



Charting the future

Empowering girls to prevent early pregnancy

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Executive summary

Adolescent pregnancy is dangerous – and sometimes fatal. In developing countries it is the leading cause of death for adolescent girls, affecting—in general—the poorest girls in the poorest countries. Adolescent pregnancy is dangerous for babies too—those born to teen mothers are 50% more likely to die in their first month of life than those born to women in their 20s.

Children's chances of survival have improved dramatically in the last two decades – 12,000 fewer children died every day in 2010 than in 1990*. However, to make further progress towards the fourth Millennium Development Goal—reducing the under-five mortality rate by two thirds—we must reduce adolescent pregnancy, which all too often results in the deaths of two children – one a newborn infant, the other an adolescent girl. Girls' need for family planning is an urgent priority that needs international political action at the highest level.

Although adolescent fertility rates are falling on a global level, approximately 18 million girls under the age of 20 give birth each year†. Two million of these girls are under the age of 15. While numerically speaking most teenage births take place in south Asia, the countries with the highest adolescent fertility rates are clustered in sub-Saharan Africa.

Family planning and adolescent girls: three key facts

Analysis of the available data reveals three under-appreciated facts that have important implications for policy-makers seeking to increase the uptake of family planning services:

- 1 **90% of adolescent pregnancies in the developing world are to girls who are already married**‡. While child marriage, like adolescent pregnancy, is declining on a global basis, one-in-three women aged 20–24 were married before the age of 18. Globally, 1.5 million girls – more than 10% of all young women – were married before the age of 15. Once girls are married, their husbands and in-laws typically encourage early pregnancy.
- 2 **Married teenage girls are less likely to use contraception than either unmarried teens or older married women**. Married adolescents in all countries are less likely to use contraception than unmarried teens. In the Democratic Republic of the Congo, for example, unmarried teenage girls are twice as likely as their married peers to use a modern method; in Sierra Leone, they are 17 times more likely. As husbands are most often the primary, if not sole, family decision-maker, and as fatherhood is a key sign of virility in many cultures, girls have little space to negotiate contraceptive use – even if they desire to do so. Moreover, a review of Demographic and Health Surveys shows that not only are married teenage girls less likely to use contraception, they are also less likely to report that they have an unmet need for it.
- 3 **Up to 75% of the 18 million annual adolescent pregnancies are intended and planned**§. Data from the World Health Organization highlights that throughout much of sub-Saharan Africa and south Asia motherhood is often simply seen as 'what girls are for' – their social value is firmly rooted in their capacity for reproduction. Motherhood is viewed as the final step towards becoming an adult and is the foundation of a girl's identity and position within the family. As young girls grow up, many internalise these values and beliefs; by adolescence few see a reason to postpone motherhood.

* UN Inter-agency Group for Child Mortality Estimation, 2011

† WHO 2012c

‡ WHO 2012c

§ WHO 2008b

Contraceptive supply and demand among adolescent girls

Providing reliable access to quality contraceptive products is a significant challenge for many developing countries. As such, adolescent girls, like older women, face many concrete barriers to accessing family planning services. Clinics, for example, are not easily accessible for rural residents; furthermore, many have a difficult time maintaining quality staff and keeping contraceptives in stock.** The cost of contraceptives is also a significant barrier for young women – who must also deal with unique age-related needs for privacy and, in some cases, laws that prohibit access for the unmarried.

This report recognises the necessity of providing commodities and services. However, drawing on the three key facts above, it concludes that efforts to 'solve' the problem of adolescent pregnancy must simultaneously address the social norms, gender roles and traditions that limit girls' options for their future.

In developing countries, teenage pregnancy is rarely the accidental result of sexual experimentation. For many girls in sub-Saharan Africa and south Asia in particular, child-bearing is something that they have little personal control over. Often forced into marriage and encouraged to become pregnant as quickly as possible, too many girls are never given the chance to imagine a future that is not centred around early motherhood.

Eight barriers to adolescents' contraceptive uptake

The report discusses eight key barriers, both demand- and supply-side, that limit adolescents' contraceptive uptake. It recognises that individuals, families and communities each play key roles in generating that demand – and that supply is shaped by economics, policies and politics, as well as service access and quality. These barriers are as follows:

- 1 **Individual attitudinal barriers:** research suggests that most adolescent girls – having internalised powerful sociocultural values (see 3 below) – **desire** to become pregnant.
- 2 **Emotional and interpersonal barriers** to the uptake of family planning services stem from the attitudes and desires of husbands/partners and other family members regarding girls' fertility.
- 3 **Broader sociocultural and religious norms and practices** have an impact on adolescent girls' use of contraception in so far as the social value they ascribe to girls versus boys and the gender roles that are deemed appropriate for each.
- 4 Teens also face **cognitive barriers** in that they lack awareness and understanding of conception and contraception.
- 5 **Geographic barriers** are particularly significant for rural teenagers and those who are isolated at home on account of socio-cultural norms.
- 6 The cost of contraception poses an **economic barrier** for many adolescent girls.
- 7 **Administrative barriers** limit unmarried teens' access to contraception.
- 8 Where teenage girls are stigmatised for their sexuality, **barriers relating to quality of care**, especially the attitudes of providers, are significant.

How culture, traditions and education shape girls' access to family planning

These eight barriers are highly interdependent – reflecting the fact that supply and demand are intrinsically linked and are both crucial if we are to reduce adolescent pregnancy. This report, however, emphasises that the primary drivers of teen pregnancy are cultural practices and traditions, which perpetuate gender inequalities and hinder girls' empowerment.

Where girls have no right to refuse sex – or to use contraception – supply alone is unlikely to have a significant impact on fertility. Valued primarily for their reproductive capacities, and particularly in areas where son preference is strong, even girls themselves often see little reason to postpone pregnancy.

** Save the Children, 2012.

Cultural barriers are closely linked to cognitive barriers. Girls and boys too often face puberty with little understanding of how conception and contraception “work”. In Central America, for instance, survey evidence suggests that almost one in three adolescents did not know that pregnancy could occur the first time a girl had sex^{††}. In a study in India, one in four girls did not know that pregnancy could occur mid-menstrual cycle and there was a general lack of awareness amongst girls that a missed period could signal pregnancy^{‡‡}.

While *most* adolescents are aware of modern methods of family planning, they are often misinformed about how they work. Consequently, even when adolescents use contraception they are prone to using it incorrectly and inconsistently – which results in higher failure rates. A study in four sub-Saharan countries found that less than one-third of teenagers had a level of knowledge that was detailed enough to prevent pregnancy^{§§}.

Fear of the long-term consequences of contraception is pervasive and is often shared by the adults in a girl’s life. Many girls are concerned, for example, that hormonal contraceptives will permanently impact their fertility – believing that they are capable of causing sterility, serious illness or death. In order for girls to choose to use contraception, accurate information, framed in culturally sensitive ways to ensure that it is genuinely heard and understood, is required.

Keeping girls in school – and teaching them basic biology – is clearly an important step in preventing adolescent pregnancy. However, girls’ education is shaped by the same cultural practices and traditions that shape their fertility preferences – and continues to be undervalued in many developing countries. Where a girl’s main role is to give children to her husband’s family, her education is not prioritised. She is thus unlikely to be allowed to stay in school to acquire either the knowledge she needs to control her fertility or the skills and economic independence she needs to make her voice heard.

Education gives girls options; in addition to promoting a sense of personal responsibility and imparting a basic body of knowledge, it lets girls imagine and plan their own futures – a key factor shaping their beliefs about the timing of motherhood. Girls who stay in school are less likely to marry early, have early sex, or become pregnant as adolescents. A review of 26 Demographic and Health Surveys found that compared to girls with no education, girls who stayed in school for ten years were likely to marry six years later^{***}.

Not forgetting unmarried girls

While much of the focus here is on married girls, it is important not to forget their unmarried peers. There is a sexual transition unfolding around the world, wherein sexuality is increasingly decoupled from marriage – as the age of puberty falls, due to better nutrition and living standards, and the age of marriage rises. Consequently, there is a growing need to ‘mind the gap’, ensuring that unmarried adolescents have access to sexual and reproductive health services that may traditionally have only been available to married women.

Adults, from parents to medical practitioners, are frequently uncomfortable with adolescent sexuality and clearly prefer that teenage girls remain abstinent until marriage. However, the evidence is increasingly clear that as the transition unfolds adolescents are less likely to heed the ‘abstinence only’ message—and that a back-up plan, involving contraception, is vital.

Policy solutions: the five dimensions of empowerment

Our review of the evidence on adolescent fertility suggests that what is needed is a two-pronged approach. Enabling teenagers to make informed choices about pregnancy requires reliable, affordable access to contraceptives. However, it also requires that girls perceive a need for contraception – and feel that they are ‘allowed’ to use it. Accordingly, tackling gender inequalities and empowering girls to chart their own futures and choose motherhood only if

^{††} Remez et al. 2008

^{‡‡} Kalyanwala et al. 2010

^{§§} Biddlecom et al. 2007a as cited in Bankole and Malarcher 2010

^{***} Martin 1995

and when they are ready is of critical importance. To increase adolescents' uptake of contraception and reduce their fertility, policy-makers must dedicate strategic attention to five key dimensions of empowerment:

- 9 **Sociocultural:** To empower girls to make their own reproductive decisions there is a need for fundamental sociocultural shifts; including tackling the gender stereotypes that drive child marriage, dowry and domestic violence.
- 10 **Educational:** Girls need to be educated to become independent, economically productive members of society. For girls and women to be seen as actors beyond their reproductive capacities education through secondary school and access to economic opportunities are critical.
- 11 **Interpersonal:** Girls need to have a voice in their interpersonal relationships, with space to be heard in both their natal and marital families. Involving boys and men in this transformation is key, so that they can be vested in ensuring that their wives/partners and daughters will live in a world that is different from that of their mothers and grandmothers.
- 12 **Legal:** Girls' rights need to be underpinned by full legal protection – de jure and de facto. Awareness raising initiatives are equally important for girls to understand their legal rights—as are spaces where they can practice speaking up in support of them.
- 13 **Practical:** All adolescents, not just girls, need to be empowered with practical reproductive health knowledge – beginning with age-appropriate, school-based sex education in late primary school – and including full access to family planning information and affordable contraception in the community.

Quick win strategies

Cultural shifts take time – time that the millions of girls at risk for pregnancy this year do not have. To complement the longer-term empowerment approach outlined above, this report calls for the deployment of two complementary 'quick-win' strategies where action can be taken now.

