012d).

Preventing pregnancy thus requires dismantling the many barriers to adolescents' realization of their full potential and their ability to enjoy their rights. Paving the way to a safe and successful transition to adulthood involves engaging girls—and boys—in decision-making from the individual level to the policy-making level, enabling them to acquire the skills and the power to voice their perspectives and priorities. Actions that support this transition from adolescence to adulthood are also ones that can reduce the number of pregnancies to girls.

> "I think it is far too early in my life to have a child considering the time and the love a child needs."
>
> *Anders, 17, Denmark*

Because adolescent pregnancy is the result of diverse underlying societal, economic and other forces, preventing it requires multidimensional strategies that are oriented towards' girls empowerment and tailored to particular populations of girls, especially those who are marginalized and most vulnerable.

Addressing unintended pregnancy among adolescents requires holistic approaches. Because the challenges are great and complex, no single sector or organization can face them on its own. Only by working in partnership, across sectors, and in collaboration with adolescents themselves, can constraints on their progress be removed.

## Investing in girls

Many of the actions by governments and civil society that have lowered adolescent fertility were designed to achieve *other* objectives, such as keeping girls in school, preventing HIV infection, or stopping child marriage. All of these

actions have in some way contributed to girls' human capital development, imparted information or skills to empower girls to make decisions in life and upheld or protected girls' basic human rights.

## The protective effects of education

In 2006, Duflo et al. (2006) studied the impact of three school-based HIV-prevention interventions in Kenya: the training of teachers in the Government's HIV/AIDS-education curriculum; the encouragement of students to debate the role of condoms and write essays on how to protect themselves from HIV/AIDS; and a measure to reduce the cost of education. The study involved 70,000 students from 328 primary schools and looked at the effectiveness of these interventions on childbearing, seen by the study's authors as a proxy for risky behaviours that may result in pregnancy. After two years, the study found that the teacher-training programme had little impact on students' knowledge, self-reported sexual activity or condom use. The condom debates and essays were found to increase practical knowledge and self-reported use of condoms, but yielded no concrete data related to pregnancy and childbearing. However, the reduction in the cost of education—by providing free school uniforms for students in the sixth grade—reduced dropout rates and adolescent childbearing.

Kenya abolished school fees in 2003. Since then, the main financial barrier to accessing primary education has been the cost of school uniforms, which cost about $6 each. The dropout rate among girls who received free uniforms decreased 15 per cent. This decrease translated into a 10 per cent reduction in adolescent childbearing. Reducing the cost of education helped girls stay in school longer and also

*Girls in a boarding school in Nyamuswa, Tanzania.*

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decreased the chances of their marrying and having children.

In a later study in Kenya, Duflo et al. (2011) found that simply providing children with school uniforms was sufficient to increase enrolment, reduce the drop-out rate by 18 per cent and lower the pregnancy rate by 17 per cent. "The children already enrolled in sixth grade classes were given a free uniform. Implementers also announced that students still enrolled in school the following year would be eligible for a second uniform, and distributed uniforms again the following year." (Duflo et al., 2011) The reduction in the number of pregnancies, however, occurred "entirely through a reduction in the number of pregnancies within marriage" as "there was no change in the out-of-wedlock pregnancy rate." This finding suggests that education's protective power lay in its ability to reduce child marriage rates, which in turn helped reduce adolescent pregnancy. Duflo et al. concluded that "giving girls…the opportunity to go to school if they want to do so is an extremely powerful (and inexpensive) way to reduce teen fertility."

Girls reap many immediate and long-term benefits from education, which, during adolescence, is a necessary first step for girls to overcome a history of disadvantage in civic life and paid employment (Lloyd, 2009). Enhancing the quality and relevance of learning opportunities for adolescents can prepare and empower girls for a range of adult roles beyond the traditional roles of homemaker, mother, and spouse, with benefits not just for the girls, but also for their families and communities. Being in school along with boys during adolescence fosters greater gender equality in the daily lives of adolescents. Education for adolescent girls helps them avoid early pregnancies, and lowers their risk of HIV/AIDS.

While primary education is a basic need for all, secondary education offers greater prospects of remunerative employment, with girls receiving substantially higher returns in the workplace than boys when both complete secondary school.

Gupta et al. (2008) found that "education continues to be the single most important predictor of age at marriage over time." School enrolment has a protective value in that school girls are "seen as children and not of marriageable age" (Marcus and Page, 2013). According to one study in Kenya (Duflo et al., 2011), "once one leaves school, sex and marriage are expected."

Decades of research have shown that education and schooling are key factors for not only reducing the risk of early sexual initiation, pregnancy, and early childbearing, but also for increasing the likelihood that adolescents will use condoms and other forms of contraception if they do have sexual intercourse (Blum, 2004).

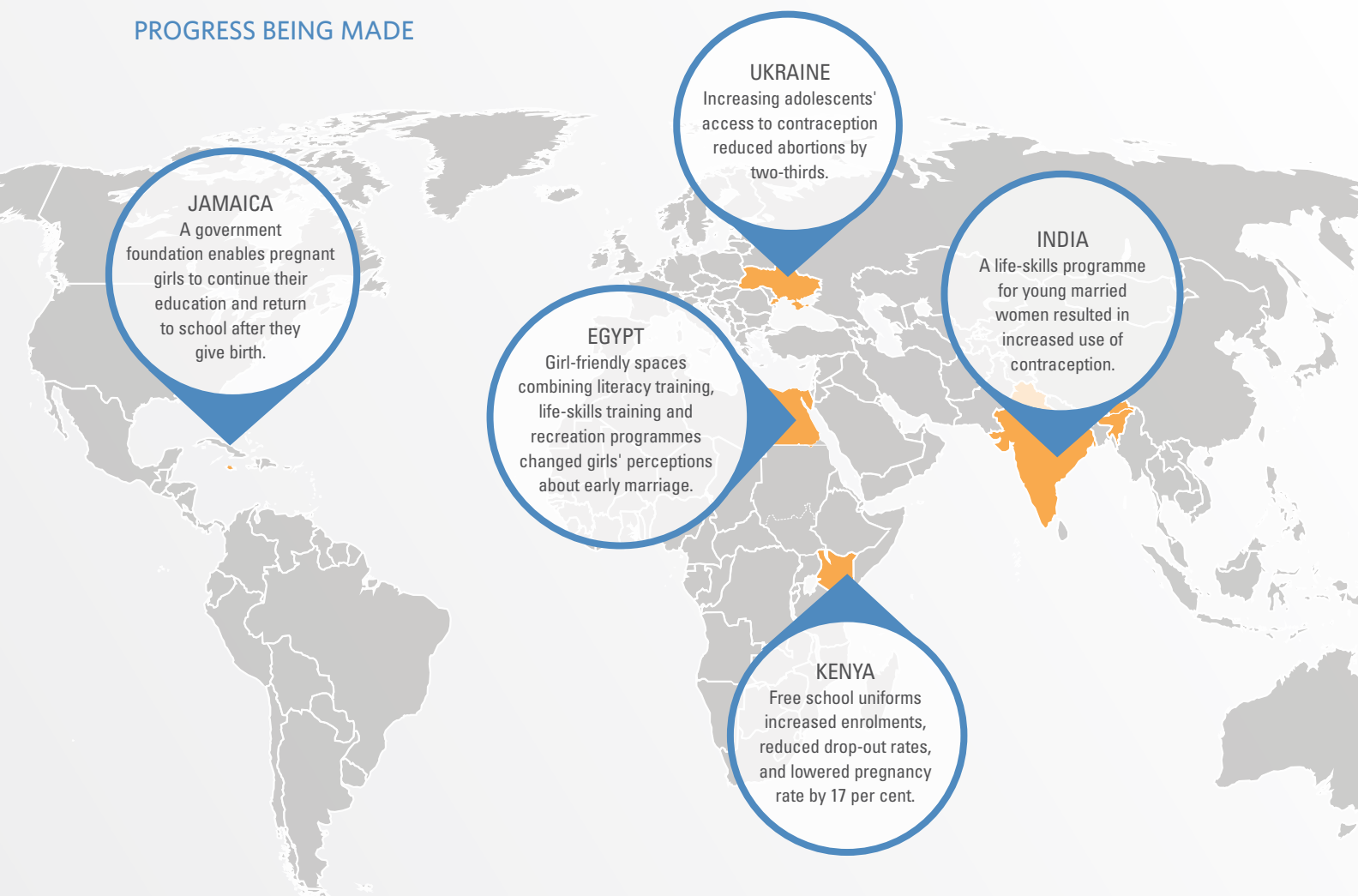
Other actions, such as conditional cash transfers, aimed at keeping girls in school have also protected girls from pregnancy. Conditional cash transfers are regular monthly or bi-monthly payments, which are contingent on families availing themselves of basic services, such as school, primary health care, sexual and reproductive health services, or free awareness-raising or education sessions.

Malawi, for example, piloted a conditional cash transfer programme to encourage girls in the Zomba district to stay in school or to encourage recent dropouts to resume their education. Zomba has a high dropout rate, low educational attainment, and the country's highest HIV prevalence rates among women ages 15 to 49. Through the Zomba programme, households received a $10 monthly transfer, equivalent to about 15 per cent of the

average household income. About 70 per cent of the transfer went to the parents, and 30 per cent went to the girl herself. In addition, the programme paid a girl's secondary school fee directly to the school, as soon as her enrolment was confirmed. Households received transfers only if girls attended school for at least 75 per cent of the days school was in session in the previous month (Baird et al., 2009). Some girls were randomly assigned to receive unconditional cash transfers: no conditions, only cash. Unconditional transfers had a more powerful effect than conditional transfers on reducing the incidence of marriage and adolescent childbearing (Baird et al., 2011).

More than three in five girls who had dropped out returned to school because of the conditional cash transfers. In addition, 93 per cent of the girls who had not previously dropped out and participated in the programme were still in school at the end of the school year, compared with 89 per cent of the girls who had not previously dropped out and did not participate in the programme.

## PROGRESS BEING MADE



Baird et al. (2009) also found that the initiative may have affected sexual behaviour and suggested that "as girls and young women returned to (or stayed in) school, they significantly delayed the onset (and, for those already sexually active, reduced the frequency) of their sexual activity. The programme also delayed marriage—which is the main alternative for schooling for young women in Malawi—and reduced the likelihood of becoming pregnant." For programme beneficiaries who were out of school at baseline, the probability of getting married and becoming pregnant declined by 40 per cent and 30 per cent, respectively.

A 2012 review, *Adolescent Fertility in Low- and Middle-Income Countries: Effects and Solutions*, found that "the evidence base supporting the effectiveness of conditional cash transfers was relatively strong in comparison to other interventions." Evidence of these transfers' impact on education is especially strong. A recent analysis of transfers in developing countries found that on average they improve secondary school attendance by 12 per cent (Saavedra and Garcia, 2012).

## Enhancing knowledge, building skills

In Zimbabwe, a programme designed to prevent HIV infection among young people also had the unintended but welcome effect of reducing the number of adolescent pregnancies (Cowan et al., 2010). Across 30 communities in seven districts in the south-eastern part of the country, professional peer educators worked with young people in and out of school to enhance knowledge and develop skills. At the same time, community-based programmes aimed to improve knowledge of parents and other stakeholders about reproductive health, improve communication between parents and their children, and build community support for adolescent reproductive health. The programme also included training for nurses and other staff in rural clinics to improve availability and accessibility of services for young people. At the end of the programme, a survey of 4,684 young people between the ages of 18 and 22 showed some improvement in knowledge levels but no impact on self-reported sexual behaviours. However, young women who participated in the programme were less likely to report that they had become pregnant compared to those in a control group.

The Empowerment and Livelihood for Adolescents programme in Uganda aimed to prevent HIV among adolescent girls *and* help them enter the labour market. Through the programme, implemented by the non-governmental organization BRAC, girls in 50 communities received life-skills training to build knowledge, improve negotiating skills and reduce risky behaviours and vocational training to help them start small-scale enterprises. After two years, the average fertility rate of girls participating in the programme was three percentage points lower than girls not in the programme—translating into a 28.6 per cent reduction—and the likelihood of girls engaging in income-generating activities rose 35 per cent (Bandiera et al., 2012).

In Guatemala, Mayan girls are the country's most disadvantaged group, with limited education, frequent childbearing, social isolation and chronic poverty. Many are married as children (Catino et al., 2011). The Population Council and other groups launched a project in 2004 to strengthen support networks for Mayan girls between the ages of eight and 18 in rural areas and help them successfully navigate adolescent transitions. The project, *Abriendo Oportunidades*

("Open Opportunities"), established community-based girls clubs and safe spaces where girls could come together, gain life and leadership skills and build social networks. As a result of the initiative, 100 per cent of participating girls completed sixth grade, compared with 81.5 per cent of all girls nationwide. Seventy-two per cent of the girls in the programme were still in school at the end of the two-year programme, compared to 53 per cent of all indigenous girls nationwide. An evaluation showed that 97 per cent of the programme's participants remained childless, compared with the national average of 78.2 per cent for girls ages 15 to 19 (Segeplan, 2010). Since then, the programme has expanded to more than 40 communities and has reached more than 3,500 indigenous girls. The programme now offers separate services for girls between the ages of eight and 12 and those between the ages of 13 and 18, with each group benefiting from age-specific services.

In many developing countries, adolescent pregnancy occurs mainly within child marriage. Eighteen is the minimum legal age for marriage for women without parental consent in 158 countries (UNFPA, 2012). However, in 146 countries, state or customary law allows girls younger than 18 to marry with the consent of parents or other authorities; in 52 countries, girls under age 15 can marry with parental consent.

Laws are important but are infrequently enforced. A recent UNICEF paper reported, for example, that in India, where 47 per cent of girls are married before 18, only 11 people were convicted of perpetuating children marriage in 2010, despite a law forbidding it (UNICEF, 2011a).

Because of the challenges in enacting and enforcing laws, some governments are taking other measures that empower girls at risk of child marriage through, for example, life-skills training, provision of safe spaces for girls to discuss their futures, the provision of information about their options, and the development of support networks. Such interventions seek to equip girls with knowledge and skills in areas relevant to their lives, including sexual and reproductive health, nutrition, and their rights under the law. Girls are empowered when they are able to learn skills that help them to develop a livelihood, communicate better, and negotiate and make decisions that directly affect their lives. Safe spaces and the support they offer help girls overcome their social isolation, interact with peers and mentors, and assess alternatives to marriage (UNFPA, 2012).

An example of such a programme is Berhane Hewan, a two-year programme in Ethiopia that began in 2004. The Berhane Hewan programme set out to protect girls from forced

▼ *Life-skills class, Ethiopia.*

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marriage and support those who are already married through the formation of groups led by female adult mentors. The programme provided economic and other incentives for girls to stay in school, including non-formal education, such as literacy and numeracy skills development, for girls who are not in school; and engagement with communities in the discussion of issues such as child marriage (Erulkar, A. S., and Muthengi, E., 2009). An estimated 41 per cent of women between the ages of 20 and 24 in Ethiopia report having been married before age 18 (UNFPA, 2012).

Through the Berhane Hewan programme, peers, the community and individuals successfully came together to improve the social, educational and health status of vulnerable girls (Bruce et al., 2012). The programme coupled community education and engagement with financial incentives. Participants were given school supplies, worth about $6 a year, as well as a goat or sheep, worth about $25, upon completion of the two-year programme. The programme reached more than 12,000 girls in the Amhara region, which has the country's highest incidence of child marriage. Girls who attended the programme—especially those between the ages of 10 and 14—were more likely to have stayed in school and were less likely to have married than their counterparts who did not participate in the programme.

In India, Pathfinder International implemented a government programme, *Prachar* ("Promote") to change behaviours with the aim of delaying marriage and promoting healthy timing and spacing of pregnancies among adolescents and young couples in Bihar. This Indian state has the highest prevalence of child marriage (63 per cent) and the highest share (25 per cent) of girls between the ages of 15 and 19 who have begun childbearing (Pathfinder International, 2011).

The *Prachar* programme included life-stage-specific training in sexual and reproductive health to unmarried girls between the ages of 12 and 19 and to boys between 15 and 19. Women change-agents conducted home visits to young married women, and men change-agents conducted home visits to boys. Parents and mothers-in-law were engaged through community meetings, and mothers-in-law also participated in the home visits. Young couples were invited to participate in "newlywed welcome ceremonies," which offered information, education and entertainment to improve knowledge about sexual and reproductive health, build life skills and promote couples' communication and joint decision-making.

At the conclusion of the programme's first phase, young married women were nearly four times more likely to use contraception as young married women not participating in the programme. Also, participants were 44 per cent less likely to be married and 39 per cent less likely to have had a child than girls outside the programme area.

The *Ishraq* ("Enlightenment") programme in Egypt began in 2001 with the aim of transforming girls' lives by changing gender norms and community perceptions about girls' roles in society, while bringing them safely and confidently into the public sphere. The programme established girl-friendly spaces in communities to enable girls to meet, learn and play, and combined literacy classes, life-skills training and sports (Brady et al., 2007). While an evaluation of the programme did not address adolescent pregnancy, it did address a number of factors associated with child marriage and early pregnancy. Specifically, literacy improved (92 per cent of participants who took the government literacy exam passed) as did school enrolment (nearly 70 per cent of programme participants entered or re-entered school). After the programme, participants expressed a desire to marry later. Additionally, the programme was associated with increased self-confidence: 65 per cent felt "strong and able to face any problem."

Consistent long-term, multi-level sexual and reproductive health programming can also contribute to prevention of adolescent pregnancy. An example of one developed country that has achieved *very low levels* of adolescent pregnancy and abortion is the Netherlands, which has a pragmatic and comprehensive approach to family planning, especially for young people. It has resulted in one of the lowest abortion rates worldwide (UNFPA, 2013d). Since 1971, family planning has been included in the national public health insurance system, providing free contraceptives. Sexuality education is universal and comprehensive, and girl's empowerment is among the highest worldwide. Sexually active young people display some of the highest rates of contraceptive use of any youth population, and as a consequence, the country's abortion rate is one of the lowest in the world (Ketting and Visser, 1994; Sedgh et al., 2007).