First, given the broader developmental value of delaying girls' first births – and keeping them in school – the economic and social value of investing in girls' empowerment needs to be emphasised. Communication activities aimed at changing the attitudes and behaviours of communities are key. Investing in girls will not just improve their own well-being but will also simultaneously contribute to achieving the MDGs, tackling the inter-generational transmission of poverty and boosting national GDP. National as well as international policy and budget priorities in turn need to reflect this reality.

Second, bound by long-standing customs and traditional gender norms, many communities do not recognise that the lives of mothers and babies are jeopardised by early pregnancy. Educational approaches that target not just girls, but also wider communities, and that emphasise the present and future dividends of 'waiting', can be powerful awareness-raising tools.

In sum, helping girls see themselves as more than potential mothers – and helping communities to do the same – is key to reducing adolescent pregnancy. Addressing educational and cultural barriers that limit girls' options is a vital longer-term strategy. Coupling this approach with targeted quick-wins and better access to contraceptive information and technologies will enable girls to choose motherhood only if and when they are ready.

1 Introduction

Despite the fact that adolescent fertility rates are falling on a global level, approximately 18 million girls under the age of 20 give birth each year.¹ Two million of these pregnancies are to children under the age of 15 and nine out of ten adolescent pregnancies in the developing world are to married girls.² Globally, about one in ten babies are born to adolescent mothers, with more than 95% of those births occurring in low- and middle-income countries,³ and up to 75% of those births intended.⁴ “The average adolescent birth rate in middle-income countries is more than twice as high as that in high-income countries, with the rate in low-income countries being five times as high.”⁵ Half of all births to adolescent girls take place in just seven countries: Bangladesh, Brazil, the Democratic Republic of Congo (DRC), Ethiopia, India, Nigeria – and the United States.⁶ But the countries with the highest adolescent fertility rates are almost all in sub-Saharan Africa.⁷

Adolescent pregnancy is dangerous. The poorest girls in the poorest countries are most likely to become pregnant during adolescence, with serious long-term and wide-ranging consequences – from health complications (for young mother and the baby) to broader economic concerns.⁸ Indeed, pregnancy is the leading cause of death for adolescent girls in developing countries, with teen mothers twice as likely to die from pregnancy-related complications as mothers in their 20s.⁹ The youngest girls are particularly at risk – the mortality rate for those under 15 is four times higher than for those in their 20s.¹⁰ As Temin and Levine note, “Age itself does not appear to be the key risk factor; rather, adolescents are at risk because they tend to be having their first baby (first births are riskier regardless of age), and they are small, poorly nourished, suffering from malaria, and relatively uninformed about how to manage a pregnancy and birth.”¹¹ Adolescents, and particularly young adolescents, are more likely to have long and obstructed labours due to their smaller size and immature pelvic structure.¹² This not only increases their risk of death, but also their risk of developing fistula. “Up to 65% of women with obstetric fistula develop this as adolescents”.⁺⁺⁺

Finally, unsafe abortion kills many pregnant adolescents;¹⁴ it is estimated that one-third of teen pregnancies end in abortion – three million of which are considered unsafe.¹⁵ Of the women who present in hospitals with abortion complications, a disproportionate 60% are adolescents.¹⁶ Pregnant adolescents are more vulnerable than adult women for a variety of reasons. First, they often fail to recognise the signs of early pregnancy, meaning that they are more likely to rely on second trimester terminations, which are more dangerous.¹⁷ Second, given that adolescents often live in environments in which premarital pregnancy is deeply stigmatised, and lack ready cash to pay a medical professional, they are far more likely to rely on unqualified backstreet providers.¹⁸

Babies born to adolescent mothers are also at greater risk. A recent systematic review found that adolescent pregnancy was associated with premature delivery, stillbirth, foetal distress, birth asphyxia, low birthweight, and miscarriage.¹⁹ Babies born to teen mothers are also far more likely to die than those born to older women. “Stillbirths and death in the first week of life are 50% higher among babies born to mothers younger than 20 years than among babies born to mothers 20–29 years old.”²⁰ The risks continue throughout childhood; even controlling for household wealth and maternal education, “when the first born child is born to a young mother (12 to 20 years old), then the child is at a greater risk of dying before the age of five, being stunted, being underweight, and suffering from anaemia”.²¹

Obstetric fistula is a medical condition in which a hole develops between the vagina and either the bladder or the rectum. This allows faeces or urine to leak uncontrollably through the vaginal opening. Most often caused when tissue dies as a result of blood restriction during obstructed labour, fistula affects up to 3.5 million women around the world. Many are abandoned by their families and most live their lives in social isolation. For more information, see: ‘How many women have obstetric fistula’, Operation OF (Obstetric Fistula) website: www.operationof.org/the-problem/how-many-women-have-obstetric-fistula/

The impacts of adolescent pregnancy are felt far beyond the walls of the family home. It also has a demonstrable impact on the social and economic development of communities and countries.²² A report by the World Bank highlighted the lifetime opportunity costs of adolescent pregnancy on national economies. They ranged from 1% of gross domestic product (GDP) in China to 12% in India, and 30% in Uganda.²³ In India, adolescent pregnancy was estimated to lead to “over \$100 billion in lost income, an amount equivalent to twenty years of total humanitarian assistance world-wide”.²⁴

Much of this impact is channelled through girls’ education; each extra year of schooling a girl receives is estimated to raise her income by 10–20%,²⁵ with returns on girls’ education higher than those of boys.²⁶ There is a strong evidence base demonstrating that keeping girls in school and delaying their first pregnancy is a win-win situation, which has the potential to cascade through generations.²⁷ In Brazil, for instance, “women’s resources have 20 times more impact than men’s resources on child health”.²⁸ In India, educated women are less likely to be the victims of domestic violence, while in Bangladesh, women who have been to school are “three times more likely to participate in political meetings”.²⁹

1.1 Report focus and organisation

On a global level, the adolescent fertility rate is falling. Trends in most, but not all, countries with longitudinal data are positive – several Latin American countries being key outliers.³⁰ However, this is not the time for complacency. Given what we know about the impacts of early childbearing, and their consequences for achieving the Millennium Development Goal (MDG) targets, it is crucial that we understand and acknowledge the barriers that girls face in controlling their fertility – and help them negotiate effective solutions.

This report begins with a situation analysis of adolescent pregnancy (Section 2), highlighting where today’s adolescents live and where their fertility levels are highest, as well as looking at the drivers of their fertility rates. Section 3 provides a more detailed discussion of the multiple barriers that girls face in controlling their fertility. Section 4 presents our conclusions about the main drivers of adolescent pregnancy and introduces our policy and programming recommendations, which can be found in Section 5. Our recommendations for reducing adolescent pregnancy include “quick wins” as well as medium and longer-term solutions that address both the proximate and distal causes of early fertility. A detailed recommendations table that offers specific good practice examples from throughout the developing world can be found, along with full methodological details, in the companion Supplementary Materials file.

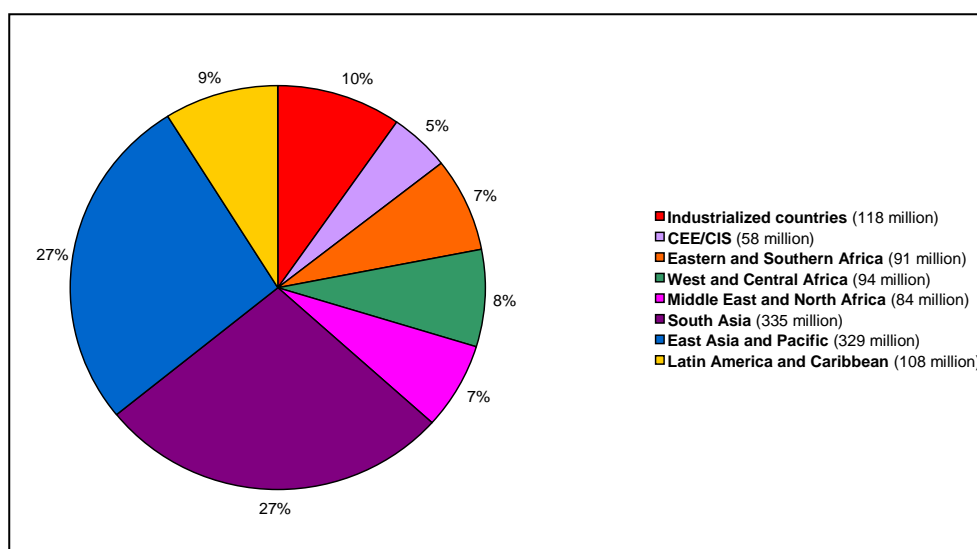
2 Situation analysis

We now turn to an overview of adolescent fertility trends in the developing world, looking at shifts over time as well as similarities and differences within and across regions.

2.1 Global adolescent population

The current generation of adolescents is the largest the world has ever seen. In 2009, the global adolescent population (10–19 years) stood at 1.2 billion – with nearly nine in ten adolescents living in developing countries.³¹ As Figure 1 shows, more than half of the world's adolescent population live in Asia.³² However, driven by stubbornly high rates of adolescent pregnancy and lifetime fertility, it is predicted that by 2050, sub-Saharan Africa will have moved into first place.³³ In Niger, Mali and Uganda, approximately 55% of the population is currently under the age of 18; rates are approximately 50% in many other sub-Saharan African countries.³⁴ As Bankole and Malarcher note, "Investing in young people is of great importance not only because of the size of the adolescent population but also because of the roles this group will play in shaping the future of their societies"³⁵ – and our collective future.

Figure 1: Adolescent population (10-19 years) by region, 2009



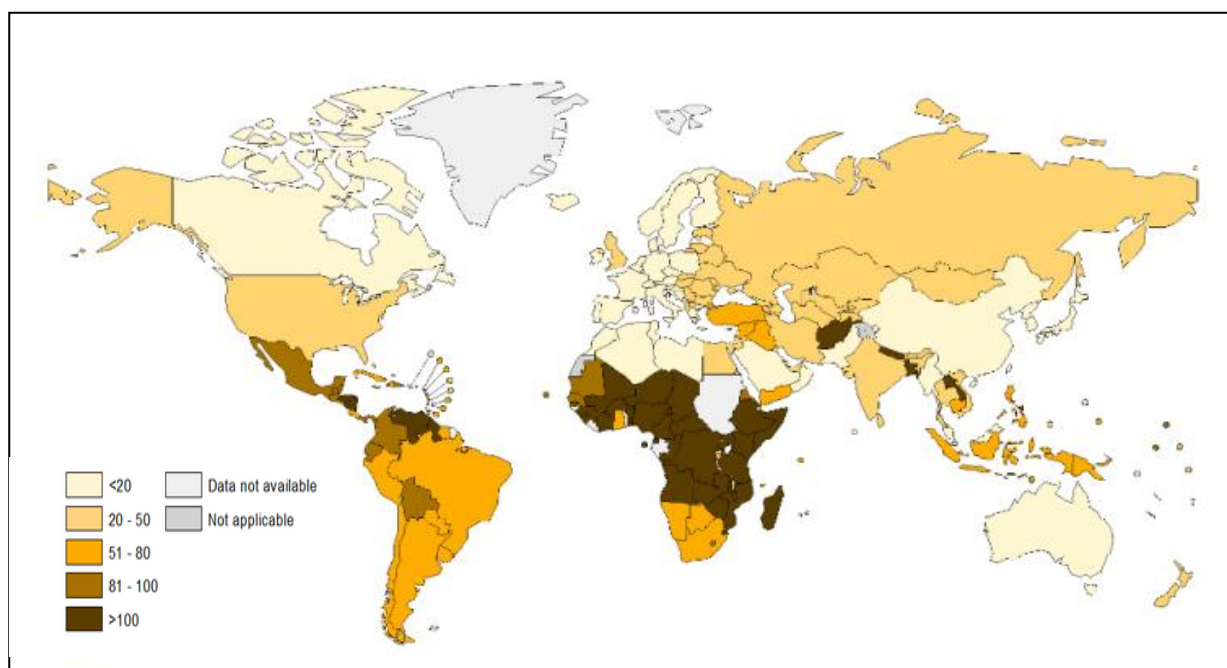
Source: UNICEF, 2011b

Many of these adolescents – particularly girls – lead precarious lives. Each year, another 10 million are married before adulthood.³⁶ Compared with their unmarried peers, married adolescents are more isolated, rarely attend school, have less decision-making power over their own lives, and are subjected to more frequent sex – all of which affect their ability to delay pregnancy.³⁷ The very youngest girls are at the highest risk. They are the most physically vulnerable and, due to their social and emotional immaturity, are the least able to speak for themselves.³⁸ Adolescents who are not married but are out of school – many of whom work as domestics or in street markets – represent another vulnerable group. This cohort of adolescent girls is also at high risk for coerced sex and rape.³⁹

2.2 Adolescent fertility

According to the World Bank, in 2010, the global adolescent fertility rate (15–19 years) stood at 53 births per 1,000 women. Across developing countries in sub-Saharan Africa, the rate was 107.6 per 1,000; in South Asia, it was 72.8 per 1,000, and in developing countries in Latin America and the Caribbean, it was 71.9 per 1,000. While larger countries such as India, Brazil and the United States account for a substantial portion of the 18 million babies born each year to adolescents,⁴⁰ the highest adolescent fertility rates are found in sub-Saharan Africa (see Figures 2 and 3).

Figure 2: Adolescent fertility rate per 1,000, 2000-2010



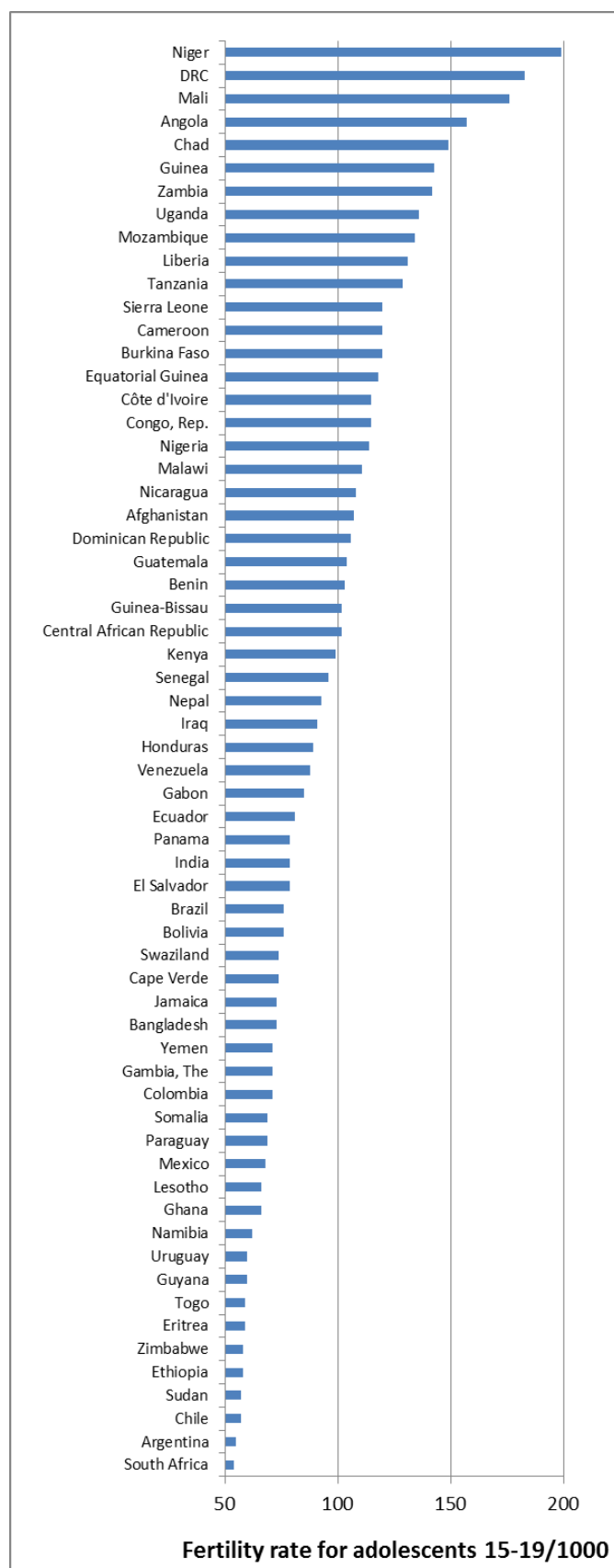
Source: WHO, 2012d

Nigerian girl, age 14, married at 13

"I had hardly started menstruating. It was my first time I saw blood come from my vagina for three days. I was afraid to tell my people but I finally told my grandmother. Then she said that I'm now a mature woman, but that's all she said. Then I started having stomach pains. My husband saw me weeping several times and he asked me why. I told him I did not know but I'm having stomach pains, not knowing it was pregnancy."

Source: Erulkar and Bello, 2007

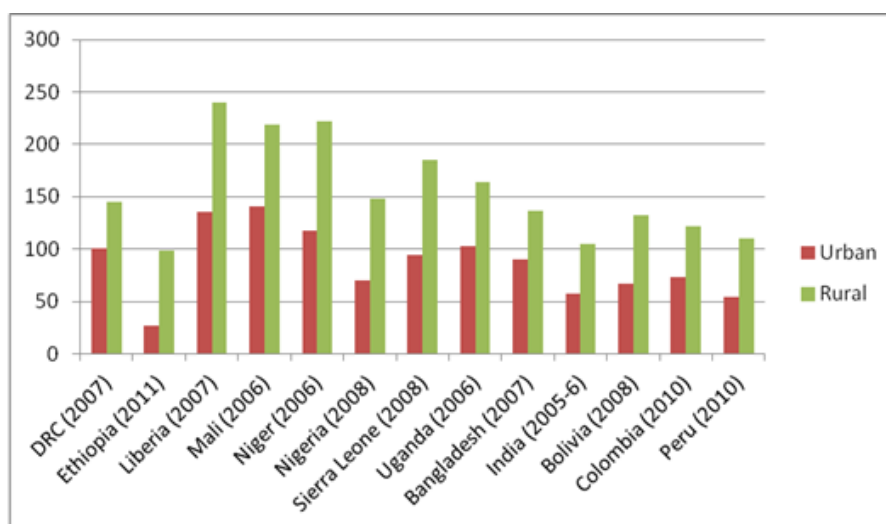
Figure 3: Countries with an adolescent fertility rate higher than the global average of 53 per 1,000, 2010



Source: World Bank Data, 2012

However, national averages obscure significant regional and local variation in fertility. As Figure 4 shows, rural adolescents in all regions have higher fertility rates than urban teens. Particular pockets such as the North West region of Nigeria (216 per 1,000 versus a rural average of 148 per 1,000) and the state of Bihar in India (128 per 1,000 versus a rural average of 105 per 1,000) have even higher rates of adolescent pregnancy.