## The right to age-appropriate, comprehensive sexuality education

Curriculum-based comprehensive sexuality education provides young people with age-appropriate, culturally relevant and scientifically accurate information. It also provides young people with structured opportunities to explore attitudes and values and to practise skills they will need to be able to make informed decisions about their sexual lives.

Adolescents and young people have a right to comprehensive and non-discriminatory sexuality education through several human rights agreements and documents, including the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination against Women; and the Convention on the Rights of Persons with Disabilities. Comprehensive sexuality education is essential for the realization of other human rights (UNFPA, 2010).

In a review of 87 comprehensive sexuality education programmes including 29 from developing countries, UNESCO (2009) found that nearly all of the programmes increased knowledge, and two-thirds had a positive impact on behaviour: Many adolescents delayed sexual debut, reduced the frequency of sex and number of sexual partners, increased condom or contraceptive use, or reduced sexual risk-taking. More than one-quarter of programmes improved two or more of these behaviours.

Another study concluded: "There is now clear evidence that sexuality education programmes can help young people to delay sexual activity and improve their contraceptive use when they begin to have sex. Moreover, studies to date provide an evidence base for programmes that go beyond just reducing sexual activity—namely, unintended pregnancy and sexually transmitted infections—to instead address young peoples' sexual health and well-being more holistically" (Boonstra, 2011).

There are two main approaches to sexuality education: advocating abstinence only or providing age-appropriate, comprehensive programmes. Two large reviews (Oxford, 2007; Kirby, 2008) found that abstinence-only programmes are not effective at stopping or delaying sex. Comprehensive sexuality education "teaches about abstinence as the best method for avoiding sexually transmitted diseases and unintended pregnancy but also teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with sexually transmitted diseases, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals and options" (Advocates for Youth, 2001).

Looking at comprehensive programmes, UNESCO found that "nearly all of the programmes increased knowledge, and two-thirds had a positive impact on behaviour…" including delaying sexual debut. In the United States, the highest rates of adolescent pregnancy tend to be in states where abstinence-only education predominates. The lowest rates occur in states where information about sexuality and contraception is provided in a non-judgmental manner (Szalavitz, 2013).

In reviewing the progress and achievements of comprehensive sexuality education since the 1994 International Conference on Population and Development, the international community

has learned a number of lessons about comprehensive sexuality education. One is that even in the face of the HIV/AIDS pandemic, governments have been slow to implement comprehensive sexuality education, and even slower to reach the most vulnerable young people (Haberland and Rogow, 2013).

A second lesson is that comprehensive sexuality education can be effective beyond the prevention of high-risk behaviours. Research shows that programmes that tend to have the greatest impact on adolescent pregnancy and sexually transmitted infections are those that emphasize critical thinking about gender and power in relationships (Haberland and Rogow, 2013). These findings offer promise for a new generation of programmes that can have a concrete, positive impact on the well-being of young people.

New research shows that comprehensive sexuality education programmes are more likely to have an impact on reducing adolescent pregnancy and sexually transmitted infections when they address gender and power issues. Studies from both developing and developed countries confirm that young people who believe in gender equality have better sexual health outcomes than their peers. In contrast, those young people who hold less egalitarian attitudes tend to have worse sexual health outcomes (International Sexuality and HIV Curriculum Working Group, 2011).

Gender equality and human rights are key to preventing the spread of HIV and to enabling young people to grow up to enjoy good health. For example, young people who, compared to their peers, adopt egalitarian attitudes about gender roles are more likely to delay sexual debut, use condoms, and practice contraception; they also have lower rates of sexually transmitted infections and unintended pregnancy and are less likely to be in relationships characterized by violence. Another study found that a targeted programme to increase girls' understanding of the risks of intergenerational sex reduced pregnancy by 28 per cent (Dupas, 2011).

Most comprehensive sexuality education is delivered through school-based curricula. However, not all adolescents attend school and not all remain in school until they initiate sex. Married girls between the ages of 10 and 14 and who are not in school thus have virtually no access to sexuality education. It is therefore important to make additional efforts to meet the needs of adolescents who are out of school. Curriculum- and group-based sexuality and HIV education programmes can reach those who are not in school if they are implemented by providers of health and other services for youth, community centres, or other local institutions accessible to adolescents (Kirby et al., 2006).

According to UNESCO (2013), 57 million children of primary school age and 69 million children of lower-secondary school age do not attend school. Most of them live in developing countries, and slightly more than half are girls. Two approaches with potential for reaching large numbers of out-of-school adolescents—although not necessarily as stand-alone programmes for preventing pregnancy—involve the use of the mass media and interactive radio instruction.

Recent reviews of mass media campaigns that promoted adolescent sexual health, mostly in developing countries, found that they commonly increased knowledge, and the majority

influenced behaviours such as condom use (Gurman and Underwood, 2008; Bertrand et al., 2006). Some reduced the number of partners for women, decreased their frequency of casual sex or sex with "sugar daddies" and increased abstinence.

In Zambia, the HEART (Helping Each Other Act Responsibly Together) campaign, designed for and by adolescents ages 13 to 19, helped raise awareness about HIV prevention and condom use and sought to create a social context in which prevailing social norms could be discussed, questioned and reassessed to reduce sexual transmission of HIV. An evaluation found that, compared with those who did not view the programming, viewers were 87 per cent more likely to use condoms, and 67 per cent more likely to have used a condom the last time they had sex. Condom use is a behaviour that can help prevent pregnancy (AIDSTAR-One, n.d.).

*Contraception information at CEMOPLAF centre in Ecuador.*

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Brazil's Programme for Sexual and Emotional Education: A New Perspective is framed within a perspective of rights and is focused on preventing unsafe sexual practices and promoting positive approaches that address what it means to have a "healthy and pleasurable sex life." The programme, which also addresses gender equity, uses an integrated approach that reaches adolescents in and out of the classroom and involves teachers, health care providers, families and the community. Adolescents are also reached through radio programmes, school newspapers, plays and informational workshops. An evaluation that polled 4,795 youth in 20 public schools in the state of Minas Gerais found that after the programme, the group receiving sexuality education had a higher percentage using condoms with either a casual partner or a steady partner and a higher percentage using a modern contraceptive, compared with a control group. Additionally, the programme did not result in an increase in sexual activity (Andrade et al., 2009).

Media campaigns have been more effective at reaching urban adolescents (both in and out of school) than rural adolescents, although their reach is expanding with the increasing availability of social media and mobile communications technologies.

However, just as the media can be part of the solution by advocating for prevention, they may also glamourize sex and adolescent childbearing, as in MTV's *Teen Mom 2* television series in the United States.

Advertising campaigns are another way of educating or informing the public. Some of these campaigns rely on fear or scare tactics to

change behaviour through the threat of impending danger or harm (Maddux et al., 1983). Fear tactics present a risk, identify who is vulnerable to that risk and urge a particular action, such as taking steps to prevent an adolescent pregnancy. Research on fear-based messaging that, for example, encourages people to stop smoking or lose weight, shows these campaigns have little effect when they provide strong fear messages with no recommended action or when the recommended action is not easily taken or is perceived to be ineffective. Such approaches are also ineffective when there are no acknowledgments of barriers to action and how they can be overcome, and no support for recipients so they believe that they are capable of taking the action. For these approaches to work, the perceived efficacy of action must be greater than the perceived threat.

Content delivery systems are also evolving, as many programmes launch online curricula (Haberland and Rogow, 2013). Despite the current lack of compelling evidence that this delivery mechanism offers measurable advantages in outcomes, the potential for low-cost, global reach suggests the likelihood of an increasing number of Internet-based programmes in the future. Investment in rigorous research to assess its effects is needed. Meanwhile, some existing programmes, such as Afluentes in Mexico and Butterfly in Nigeria, are using computer-based programmes to provide training or technical support to teachers.

Life-skills programmes offer another way for adolescents to acquire information that can help them prevent a pregnancy. UNICEF (2012) finds that about 70 countries have national-level life-skills training programmes, which vary across country and cultural context. In general, however, life-skills training focuses on building five core skills: decision-making and problem-solving; creative thinking and critical thinking; communication and interpersonal skills; self-awareness and empathy; and coping with emotions and stress. Much of the focus of life-skills training has been on the development of protective psychological skills, communication skills and knowledge to avoid risk.

For 10 years starting in 1996, the Life Skills Programme in Maharashtra, India, included weekly hour-long sessions, some of which focused on health, child health and nutrition. The programme was designed to reach unmarried girls between the ages of 12 and 18, with an emphasis on girls who were out of school and working. It involved parents in programme development and teachers to lead the classes. An evaluation showed significant impact: In the area covered by the programme, the median age of marriage rose from 16 to 17, and the control group was four times more likely to marry before age 18 than the programme group.

> "The way the media puts it is that everyone should have sex! Everything is about sex . . . commercials . . . everything. Of course, people start living by it and people get careless."
>
> *17-year-old girl, Sweden*

▲ *Youth peer educators of Geração Biz in Maputo, Mozambique.*
© UNFPA/Pedro Sá da Bandeira

Additionally, the proportion of marriages of girls before age 18 fell to 61.8 per cent compared to 80.7 per cent for girls outside the programme (Pande et al., 2006).

Attitudes of boys and men have a significant impact on the health, rights, social status and well-being of girls and thus on girls' vulnerability to pregnancy. In many countries, UNFPA supports programmes to work with boys, male adolescents and youth on sexuality, family life and life-skills education to question current stereotypes about masculinity, male risk-taking behaviour (especially sexual behaviour) and to promote their understanding of and support for women's rights and gender equality. In some countries, UNFPA has partnered with national institutions to raise awareness of the impact of negative attitudes and harmful practices on girls and women through school-based, age-appropriate, comprehensive sexuality education or with civil society organizations to engage men and boys in dialogue about their attitudes towards issues such as child marriage, contraception and matters of sexual and reproductive health and reproductive rights.

## Investing in services for adolescents and young people

Adolescents—married or unmarried—often lack access to contraceptives and information about their use. Barriers include a lack of knowledge of where to obtain them, fear about being rejected by service providers, opposition by a male partner, community stigma about contraception or adolescent sexuality, inconvenient locations or clinic hours, costs, and concerns about privacy and confidentiality.

To make it easier for adolescents to learn about preventing pregnancy and sexually transmitted infections, including HIV, or to obtain contraceptives, an increasing number of countries have established youth-friendly sexual and reproductive health services. Youth-friendly services typically ensure adolescents' privacy, are in locations—and are open at hours—that are convenient to young people, are staffed by providers who are trained in meeting young people's needs, and offer a complete package of essential services.

Nicaragua, for example, is increasing disadvantaged adolescents' and young people's access to sexual and reproductive health services, including

contraception, through its Competitive Voucher Scheme. Vouchers for free services are distributed by local non-governmental organizations to adolescents and youth in Managua's markets, outside public schools, on the streets and in clinics. Outreach workers also distribute vouchers door to door. Each voucher is valid for three months and may be transferred to another adolescent in greater need. It can be used to cover one consultation and one follow-up visit for: counselling, family planning, pregnancy testing, antenatal care, treatment of sexually transmitted infections, or any combination of services. The programme also trained clinic staff in counselling for adolescents, issues of adolescent sexuality, and identifying and addressing sexual abuse (Muewissen, 2006).

Preliminary findings from an evaluation showed that vouchers were associated with greater use of sexual and reproductive health care, knowledge of contraceptives, knowledge of sexually transmitted infections and increased use of condoms.

Through Mozambique's Geração Biz (Busy Generation) programme, the ministries of health, education and youth and sports jointly provide youth-friendly sexual and reproductive health services, school-based information campaigns about contraception and HIV prevention and community-based information to reach young people who are not in school. Through a network of 5,000 peer counsellors, Geração Biz provides non-judgmental, confidential information and services to Mozambique's youth. The multi-sectorial nature of the programme that engages policymakers, health care providers, educators and community stakeholders as well as youth themselves is a key contributing factor to an increase in adolescents' and young people's knowledge about and use of contraception (Hainsworth et al. 2009).

The Development Initiative Supporting Healthy Adolescents (DISHA) programme in India combines community-level mentoring and community dialogue with the scaling up of health services and comprehensive sexuality education, contraceptive education and provision, and life skills training. In 176 villages, the programme has created youth groups and resource centres where adolescents can learn about sexual and reproductive health, receive services and enrol in training for future livelihoods. The programme also trains local health providers in youth-friendly care, organizes volunteers to distribute modern methods of family planning, deploys peer educators, organizes counselling sessions, and provides a forum for young people and adults to come together to talk about youth's role in society.

Using a quasi-experimental design with a comparison group, the evaluation showed that the age of marriage among programme participants rose from 15.9 years to 17.9 years; and married youth exposed to DISHA were nearly

"Once a condom broke, and we only discovered it afterwards. My girlfriend panicked, which I fully understand. But I actually think we managed the situation well. We found a pharmacy where we bought emergency contraception."

*Lasse, 18, Denmark*

## ADOLESCENT ABORTION RATES DROP BY TWO-THIRDS IN UKRAINE

One million abortions were reported each year in Ukraine in the early 1990s. Since then, the number has decreased by more than 80 per cent, mainly because of increased access to contraceptives and family planning information and services.

The abortion rate among adolescents between the ages of 15 and 17 has also declined, from 7.74 abortions per 1,000 girls, to 2.51 today. This decrease is attributed to Government efforts to increase access to youth-friendly health services and to legislation, policies and programmes that prioritize young people's sexual and reproductive health.

One such programme, the Government's "Reproductive Health of the Nation," aims to preserve the reproductive health of the population and positively influence reproductive health among adolescents. Another, the national Youth of Ukraine programme promotes healthy lifestyles as a national priority.

UNFPA, the World Health Organization and UNICEF are supporting the Ministry of Health's development of a comprehensive regulatory and institutional framework for youth-friendly health services.

Access to quality family planning services, including counselling on modern methods of contraception, has improved, and awareness about the health benefits of family planning has grown. The Government has entered into partnerships with pharmaceutical companies and pharmacies to broaden the range of available contraceptives and reduce their price, and the Ministry of Health has strengthened its capacity to support and promote family planning initiatives, including those available to adolescents and youth.

Viktoriya Verenych, an obstetrician-gynaecologist at a youth-friendly clinic in Kyiv, says that over the past five years, she has noticed a trend of earlier sexual debut among her clients.

"It is very important that at this point in their lives, they have access to qualified counselling on prevention of unwanted pregnancies, HIV and sexually transmitted infections," Verenych says. "This counselling must be provided in a youth-friendly manner."

60 per cent more likely to report the current use of a modern contraceptive compared to similar youth not exposed to the programme. Likewise, attitudes towards child marriage changed. At the start of the programme, 66 per cent of boys and 60 per cent of girls believed that the ideal age of marriage for girls was 18 or older. After the programme, the comparable figures were 94 per cent of boys and 87 per cent of girls (Kanesathasan et al., 2008).

Access to emergency contraception is especially important for adolescents, especially girls, who often lack the skills or the power to negotiate use of condoms and are vulnerable to sexual coercion, exploitation and violence. Emergency contraception is a method to prevent pregnancy within five days of unprotected intercourse, failure or misuse of a contraceptive (such as a forgotten pill), rape or coerced sex. It disrupts ovulation and reduces the likelihood of pregnancy by up to 90 per cent. It cannot prevent implantation of a fertilized egg, harm a developing embryo or end a pregnancy.

Barriers to adolescents' accessing emergency contraception include lack of knowledge about it, reluctance of health care workers to provide it, cost, community opposition to its use and legal restrictions.

In 22 countries, a dedicated and registered emergency contraceptive pill is unavailable (International Consortium for Emergency Contraception, 2013). Even in countries where emergency contraception is available, adolescents may be reluctant to obtain it from traditional health outlets, such as clinics, which may be staffed by judgmental providers. To make it easier for adolescents to obtain emergency contraception, the non-governmental organization PATH developed a project in Cambodia, Kenya,

and Nicaragua to strengthen the capacity of pharmacies to provide youth-friendly reproductive health services with a focus on emergency contraception. The initiative trained pharmacy staff and peer educators to provide accurate, up-to-date information on emergency contraception and other reproductive health services.

An assessment of the initiative found that the project increased the capacity of pharmacy personnel to provide high-quality reproductive health services to youth. Data suggest that pharmacy staff gained knowledge of emergency contraceptive pills, sexually transmitted infections and modern methods of contraception.

## RESPONDING TO THE NEEDS OF ADOLESCENTS AND YOUTH IN COLOMBIA

On the second floor of a modern building, the youth-friendly health centre in Duitama, Colombia, has a few white walls, but most have been painted by local adolescent graffiti artists. Of Duitama's 111,000 inhabitants, about one quarter are between the ages of 10 and 24.

Every month, more than 600 young people take advantage of the centre's services, which include everything from dentistry to sexual and reproductive health and psychotherapy.

"It's not only about health, it's also about communication," says Nubia Stella Robayo, a nurse specializing in maternal and perinatal health services for adolescents.

"Most of the girls have financial problems," Robayo says. "Eighty per cent of their pregnancies were unplanned." And most of the girls and boys who come to the centre for the first time are not using contraceptives.

Robayo says many of the girls she sees think that their bodies are too immature to become pregnant, so they think they do not need to worry about using a condom. This is especially the case among girls from surrounding rural areas. The confusion about sexuality and pregnancy, she says, points to a need for better sexuality education and information.

"When I first heard about youth-friendly services, I thought it was a fabulous idea and I said 'we have to do it'," says Lucila Esperanza Perez, the centre's manager, who says preventing adolescent pregnancy is the main goal. Perez herself had had two children by the time she was 20 and knows first-hand the challenges adolescent pregnancy can pose. "We wanted a centre where young people could receive the information they need to manage their sexual and reproductive lives," Perez says. "And young people were consulted from the beginning of the project; they have been the true managers."