Figure 4: Adolescent fertility rate by residence location



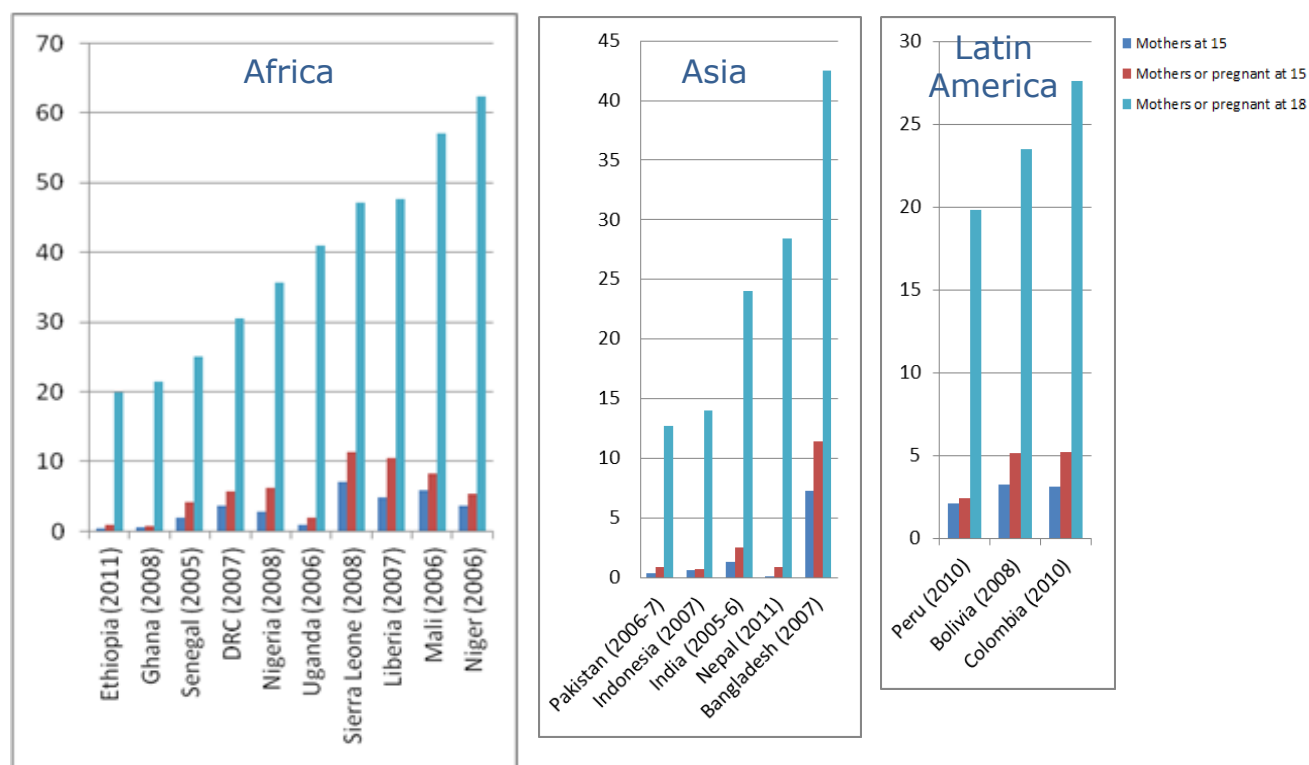
Source: DHS data

Another way of examining the same picture is to look at the percentage of adolescents who have already begun childbearing. As Figure 5 shows, the pattern of adolescent pregnancy varies considerably within and especially across regions. More than 60% of teens in Niger have begun childbearing by the age of 18, compared with 43% in Bangladesh and 28% in Colombia. Bangladesh and Sierra Leone, on the other hand, have the highest percentage of teens who have begun childbearing by 15 – at slightly more than 11%. Moreover, 7% of adolescent girls in those two countries were *already* mothers at the age of 15. Notably, Bolivia and Colombia, despite having comparatively lower adolescent fertility rates, have remarkably high rates of very early motherhood. More than 5% of adolescents in those two countries were already mothers at 15.

Sudanese woman

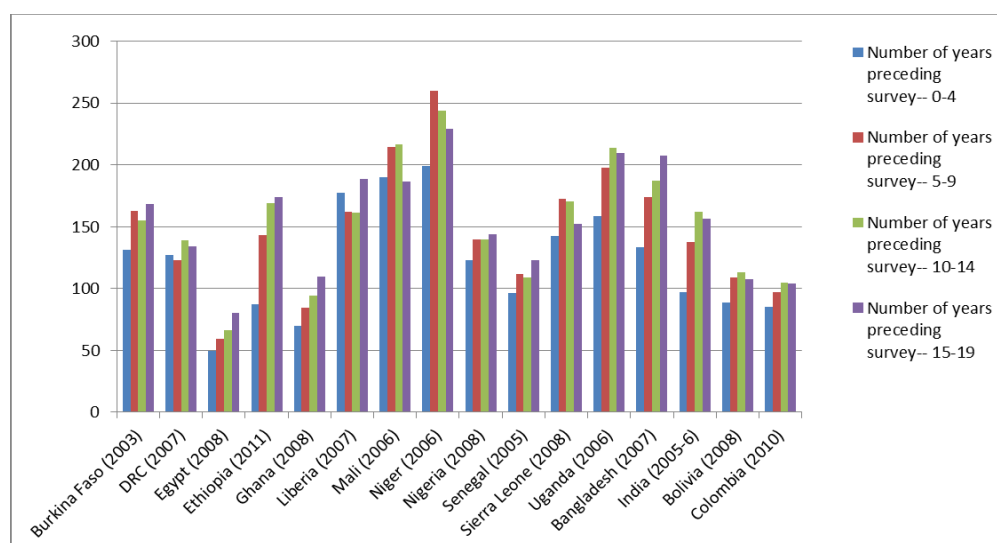
"I was married when I was 16 years old, and I immediately became pregnant. There was no doctor in the village, and I had an obstructed labour. They transferred me to the nearest hospital, at a distance of nine hours by car. When I arrived, the baby was already dead, and I developed a fistula."

Source: UNFPA, 2010b

Figure 5: Percentage of adolescents who have begun childbearing, by region

Source: DHS data

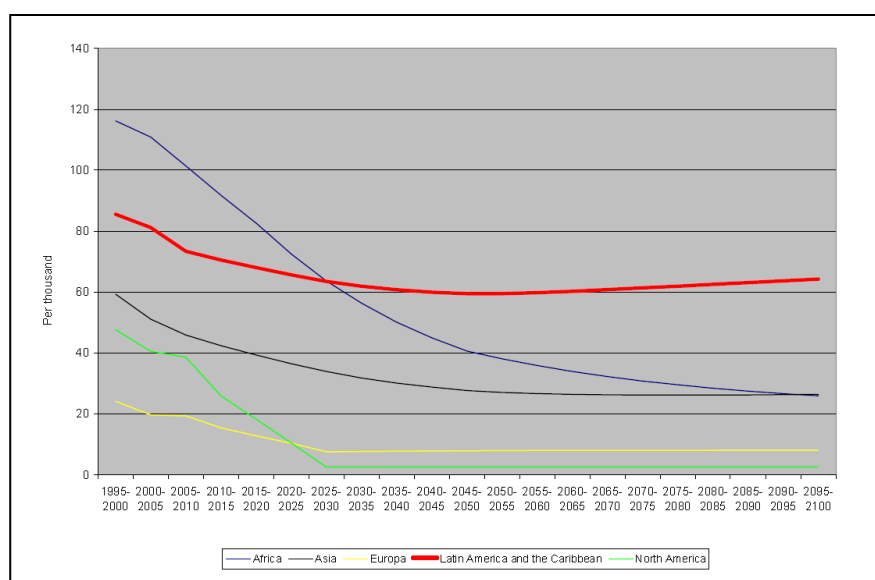
However, progress in reducing adolescent pregnancy is being made. As Figure 6 shows, in Nigeria, for example, adolescent fertility rates have fallen from 144 per 1,000 (for women born between 1969 and 1973) to 123 per 1,000 (for women born between 1984 and 1988). In Niger, the adolescent fertility rate has fallen from 229 per 1,000 (for women born between 1967 and 1971) to 199 per 1,000 (for women born between 1982 and 1986). In India, the rate has fallen from 157 per 1,000 (for women born between 1966 and 1970) to 97 per 1,000 (for women born between 1981 and 1985).

Figure 6: Trends in adolescent fertility rates

Source: DHS data

These data, however, hide intriguing patterns and projections that have important implications for reducing adolescent fertility in the coming years. Despite the fact that Asia currently has lower adolescent fertility rates than Africa, it produces the largest number of babies born to teens each year. Africa's fertility rates, on the other hand, are at present the world's highest. Latin America, which has relatively lower adolescent fertility rates, would seem at first glance not to merit serious attention, but this would be a mistake; its adolescent fertility rates not only remain persistently high but also, as Rodríguez notes, "undermine(s) the optimistic hypothesis that adolescent fertility will decline inexorably purely because it has done so in other regions of the world".⁴¹ In fact, several countries in the Latin America and Caribbean (LAC) region – the most economically unequal region in the world – have adolescent fertility rates that are climbing, even in the face of declines in overall fertility.⁴² As Figure 7 shows, current projections by the UN Population Division have Latin American adolescent fertility rates surpassing those of Africa by 2030 and remaining stable throughout the century.

Figure 7: Projections for adolescent fertility rates to the end of the century



Source: Rodríguez, 2011

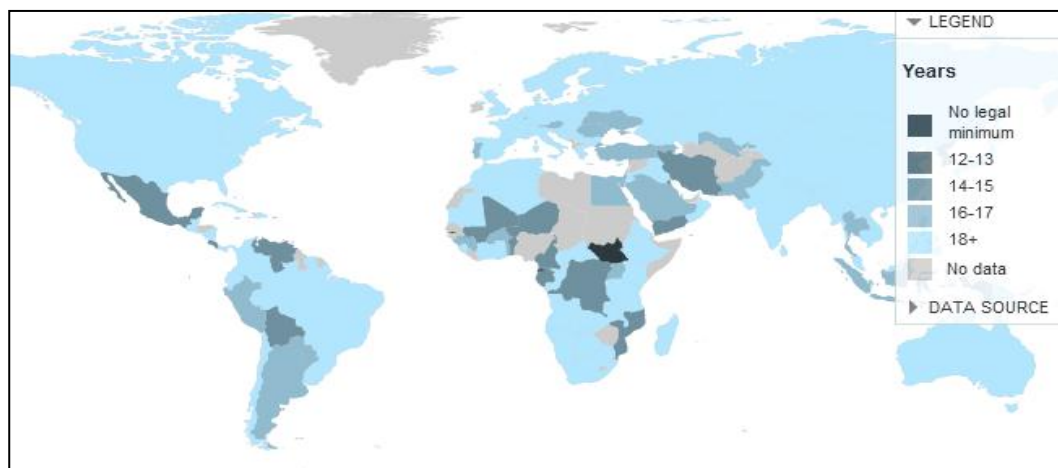
However, statistics on births to adolescent mothers do not reflect the bigger picture. It is estimated that up to one in three adolescent pregnancies ends in abortion.⁴³ However, because abortion is highly restricted in many countries, data are difficult to come by – particularly data disaggregated by age.⁴⁴ According to a report by the Guttmacher Institute,⁴⁵ 92% of African women and 97% of Latin American women live under highly restrictive abortion laws. Evidence suggests that regardless of legality, however, women have abortions at roughly the same rate; those living in restrictive environments simply have them illegally and unsafely, at far greater risk to themselves.⁴⁶ ¶¶ In Asia, the annual abortion rate is estimated at 28 per 1,000 women; in Latin America, it is estimated at 31–32 per 1,000 women; and in Africa, it is estimated at 29 per 1,000 women.⁴⁷ Lauro posits that “contemporary use of abortion in sub-Saharan Africa often substitutes for and sometimes surpasses modern contraceptive practice”, for both adolescents and adult women.⁴⁸ While abortion is largely both illegal and unsafe, it is readily available and – ironically – often perceived as a safer way to limit and space births than contraceptives, which are often believed to cause permanent sterility.⁴⁹

¶¶¶ Guttmacher's report covers both developed and developing countries in all regions of the world. It uses data from a variety of national and international sources.