A service is considered youth-friendly when it meets the needs of adolescents and youth, recognizes their rights, and becomes a place where they can be informed, guided and taken care of, she explains. Health, she adds, is a state of physical, mental, spiritual and social well-being.

Catherine, 19, is 32 weeks pregnant and gets her antenatal check-ups at the centre. "Pregnancy is hard if it is not planned," she says, "as there are too many goals and dreams to be deferred."

Catherine says the nurses and doctors at the centre make her feel appreciated. "The nurses and doctors speak to you with affection, and they are always receptive to any question or situation you may have," she says.

Juan, 20, has joined one of the centre's peer groups, where young people have an opportunity to share their experiences and knowledge with other young people in schools and throughout the community. His peer group also leads workshops, forums and other activities that bring young people together to discuss issues ranging from responsible sexuality to gender-based violence. Sometimes as many as 1,000 young people turn up for events.

While more and more young people are using the centre's services, and adolescent pregnancies are starting to decrease, Perez says "there is a lot to do" to help even more people prevent pregnancies and address other problems that affect Duitama's youth, such as preventing sexual violence and stopping substance abuse.

In all three countries, knowledge of emergency contraception by pharmacy staff increased considerably. Before the training, initial assessment data showed that up to 30 per cent of pharmacy staff were providing emergency contraceptive pills correctly; after the training, that figure rose to about 80 per cent (Parker, 2005).

## Ending sexual coercion and violence

Sexual violence usually refers to sexual intercourse that is physically forced, especially rape. Sexual coercion is more broadly the act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behaviour against his or her will (Baumgartner et al., 2009). Definitions that aggregate all forms of sexual coercion and sexual violence make it difficult to establish a relationship between adolescent pregnancy and sexual violence, such as rape, or sexual coercion which adolescents may or may not identify as violence.

Almost 50 per cent of all sexual assaults around the world are against girls below age 16.

Stopping coercion and violence against adolescents—or anyone—is an imperative everywhere and requires continuous actions on many fronts, from strengthening criminal justice systems so that perpetrators are brought to justice and that survivors are supported, to training health care providers to recognize and report it and to changing the attitudes of men and boys so that coercion and violence are prevented.

India, Haiti and the Democratic Republic of the Congo are three countries that have recently moved to strengthen laws against sexual violence, but to date there has not been an evaluation of such laws either there or elsewhere as to how well they protect girls from rape and unwanted pregnancy (Heise, 2011). However, much like laws prohibiting child marriage, their efficacy resides in enforcement and the public's support for them. But also like child marriage laws, laws that penalize sexual and gender-based violence send a strong message that protecting the rights of vulnerable young people and especially adolescent girls is a national priority.

A review of evidence on interventions to reduce violence against adolescent girls (Blanc et al., 2012) notes that violence-prevention initiatives are typically implemented within the broader context of programmes that address life skills, create safe spaces for girls, and change notions of masculinity among boys and young men. Or they are embedded in broader youth-focused programmes that address sexual and reproductive health. These programmes have, for example, worked through sports associations (Brady and Khan, 2002), life-skills and peer-support programmes (Askew et al., 2004; Ajuwon and Brieger, 2007; Jewkes et al., 2008), female mentorship/guardian programmes (Mgalla et al., 1998), programmes promoting HIV prevention and reproductive health education, (Hallman and Roca 2011) and workshops targeting men (Peacock and Levack, 2004). Others have modified in-school sexuality education or life-skills curricula to include wider discussion of gender-based violence and sexual coercion (Ross et al., 2007).

This review points out, however, that while these initiatives have succeeded in empowering girls, building communication skills and

developing gender-equitable attitudes, a decline in partner violence was noted only in cases when actions also focused on economic empowerment, gender and sexual health, and group solidarity (Pronyk et al., 2006; Jewkes et al., 2008) and/or engaged men and boys (Verma et al., 2008).

## Investing in girls who are pregnant or have children

Much can be done to reduce the harmful health, social and economic effects of pregnancy on girls and ensure that opportunities for education, jobs, livelihoods and participation in the affairs of their communities are not lost, for both married and unmarried adolescents.

Ensuring access to services for pregnant adolescents or new mothers often means providing financial support for health care and diet, advice about breastfeeding, help returning to school or training, shelter and services if they have been rejected by their families and contraceptive or birth-spacing information and services.

Critical factors for improving maternal health for adolescents include access to and use of antenatal care to identify and treat underlying health issues, including malaria, HIV or anaemia, providing obstetric care to ensure the safe delivery of young mothers and their infants, treating complications from unsafe abortion, providing postnatal and newborn care, and making contraception available to allow birth spacing (Advocates for Youth, 2007).

But for millions of adolescents around the world, access to services is limited by a range of economic, social and geographical factors as well as availability. Personal autonomy—or the lack of it—is a key determinant of access and use. This obstacle is particularly daunting for girls who are in marriages and have little say in decisions regarding their own health and little or no access to money needed for transportation to clinics or to pay for care (World Health Organization, 2007). Girls may also not seek care if they believe providers of services will be judgmental or refuse to accommodate them.

In general, adolescents seek care later, and receive less. Pregnant girls often lack knowledge about which services exist, when care should be sought and how to find care at the right time. Girls who do not receive antenatal care are less

> "When I was 17, I got a boyfriend at school. I asked my girlfriends about sex and they said you cannot get pregnant the first 10 days after your period. But I got pregnant. The boy was so scared he ran away, and my parents wanted to kill me. Luckily, a teacher from my school came along and helped me break the news to my parents. The teacher also told them that I could go back to school after giving birth. At first, my parents didn't accept, but afterwards they were convinced. Now, I finished school at 20 years old and I want to be a teacher. I wish the topic is more discussed at school so that girls don't make the mistake I did."
>
> *Phoebe, 20, Uganda*

likely to be prepared for an emergency before, during or after childbirth. Rural women may be several kilometres walk from the nearest health care facility (World Health Organization and UNFPA, 2006). They may be much further from a facility that can provide emergency obstetric care.

Brazil is one country that has taken steps to increase pregnant girls' access to antenatal, delivery and postnatal care. The Institute of Perinatology of Bahia, IPERBA, is a referral centre for high-risk pregnancies in Bahia, an impoverished state in the northeastern part of the country. IPERBA's multidisciplinary team addresses many dimensions of childbearing: sensitive patient-centred childbirth, preventing mother-to-child transmission of HIV and syphilis, and assistance to survivors of gender violence. The hospital is also well-known for offering specialized care for pregnant adolescents. It deals with more than a thousand cases per year, representing 23 per cent of all childbirths there.

The Better Life Options Programme in India takes a holistic approach in its services for pregnant adolescents in urban slums of Delhi, rural Madhya Pradesh and rural Gujarat. The programme integrates education, livelihoods, life skills, literacy training, vocational training and reproductive health, with the overall aim to broaden girls' life options (World Health Organization, 2007). The programme also promotes social change through the education of parents, family and community decision makers. An evaluation found that girls participating in the programme were more likely than girls not in the programme to follow antenatal nutritional regimens (iron and folate supplements) and deliver in a hospital or at home with a skilled birth attendant.

The longer girls stay out of school, the less likely they are to return. To enable pregnant adolescents or new mothers to stay in or return to school, they need supportive national and local school policies. But even with supportive policies, many may not resume their education. For example, despite progressive legislation in South Africa allowing young women to return to school post pregnancy, only around a third actually re-enter the schooling system (Grant and Hallman, 2006). To improve this picture, some girls will need child care, financial support and individualized, one-on-one support and counselling to help them deal with their new responsibilities and feeling different from their peers.

The Women's Centre of Jamaica Foundation assists girls 17 and younger who have dropped out or have been forced out of school due to a pregnancy. Teen mothers are allowed to continue their education at the Centre location nearest to them for at least one school term, and then return to the formal school system after the birth of their babies. There are seven main centres and

> "I had my first child when I was 14 and the second one at 17. To survive with my children, I work in people's gardens for 700 Rwandan francs [about $1] a day or wash people's clothes."
>
> *Emerithe, 18, Rwanda*

eight outreach centres which offer, among other services, continuing education for adolescent mothers. Compared with adolescent mothers not participating in the Centre's programme, the rate of repeat pregnancies has been lower among girls in the programme, and more girls have continued their education, including sitting exams and re-entry into the formal education system.

## Reaching girls 10 to 14 years old

A number of initiatives have reached or targeted adolescent girls age 14 or younger, whose needs, circumstances and vulnerabilities are very different from those of older adolescents. The more successful interventions have promoted gender equality, helped keep girls in school or reduced poverty and the economic incentives for child marriages among the most disadvantaged segments of society (Blum et al., 2013).

Several of the more successful initiatives include India's Life Skills Programme in Maharashtra, Ethiopia's Berhane Hewan programme and Guatemala's Open Opportunities programme, mentioned above.

Another successful initiative is Rwanda's FAM Project, an interactive training programme targeted to 10 to 14-year-olds that deals with issues such as puberty, fertility, gender norms, communications and relationships. Developed by the Institute for Reproductive Health and implemented in Rwanda in conjunction with Catholic Relief Services, the project increased knowledge and improved child-parent communications about sexuality and gender roles.

Through Nepal's "Choices Curriculum," developed by Save the Children, children's clubs teach very young adolescents about gender equality and raise awareness about issues such as discrimination and gender-based violence.

However, many countries have given little attention to this age group apart from taking steps to keep them in school. Policymakers may assume that adolescents ages 10 to 14 are under the protection of a parent or guardian and thus devise programmes that depend on parents' engagement. But for some young adolescents, parents may not be present in their lives.

## Engaging boys and men

The gender-related attitudes expressed by men and boys directly affect the health and well-being of women and girls.

Promoting gender equality by empowering women and engaging men is fundamental to achieving a number of development objectives, such as reducing poverty and improving sexual and reproductive health. Men's and boys' relationships with women and girls can support or hamper these objectives (UNFPA, 2013b).

A review of actions to engage men and boys in rectifying gender inequities in health interventions found that well-designed programmes with men and boys can lead to changes in attitudes and behaviours in areas such as sexual and reproductive health, maternal and newborn health, HIV prevention and gender socialization (World Health Organization, 2007). Integrated programmes, especially ones that combine community outreach, mobilization and mass media campaigns with group education, are the most effective at changing behaviour (UNFPA, 2013b).

Reaching out to young men is an especially good investment because they are more responsive to health information and to opportunities to view gender relations differently. Research shows that unhealthy perceptions of sex, including seeing women as sexual objects, viewing sex as performance-oriented and using pressure or

force to obtain sex, begin in adolescence. Forms of gender discrimination affect girls and women, but dominant perceptions of masculinity among young men and adolescent boys are a driving force for male risk-taking behaviour, including street violence and unsafe sexual practices (UNFPA, 2013b). Strengthening opportunities for boys and young men to participate in supporting gender-equality efforts will have an impact not only on women and girls but also on their own lives. They are more likely to grow into future generations of men who live by gender-equitable principles.

With UNFPA support, Nicaragua took a "gender-transformative approach" to preventing sexual violence and pregnancy through an initiative, *Que Tuani No Ser Machista*. Gender-transformative programmes challenge and transform rigid gender norms and relations and generally entail moving beyond the individual level to also address the interpersonal, socio-cultural, structural and community factors that

## JAMAICA OFFERS A MODEL FOR PREVENTING ADOLESCENT PREGNANCY AND SUPPORTING YOUNG MOTHERS

"Becoming pregnant at such a young age was a terrifying experience. I did not know what to do when I found out," said 17-year-old Joelle as she recounted the emotional turmoil of being pregnant during her teenage years.

"It was going to be my final year in high school. I would have been graduating and making my parents proud," she recalled. "I was so horrified, ashamed and devastated to see that all the things I wanted would not happen."

Joelle was one of two girls who candidly shared their experience with the First Lady of Burkina Faso, Chantal Compaoré, and her team, who were in Kingston, Jamaica to learn about the strategies the Government has employed to address adolescent pregnancy in the country.

The Adolescent Mothers Programme of the Women's Center Foundation of Jamaica that Joelle is enrolled in is a centrepiece of these strategies, a UNFPA "good practice" programme and a model for other countries grappling with the issue of teen pregnancy.

Joelle described the organization and the counsellors who are caring for her during this difficult period as "firefighters who rescued me from the mental burning building I was in."

### *Getting results*

Since 1978, Jamaica's Programme for Adolescent Mothers has been providing continuing education, counselling and practical skills training for mothers under age 17. Through the programme, they can pursue their education at the nearest Women's Centre for at least one semester and then return to the formal school system after their babies are born.

The Foundation operates seven main centres and nine outreach stations across Jamaica, and provided continuing education to 1,402 adolescent mothers in the 2011–2012 school year, more than half of whom successfully returned to the formal school system. The Centre also offers a range of other services such as day care facilities and walk-in counselling for women and men of all ages. This includes counselling for "baby fathers," their parents and the parents of teen mothers.

### *Putting family planning at the core*

Family planning is an integral element of the counselling programme offered at each branch of the Women's Centre of Jamaica, and UNFPA has partnered with the organization for years to help reduce the risk of unintended second pregnancies among mothers they counsel.

With the knowledge and consent of their parents, the young mothers are provided with sexual and reproductive health information and offered a contraceptive method of their choice, which helps them to delay a second pregnancy and enables them to complete their education. With support from UNFPA, the Women's

influence gender-related attitudes and behaviours (Promundo, 2010).

Through group education and advocacy campaigns, the Nicaraguan initiative prompted boys between ages 10 and 15 in 43 communities to reflect on what it means to be macho and why, and encouraged them to question gender norms and stereotypes. Group education included exercises that encouraged boys to express their feelings, especially about what it means to be a young man. An estimated 3,000 teenagers

> "I am always imagining what my life would be like if I had met someone before I was pregnant, someone who taught me to be assertive, someone who talked to me about relationships, the advantages and disadvantages of engaging in sex so young. Maybe I would not be in this situation."
>
> *Swinton, 20, pregnant at 15, Zimbabwe*

Centre distributed more than 10,000 male condoms and 6,000 female condoms between 2008 and 2011 alone.

Over the years, the Centre has succeeded in keeping the second pregnancy rate of the adolescent mothers enrolled in its programme below 2 per cent. It has also been effective in helping students complete their secondary education and even advance to university.

### *Back to school: The success of advocacy*

In Jamaica, the immediate consequence of teenage pregnancy is expulsion from school, so reintegrating adolescent mothers into the formal education system has been a priority.

These efforts have recently paid off in a landmark achievement when the "Policy on the Re-Integration of Adolescent Mothers into the Formal Education System" was approved by the Cabinet in May 2013. This policy breakthrough, spearheaded by the Women's Centre of Jamaica Foundation and the Ministry of Education, with support from UNFPA, will allow all school-aged mothers to continue their education after the birth of their child.

As of September 2013, when the new policy went into effect, teenage mothers no longer face the risk of being denied entry back to school. Schools are now mandated to accept adolescent mothers back into the formal education system after they give birth. Moreover, the young moms will have the choice to attend a new school or to return to the one they left.

"The education of our girls is a strength of Jamaican culture and history," says Ronald Thwaites, Jamaica's Minister of Education. "We want to give every girl an education, no matter what her circumstances, even if she has become pregnant and had a child. We want to lift her up, make sure she gets the best opportunity. We are a nation of second chances."

### *Innovation fosters success: Engaging men, nurseries*

While addressing the young mothers' challenges is the main priority, engaging men and providing them with information and counselling has also been a central element in the Women's Centre's successful strategy.

As part of the Centre's ongoing peer counselling services, UNFPA has supported the training of 50 young men in the Clarendon and Manchester regions of Jamaica. Through various activities, they help to sensitize their peers on sexual and reproductive health issues including family planning, HIV prevention and sexual and reproductive health services. The young men attend Centres or outreach sites close to their homes and provide their respective outreach managers with reports on their activities.

## ICPD AND THE ROLE OF MEN

The Programme of Action of the International Conference on Population and Development calls on leaders to "...promote the full involvement of men in family life and the full integration of women in community life," ensuring that "men and women are equal partners" (paragraphs 4.24, 4.29). It notes that "[s]pecial efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high-risk pregnancies" (paragraph 4.27).

participated in the first phase (2009-2010), and up to 20,000 in the second phase (2010-2011).

### *Engaging boys through mass media and innovative technologies*

Globally, mass-media campaigns have shown some level of effectiveness in sexual and reproductive health (including HIV prevention, treatment, care and support), gender-based violence, fatherhood and maternal, newborn and child health. Effective campaigns generally go beyond merely providing information to encouraging boys and men to talk about specific issues, such as violence against women. Some effective campaigns also use messages related to gender-equitable lifestyles, in a sense promoting or reinforcing specific types of male identity. Mass-media campaigns on their own seem to produce limited behavioural *change* but show significant change in behavioural *intentions* (Bard et al., 2007).

UNFPA supported the development of *Breakaway*, an electronic football game aimed at raising awareness among boys between the ages of eight and 16 about violence against girls and women. In *Breakaway*, the player encounters real-life situations that resonate with a boy's or young man's experience such as peer pressure, competition, collaboration, teamwork, bullying, and negative gender stereotypes. The game gives players choices that allow them to make decisions, face consequences, reflect, and practice behaviours in a game and story format. Through the interactive football match, players learn that things are not as they seem, and their choices and actions will affect the lives of everyone around them. First released and distributed locally in Africa around the FIFA World Cup in June 2010, the game is now disseminated globally through the Internet in English, French, Spanish and Portuguese. A number of UNFPA Country Offices and partners are supporting use of the tool through dissemination and outreach opportunities.

## Conclusion

Many of the actions by governments, civil society and international organizations that have helped girls prevent pregnancy were not specifically designed for that purpose. Multidimensional interventions that aim to develop girls' human capital, focus on their agency to make decisions about their reproductive health and sexuality, and promote gender equality and respect for human rights, have had documentable impact on preventing pregnancies.