2.3 Adolescent marriage

Given that 90% of adolescent births in the developing world are to married teens, understanding the phenomenon of child marriage is vital.⁵⁰ In many countries, child marriage – defined as any marriage involving a person under the age of 18 – is still legal.⁵¹ As Figure 8 shows, countries ranging from Bolivia and Mozambique (legal at 14) to Mali and Iran (legal at 15) still allow young teens to marry.⁵²

Figure 8: Minimum legal age for marriage



Source: Girls Discovered, 2012

However, these laws, which violate both the Convention on the Elimination of Discrimination Against Women and the Convention on the Rights of the Child, only tell half the story. In most of the countries with the highest rates of adolescent marriage, the legal age for marriage is already 18 years or older.⁵³ In Nigeria and India, for example, federal law prohibits girls under the age of 18 from marrying. However, in Nigeria, state law, including the Sharia law of the North, supersedes federal law – meaning that more than half of all girls in the North West region were married by the age of 15, and more than 80% were married by the age of 18.⁵³ In India, the laws are often simply ignored, particularly in the poorest, rural areas; in 2005, nearly half of young Indian women were married before the age of 18.⁵⁴

Nigerien teen, married at 13

"People were dancing but I was crying. At the end of the day, they pronounced us husband and wife. I ran away and hid at a relative's house, but they found me and brought me back to my husband."

UNFPA, 2007

While rates of child marriage are falling, UNICEF notes that worldwide, the pace of change remains slow, with one in three women aged 20–24 being married by the age of 18, compared with 48% of women aged 45–49 (2010 figures). Globally, more than 12% of young women – some 1.5 million girls – are married before they reach the age of 15.⁵⁵ As Figure 9 shows, Niger, closely followed by Chad

and Mali, has the highest rates of child marriage, with more than one-third of women aged 20–24 married before the age of 15 and three-quarters married by the age of 18. These national averages, however, obscure significant regional variation. Brown, for example, notes that: "68 per cent of girls in the Indian state of Rajasthan are married by 18" and "In the western Malian region of Kayes the incidence of early marriage has been estimated at over 80 per cent".⁵⁶ In all countries, rates of child marriage are higher in rural than in urban areas.

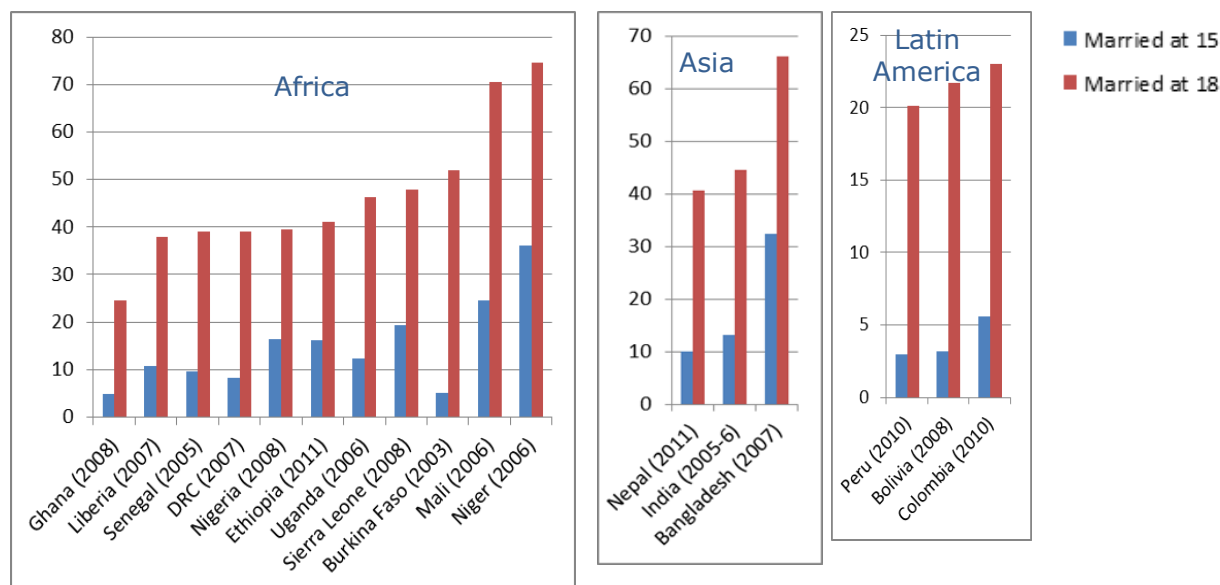
⁵⁵ These countries include Bangladesh, Burkina Faso, the Central African Republic, Eritrea, Ethiopia, India, Malawi, Mali, Mozambique, Nepal, Nicaragua and Uganda.

18-year-old Egyptian man

"There was another girl called Zainab. Her parents forced her to get married at 14. She dropped out of school and got pregnant soon after. But the pregnancy was traumatic and she suffered the first of two miscarriages. I have been told she still suffers from health problems because of what happened to her. I have a 15-year-old sister and I dread to think of her being made to marry against her will and going through a similar ordeal."

Plan UK, 2011

Figure 9: Age at first marriage in selected countries, by region



Source: DHS data

2.4 Adolescent sex

17-year-old Ugandan girl

"He would pick me up from home secretly and take me for film shows in town. I would always lie to my mother that I had gone to my Auntie's place and would spend nights with him. At the end of it all, he asked me to show him that I loved him by having sex with him and I complied. I could not refuse because I was ashamed of all the things he had done for me."

Moore and Biddlecom, 2007

Ethiopian girl, married at 15

"It hurts to sleep with a man before you're old enough to do so."

Girls Not Brides, nd

Tracking the age at which adolescents first have sexual intercourse is another vital precursor to understanding teen pregnancy, as the longer the exposure an adolescent girl has to sexual activity, the more likely she is to become pregnant.

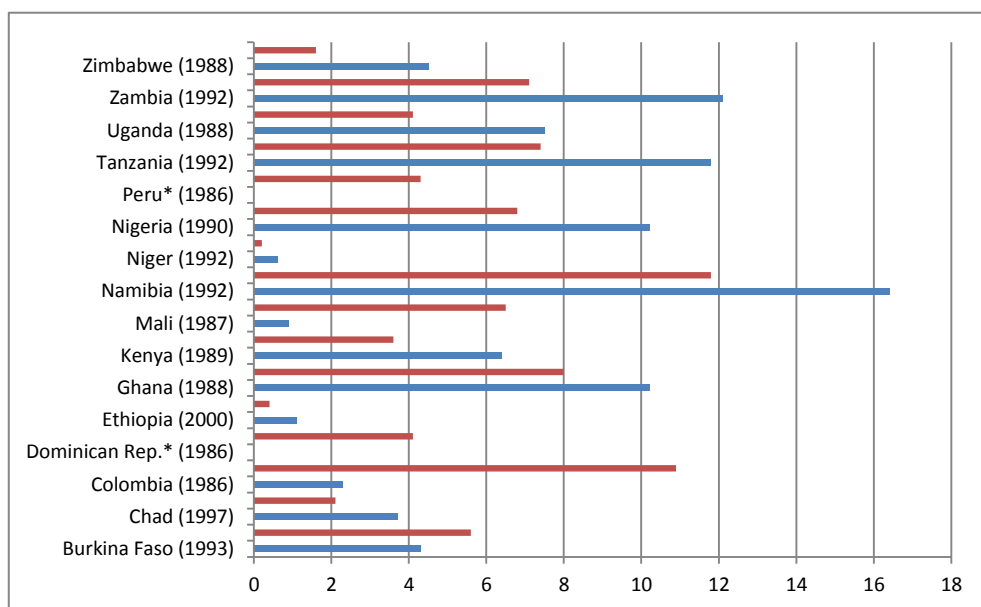
Two key facts stand out. First, the age of first sex in many sub-Saharan African countries – the region with the world's highest adolescent fertility rates – has either stayed the same or increased.⁵⁷ While the rhetoric that surrounds adolescent pregnancy would like to focus on early promiscuity,⁵⁸ the data do not support that proposition, as Figure 10 shows. Second, as Figure 11 shows, in the countries with the highest teen pregnancy rates (and with complete data), adolescent girls are significantly more likely than adolescent boys to have had early sex – largely because they are already married.⁵⁹ In some countries in sub-Saharan Africa and South Asia, girls are up to ten times more likely than boys to have

had early sex, both because of marriage and because they are more vulnerable than boys to rape and coerced sex. However, voluntary premarital sex is not uncommon: "in most countries

**** Longitudinal data are not available for Asian countries. In Latin America, there is evidence of earlier sexual debut.

of the developed world and sub-Saharan Africa (except Nigeria and Rwanda), a third or more of unmarried adolescent girls have had sexual intercourse" before the age of 20.⁶⁰

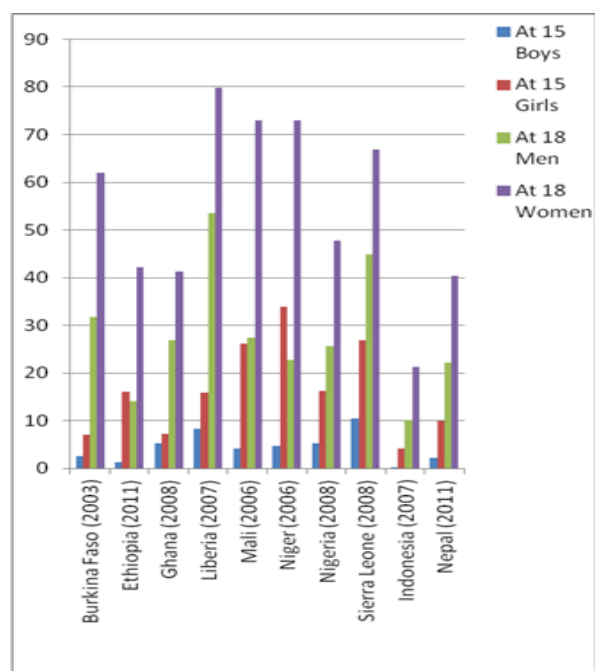
Figure 10: Trends in percentage of unmarried sexually active adolescent girls, selected countries with two surveys



Source: Blanc *et al.*, 2009

*indicates a data value of "0"

Figure 11: Percentage of young adults who had had sex by 15 and 18



Source: DHS data

2.5 Adolescent contraceptive use

Pregnant Jamaican teen

"I see other girls having sex and not getting pregnant, so I thought it would be the same for me."

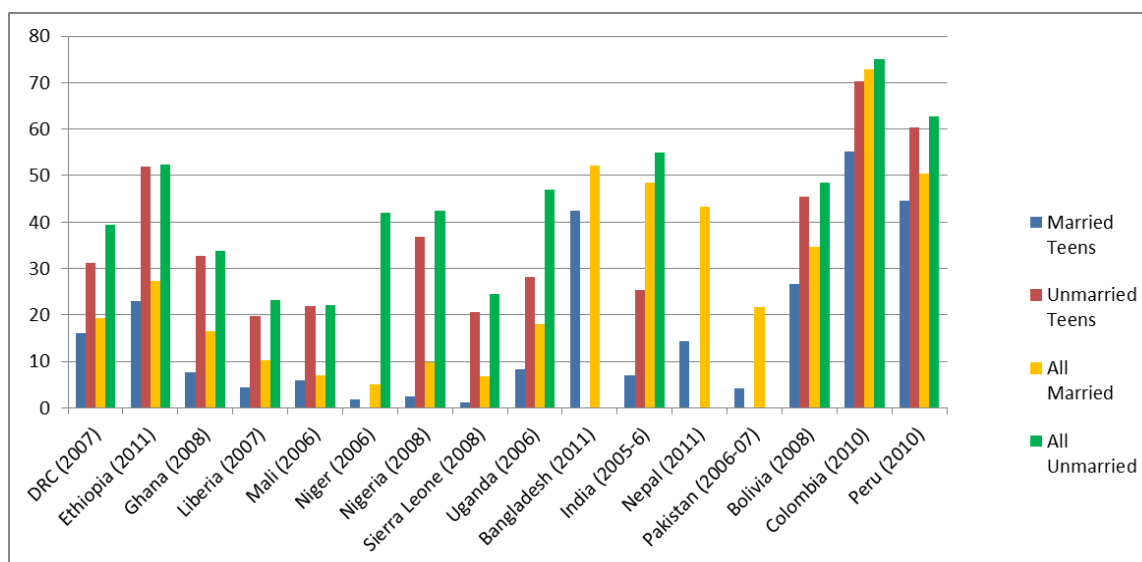
Watson, 2011

Adolescent fertility is, of course, highly dependent not just on adolescent sexual activity, but on contraceptive uptake. Blanc *et al* note that: "Among the 25 countries with appropriate data from the most recent survey, roughly 25% of all young women, on average, had used contraceptives by age 19; ever-use by age 19 was as high as 51–61% in Bangladesh, Brazil and Colombia. Among the 16 countries with contraceptive history data for at least two surveys, 12 experienced increases in the proportion of

adolescent females using contraceptives by age 19."⁶¹ However, as Juárez *et al* note, contraceptive use remains very low among the youngest adolescents and extremely low within marriage, particularly across sub-Saharan Africa.⁶²

As Figure 12 shows, married adolescents in all countries are less likely to use contraception than unmarried teens. In the Democratic Republic of Congo (DRC), for example, unmarried teens are twice as likely as their married peers to use a modern contraceptive method. In Sierra Leone, on the other hand, they are 17 times more likely to use such a method. Differences in Latin America and Asia are smaller, though it should be noted that in most South Asian countries, data are not even collected from unmarried women. Figure 12 also shows that adolescents, married or unmarried, are significantly less likely to use a modern method⁺⁺⁺⁺ than "all" women. Married teens' current use of a modern method is markedly lower than that of all married women – and unmarried teens are less likely to be currently using a modern method than are all unmarried women.

Figure 12: Percentage of women, by age and marital status, currently using any modern method of contraception



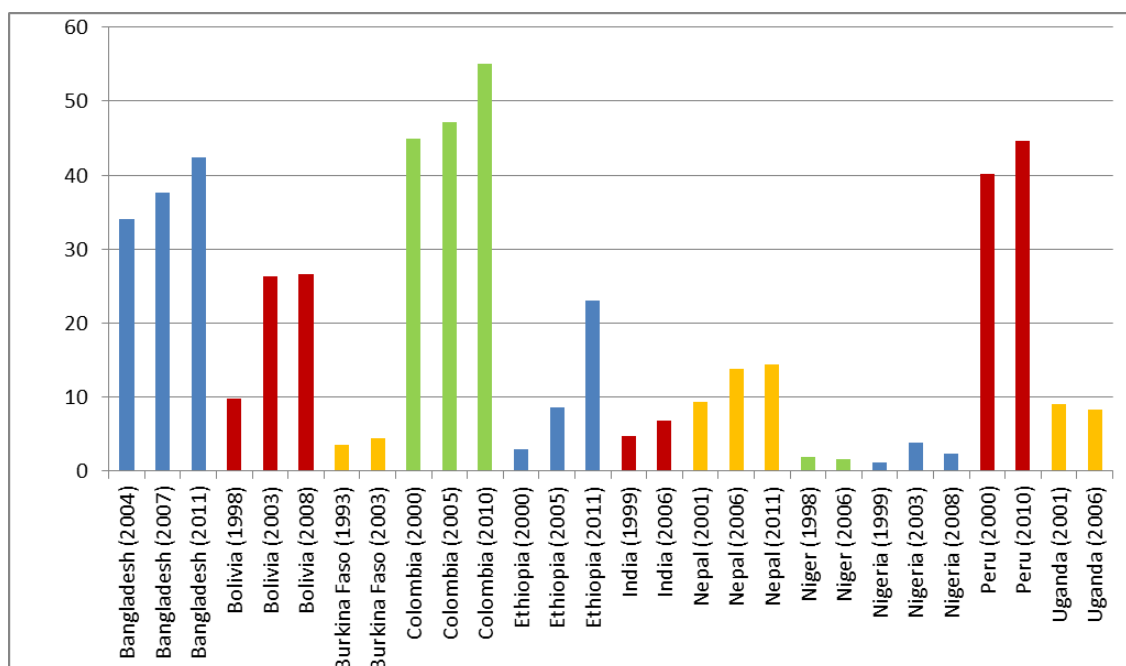
Source: DHS data

As low as adolescent contraceptive use is, the overall trends are positive. As Figure 13 shows, in countries where there are multiple rounds of Demographic and Health Survey (DHS) data, most show increases in married teens' current use of contraception. In Bangladesh, for

⁺⁺⁺⁺ "Modern methods" of contraception, as defined by the DHS, include the pill, the IUD (coil), injectables, implants, male condoms, female condoms, and sterilisation. "Traditional methods", which are much less effective, include withdrawal and the rhythm method. Adolescents' preferred methods vary. In the DRC, Nigeria, Nepal and Pakistan, for example, married adolescents prefer condoms. In Liberia, Ethiopia and Uganda, they prefer injectables. In Ghana, Mali and India, they prefer the pill. Unmarried teens almost universally prefer male condoms.

example, between 1994 and 2007, use of a modern method climbed from 19.6% to 37.6%. In Ethiopia, rates rose from 3% in 2000 to 23% in 2011. Not all the trends, however, are positive. Indian teens' use of a modern method remains very low over time, barely budging from 4.7% in 1999 to 6.9% in 2006. Even more troubling are Uganda and Niger, which have seen decreases in their already low levels of teen contraceptive use.

Figure 13: Percentage of married adolescents currently using a modern method, by country and year



Source: DHS data

Bangladeshi women, married at 15

"I couldn't take the pill out of fear."

"If I don't conceive now, I might never have a child..."

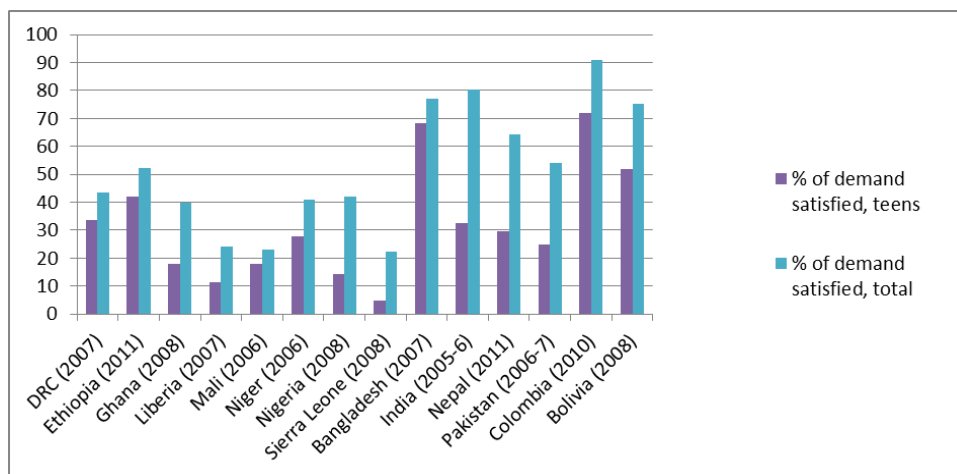
Sethuraman et al, 2007

There is still, however, considerable scope for increasing the uptake of contraceptives among adolescents. As Figure 14 shows, across all countries in all regions, married teens have more unmet need than "all" married women. Even in Colombia and Bangladesh, where approximately 70% of teens' demand for family planning is satisfied, rates remain significantly below those of adults.^{****} In India, where female sterilisation is the primary form of contraception, young

women are less than half as likely as their adult peers to report that their need for family planning has been satisfied, as they would prefer better access to temporary methods such as the pill and condoms.

^{****} DHS notes that the concepts of demand and unmet need are incredibly complex. They are measured with 15 different survey questions that have subtly varied between countries and over time. The definitions have been revised as of 2012. See www.measuredhs.com/topics/Unmet-Need.cfm for details.