Most of the programmes featured in this chapter have been evaluated and have been deemed effective at supporting some aspect of girls' safe and healthy transition from adolescence to adulthood. Some categories of intervention—such as providing comprehensive sexuality education—have also been broadly evaluated as being effective in increasing knowledge about sexual and reproductive health, including contraception, changing

behaviours of boys and girls, or increasing use of contraception.

Yet there are many innovative initiatives, not featured in this chapter, that aim to reduce the prevalence of child marriage, keep girls in school, change attitudes about gender roles and gender equality and increase adolescents' access to sexual and reproductive health, including contraception, that have *not yet* been evaluated but warrant further study to determine their effectiveness in improving girls' lives.

Two important lessons may be drawn from countries' experiences described in this chapter: investing in girls empowers them in many ways, including enabling them to prevent pregnancy; and dismantling the barriers to girls' enjoyment of their rights and addressing the underlying causes of adolescent pregnancy can positively transform girls' lives and futures.

The most vulnerable girls, including those who are extremely poor, ethnic minorities or from indigenous populations, and very young adolescents who have been forced into marriage, require additional support but are often left out of development or sexual and reproductive health programmes. In most cases, contextual data and information about these girls are scarce or non-existent, and little is known about their vulnerabilities and challenges, so it is not surprising that few governments or civil society organizations have formulated policies, programmes or laws that can protect or empower them.

A growing number of governments are investing in adolescents in ways that empower them to prevent a pregnancy, but fewer have invested in systems and services that support a girl who has become pregnant or who has had a child and that can help protect her health and the health of her child and help her realize her potential in life.

## TOWARDS A NEW BEGINNING IN THE PHILIPPINES

Before Geah became pregnant at 17, she considered herself a typical teenage girl who would hang out with friends and boyfriend, against the wishes of her parents who thought she should stay home, focus on her studies and finish school.

Though her pregnancy was unexpected, she said, she was excited and happy to know that soon she would have a baby, just like some of her friends did. Her boyfriend was happy about it too, but because he did not have a job and depended on his parents, he could not offer much help to her.

One day, Geah went to a health centre in Bago for a check-up. One of the workers there knew Geah and informed her mother, who was furious when she found out about the pregnancy but nevertheless promised to support her and took her regularly to a clinic for antenatal care.

During the pregnancy, Geah remained in school but dropped out after giving birth.

Several months later, she and her parents and younger brother were invited to participate in a course to teach parents and family members about adolescent health and development, to equip them with knowledge and skills to understand the challenges faced by adolescent mothers and to help them cope with the stressors. The course was hosted by the Salas Youth ACCESS Center, established by the City Government of Bago through the City Population Office in partnership with Rafael Salas Foundation and with funding assistance from UNFPA in the Philippines.

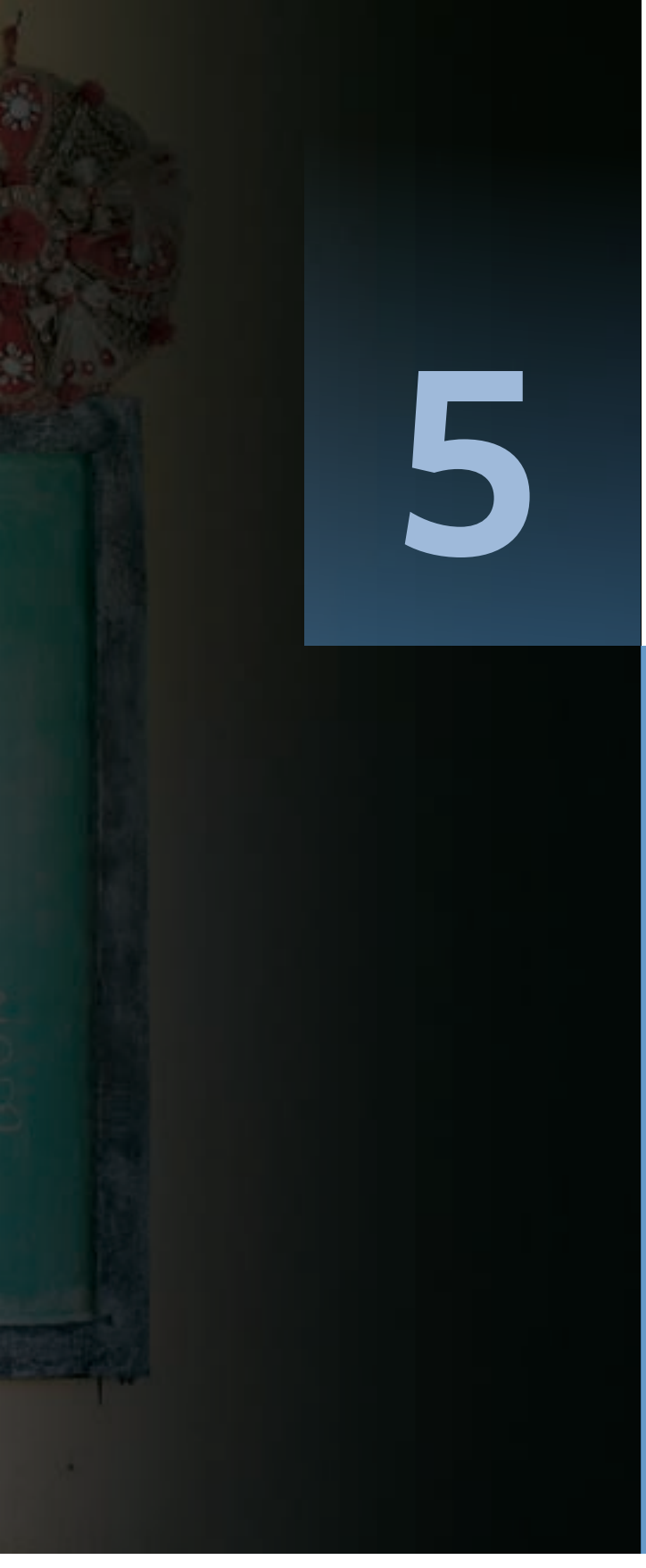
ACCESS is staffed by trained youth peer counsellors and caters to the needs of both in-school and out-of-school youth.

Geah said that after the training, her parents understood her situation better and gave her more support and encouragement. The lines of communication with her parents also improved, she said.

Support from her parents and ACCESS enabled her to return to school. ACCESS also provided contraceptives to help her delay her next pregnancy until after she completes her education, which she says will help her get a good job and make enough money to provide for her family.

*—Angie Tanong, Commission on Population*

मैजिक कैलकुलेटर



# 5 Charting the way forward

Adolescents are shaping humanity's present and future. Depending on the opportunities and choices they have during this period in life, they can enter adulthood as empowered and active citizens, or be neglected, voiceless and entrenched in poverty.

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Millions of girls become pregnant every year in developing countries and to a lesser extent in developed countries. The impact on their health, economic prospects, rights and futures is indisputable, as is the impact on their children, families and communities.

Most countries have taken action aimed at *preventing* adolescent pregnancy, and in fewer cases, to support girls who have become pregnant. But many of the measures to date have been primarily about changing the behaviour of *the girl*, failing to address underlying determinants and drivers, including gender inequality, poverty, sexual violence and coercion, child marriage, exclusion from educational and job opportunities and negative attitudes and stereotypes about adolescent girls, as well as neglecting to take into account the role of boys and men.

▼ *Youth-friendly health centre in Guatemala.*
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In 1994, the 179 governments represented at the International Conference on Population and Development (ICPD) acknowledged that poor educational and economic opportunities and sexual exploitation are important factors in the high levels of adolescent child-bearing. "In both developed and developing countries, adolescents faced with few apparent life choices have little incentive to avoid pregnancy and childbearing." But they also acknowledged that the reproductive health needs of adolescents as a group had been "largely ignored," and they called on governments to make information and services available to help protect girls and young women from unwanted pregnancies and to educate young men "to respect women's self-determination." Governments, in the ICPD Programme of Action, also underscored the need to take actions to promote gender equality and equity.

The challenges girls were facing in 1994 persist today and are compounded by new pressures stemming from the proliferation of mass and social media that can sometimes glorify adolescent pregnancy and reinforce negative attitudes about girls and women. The ICPD Programme of Action points the way forward in helping girls face these ongoing and emerging challenges.

But the challenges are not the same for all adolescent girls. While there is a growing body of evidence on the determinants of pregnancy and the impact on girls 15 or older, very little research has been carried out about pregnancies among girls 14 or younger. Yet, from what we do know, the impact of a pregnancy on a very young adolescent girl is profound. Actions to prevent pregnancy among older adolescents are under way in most countries today. But only a handful of countries have made a deliberate effort to reach very young adolescents, who are typically

overlooked by policymakers and development programmes everywhere. A deeper understanding of the challenges confronting 10 to 14-year-olds is urgently needed, and pregnancy prevention and support for very young adolescent mothers must be advanced to the top of the sexual and reproductive health and reproductive rights agenda of governments, development institutions and civil society. It is with this group that the greatest need lies and that the obstacles have been thus far insurmountable.

> "My uncle slept with me. I don't go to school anymore. At school, they do not accept girls who become pregnant."
>
> *Affoué, 13, Côte d'Ivoire*

## 1 Reach girls ages 10 to 14

*Intervene early with preventive measures*

The needs, vulnerabilities and challenges of very young adolescents—between ages 10 and 14—are often overlooked by policymakers. But interventions at this critical stage of their development, characterized by profound physical, cognitive and social changes that occur in puberty, are needed to ensure girls' safe and healthy transition through adolescence into adulthood.

Governments, communities and civil society should seize opportunities arising during this formative period to begin laying the foundations for girls' sexual and reproductive health and reproductive rights—and enjoyment of all their human rights in the long run. Strategic timing of preventive interventions, including the provision of age-appropriate comprehensive sexuality education and steps to enable girls to attend and remain in school, allows for positive outcomes before the circumstances of young adolescents' lives are set.

*Give visibility to girls traditionally invisible to policymakers*

Effective policymaking has been hampered in many countries by a dearth of data and contextual information about very young adolescents. Researchers and policymakers should join forces to fill this data void to ensure very young adolescents are not overlooked by or excluded from services and to ensure their rights are protected.

National censuses and future household surveys should include a basic set of questions about 10 to 14-year-olds. These questions should address whether biological parents are alive and living in the household, whether the adolescents are married or already parents themselves, how much education they have attained and whether they are still in school, and whether they hold jobs or work outside the home. Where such data exist, they should be easily accessible, and be analysed separately from data on older adolescent girls.

At the same time, data on younger and older adolescent girls should be combined to identify and highlight the trajectory from childhood through adolescence to adulthood. Such an analysis reveals critical junctures in the lives of girls that are preceded by critical investment windows. Such data and analyses when presented to stakeholders can be used to inform policy and programme priorities, ensure properly weighted resource allocation, influence programme design

and even serve as a community-level advocacy tool to ensure that younger and older adolescents get their due.

Programmes should ensure a match between need and actual reach through the collection of simple but high-quality monitoring data so that 10 to 14-year-old adolescent girls at greatest risk of school dropout, child marriage, sexual violence and coercion, and early or unintended pregnancy may be reached with appropriate inputs and interventions.

Research on what younger (and older) male and female adolescents need (and want) to know and when they need to know it, with respect to the sequence of events in their lives and the cultures of which they are a part, would help to determine the "age appropriateness" and content of interventions in different communities (World Health Organization, 2011b).

> "We were in love, we thought it was going to be forever, we wanted a baby... After we realized that we were pregnant, we got scared... you don't know what you are facing or what is coming... It disrupted my schooling...I was nursing and I used to look at my classmates through the window and kept on thinking that I could also be going to school."
>
> *Dunia, 34, pregnant at 17, Costa Rica*

## 2 Invest strategically in adolescent girls' education

Preliminary findings from a new global review of countries' progress in implementing the ICPD Programme of Action show that higher literacy rates for girls ages 15 to 19 are associated with significantly lower adolescent birth rates (UNFPA, 2013e). Education of all children is a right in itself and increases their capacity to participate socially, economically and politically in their communities' affairs. When a girl stays in school and gets an education, especially during adolescence, she is more likely to avoid child marriage and delay childbearing. Of the 176 countries and seven territories surveyed, 82 per cent indicated commitment to ensuring equal access of girls to education at all levels, and about 81 per cent indicated commitment to keeping more girls and adolescents in secondary school. While the commitment is widespread, much more must be done to reach all girls. The survey also found that adolescent birth rates are lower in higher-income groups, but in all income groups, higher literacy among young women is associated with significantly lower adolescent birth rates. Investing in girls' education is also associated with the overall empowerment of girls, enhances their status in their communities, improves their health and increases their bargaining power in marriages.

Specific actions to make it easier for girls to enrol in and remain in school longer include: waiving school fees; providing free uniforms, text books and supplies; offering free meals; awarding scholarships to girls from low-income families; using conditional cash transfers to get girls in school, stay in school and do better in school; recruiting and retaining female teachers;

and providing a safe environment for girls in the classroom and en route to class and their homes. The quality of education and how girls are treated by classmates, teachers and staff are also important determinants of whether girls stay in school. Raising awareness among parents and families about the long-term benefits of educating girls can also help keep girls in school.

In many countries, girls who become pregnant are expelled and not allowed to return after giving birth, undermining their futures and denying them one of their basic human rights. The global survey of countries on the implementation of the ICPD found that about 40 per cent of countries were committed to facilitating school completion of pregnant girls. Enabling girls to finish their education would require developing, promulgating and enforcing policies that allow girls to return to school after a pregnancy or birth, providing child care, financial support and counselling to young mothers, or providing alternative education and skills training for girls who do not return to formal schooling. Such strategies also reduce second pregnancies and improve the prospects for the young mother and her child.

## 3 Adopt approaches grounded in human rights and meet international human rights obligations

Interventions that respect human rights can tear down obstacles to girls' enjoyment of their rights to education, health, security and their rights to be safe from violence, discrimination and poverty. Such approaches can help governments address many of the underlying causes of adolescent pregnancy, including chronic gender inequality, inequitable access to services and opportunities, and child marriage. They can also help transform the social and economic forces working against the adolescent girl into even more powerful forces that support her development, health, autonomy, well-being and empowerment.

Adopting human rights approaches also entails States' fulfilling their obligations, as duty-bearers, under human rights instruments such as the Convention on the Rights of the Child and the Universal Declaration of Human Rights. States are therefore accountable to their citizens—the rights-holders—to ensure that national laws and policies enable everyone to exercise all their human rights and comply with human rights standards, including but not limited to, recognizing and applying the "evolving capacity of the child" standard regarding access to sexual and reproductive health care information and services. Adolescents themselves should participate in the development and monitoring of laws and policies that affect their sexual and reproductive health.

Mechanisms for reporting, investigating and filing claims about reproductive rights violations will accomplish little if adolescents are unable to access them or do not even know they exist. Developing effective and responsive accountability systems and making them known to all stakeholders are therefore crucial. In addition, collecting and analysing age- and income-disaggregated data related to adolescent pregnancies can help ensure that laws and policies appropriately address needs and unmet demand for services from all segments of the population, especially marginalized adolescents. Data are especially scarce for girls ages 10 to 14, yet these figures are particularly important because they can yield insights into

this often-overlooked group's unique needs, vulnerabilities and challenges.

At the ICPD, governments across the globe recognized the special needs of adolescents and youth and the unique barriers they face in accessing quality reproductive health information and services. Participating governments agreed to remove regulatory, legal, and social barriers that inhibit adolescents' access to services. They also agreed that health services must safeguard the rights of adolescents to privacy and confidentiality, employing the evolving capacities standard for autonomous decision-making.

## 4 Ensure adolescents' access to comprehensive sexuality education, services and maternal health care

### *Expand access to comprehensive sexuality education*

Age-appropriate, comprehensive sexuality education provides adolescents with vital information about preventing pregnancy and sexually transmitted infections, including HIV, and can promote gender equality. The ICPD global survey shows that about 76 per cent of countries were committed to age-appropriate sexuality education, about 70 per cent were committed to revising curricula to make them more gender-sensitive and 69 per cent supported life-skills training for young people through formal education. Increasing access to age-appropriate comprehensive sexuality education—so that it reaches boys and girls and adolescents who are in or out of school, including those from indigenous peoples and ethnic minorities—would contribute to improved health of girls and boys, promote equitable gender relations, help prevent pregnancy, and in turn help girls remain in school and realize their full potential.

### *Strengthen gender equality and rights aspects of the curriculum*

Research shows that the comprehensive sexuality education programmes that have had the greatest impact on reducing adolescent pregnancy and sexually transmitted infections were those that addressed gender and power issues (Haberland and Rogow, 2013). Studies show that young people who believe in gender equality have better sexual health outcomes than their peers (International Sexuality and HIV Curriculum Working Group, 2011).

Comprehensive sexuality education should therefore address issues of gender and rights in a meaningful way. Young people who, compared to their peers, adopt egalitarian attitudes about gender roles are more likely to delay sexual debut, use condoms, and practice contraception; they also have lower rates of sexually transmitted infections and unintended pregnancy (Dupas, 2011).

In addition, sexuality education is more likely to be effective in protecting adolescents' health and preventing pregnancy if it is age-appropriate, comprehensive, based on evidence and core values and human rights, gender-sensitive, promotes academic growth and critical thinking, fosters civic engagement, and is culturally appropriate.

The picture, however, remains sobering with regard to reaching marginalized adolescents, including those living in extreme poverty and married girls. Very few programmes reach these groups, especially adolescents who are not in school. Developing out-of-school programmes is therefore essential.

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*Establish, strengthen and increase access to health services that adolescents will use*

Girls need a range of support, programmes and services, including health services. However, services tailored to adolescents' specific needs in many areas are limited, even though 78 per cent of the countries surveyed indicated they are committed to increasing access to comprehensive sexual and reproductive health services for adolescents—married or unmarried (UNFPA, 2013e). Even when adolescent-friendly services are available, adolescents may not have access to them for reasons including inconvenient locations or opening hours, cost or the stigma they may experience in their communities. Moreover, adolescents will not use them if they are treated poorly by providers.

Policymakers committed to increasing adolescents' access to and use of services should ensure that providers are trained to work with young people, respect confidentiality and offer complete, evidence-based and accurate information. Adolescent-friendly services should also offer low-cost or free contraception, including male and female condoms, emergency contraception, and a full range of modern methods, including long-acting reversible methods, according to adolescents' preferences and needs.

Improved service delivery must be coupled with strong community mobilization and dedicated outreach so young people know which services are available to them and how they can obtain them. Voucher schemes can help disadvantaged adolescents access services that

they might not otherwise use because of cost. Community outreach is also necessary to raise awareness, build support for services for adolescents and reduce the stigma often associated with seeking contraception or being sexually active before a certain age or outside of marriage.

Critically important is the reality that one size does not fit all, given the diversity of young people's needs and the contexts of their lives. Some may prefer accessing services through channels such as health facilities while others may prefer to access them through schools or from pharmacies or other sources in the community. The key is to ensure common standards of high quality and confidentiality, regardless of the channel, while at the same time aiming to integrate, implement and constantly monitor an essential package of services for adolescents within existing health services so as to promote sustainability.

Moreover, special efforts are needed to identify and target the most vulnerable adolescent girls at risk of early pregnancy and other poor sexual and reproductive health outcomes. Given that married girls have a very high unmet need for contraception compared to other age groups, targeting them within existing family planning and contraceptive efforts would go a long way in terms of realizing their rights, achieving equity and better health outcomes, and efficiency within systems.

When health services are of good quality, affordable and sensitive to the unique circumstances of adolescents, buttressed with community support, outreach, and innovative referral mechanisms, young people will use them.

At the same time, actions should be taken to change male attitudes towards girls' sexual and reproductive health and reproductive rights. In many instances, male partners restrict access to services or refuse to use contraception, and at other times males are restricted from using reproductive health services, reinforcing biases that reproductive health is solely the business of females.

UNFPA's Adolescent and Youth Strategy prioritizes actions to improve the quality of sexual and reproductive health services, including HIV services, for adolescents and youth. This includes supporting advocacy efforts to lift legal and policy barriers impeding access to health services; partnering with governments, civil society and young people to develop and strengthen national programmes delivering quality adolescent sexual and reproductive health services and strengthening young people's leadership and voice in the process.

### *Increase girls' access to and use of antenatal care, skilled birth attendants and post-abortion services*

The same stigma and economic, geographical and social obstacles that keep girls from accessing contraception may also keep pregnant girls from accessing services that can protect their health and the health of their newborns.

Ensuring that quality antenatal, delivery and post-partum care is accessible, equitable and affordable can mitigate the health risks to adolescents and their children. Service providers should therefore increase the numbers and reach of skilled health workers to provide antenatal, delivery, and post-partum care to adolescent girls. Access to emergency obstetric care is especially important since it would help prevent maternal death and morbidity, including obstetric fistulae.

Adolescent girls between the ages of 15 and 19 account for as many as 3.2 million unsafe abortions annually in developing countries (Shah and Ahman, 2012). With unsafe abortion comes

great risk of injury, illness and maternal death. Post-abortion services should therefore be made available to adolescents. Where abortion is legal, it should be safe and accessible. Increasing adolescents' access to contraception can not only help prevent abortion, but it can also help prevent death and injury from complications from pregnancy and delivery (UNFPA, 2012a).

Girls who give birth during adolescence are at high risk of having a second pregnancy soon after the first. Service providers could help prevent or space second pregnancies by offering contraception to girls who have given birth or who have had an abortion. Increasing access to long-acting reversible methods of contraception can help prevent unintended second pregnancies.

> "I went for an abortion, but they asked me for 15,000 dirhams [about $1,800], which I did not have... I asked my parents for help, but did not get it. When the pregnancy signs started to show, they kicked me out of the house and there was nothing I could do about it."
>
> *18-year-old girl, Morocco*

## 5 Prevent child marriage, sexual violence and coercion

*Enact and enforce laws to ban child marriage and address its underlying causes*

Since the 1994 ICPD, 158 countries have implemented laws to increase the legal age of marriage to 18, but laws that are not enforced have little impact on practice. Today, an estimated 67 million girls globally were married before their 18th birthday (UNFPA, 2013e). The overwhelming majority of adolescent pregnancies in developing countries occur within marriage. Ending child marriage would not only help protect girls' rights but would also go a long way towards reducing the prevalence of adolescent pregnancy.

Zero tolerance towards child marriage is the goal. However, until that aspiration becomes a reality, millions of girls will become child brides and mothers. These girls occupy a difficult and often neglected space within society, receiving scant, if any, attention from social protection programmes. While they are still *children*—developmentally, biologically, physically, psychologically and emotionally—their marital status signals an end to their status as children and renders them adults in the eyes of their societies. Neither youth-oriented programmes nor those targeting adult women are likely to address the unique circumstances of married girls or the needs of girls at risk of child marriage, unless they do so in a planned and deliberate manner.

Enacting laws that ban child marriage is a good first step. But unless laws are enforced and communities support these laws, they will have little impact. Stopping child marriage requires combining a variety of interventions into multi-sectoral, multi-level responses, especially at the community level, to change harmful

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social norms and to empower girls. Timing is key; these interventions, especially schooling and asset-building for girls, must be directed at young adolescents (10 to 14 years old)—before or around the time of puberty—in order to counter pressures on girls for marriage and childbearing for social and economic security. Programmes have yielded demonstrable results at the community level even in a short amount of time.

Specifically, governments, civil society, community leaders and families that are serious about ending child marriage should consider:

- Helping girls go to and stay in school and learn skills so they can develop a livelihood, communicate better, negotiate, and make decisions that directly affect their lives;
- Initiating programmes for community leaders, religious leaders and parents to increase their support for girls' rights and education, later marriage and for changing harmful norms and practices;
- Supporting programmes that give girls alternatives to child marriage, including safe spaces for girls to build agency, help them overcome social isolation, allow them to interact with peers and mentors, gain critical life skills and consider aspirations that do not involve child marriage and early motherhood;
- Offering conditional cash transfers to keep girls in school and unconditional cash transfers to prevent child marriage and pregnancy;
- Providing information about life options and development of life plans and support networks;
- Promulgating, enforcing and building community support for laws on the minimum age of marriage;

- Registering all births and marriages so that cases of child marriage may be more easily identified, and enforcing existing registration laws;
- Training law enforcement officials to identify and handle cases of child marriage and hold perpetrators accountable under the law.

*Protect girls from violence and coercion*

An unknown number of girls around the world become pregnant as the result of sexual violence or as a result of sexual coercion. In addition, girls who are pregnant are at risk of gender-based violence, typically committed by male partners or others known to them. In some places, perpetrators can avoid punishment and family shame by marrying their victims.

However, stopping sexual violence and sexual coercion requires more than enacting and enforcing laws and prosecuting perpetrators, no matter who they are. Preventive measures are also necessary. As with many of the determinants of adolescent pregnancy, long-term solutions must be multidimensional and address underlying problems, such as gender inequality, negative attitudes of boys and men towards girls, norms that perpetuate violence and impunity, poverty that compels girls to engage in sex as a survival strategy, and inadequate protection of human rights.

But in the short run, governments and others should consider:

- Sensitizing boys as well as girls about sexual violence, gender-based violence and sexual coercion through youth-focused initiatives, including sports, life-skills and peer-support programmes, mentoring organizations, HIV-prevention and reproductive health education, social networks and discussion groups for boys and men;
- Modifying sexuality education or life-skills curricula to include wider discussions of violence, coercion, human rights and healthy and respectful relationships;
- Pursuing in-school interventions to change misconceptions and build awareness of adolescents' rights and issues of gender equality;
- Improving the response of the health sector and law enforcement by enhancing provider knowledge, attitudes, and practices, including the ability to detect and respond to cases of violence;
- Taking legal and policy measures to prevent sexual violence, provide rehabilitation and redress to survivors, and investigate, prosecute and punish offenders;
- Adding an awareness-raising component on sexual coercion and violence to programmes focused on adolescent economic empowerment or in programmes that engage men and boys;
- Supporting programmes that build disadvantaged girls' economic, social and health assets to reduce their vulnerability to sexual violence or the need to engage in transactional sex to support themselves;
- Investigating, prosecuting and punishing perpetrators of violence to the fullest extent of the law.

> "As I look back... I remember many goals I wanted for myself but could not achieve."
>
> *Jessica, 39, pregnant at 18, USA*

## 6 Support multilevel programmes

*Address all sources of girls' vulnerability*

Actions to prevent pregnancy must be taken at multiple levels. Narrowly focused interventions are not enough, and efforts centred on changing a girl's behaviour fail to reflect the multidimensional nature of the challenge. Keeping girls on healthy, safe and affirming life trajectories requires comprehensive, strategic, and targeted investments in adolescents that address the multiple sources of their vulnerabilities, which vary by age, income group, place of residence and many other factors. It also requires deliberate efforts to recognize the diverse circumstances of adolescents and identify girls at greatest risk of adolescent pregnancy and poor reproductive health outcomes. Such multi-sectoral programmes are needed to build girls' assets across the board—in health, education and livelihoods—but also to empower girls through social support networks and increasing their status at home, in the family, in the community and in relationships. These programmes should not only cross sectors but should also operate at several levels of influence, from the individual and the community up to the national government. Such investments will take significant time and resources. But if they reach girls early, they can significantly improve the lives of girls and increase their contributions to their families and communities.

Policymakers and programme managers should leverage new opportunities offered by larger scale efforts in other sectors, especially education, health and poverty reduction. Strong coordination across these different sectors will be needed to promote greater synergy and maximize impact from these efforts. Actions are needed to prevent adolescent pregnancy as well as to ameliorate the impact on the girl.

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## 7 Engage men and boys

*Adopt gender-transformative approaches*

Many countries have adopted gender-sensitive approaches to achieve an array of development goals, such as improving sexual and reproductive health. These approaches take into account the specific needs and realities of men, women, boys and girls but do not necessarily seek to transform or influence gender relations. Gender-*transformative* programmes—those that seek to challenge the underlying social norms that make up the way gender roles and responsibilities are perceived—have been shown to have a greater impact on sexual and reproductive health programmes. By addressing the root causes of gender inequality, gender-transformative approaches are more likely to achieve long-term change in areas including sexual and reproductive health, including that of adolescent girls. Initiatives that do

not address social norms risk treating symptoms rather than addressing the underlying causes of inequality (UNFPA, 2013b). Without working with men and boys, discrimination, violence and inequality will continue.

*Engage boys before their attitudes about gender and sexuality are cemented*

Working with adolescent boys is essential to equip them with the tools they need to lead more gender-equitable lives. Sufficient opportunities and knowledge must be afforded for how young people, particularly boys and young men, can challenge gender norms, stereotypes and harmful practices. Furthermore, reaching adolescent boys through age-appropriate comprehensive sexuality education, which allows them to reflect and question predominant norms around masculinity and femininity, is a critical way to better ensure future generations of gender-equitable men.

Boys should be involved in the development of age-appropriate tools and approaches for the promotion of gender equality and adolescent sexual and reproductive health and reproductive rights. Communicating positive messages—that change is possible and that boys can positively influence not only their own lives but also that of girls—can increase boys' participation and responsiveness.

As part of age-appropriate comprehensive sexuality education curricula, young people, in particular boys and young men, should be provided with guidance and opportunities to reflect on dominant versions of "manhood" and the expectations that come with it, as well as build empathy and foster principles of respect and equality. Research demonstrates that boys start to cement their perceptions about sexuality and intimate relationships in adolescence and often carry those understandings into adulthood.

*Engage fathers too*

Fathers play a critical role in helping their children transition successfully from adolescence to adulthood and are in a position to be positive role models, encouraging boys to become gender-sensitive adults.

## 8 Lay the groundwork to support adolescent health and rights after 2015

*In the post-2015 development agenda, support goals, targets and indicators for empowering girls, ending child marriage and ensuring sexual and reproductive health*

A little more than two years remain to realize the United Nations Millennium Development Goals (MDGs).

Governments, civil society organizations, the United Nations and other major stakeholders are already formulating a sustainable development agenda that will build on and succeed the MDGs after 2015. What has already been agreed by the United Nations System Task Team on the Post-2015 Agenda is that the successor framework must be grounded in principles of human rights, equality and sustainability.

In December 2012, UNFPA recommended that the post-2015 agenda recognize and embed gender equality, within the framework of human rights, across its goals, since it is essential for elimination of inequality and necessary to enhance sustainability of development efforts (UNFPA, 2013f).

In a human rights-based approach to development, people, including women and young

people, are not considered passive recipients of goods, services or commodities, but, rather, as *rights-holders*, and therefore should be empowered. As active agents of their own development, rights-holders drive the sustainability of development. They are enabled to make choices, to influence policymaking processes and to hold their governments accountable.

The State, as the main *duty-bearer*, has corresponding obligations to respect, protect and fulfil human rights, including reproductive rights. Human rights approaches also call for the establishment and strengthening of independent national human rights accountability systems.

UNFPA also recommended that the post-2015 agenda uphold the rights of young people and call for investment in quality education, decent employment opportunities, effective livelihood skills, access to sexual and reproductive health and comprehensive sexuality education to strengthen young people's individual resilience and create the circumstances under which they are more likely to reach their full potential. Adolescents and youth, particularly poor, rural and indigenous girls, lack adequate access to the sexual and reproductive health information and services needed to avoid unintended pregnancies, unsafe abortions and sexually transmitted infections, including HIV. Unmet need for contraception remains high, and demand is rising. Many adolescent girls are exposed to child marriage, forced sexual relationships and other harmful practices, such as female genital mutilation/cutting and human trafficking. These practices are human rights violations and have damaging psychosocial effects, reducing girls' opportunities to complete their education, develop employable skills and participate fully in community and national development.

In May 2013, a 27-member High-Level Panel of Eminent Persons on the Post-2015 Development Agenda released a report with recommendations on the way forward (United Nations, 2013). The Secretary-General appointed the panel whose report focused on the dimensions of economic growth, social equality and environmental sustainability. The report stated that "new goals and targets need to be grounded in respect for human rights" and that the post-2015 agenda should feature "a limited number of high-priority goals and targets… supported by measurable indicators."

Among the panel's proposed universal goals are the empowerment of girls and women and the achievement of gender equality, with ending child marriage as an accompanying indicator of success.

Another proposed goal is the provision of quality education and lifelong learning, ensuring that every child, "regardless of circumstance," has access to lower secondary education. A proposed goal of ensuring healthy lives includes an indicator for ensuring universal sexual and reproductive health and rights.

In addition, national, regional and other consultations that have been taking place since late 2012 have also resulted in recommendations for including women's empowerment, equality, sexual and reproductive health, and the rights of adolescents, particularly girls, in the post-2015 agenda.

Governments that are committed to empowering adolescents, upholding their right to education and health, including sexual and reproductive health—all of which can have a tremendous impact on adolescent pregnancy—should consider supporting goals and indicators proposed by the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda.

## Towards empowered adolescent girls and fulfilled potential

Adolescents are shaping humanity's present and future. Depending on the opportunities and choices they have during this period in life, they can enter adulthood as empowered and active citizens, or be neglected, voiceless and entrenched in poverty.

When adolescent pregnancy occurs, it can derail a girl's healthy development and prevent her from achieving her full potential and enjoying her basic human rights. The impact can reverberate throughout her life and carry over to the next generation.

Experience from effective programmes shows that what is needed is a transformative shift away from narrowly focused interventions, targeted *at* girls or *at* preventing pregnancy, and towards broad-based approaches that build girls' human capital, focus on their agency to make decisions about their lives (including matters of sexual and reproductive health), and present real opportunities for girls so that pregnancy is not seen as their destiny. This new paradigm should instead target the circumstances, conditions, norms, values and structural forces that perpetuate adolescent pregnancies on the one hand and that isolate and marginalize pregnant girls on the other.

Interventions that have the power to reduce vulnerability to early pregnancy, especially among the poorest, least-educated and marginalized girls, are those that are grounded in principles of equity, equality and rights. Investments in girls—in building their human capital and their agency—can yield enormous social and economic returns, to individuals, their families, communities and nations.

Girls need access to sexual and reproductive health services and information. They also need to be unburdened from the economic and social pressures that too often translate into a pregnancy and the poverty, poor health and unrealized human potential that come with it. Girls who have become pregnant need support, not stigma.

Engagement by all stakeholders—families, communities, schools, health care providers and more—is essential to bring about change by reshaping social norms, traditions and practices that perpetuate adolescent pregnancy and compromise girls' futures. Cooperation among all stakeholders can mobilize political will for investments to empower adolescent girls and build their agency.

▲ *Youth peer provider works with local health centres to reach Ethiopian youth and adolescents with contraceptive information and supplies.*

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Everyone has a role to play. The media and entertainment industries can help through positive images of adolescent girls and women. Governments can rededicate themselves to the elimination of child marriage and gender-based violence. Parents should be attuned to the gender-discriminatory messages they transmit to their children. Opinion leaders, community leaders, teachers and health care providers should reinforce the messages that *all* children are of equal worth and have rights to health, education, participation and equal opportunity.

Policymakers must involve girls—and boys—in the design, implementation, and evaluation of measures intended to help girls prevent pregnancy or manage their lives if they become pregnant. Speaking with, and listening to, girls and gaining in-depth understanding of their needs, challenges and vulnerabilities are imperative. According to the 179 governments that endorsed the ICPD Programme of Action in 1994, actions intended to benefit adolescents "have proven most effective when they secure the full involvement of adolescents in identifying their reproductive and sexual health needs and in designing programmes that respond to those needs."

Building a gender-equitable society in which girls are empowered, educated, healthy and protected from child marriage, live in dignity and security and are able to make decisions about their futures and exercise their rights is essential.

UNFPA strives to uphold every girl's right to grow up unencumbered by gender inequality and discrimination, violence, child marriage and pregnancy so they may make a safe, healthy and successful transition from adolescence into adulthood. Childhood must never be derailed by motherhood.