Figure 14: Percentage of demand for family planning that is satisfied for married women, by age

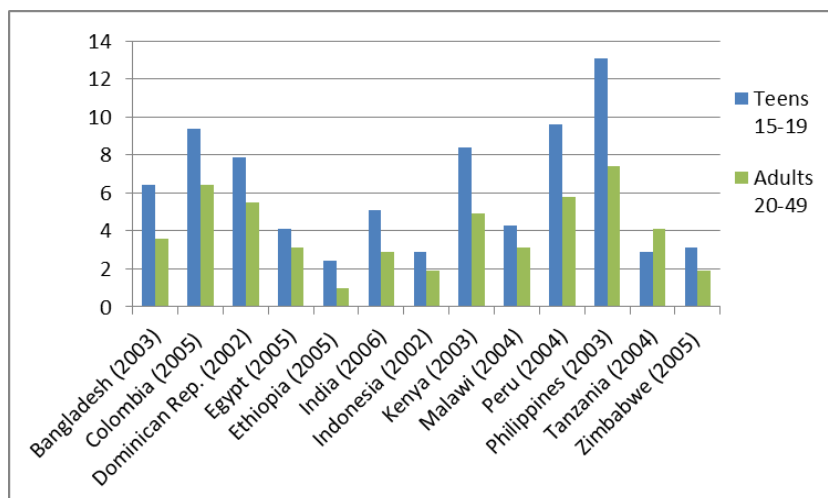


Source: DHS data

As we discuss in greater detail in Section 3, there are many problems with adolescents' knowledge of, access to and use of contraception. On average, teens begin having sex a year before they begin using contraception.⁶³ Furthermore, because unmarried teens have sporadic sex, they often do not plan ahead for contraception. Even when adolescents do use contraception, they are particularly prone to using it incorrectly and inconsistently, which results in higher failure rates.⁶⁴ As Figure 15 shows, failure rates for adolescents were about 25% higher than those for older women.⁶⁵ Discontinuation rates are also significantly higher for teens than they are for older women, as illustrated in Figure 16. Finally, rates of coerced and forced sex for adolescents are significant: "It is estimated that around the world between 40 and 60% of all sexual abuse occurs in youth who are younger than 16 years old."⁶⁶ Taken together, these facts support a tremendous need for access to emergency contraception, which – if used correctly in the days immediately following unprotected sex – prevents conception by delaying ovulation^{§§§§} (see more detailed discussion on coerced sex below).

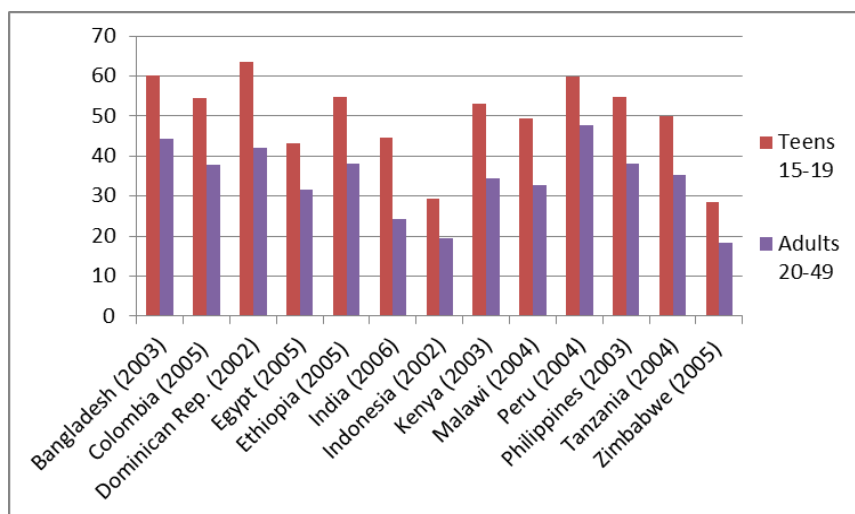
§§§§ Emergency contraception (EC) is often confused with the "abortion pill". EC is a form of contraception and has no impact on embryonic development or implantation if fertilisation has already occurred.

Figure 15: Percentage first year contraceptive failure rate by user's age at adoption: selected countries with DHS calendar data 2002-2006



Source: Blanc *et al*, 2009

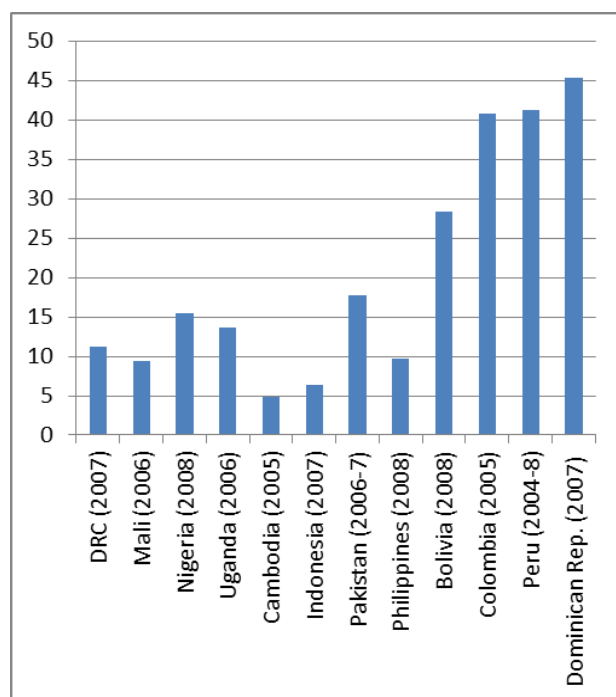
Figure 16: Percentage first-year contraceptive discontinuation rates for any reason, by user's age at adoption: selected countries with DHS calendar data 2002-2006



Source: Blanc *et al*, 2009

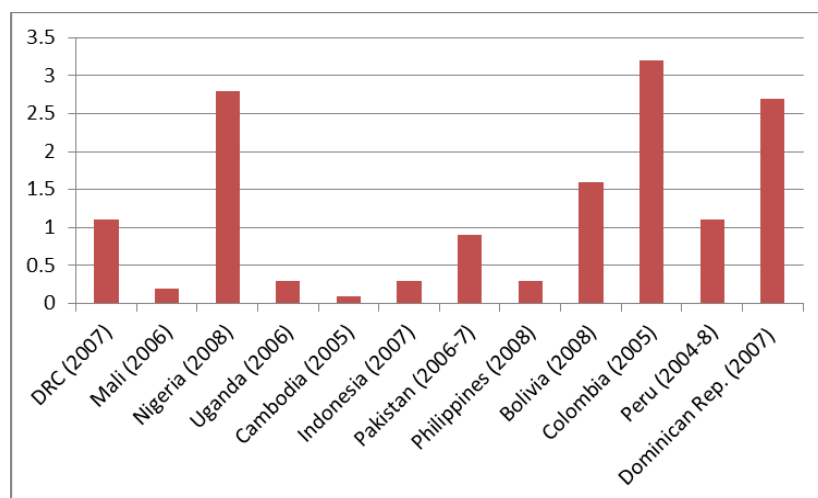
Despite this, the data, which are very thin, indicate that few women of any age even know about post-coital contraception options. As Figure 17 shows, only in Latin America is emergency contraception well known.⁶⁷ The use of emergency contraception is exceedingly low in all countries (see Figure 18). Across sub-Saharan Africa, adolescents' knowledge was even lower, as will be discussed in detail in the next section.

Figure 17: Percentage of women with knowledge of emergency contraceptives



Source: International Consortium for Emergency Contraception, 2012

Figure 18: Percentage of women who have used emergency contraceptives



Source: International Consortium for Emergency Contraception, 2012

3 Barriers to adolescents' use of contraceptives

Adolescent girls face a plethora of barriers to controlling their fertility.⁶⁸ For some, pregnancy is the accidental result of sexual experimentation in the context of little knowledge of biology. For most, however, childbearing is something they have little personal control over. Worldwide, most teen pregnancies take place in the context of teen marriage.⁶⁹ Forced into sexual relations and encouraged to become pregnant as quickly as possible, many adolescent girls are given no chance to make decisions about their bodies or their futures.

The United Nations Population Fund (UNFPA) and the Program for Appropriate Technology in Health (PATH) have identified eight key hurdles that women must negotiate in order to successfully utilise contraception.⁷⁰ We have adapted these to take into account the unique developmental and social positions of adolescents (see Box 1).

Box 1: Barriers to adolescent contraceptive use

1. **Individual attitudinal barriers:** research suggests that young women must want to avoid pregnancy; where girls have internalised powerful socio-cultural values, their own individual attitudes are often a barrier to contraceptive uptake. The powerful influence of these values can be seen in the fact that worldwide, up to three out of four adolescent pregnancies are planned.⁷¹
2. **Emotional and interpersonal barriers** to the uptake of family planning services stem from the attitudes and desires of young women's families and friends. Married girls' access to contraceptives, and their beliefs regarding need, is largely determined by the adults in their marital families – their husbands and their in-laws – who most often encourage early fertility. Unmarried girls, on the other hand, are often stigmatised for their sexuality, their contraceptive access constrained by embarrassment and shame born of hypocritical social pressures that both require virginity and expect them to "service" men.
3. **Broader socio-cultural and religious norms and practices** affect the use of contraception in terms of the social value they ascribe to girls versus boys and appropriate gender roles for each. Where a girl's empowerment is limited and her "purpose" is to produce children for her husband's family, the need for family planning is limited – and restrictions on premarital sexual relations are significant.
4. Teens also face important **cognitive barriers** in that they often lack knowledge and understanding of conception and contraception. In order to choose and use a method, teens must know what options are available, how they work, and what side effects they have. Evidence indicates that this is currently not the case.
5. **Geographic barriers** are particularly significant for rural teens and those whose mobility is restricted by culture. However, psychosocial barriers often leave even urban teens with limited access to clinics and contraceptives.
6. The cost of contraception can pose an **economic barrier** for adolescents.
7. **Administrative barriers** can limit unmarried teens' access to contraception; legal codes must not prevent teens from utilising services or require spousal consent, and clinic hours must be reasonable.
8. Where teens are stigmatised for their sexuality, **barriers relating to quality of care**, especially the attitudes of providers, are significant.