"Pregnancy is not like going to a party and then it's over... it affects our studies and brings family conflicts... Before you even think about having sexual relationships, you should always think about the consequences... the future. It is important to be prepared... and to know what we want, and then we can make decisions."

*Valeria, 15, Nicaragua*

# Indicators


Monitoring ICPD goals: selected indicators page 100

Demographic indicators page 106

Notes page 109

# Monitoring ICPD goals: selected indicators

| Country, territory or other area | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 1991/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/2012 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| Afghanistan | 460 | 36 | 90 | 92 | 22 | 16 | | | | 34 | 13 |
| Albania | 27 | 99 | 11 | 16 | 69 | 10 | 13 | 98 | 95 | 71 | 68 |
| Algeria | 97 | 95 | 4 | 32 | 61 | 52 | | 98 | 97 | 72 | 74 |
| Angola | 450 | 49 | 165 | 156 | 18 | | | 93 | 78 | 15 | 12 |
| Antigua and Barbuda | | 100 | 67 | 11 | | | | 87 | 85 | 85 | 85 |
| Argentina | 77 | 99 | 68 | 13 | 79 | 70 | | 100 | 99 | 80 | 88 |
| Armenia | 30 | 100 | 28 | 21 | 55 | 27 | 14 | 95 | 98 | 85 | 88 |
| Aruba | | | 36 | 17 | | | | 93 | 96 | 70 | 74 |
| Australia[1] | 7 | 99 | 16 | 5 | 72 | 68 | | 97 | 98 | 85 | 86 |
| Austria | 4 | 99 | 10 | 4 | 70 | 68 | | | | | |
| Azerbaijan | 43 | 89 | 41 | 47 | 51 | 13 | 15 | 88 | 86 | 87 | 85 |
| Bahamas | 47 | 99 | 41 | 13 | | | | 94 | 96 | 82 | 88 |
| Bahrain | 20 | 97 | 12 | 9 | 62 | 31 | | 99 | 100 | 92 | 97 |
| Bangladesh | 240 | 31 | 133 | 42 | 61 | 52 | 14 | | | 43 | 51 |
| Barbados | 51 | 100 | 50 | 12 | | | | 90 | 97 | 83 | 95 |
| Belarus | 4 | 100 | 21 | 7 | 73 | 56 | | | | | |
| Belgium | 8 | 99 | 11 | 4 | 70 | 69 | 3 | 99 | 99 | 90 | 87 |
| Belize | 53 | 94 | 90 | 15 | 55 | 52 | 16 | 100 | 91 | 64 | 65 |
| Benin | 350 | 84 | 114 | 108 | 13 | 8 | 27 | | | 27 | 13 |
| Bhutan | 180 | 58 | 59 | 48 | 66 | 65 | 12 | 89 | 92 | 54 | 62 |
| Bolivia (Plurinational State of) | 190 | 71 | 89 | 52 | 61 | 34 | 20 | 91 | 91 | 70 | 70 |
| Bosnia and Herzegovina | 8 | 100 | 17 | 9 | 46 | 12 | 9 | 89 | 91 | | |
| Botswana | 160 | 99 | 51 | 41 | 53 | 51 | | 87 | 88 | 57 | 66 |
| Brazil | 56 | 99 | 71 | 24 | 80 | 77 | 6 | 95 | 97 | | |
| Brunei Darussalam | 24 | 10 | 18 | 5 | | | | | | 98 | 100 |
| Bulgaria | 11 | 99 | 48 | 11 | 69 | 40 | 30 | 99 | 100 | 84 | 82 |
| Burkina Faso | 300 | 67 | 130 | 137 | 16 | 15 | 25 | 66 | 63 | 21 | 17 |
| Burundi | 800 | 60 | 65 | 139 | 22 | 18 | 32 | 91 | 89 | 20 | 17 |
| Cambodia | 250 | 71 | 48 | 51 | 51 | 35 | 17 | 96 | 95 | 39 | 36 |
| Cameroon, Republic of | 690 | 64 | 127 | 115 | 23 | 14 | 24 | 100 | 87 | 44 | 39 |
| Canada | 12 | 99 | 14 | 5 | 74 | 72 | | 100 | 100 | | |
| Cape Verde | 79 | 76 | 92 | 20 | 61 | 57 | 17 | 95 | 92 | 60 | 69 |
| Central African Republic | 890 | 41 | 133 | 150 | 19 | 9 | 19 | 78 | 60 | 18 | 10 |
| Chad | 1100 | 17 | 193 | 155 | 5 | 2 | 28 | 74 | 51 | 16 | 5 |
| Chile | 25 | 100 | 54 | 7 | 64 | | | 93 | 93 | 83 | 87 |
| China[2] | 37 | 96 | 6 | 16 | 85 | 84 | 2 | | | | |
| China, Hong Kong SAR[3] | | | 3 | 3 | 80 | 75 | | 95 | 100 | 72 | 74 |
| China, Macao SAR[4] | | | 3 | 5 | | | | 87 | 88 | 80 | 77 |
| Colombia | 92 | 99 | 85 | 23 | 79 | 73 | 8 | 90 | 90 | 73 | 79 |

| Country, territory or other area | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 1991/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/2012 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| Comoros | 280 | | 95 | 92 | 26 | 19 | 36 | 81 | 75 | | |
| Congo, Democratic Republic of the | 540 | 80 | 135 | 180 | 18 | 6 | 24 | 34 | 32 | | |
| Congo, Republic of the | 560 | 94 | 132 | 97 | 45 | 20 | 20 | 95 | 90 | | |
| Costa Rica | 40 | 95 | 67 | 10 | 82 | 80 | 5 | | | | |
| Côte d'Ivoire | 400 | 59 | 111 | 107 | 18 | 13 | 29 | 67 | 56 | | |
| Croatia | 17 | 100 | 13 | 6 | | | | 95 | 97 | 88 | 94 |
| Cuba | 73 | 100 | 51 | 6 | 74 | 73 | 9 | 98 | 98 | 87 | 87 |
| Curaçao | | | | 13 | | | | | | | |
| Cyprus | 10 | 98 | 4 | 4 | | | | 99 | 99 | 88 | 90 |
| Czech Republic | 5 | 100 | 11 | 3 | 86 | 78 | 4 | | | | |
| Denmark | 12 | 99 | 6 | 4 | | | | 95 | 97 | 88 | 91 |
| Djibouti | 200 | 78 | 27 | 83 | 18 | 17 | | 57 | 51 | 28 | 20 |
| Dominica | | 100 | 48 | | | | | 96 | 97 | 80 | 89 |
| Dominican Republic | 150 | 95 | 98 | 28 | 73 | 70 | 11 | 93 | 91 | 58 | 67 |
| Ecuador | 110 | 89 | 100 | 21 | 73 | 59 | 7 | 99 | 100 | 73 | 75 |
| Egypt | 66 | 79 | 50 | 24 | 60 | 58 | 12 | 99 | 96 | | |
| El Salvador | 81 | 85 | 65 | 21 | 72 | 66 | 9 | 96 | 96 | 59 | 61 |
| Equatorial Guinea | 240 | | 128 | 143 | 10 | 6 | | 59 | 59 | | |
| Eritrea | 240 | | 85 | 56 | 8 | 5 | 29 | 40 | 34 | 32 | 25 |
| Estonia | 2 | 99 | 21 | 5 | 63 | 58 | | 98 | 97 | 91 | 93 |
| Ethiopia | 350 | 10 | 79 | 74 | 29 | 27 | 26 | 90 | 84 | 17 | 11 |
| Fiji | 26 | 100 | 31 | 20 | | | | 99 | 99 | 81 | 88 |
| Finland | 5 | 99 | 8 | 3 | | | | 98 | 98 | 93 | 94 |
| France | 8 | 98 | 12 | 4 | 76 | 74 | 2 | 99 | 99 | 98 | 100 |
| French Guiana | | | 84 | 14 | | | | | | | |
| French Polynesia | | | 41 | 8 | | | | | | | |
| Gabon | 230 | | 144 | 65 | 31 | 19 | 28 | | | | |
| Gambia | 360 | 56 | 104 | 100 | 13 | 9 | 22 | 68 | 71 | | |
| Georgia | 67 | 97 | 44 | 22 | 53 | 35 | 12 | 96 | 94 | 84 | 80 |
| Germany | 7 | 99 | 9 | 4 | 66 | 62 | | 100 | 100 | | |
| Ghana | 350 | 55 | 70 | 78 | 24 | 17 | 36 | 83 | 82 | 48 | 44 |
| Greece | 3 | | 12 | 4 | 76 | 46 | | 99 | 99 | 98 | 98 |
| Grenada | 24 | 100 | 53 | 12 | 54 | 52 | | 96 | 99 | 84 | 84 |
| Guadeloupe | | | 21 | 6 | | | | | | | |
| Guam | | | 52 | 11 | 67 | 58 | | | | | |
| Guatemala | 120 | 51 | 92 | 31 | 43 | 34 | 28 | 99 | 97 | 48 | 44 |
| Guinea | 610 | 46 | 153 | 127 | 6 | 5 | 22 | 90 | 76 | 42 | 27 |
| Guinea-Bissau | 790 | 44 | 137 | 156 | 14 | 10 | 6 | 77 | 73 | 11 | 6 |
| Guyana | 280 | 87 | 97 | 34 | 43 | 40 | 29 | 81 | 85 | 71 | 81 |
| Haiti | 350 | 26 | 69 | 67 | 35 | 31 | 37 | | | | |
| Honduras | 100 | 66 | 108 | 32 | 65 | 56 | 17 | 97 | 98 | | |
| Hungary | 21 | 99 | 19 | 6 | 81 | 71 | 7 | 97 | 98 | 92 | 92 |

# Monitoring ICPD goals: selected indicators

| Country, territory or other area | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 1991/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/2012 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| Iceland | 5 | | 15 | 3 | | | | 99 | 99 | 88 | 89 |
| India | 200 | 58 | 76 | 56 | 55 | 48 | 21 | 99 | 99 | | |
| Indonesia | 220 | 80 | 66 | 31 | 62 | 58 | 11 | 98 | 100 | 74 | 74 |
| Iran (Islamic Republic of) | 21 | 97 | 31 | 22 | 73 | 59 | | 99 | 100 | 82 | 80 |
| Iraq | 63 | 89 | 68 | 32 | 53 | 34 | 8 | 94 | 84 | 49 | 39 |
| Ireland | 6 | 100 | 16 | 4 | 65 | 61 | | 99 | 100 | 98 | 100 |
| Israel | 7 | | 14 | 4 | | | | 97 | 98 | 97 | 100 |
| Italy | 4 | 100 | 7 | 3 | 63 | 41 | 12 | 100 | 99 | 94 | 94 |
| Jamaica | 110 | 98 | 72 | 25 | 69 | 66 | 12 | 83 | 81 | 80 | 87 |
| Japan | 5 | 100 | 5 | 3 | 54 | 44 | | 100 | 100 | 99 | 100 |
| Jordan | 63 | 99 | 32 | 20 | 59 | 41 | 13 | 91 | 91 | 83 | 88 |
| Kazakhstan | 51 | 99 | 31 | 30 | 51 | 50 | 12 | 100 | 100 | 90 | 90 |
| Kenya | 360 | 44 | 106 | 77 | 46 | 39 | 26 | 84 | 85 | 52 | 48 |
| Kiribati | | 98 | 39 | 42 | 22 | 18 | 28 | | | 65 | 72 |
| Korea, Democratic People's Republic of | 81 | 100 | 1 | 28 | | | | | | | |
| Korea, Republic of | 16 | 100 | 2 | 4 | 80 | 70 | | 99 | 98 | 96 | 95 |
| Kuwait | 14 | 99 | 14 | 11 | 52 | 39 | | 97 | 100 | 86 | 93 |
| Kyrgyzstan | 71 | 98 | 31 | 42 | 48 | 46 | 12 | 96 | 96 | 81 | 80 |
| Lao People's Democratic Republic | 470 | 37 | 110 | 45 | 38 | 35 | 27 | 98 | 96 | 43 | 39 |
| Latvia | 34 | 99 | 15 | 9 | 68 | 56 | 17 | 95 | 96 | 83 | 83 |
| Lebanon | 25 | | 18 | 10 | 58 | 34 | | 97 | 97 | 72 | 80 |
| Lesotho | 620 | 62 | 92 | 82 | 47 | 46 | 23 | 74 | 76 | 23 | 37 |
| Liberia | 770 | 46 | 177 | 85 | 11 | 10 | 36 | 42 | 40 | | |
| Libya | 58 | 98 | 4 | 16 | 45 | 26 | | | | | |
| Lithuania | 8 | | 17 | 7 | 63 | 50 | 18 | 94 | 93 | 91 | 91 |
| Luxembourg | 20 | | 7 | 3 | | | | 94 | 96 | 85 | 88 |
| Madagascar | 240 | 44 | 147 | 55 | 40 | 28 | 19 | 79 | 80 | 23 | 24 |
| Malawi | 460 | 71 | 157 | 119 | 46 | 42 | 26 | 91 | 98 | 30 | 29 |
| Malaysia | 29 | 99 | 14 | 5 | 49 | 32 | | 96 | 96 | 66 | 71 |
| Maldives | 60 | 95 | 19 | 13 | 35 | 27 | 29 | 94 | 95 | 46 | 52 |
| Mali | 540 | 49 | 190 | 165 | 8 | 6 | 28 | 72 | 63 | 36 | 25 |
| Malta | 8 | 100 | 20 | 7 | 86 | 46 | | 93 | 94 | 82 | 80 |
| Martinique | | | 20 | 7 | | | | | | | |
| Mauritania | 510 | 57 | 88 | 107 | 9 | 8 | 32 | 73 | 77 | 17 | 15 |
| Mauritius[5] | 60 | 100 | 31 | 13 | 76 | 39 | 4 | | | 74 | 74 |
| Mexico | 50 | 95 | 87 | 17 | 71 | 67 | 12 | 99 | 100 | 71 | 74 |
| Micronesia (Federated States of) | 100 | 100 | 52 | 40 | | | | | | | |
| Moldova, Republic of | 41 | 100 | 26 | 17 | 68 | 43 | 11 | 91 | 90 | 77 | 78 |
| Mongolia | 63 | 99 | 20 | 31 | 55 | | 22 | 99 | 98 | 74 | 79 |
| Montenegro | 8 | 100 | 24 | 10 | 39 | 17 | | 93 | 94 | | |
| Morocco | 100 | 74 | 18 | 32 | 67 | 57 | 12 | 97 | 96 | 38 | 32 |
| Mozambique | 490 | 54 | 193 | 116 | 12 | 11 | 19 | 93 | 88 | 18 | 17 |

| Country, territory or other area | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 1991/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/2012 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| Myanmar | 200 | 71 | 17 | 63 | 46 | 46 | 19 | | | 49 | 52 |
| Namibia | 200 | 81 | 74 | 42 | 55 | 54 | 21 | 84 | 88 | 44 | 57 |
| Nepal | 170 | 36 | 81 | 44 | 50 | 43 | 28 | 78 | 64 | | |
| Netherlands | 6 | | 5 | 4 | 69 | 67 | | 100 | 99 | 87 | 88 |
| New Caledonia | | | 21 | 15 | 75 | 72 | | | | | |
| New Zealand | 15 | 96 | 29 | 5 | | | | 99 | 100 | 94 | 95 |
| Nicaragua | 95 | 74 | 109 | 20 | 72 | 69 | 11 | 93 | 95 | 43 | 49 |
| Niger | 590 | 18 | 199 | 127 | 14 | 12 | 16 | 71 | 60 | 14 | 9 |
| Nigeria | 630 | 34 | 123 | 122 | 14 | 9 | 19 | 60 | 55 | | |
| Norway | 7 | 99 | 10 | 3 | 88 | 82 | | 99 | 99 | 94 | 94 |
| Oman | 32 | 99 | 12 | 9 | 32 | 25 | | 98 | 97 | 94 | 94 |
| Pakistan | 260 | 45 | 16 | 71 | 27 | 19 | 25 | 79 | 65 | 40 | 29 |
| Palestine[7] | 64 | | 60 | 23 | 50 | 39 | | 90 | 90 | 77 | 85 |
| Panama | 92 | 89 | 88 | 18 | 52 | 49 | | 98 | 97 | 65 | 71 |
| Papua New Guinea | 230 | 43 | 70 | 62 | 32 | 24 | 27 | | | | |
| Paraguay | 99 | 85 | 63 | 37 | 79 | 70 | 5 | 84 | 84 | 59 | 63 |
| Peru | 67 | 85 | 72 | 26 | 69 | 50 | 6 | 97 | 97 | 77 | 78 |
| Philippines | 99 | 62 | 53 | 27 | 49 | 36 | 22 | 88 | 90 | 56 | 67 |
| Poland | 5 | 100 | 16 | 6 | 73 | 28 | | 97 | 97 | 90 | 92 |
| Portugal | 8 | | 16 | 3 | 87 | 83 | | 99 | 100 | 78 | 86 |
| Puerto Rico | | | 55 | 8 | 84 | 72 | 4 | 81 | 86 | | |
| Qatar | 7 | 100 | 15 | 8 | 43 | 32 | | 95 | 95 | 87 | 96 |
| Réunion | | | 43 | 5 | 67 | 64 | | | | | |
| Romania | 27 | 99 | 41 | 12 | 70 | 51 | 12 | 88 | 87 | 82 | 83 |
| Russian Federation | 34 | 100 | 30 | 12 | 80 | 65 | | 95 | 96 | | |
| Rwanda | 340 | 69 | 41 | 74 | 52 | 44 | 21 | 89 | 92 | | |
| Saint Kitts and Nevis | | 100 | 67 | | | | | 86 | 89 | 84 | 88 |
| Saint Lucia | 35 | 99 | 49 | 14 | | | | 88 | 88 | 85 | 85 |
| Saint Vincent and the Grenadines | 48 | 99 | 70 | 21 | | | | 100 | 97 | 84 | 86 |
| Samoa | 100 | 81 | 29 | 23 | 29 | 27 | 48 | 91 | 96 | 71 | 82 |
| San Marino | | | 1 | | | | | 91 | 93 | | |
| São Tomé and Principe | 70 | 81 | 110 | 63 | 38 | 33 | 38 | 97 | 98 | 30 | 34 |
| Saudi Arabia | 24 | 100 | 7 | 12 | 24 | | | 97 | 97 | | |
| Senegal | 370 | 65 | 93 | 75 | 13 | 12 | 29 | 77 | 81 | 24 | 19 |
| Serbia[6] | 12 | 100 | 22 | 13 | 61 | 22 | 7 | 95 | 94 | 90 | 91 |
| Seychelles | | 99 | 62 | 10 | | | | 96 | 94 | 92 | 100 |
| Sierra Leone | 890 | 61 | 98 | 187 | 11 | 10 | 27 | | | | |
| Singapore | 3 | 100 | 6 | 2 | 62 | 55 | | | | | |
| Slovakia | 6 | 100 | 21 | 7 | 80 | 66 | | | | | |
| Slovenia | 12 | 100 | 5 | 3 | 79 | 63 | 9 | 98 | 98 | 92 | 93 |
| Solomon Islands | 93 | 70 | 70 | 47 | 35 | 27 | 11 | 88 | 87 | 44 | 42 |
| Somalia | 1000 | 9 | 123 | 131 | 15 | 1 | | | | | |

# Monitoring ICPD goals: selected indicators

| Country, territory or other area | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 2005/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/20112 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| South Africa | 300 | | 54 | 51 | 60 | 60 | 14 | 90 | 91 | 59 | 65 |
| South Sudan | | | | 123 | 4 | 1 | | | | | |
| Spain | 6 | | 13 | 4 | 66 | 62 | 12 | 100 | 100 | 94 | 96 |
| Sri Lanka | 35 | 99 | 24 | 11 | 68 | 53 | 7 | 93 | 93 | 86 | 91 |
| Sudan | 730 | | 70 | 86 | 9 | | 29 | 50 | 42 | | |
| Suriname | 130 | 87 | 66 | 23 | 46 | 45 | | 92 | 93 | 52 | 63 |
| Swaziland | 320 | 82 | 111 | 92 | 65 | 63 | 13 | 84 | 86 | 32 | 38 |
| Sweden | 4 | | 6 | 3 | 75 | 65 | | 100 | 99 | 93 | 93 |
| Switzerland | 8 | | 4 | 4 | 82 | 78 | | 99 | 100 | 83 | 81 |
| Syrian Arab Republic | 70 | 96 | 75 | 21 | 58 | 43 | | 99 | 100 | 68 | 68 |
| Tajikistan | 65 | 88 | 27 | 73 | 28 | 26 | | 100 | 96 | 91 | 81 |
| Tanzania, United Republic of | 460 | 49 | 128 | 72 | 34 | 26 | 25 | 98 | 98 | | |
| Thailand | 48 | 99 | 47 | 12 | 80 | 78 | 3 | 90 | 89 | 69 | 74 |
| The former Yugoslav Republic of Macedonia | 10 | 100 | 20 | 11 | | | | 97 | 99 | 82 | 81 |
| Timor-Leste, Democratic Republic of | 300 | 30 | 54 | 49 | 22 | 21 | 32 | 91 | 91 | 37 | 41 |
| Togo | 300 | 44 | 89 | 103 | 15 | 13 | 37 | | | 33 | 16 |
| Tonga | 110 | 99 | 16 | 24 | | | | 94 | 89 | 67 | 80 |
| Trinidad and Tobago | 46 | 97 | 33 | 31 | 43 | 38 | | 98 | 97 | 65 | 70 |
| Tunisia | 56 | 95 | 6 | 17 | 63 | | 7 | 100 | 99 | | |
| Turkey | 20 | 91 | 38 | 18 | 73 | 46 | 6 | 100 | 98 | 81 | 76 |
| Turkmenistan | 67 | 100 | 21 | 60 | 62 | 53 | 13 | | | | |
| Turks and Caicos Islands | | | 26 | | | | | 77 | 84 | 72 | 69 |
| Tuvalu | | 93 | 28 | | 31 | 22 | 24 | | | | |
| Uganda | 310 | 58 | 159 | 86 | 30 | 26 | 34 | 93 | 95 | 17 | 15 |
| Ukraine | 32 | 99 | 30 | 14 | 67 | 48 | 10 | 92 | 93 | 85 | 85 |
| United Arab Emirates | 12 | 100 | 34 | 7 | 28 | 24 | | 94 | 98 | 80 | 82 |
| United Kingdom | 12 | | 25 | 5 | 84 | 84 | | 100 | 100 | 97 | 100 |
| United States of America | 21 | 99 | 39 | 7 | 76 | 70 | 8 | 95 | 96 | 89 | 90 |
| United States Virgin Islands | | | 52 | 11 | 78 | 73 | | | | | |
| Uruguay | 29 | 100 | 60 | 14 | 77 | 75 | | 100 | 99 | 68 | 76 |
| Uzbekistan | 28 | 100 | 26 | 53 | 65 | 59 | 14 | 94 | 91 | | |
| Vanuatu | 110 | 74 | 92 | 28 | 38 | 37 | | 98 | 97 | 46 | 49 |
| Venezuela (Bolivarian Republic of) | 92 | 98 | 101 | 19 | 70 | 62 | 19 | 95 | 95 | 69 | 77 |
| Viet Nam | 59 | 92 | 35 | 20 | 78 | 60 | 4 | | | | |
| Western Sahara | | | | 46 | | | | | | | |
| Yemen | 200 | 36 | 80 | 76 | 28 | 19 | 40 | 83 | 70 | 48 | 31 |
| Zambia | 440 | 47 | 151 | 102 | 41 | 27 | 27 | 96 | 98 | | |
| Zimbabwe | 570 | 66 | 115 | 53 | 59 | 57 | 15 | | | | |

## World and regional data[16]

| | Maternal and Newborn Health | | | | Sexual and Reproductive Health | | | Education | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Maternal mortality ratio (deaths per 100,000 live births), 2010 | Births attended by skilled health personnel, per cent 2005/2012 | Adolescent birth rate per 1,000 women aged 15 to 19, 1991/2010 | Under age five mortality rate per 1,000 live births, 2010-2015 | Contraceptive prevalence rate, women aged 15-49, any method 1990/2012 | Contraceptive prevalence rate, women aged 15-49, modern method 1990/2012 | Unmet need for family planning, per cent, 1988/2012 | Primary school enrolment, net per cent of primary school-age children 1999/2012 | | Secondary school enrolment, net per cent of school-age children, 1999/2012 | |
| | | | | | | | | male | female | male | female |
| **World** | 210 | 70 | 49 | 52 | 64 | 57 | 12 | 92 | 90 | 64 | 61 |
| **More developed regions**[8] | 16 | | 24 | 7 | 71 | 62 | 9 | 97 | 97 | 90 | 91 |
| **Less developed regions**[9] | 240 | | 53 | 57 | 63 | 57 | 13 | 91 | 89 | 61 | 57 |
| **Least developed countries**[10] | 430 | | 106 | 99 | 38 | 31 | 23 | 83 | 79 | 36 | 30 |
| **Arab States**[11] | 140 | 76 | 48 | 44 | 53 | 44 | 17 | 89 | 83 | 64 | 58 |
| **Asia and the Pacific**[12] | 160 | 69 | 35 | 40 | 68 | 63 | 10 | 95 | 94 | 63 | 60 |
| **Eastern Europe and Central Asia**[13] | 32 | 98 | 32 | 26 | 67 | 53 | 11 | 94 | 94 | 86 | 85 |
| **Latin America and the Caribbean**[14] | 81 | 91 | 73 | 23 | 73 | 67 | 10 | 95 | 96 | 74 | 78 |
| **Sub-Saharan Africa**[15] | 500 | 48 | 117 | 110 | 28 | 21 | 25 | 80 | 77 | 27 | 21 |

# Demographic indicators

Male Female

| Country, territory or other area | Total population in millions, 2013 | Average annual rate of population change, per cent 2010-2015 | Life expectancy at birth (years), 2010-2015 | | Total fertility rate, per woman, 2010-2015 | Population aged 10-19, per cent, 2010 |
|---|---|---|---|---|---|---|
| Afghanistan | 30.6 | 2.4 | 59 | 62 | 5.0 | 23 |
| Albania | 3.2 | 0.3 | 75 | 81 | 1.8 | 19 |
| Algeria | 39.2 | 1.8 | 69 | 73 | 2.8 | 17 |
| Angola | 21.5 | 3.1 | 50 | 53 | 5.9 | 21 |
| Antigua and Barbuda | 0.1 | 1.0 | 73 | 78 | 2.1 | 18 |
| Argentina | 41.4 | 0.9 | 73 | 80 | 2.2 | 16 |
| Armenia | 3.0 | 0.2 | 71 | 78 | 1.7 | 15 |
| Aruba | 0.1 | 0.4 | 73 | 78 | 1.7 | 15 |
| Australia[1] | 23.3 | 1.3 | 80 | 85 | 1.9 | 13 |
| Austria | 8.5 | 0.4 | 78 | 84 | 1.5 | 11 |
| Azerbaijan | 9.4 | 1.1 | 68 | 74 | 1.9 | 17 |
| Bahamas | 0.4 | 1.4 | 72 | 78 | 1.9 | 16 |
| Bahrain | 1.3 | 1.7 | 76 | 77 | 2.1 | 11 |
| Bangladesh | 156.6 | 1.2 | 70 | 71 | 2.2 | 21 |
| Barbados | 0.3 | 0.5 | 73 | 78 | 1.8 | 14 |
| Belarus | 9.4 | -0.5 | 64 | 76 | 1.5 | 11 |
| Belgium | 11.1 | 0.4 | 78 | 83 | 1.8 | 11 |
| Belize | 0.3 | 2.4 | 71 | 77 | 2.7 | 20 |
| Benin | 10.3 | 2.7 | 58 | 61 | 4.9 | 21 |
| Bhutan | 0.8 | 1.6 | 68 | 68 | 2.3 | 20 |
| Bolivia (Plurinational State of) | 10.7 | 1.6 | 65 | 69 | 3.3 | 21 |
| Bosnia and Herzegovina | 3.8 | -0.1 | 74 | 79 | 1.3 | 14 |
| Botswana | 2.0 | 0.9 | 48 | 47 | 2.6 | 22 |
| Brazil | 200.4 | 0.8 | 70 | 77 | 1.8 | 17 |
| Brunei Darussalam | 0.4 | 1.4 | 77 | 80 | 2.0 | 17 |
| Bulgaria | 7.2 | -0.8 | 70 | 77 | 1.5 | 10 |
| Burkina Faso | 16.9 | 2.8 | 55 | 57 | 5.6 | 22 |
| Burundi | 10.2 | 3.2 | 52 | 56 | 6.1 | 21 |
| Cambodia | 15.1 | 1.7 | 69 | 74 | 2.9 | 21 |
| Cameroon, Republic of | 22.3 | 2.5 | 54 | 56 | 4.8 | 22 |
| Canada | 35.2 | 1.0 | 79 | 84 | 1.7 | 12 |
| Cape Verde | 0.5 | 0.8 | 71 | 79 | 2.3 | 23 |
| Central African Republic | 4.6 | 2.0 | 48 | 52 | 4.4 | 22 |
| Chad | 12.8 | 3.0 | 50 | 52 | 6.3 | 22 |
| Chile | 17.6 | 0.9 | 77 | 83 | 1.8 | 16 |
| China[2] | 1385.6 | 0.6 | 74 | 77 | 1.7 | 14 |
| China, Hong Kong SAR[3] | 7.2 | 0.7 | 80 | 86 | 1.1 | 11 |
| China, Macao SAR[4] | 0.6 | 1.8 | 78 | 83 | 1.1 | 11 |
| Colombia | 48.3 | 1.3 | 70 | 78 | 2.3 | 18 |
| Comoros | 0.7 | 2.4 | 59 | 62 | 4.7 | 20 |
| Congo, Democratic Republic of the | 67.5 | 2.7 | 48 | 52 | 6.0 | 22 |
| Congo, Republic of the | 4.4 | 2.6 | 57 | 60 | 5.0 | 20 |
| Costa Rica | 4.9 | 1.4 | 78 | 82 | 1.8 | 17 |
| Côte d'Ivoire | 20.3 | 2.3 | 50 | 51 | 4.9 | 22 |
| Croatia | 4.3 | -0.4 | 74 | 80 | 1.5 | 11 |
| Cuba | 11.3 | -0.1 | 77 | 81 | 1.5 | 13 |
| Curaçao | 0.2 | 2.2 | 74 | 80 | 1.9 | 14 |
| Cyprus | 1.1 | 1.1 | 78 | 82 | 1.5 | 13 |
| Czech Republic | 10.7 | 0.4 | 75 | 81 | 1.6 | 10 |
| Denmark | 5.6 | 0.4 | 77 | 81 | 1.9 | 12 |
| Djibouti | 0.9 | 1.5 | 60 | 63 | 3.4 | 21 |
| Dominica | 0.1 | 0.4 | | | | |
| Dominican Republic | 10.4 | 1.2 | 70 | 77 | 2.5 | 19 |
| Ecuador | 15.7 | 1.6 | 74 | 79 | 2.6 | 19 |
| Egypt | 82.1 | 1.6 | 69 | 73 | 2.8 | 19 |
| El Salvador | 6.3 | 0.7 | 68 | 77 | 2.2 | 23 |
| Equatorial Guinea | 0.8 | 2.8 | 51 | 54 | 4.9 | 20 |
| Eritrea | 6.3 | 3.2 | 60 | 65 | 4.7 | 20 |
| Estonia | 1.3 | -0.3 | 69 | 80 | 1.6 | 11 |
| Ethiopia | 94.1 | 2.6 | 62 | 65 | 4.6 | 23 |
| Fiji | 0.9 | 0.7 | 67 | 73 | 2.6 | 18 |
| Finland | 5.4 | 0.3 | 77 | 84 | 1.9 | 12 |
| France | 64.3 | 0.5 | 78 | 85 | 2.0 | 12 |
| French Guiana | 0.2 | 2.5 | 74 | 81 | 3.1 | 18 |
| French Polynesia | 0.3 | 1.1 | 74 | 79 | 2.1 | 18 |
| Gabon | 1.7 | 2.4 | 62 | 64 | 4.1 | 20 |
| Gambia | 1.8 | 3.2 | 57 | 60 | 5.8 | 21 |
| Georgia | 4.3 | -0.4 | 70 | 78 | 1.8 | 13 |
| Germany | 82.7 | -0.1 | 78 | 83 | 1.4 | 10 |
| Ghana | 25.9 | 2.1 | 60 | 62 | 3.9 | 21 |
| Greece | 11.1 | 0.0 | 78 | 83 | 1.5 | 10 |
| Grenada | 0.1 | 0.4 | 70 | 75 | 2.2 | 20 |
| Guadeloupe | 0.5 | 0.5 | 77 | 84 | 2.1 | 15 |
| Guam | 0.2 | 1.3 | 76 | 81 | 2.4 | 18 |
| Guatemala | 15.5 | 2.5 | 68 | 75 | 3.8 | 22 |
| Guinea | 11.7 | 2.5 | 55 | 57 | 5.0 | 21 |
| Guinea-Bissau | 1.7 | 2.4 | 53 | 56 | 5.0 | 21 |
| Guyana | 0.8 | 0.5 | 64 | 69 | 2.6 | 20 |
| Haiti | 10.3 | 1.4 | 61 | 65 | 3.2 | 22 |
| Honduras | 8.1 | 2.0 | 71 | 76 | 3.0 | 22 |
| Hungary | 10.0 | -0.2 | 70 | 79 | 1.4 | 11 |
| Iceland | 0.3 | 1.1 | 80 | 84 | 2.1 | 14 |
| India | 1252.1 | 1.2 | 65 | 68 | 2.5 | 19 |
| Indonesia | 249.9 | 1.2 | 69 | 73 | 2.3 | 17 |
| Iran (Islamic Republic of) | 77.4 | 1.3 | 72 | 76 | 1.9 | 17 |

Male Female

| Country, territory or other area | Total population in millions, 2013 | Average annual rate of population change, per cent 2010-2015 | Life expectancy at birth (years), 2010-2015 | | Total fertility rate, per woman, 2010-2015 | Population aged 10-19, per cent, 2010 |
|---|---|---|---|---|---|---|
| Iraq | 33.8 | 2.9 | 66 | 73 | 4.1 | 21 |
| Ireland | 4.6 | 1.1 | 78 | 83 | 2.0 | 12 |
| Israel | 7.7 | 1.3 | 80 | 83 | 2.9 | 15 |
| Italy | 61.0 | 0.2 | 80 | 85 | 1.5 | 9 |
| Jamaica | 2.8 | 0.5 | 71 | 76 | 2.3 | 20 |
| Japan | 127.1 | -0.1 | 80 | 87 | 1.4 | 9 |
| Jordan | 7.3 | 3.5 | 72 | 76 | 3.3 | 18 |
| Kazakhstan | 16.4 | 1.0 | 61 | 72 | 2.4 | 15 |
| Kenya | 44.4 | 2.7 | 60 | 63 | 4.4 | 21 |
| Kiribati | 0.1 | 1.5 | 66 | 72 | 3.0 | 21 |
| Korea, Democratic People's Republic of | 24.9 | 0.5 | 66 | 73 | 2.0 | 16 |
| Korea, Republic of | 49.3 | 0.5 | 78 | 85 | 1.3 | 13 |
| Kuwait | 3.4 | 3.6 | 73 | 75 | 2.6 | 13 |
| Kyrgyzstan | 5.5 | 1.4 | 63 | 72 | 3.1 | 20 |
| Lao People's Democratic Republic | 6.8 | 1.9 | 67 | 69 | 3.0 | 23 |
| Latvia | 2.1 | -0.6 | 67 | 77 | 1.6 | 11 |
| Lebanon | 4.8 | 3.0 | 78 | 82 | 1.5 | 18 |
| Lesotho | 2.1 | 1.1 | 49 | 50 | 3.1 | 24 |
| Liberia | 4.3 | 2.6 | 59 | 61 | 4.8 | 21 |
| Libya | 6.2 | 0.9 | 73 | 77 | 2.4 | 18 |
| Lithuania | 3.0 | -0.5 | 66 | 78 | 1.5 | 13 |
| Luxembourg | 0.5 | 1.3 | 78 | 83 | 1.7 | 12 |
| Madagascar | 22.9 | 2.8 | 63 | 66 | 4.5 | 22 |
| Malawi | 16.4 | 2.8 | 55 | 55 | 5.4 | 22 |
| Malaysia | 29.7 | 1.6 | 73 | 77 | 2.0 | 19 |
| Maldives | 0.3 | 1.9 | 77 | 79 | 2.3 | 21 |
| Mali | 15.3 | 3.0 | 55 | 55 | 6.9 | 21 |
| Malta | 0.4 | 0.3 | 77 | 82 | 1.4 | 12 |
| Martinique | 0.4 | 0.2 | 78 | 84 | 1.8 | 14 |
| Mauritania | 3.9 | 2.5 | 60 | 63 | 4.7 | 21 |
| Mauritius[5] | 1.2 | 0.4 | 70 | 77 | 1.5 | 16 |
| Mexico | 122.3 | 1.2 | 75 | 80 | 2.2 | 19 |
| Micronesia (Federated States of) | 0.1 | 0.2 | 68 | 70 | 3.3 | 26 |
| Moldova, Republic of | 3.5 | -0.8 | 65 | 73 | 1.5 | 14 |
| Mongolia | 2.8 | 1.5 | 64 | 71 | 2.4 | 18 |
| Montenegro | 0.6 | 0.0 | 72 | 77 | 1.7 | 14 |
| Morocco | 33.0 | 1.4 | 69 | 73 | 2.8 | 19 |
| Mozambique | 25.8 | 2.5 | 49 | 51 | 5.2 | 21 |
| Myanmar | 53.3 | 0.8 | 63 | 67 | 2.0 | 18 |
| Namibia | 2.3 | 1.9 | 62 | 67 | 3.1 | 23 |
| Nepal | 27.8 | 1.2 | 67 | 69 | 2.3 | 22 |
| Netherlands | 16.8 | 0.3 | 79 | 83 | 1.8 | 12 |
| New Caledonia | 0.3 | 1.3 | 74 | 79 | 2.1 | 16 |
| New Zealand | 4.5 | 1.0 | 79 | 83 | 2.1 | 14 |
| Nicaragua | 6.1 | 1.4 | 72 | 78 | 2.5 | 22 |
| Niger | 17.8 | 3.9 | 58 | 58 | 7.6 | 20 |
| Nigeria | 173.6 | 2.8 | 52 | 53 | 6.0 | 21 |
| Norway | 5.0 | 1.0 | 79 | 84 | 1.9 | 13 |
| Oman | 3.6 | 7.9 | 75 | 79 | 2.9 | 14 |
| Pakistan | 182.1 | 1.7 | 66 | 67 | 3.2 | 22 |
| Palestine[7] | 4.3 | 2.5 | 71 | 75 | 4.1 | 24 |
| Panama | 3.9 | 1.6 | 75 | 80 | 2.5 | 17 |
| Papua New Guinea | 7.3 | 2.1 | 60 | 64 | 3.8 | 21 |
| Paraguay | 6.8 | 1.7 | 70 | 75 | 2.9 | 20 |
| Peru | 30.4 | 1.3 | 72 | 77 | 2.4 | 19 |
| Philippines | 98.4 | 1.7 | 65 | 72 | 3.1 | 21 |
| Poland | 38.2 | 0.0 | 72 | 80 | 1.4 | 12 |
| Portugal | 10.6 | 0.0 | 77 | 83 | 1.3 | 10 |
| Puerto Rico | 3.7 | -0.2 | 75 | 82 | 1.6 | 16 |
| Qatar | 2.2 | 5.9 | 78 | 79 | 2.1 | 6 |
| Réunion | 0.9 | 1.2 | 76 | 83 | 2.2 | 16 |
| Romania | 21.7 | -0.3 | 70 | 77 | 1.4 | 11 |
| Russian Federation | 142.8 | -0.2 | 62 | 74 | 1.5 | 11 |
| Rwanda | 11.8 | 2.7 | 62 | 65 | 4.6 | 22 |
| Saint Kitts and Nevis | 0.1 | 1.1 | | | | |
| Saint Lucia | 0.2 | 0.8 | 72 | 77 | 1.9 | 18 |
| Saint Vincent and the Grenadines | 0.1 | 0.0 | 70 | 75 | 2.0 | 19 |
| Samoa | 0.2 | 0.8 | 70 | 76 | 4.2 | 22 |
| São Tomé and Principe | 0.2 | 2.6 | 64 | 68 | 4.1 | 20 |
| Saudi Arabia | 28.8 | 1.8 | 74 | 77 | 2.7 | 16 |
| Senegal | 14.1 | 2.9 | 62 | 65 | 5.0 | 21 |
| Serbia[6] | 9.5 | -0.5 | 71 | 77 | 1.4 | 13 |
| Seychelles | 0.1 | 0.6 | 69 | 78 | 2.2 | 15 |
| Sierra Leone | 6.1 | 1.9 | 45 | 46 | 4.7 | 21 |
| Singapore | 5.4 | 2.0 | 80 | 85 | 1.3 | 13 |
| Slovakia | 5.5 | 0.1 | 71 | 79 | 1.4 | 12 |
| Slovenia | 2.1 | 0.2 | 76 | 83 | 1.5 | 10 |
| Solomon Islands | 0.6 | 2.1 | 66 | 69 | 4.1 | 21 |
| Somalia | 10.5 | 2.9 | 53 | 57 | 6.6 | 22 |
| South Africa | 52.8 | 0.8 | 55 | 59 | 2.4 | 18 |
| South Sudan | 11.3 | 4.0 | 54 | 56 | 5.0 | 21 |
| Spain | 46.9 | 0.4 | 79 | 85 | 1.5 | 9 |
| Sri Lanka | 21.3 | 0.8 | 71 | 77 | 2.4 | 15 |

# Demographic indicators

Male Female

| Country, territory or other area | Total population in millions, 2013 | Average annual rate of population change, per cent 2010-2015 | Life expectancy at birth (years), 2010-2015 | | Total fertility rate, per woman, 2010-2015 | Population aged 10-19, per cent, 2010 |
|---|---|---|---|---|---|---|
| Sudan | 38.0 | 2.1 | 60 | 64 | 4.5 | 22 |
| Suriname | 0.5 | 0.9 | 68 | 74 | 2.3 | 18 |
| Swaziland | 1.2 | 1.5 | 50 | 49 | 3.4 | 24 |
| Sweden | 9.6 | 0.7 | 80 | 84 | 1.9 | 12 |
| Switzerland | 8.1 | 1.0 | 80 | 85 | 1.5 | 11 |
| Syrian Arab Republic | 21.9 | 0.7 | 72 | 78 | 3.0 | 21 |
| Tajikistan | 8.2 | 2.4 | 64 | 71 | 3.9 | 21 |
| Tanzania, United Republic of | 49.3 | 3.0 | 60 | 63 | 5.2 | 21 |
| Thailand | 67.0 | 0.3 | 71 | 78 | 1.4 | 14 |
| The former Yugoslav Republic of Macedonia | 2.1 | 0.1 | 73 | 77 | 1.4 | 14 |
| Timor-Leste, Democratic Republic of | 1.1 | 1.7 | 66 | 69 | 5.9 | 27 |
| Togo | 6.8 | 2.6 | 56 | 57 | 4.7 | 21 |
| Tonga | 0.1 | 0.4 | 70 | 76 | 3.8 | 22 |
| Trinidad and Tobago | 1.3 | 0.3 | 66 | 74 | 1.8 | 14 |
| Tunisia | 11.0 | 1.1 | 74 | 78 | 2.0 | 16 |
| Turkey | 74.9 | 1.2 | 72 | 79 | 2.1 | 17 |
| Turkmenistan | 5.2 | 1.3 | 61 | 70 | 2.3 | 20 |
| Turks and Caicos Islands | 0.0 | 2.1 | | | | |
| Tuvalu | 0.0 | 0.2 | | | | |
| Uganda | 37.6 | 3.3 | 58 | 60 | 5.9 | 22 |
| Ukraine | 45.2 | -0.6 | 63 | 74 | 1.5 | 11 |
| United Arab Emirates | 9.3 | 2.5 | 76 | 78 | 1.8 | 10 |
| United Kingdom | 63.1 | 0.6 | 78 | 82 | 1.9 | 12 |
| United States of America | 320.1 | 0.8 | 76 | 81 | 2.0 | 13 |
| United States Virgin Islands | 0.1 | 0.1 | 77 | 83 | 2.5 | 14 |
| Uruguay | 3.4 | 0.3 | 74 | 80 | 2.1 | 15 |
| Uzbekistan | 28.9 | 1.4 | 65 | 72 | 2.3 | 21 |
| Vanuatu | 0.3 | 2.2 | 70 | 74 | 3.4 | 20 |
| Venezuela (Bolivarian Republic of) | 30.4 | 1.5 | 72 | 78 | 2.4 | 18 |
| Viet Nam | 91.7 | 1.0 | 71 | 80 | 1.8 | 17 |
| Western Sahara | 0.6 | 3.2 | 66 | 70 | 2.4 | 16 |
| Yemen | 24.4 | 2.3 | 62 | 64 | 4.1 | 24 |
| Zambia | 14.5 | 3.2 | 56 | 59 | 5.7 | 22 |
| Zimbabwe | 14.1 | 2.8 | 59 | 61 | 3.5 | 23 |

## World and regional data[16]

| | Total population in millions, 2013 | Average annual rate of population change, per cent 2010-2015 | Life expectancy at birth (years), 2010-2015 | | Total fertility rate, per woman, 2010-2015 | Population aged 10-19, per cent, 2010 |
|---|---|---|---|---|---|---|
| **World** | **7,162** | **1.1** | **68** | **72** | **2.5** | **16.7** |
| **More developed regions[8]** | **1,253** | **0.3** | **74** | **81** | **1.7** | **11.5** |
| **Less developed regions[9]** | **5,909** | **1.3** | **67** | **70** | **2.6** | **17.9** |
| **Least developed countries[10]** | **898** | **2.3** | **59** | **62** | **4.2** | **21.4** |
| **Arab States[11]** | **350** | **1.0** | **67** | **71** | **3.3** | **20.6** |
| **Asia and the Pacific[12]** | **3,785** | **1.9** | **69** | **72** | **2.2** | **17.6** |
| **Eastern Europe and Central Asia[13]** | **330** | **0.1** | **63** | **74** | **1.8** | **12.9** |
| **Latin America and the Caribbean[14]** | **612** | **1.1** | **71** | **78** | **2.2** | **18.7** |
| **Sub-Saharan Africa[15]** | **888** | **2.6** | **55** | **57** | **5.1** | **23.0** |

## Notes for indicators

1 Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

2 For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

3 As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

4 As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China.

5 Including Agalega, Rodrigues and Saint Brandon.

6 Including Kosovo.

7 On 29 November 2012, the United Nations General Assembly passed resolution 67/19. Pursuant to operative paragraph 2 of that resolution, the General Assembly decided to "...accord to Palestine non-member observer State status in the United Nations...". Includes East Jerusalem.

8 More developed regions comprise Europe, Northern America, Australia/New Zealand and Japan.

9 Less developed regions comprise all regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

10 The least developed countries according to standard United Nations designation.

11 Including Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

12 Includes only UNFPA programme countries, territories or other areas: Afghanistan, Bangladesh, Bhutan, Cambodia, China, Cook Islands, Democratic People's Republic of Korea, Fiji, India, Indonesia, Iran (Islamic Republic of), Kiribati, Lao People's Democratic Republic, Malaysia, Maldives, Marshall Islands, Micronesia, Mongolia, Myanmar, Nauru, Nepal, Niue, Pakistan, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam.

13 Includes only UNFPA programme countries, territories or other areas: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, Uzbekistan.

14 Includes only UNFPA programme countries, territories or other areas: Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bermuda, Bolivia (Plurinational State of), Brazil, British Virgin Islands, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Netherlands Antilles, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, Venezuela (Bolivarian Republic of).

15 Includes only UNFPA programme countries, territories or other areas: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

16 Regional aggregations are weighted averages based on countries with available data.

## Technical notes
## Data sources and definitions

The statistical tables in *The State of World Population 2013* include indicators that track progress toward the goals of the Programme of Action of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analyzing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data, especially the Population Division of the United Nations Department of Economic and Social Affairs. In some instances, therefore, the data in these tables differ from those generated by national authorities.

Regional averages are based on data about countries and territories where UNFPA works, rather than on strict geographical definitions employed by the Population Division of the United Nations Department of Economic and Social Affairs. For a list of countries included in each regional category in this report, see the "Notes for indicators."

## Monitoring ICPD Goals

### Maternal and newborn health

**Maternal mortality ratio, per 100,000 live births.** Source: World Health Organization (WHO), UNICEF, UNFPA and World Bank. 2010. *Trends in maternal mortality: 1990 to 2010:* WHO. This indicator presents the number of deaths to women per 100,000 live births which result from conditions related to pregnancy, delivery, the postpartum period, and related complications. Estimates between 100-999 are rounded to the nearest 10, and above 1,000 to the nearest 100. Several of the estimates differ from official government figures. The estimates are based on reported figures wherever possible, using approaches that improve the comparability of information from different sources. See the source for details on the origin of particular national estimates. Estimates and methodologies are reviewed regularly by WHO, UNICEF, UNFPA, academic institutions and other agencies and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Because of changes in methods, prior estimates for 1995 and 2000 may not be strictly comparable with these estimates. Maternal mortality estimates reported here are based on the global database on maternal mortality, which is updated every 5 years.

**Births attended by skilled health personnel, per cent, 2005/2012.** Source: *WHO global database on maternal health indicators, 2013 update.* Geneva, World Health Organization (http://www.who.int/gho). Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a short training course, are not included.

**Adolescent birth rate, per 1,000 women aged 15-19, 1991/2010** Source: United Nations, Department of Economic and Social Affairs, Population Division (2012). *2012 Update for the MDG Database: Adolescent Birth Rate* (POP/DB/Fert/A/MDG2012). The adolescent birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk

of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

**Under age 5 mortality, per 1,000 live births.** *Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats (United Nations publication, ST/ESA/SER.A/306).* Under age 5 mortality is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates.

### Sexual and reproductive health

**Contraceptive prevalence.** United Nations, Department of Economic and Social Affairs, Population Division (2013). *2013 Update for the MDG Database: Contraceptive Prevalence* (POP/DB/CP/A/MDG2012). These data are derived from sample survey reports and estimate the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. These numbers are roughly but not completely comparable across countries due to variation in the timing of the surveys and in the details of the questions. All country and regional data refer to women aged 15-49. The most recent survey data available are cited, ranging from 1990-2011. World and regional data are based on United Nations Population Division/DESA special analyses of data from United Nations, Department of Economic and Social Affairs, Population Division. World Contraceptive Use 2012 and 2013 updates for the MDG database (see http://www.un.org/en/development/desa/population/).

**Unmet need for family planning.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *2013 Update for the MDG Database: Unmet Need for Family Planning* (POP/DB/CP/B/MDG2012). Women with unmet need for spacing births are those who are fecund and sexually active but are not using any method of contraception, and report wanting to delay the next child. This is a subcategory of total unmet need for family planning, which also includes unmet need for limiting births. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. For MDG monitoring, unmet need is expressed as a percentage based on women who are married or in a consensual union. The concept of unmet need for modern methods considers users of traditional methods as in need of modern contraception. For further analysis, see also *Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012*. Guttmacher Institute and UNFPA, 2012 and Alkema L., V. Kantorova, C. Menozzi, and A. Biddlecom "National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between1990 and 2015: a systematic and comprehensive review'. *The Lancet*, 12 March 2013. World and regional data are based on United Nations Population Division/DESA special analyses of data from United Nations, Department of Economic and Social Affairs, Population Division. World Contraceptive Use 2012 and 2013 updates for the MDG database (see http://www.un.org/en/development/desa/population/).

### Education

**Male and female net enrolment rate in primary education (adjusted), male and female net enrolment rate in secondary education, 1999-2012.** Source: UNESCO Institute for Statistics, data release of May 2012. Accessible through: stats.uis.unesco.org. The net enrolment rates indicate the enrolment of the official age group for a given level of education expressed as a percentage of the corresponding population. The adjusted net enrolment rate in primary also includes children of official primary school age enrolled in secondary education. Data are for the most recent year estimates available for the 1999-2012 period.

## Demographic indicators

**Total population, 2013.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, CD-ROM Edition.* These indicators present the estimated size of national populations at mid-year.

**Average annual rate of population change, per cent.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, CD-ROM Edition.* Average annual rate of population change is the average exponential rate of growth of the population over a given period. It is based on a medium variant projection.

**Male and female life expectancy at birth.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, CD-ROM Edition.* These indicators are measures of mortality levels, respectively, and represent the average number of years of life expected by a hypothetical cohort of individuals who would be subject during all their lives to the mortality rates of a given period. Data are projections for the period 2010-2015 and are expressed as years.

**Total fertility rate.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, CD-ROM Edition*. The measure indicates the number of children a woman would have during her reproductive years if she bore children at the rate estimated for different age groups in the specified time period. Countries may reach the projected level at different points within the period. Projections are for the period 2010-2015.

**Population aged 10-19, per cent.** Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, CD-ROM* Edition. The measure indicates the proportion of the population between the ages of 10 and 19.

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