Source: adapted from UNFPA and PATH, 2006

Adolescent pregnancy is a well-understood phenomenon. The drivers of adolescent sexuality and contraceptive uptake are known. While each of the barriers described in the box plays a role in keeping teens from successfully preventing pregnancy, three key observations stand out. First, culture is paramount to all other barriers. Where girls are primarily valued for their reproductive capabilities, social pressure from husbands, families and communities encourages both child marriage and rapid conception. Given that 90% of adolescent mothers in the developing world are married, keeping girls in school – and out of the marriage bed – is practically a silver bullet.⁷²

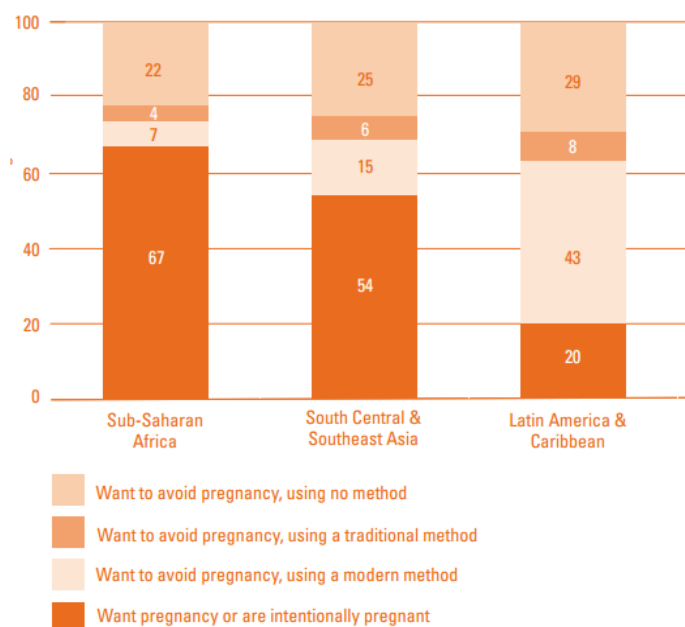
A second critical barrier facing adolescents is a lack of knowledge.⁷³ Girls and boys go through puberty with little understanding of the changes taking place in their bodies – and even less understanding of contraception. While most adolescents know about modern methods of family planning, there is often tremendous misunderstanding about how they work and fear of their long-term consequences. This fear is pervasive and is often shared by the adults in a girl's life. Accurate information, framed in culturally sensitive ways to ensure that it is genuinely heard and understood, is required.

Finally, given the sexual transition unfolding around the world, wherein sexuality is increasingly decoupled from marriage (as the age of puberty drops, due to better nutrition and living standards,⁷⁴ and the age of marriage rises), there is a growing need to “mind the gap” and ensure that unmarried adolescents have access to sexual and reproductive health services.⁷⁵ Adults, from parents to medical practitioners, are frequently uncomfortable with adolescent sexuality and clearly prefer that teens remain abstinent until marriage.⁷⁶ However, the evidence is increasingly clear that adolescents rarely heed the “abstinence only” message, and that a back-up plan involving contraception is vital.⁷⁷

3.1 Individual attitudinal barriers

As Figure 19 shows, a significant number of girls want to get pregnant.⁷⁸ While estimates vary,^{*****} according to WHO, three out of four adolescent pregnancies in the developing world are planned.⁷⁹ While these desires are largely shaped by the expectations of family and culture to the extent that they have been internalised, it is important to address them separately. Age-disaggregated data are not available, but as we discuss in more detail later, it seems likely that “desire” for motherhood is particularly driven by age. The fertility preferences of 18- and 19-year-old young women have little in common with those of 14-year-old girls.⁸⁰

Figure 19: Adolescent pregnancy desires and contraceptive use



Source: Guttmacher Institute, 2010

***** WHO (2008b) reports that 75% of adolescent pregnancies are planned. The data in Figure 19, which is from Guttmacher (2010), indicate that a lower percentage of adolescent women want to avoid pregnancy. The difference arises in that the former refers to pregnancies *in a given year* that were unintended conceptions and the latter refers to planned conceptions *in the next two years*. Regardless, both indicate that the majority of adolescent pregnancies are intended and planned.

For married teens, it is often important to prove their fertility as soon as possible.⁸¹ Particularly in South Asia and sub-Saharan Africa, pregnancy is “socially accepted, founds identity, is a source of status, and reaffirms entry into adulthood”.⁸² This reality is reflected in DHS surveys, which find that married teens are less likely to use contraception, but also have less unmet need.⁸³ Traditions such as son preference and polygamy (discussed later) also shape young women’s contraception preferences and encourage early fertility.⁸⁴

Latin American girl, mother at 16

“I took precautions for a month. After that I stopped. I had this crazy idea that I should have a baby.”

Näslund-Hadley and Binstock, 2010

While premarital pregnancy in Asia is relatively uncommon,⁸⁵ some unmarried adolescents in Africa and Latin America have little desire to avoid pregnancy. Girls may see sex, and pregnancy, as a way to hold on to their boyfriend or hasten marriage.⁸⁶ In cultures where motherhood is idealised, teen pregnancy can represent an “entry to adulthood, a way for gaining status, or even an escape from abusive

families”.⁸⁷ For example, Guzman reports that in Latin American countries with high adolescent fertility, such as El Salvador, Paraguay, Honduras and Nicaragua, more than two-thirds of adolescent mothers said their pregnancies were wanted.⁸⁸ This is particularly the case in rural areas and among teens with little education or family wealth.⁸⁹ As Näslund-Hadley, for the Inter-American Development Bank (IDB), notes, “many adolescent women are in a situation of such complex disadvantage that to them a precocious pregnancy will accelerate their life path rather than alter it”.⁹⁰ They believe that early motherhood will provide an excuse to drop out of school (which, across much of Latin America, is no guarantee of a future job), and add meaning to their lives.⁹¹

3.2 Emotional and interpersonal barriers

Young women’s use of contraception is heavily influenced by emotional and interpersonal factors – particularly the attitudes and views of their husbands and partners, which women report to be the single largest barrier to consistent use of contraceptives.⁹² This holds true regardless of whether the relationship is marital or non-marital.⁹³ In South Asia, in-laws (particularly mothers-in-law) also hold sway over married girls’ uptake of contraceptives.⁹⁴ For unmarried adolescents – who are typically engaging in sexual activity that is both socially unsanctioned and socially expected – community support for contraception is vital.⁹⁵

3.2.1 The impact of family pressure

Indian mother-in-law

“And if she is not educated, then everybody at home feels that she should have one child.”

Bangladeshi women married at 19

My mother-in-law cried: “You need not use these methods... We need grandchildren.”

My sister-in-law said: “Get the first child and then use them (the pills). If your *narhi noshto* (uterus/fallopian tube) is damaged, you’d lose everything.”

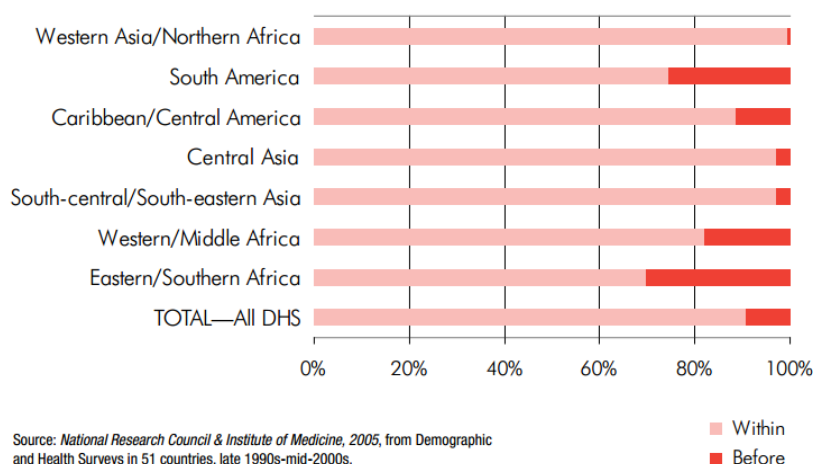
Sethuraman et al, 2007

The wants and desires of a girl’s family are key to her use of contraceptives. “Newly married adolescent girls have little power and social status in their marital family and are rarely able to negotiate for a delay in their first pregnancy.”⁹⁶ As such, and as Figure 20 shows, it is “marriage or union formation that continues to define, for the most part, the timing of parenthood in the developing world”.⁹⁷ This is particularly true for the youngest mothers: “In most countries the majority of girls who gave birth very young were also married before the age of 16.”⁹⁸ In sub-Saharan Africa and South Asia, married girls are typically under pressure from their husbands, their in-laws

and their communities to begin childbearing as soon after marriage as possible.⁹⁹ As Lloyd notes, infertility is “deeply feared”¹⁰⁰ and can result in abandonment and abuse – leading girls

to want to become pregnant as quickly as possible. In Afghanistan, “the will of the mother-in-law is a factor in determining family size”,¹⁰¹ while in Africa, evidence suggests that men play the dominant role in fertility decisions.¹⁰² There is, however, considerable variation, even within regions. A review of adolescent pregnancy in India and Bangladesh found that girls from the latter have more personal choice in the matter, and marital families were more willing to negotiate with young brides about the timing of pregnancy.¹⁰³

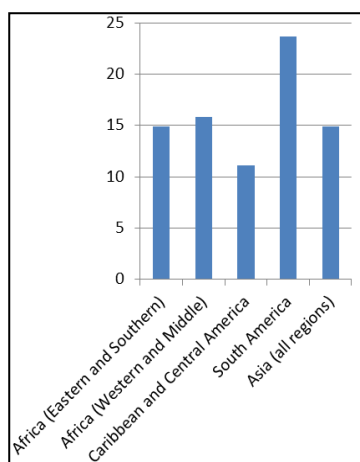
Figure 20: Percentage of first births that occur within or before marriage



Source: WHO, 2008b

It should be noted, however, that there is a directionality issue when it comes to adolescent pregnancy and marriage. While the vast majority of teens are married when they give birth, it is certainly the case that for some young women, pregnancy precedes marriage, rather than the other way around.¹⁰⁴ For example, a Population Council working paper found that girls who had premarital sex in Cameroon, Togo and Côte d'Ivoire were twice as likely to be married as girls who did not have premarital sex.¹⁰⁵ On the other hand, using DHS data, Lloyd reports that births that occur within seven months of marriage (a useful way of capturing premarital conception) are a relative rarity in all regions except South America, where they represent nearly one-quarter of all births (see Figure 21). South America is also the only region in which adolescent fertility rates have significantly risen in recent decades. In Africa, evidence suggests that in some places, “shotgun” marriages are less common than they once were, as the stigma of premarital pregnancy is easing.¹⁰⁶

Figure 21: Percentage of births that occurred within seven months of marriage, women aged 20-24



Source: Lloyd, 2005

Unmarried girls also face pressure to become pregnant. In South Africa, where 35% of girls have been pregnant before the age of 20, some teens reported that their mothers and grandmothers pressured them into becoming pregnant, as they wanted “a baby to keep them company”.¹⁰⁷ Others reported that their boyfriends pressured them into pregnancy, to prove their love and commitment. Like their married peers, “unmarried adolescent girls may have older partners and little power to negotiate the timing and frequency of sex and use of condoms or other contraceptive methods”.¹⁰⁸ Wood and Jewkes reported, for example, that some boyfriends in South Africa used physical violence to prevent their adolescent girlfriends from using contraception; others destroyed clinic cards and pills.¹⁰⁹

3.2.2 The importance of men’s attitudes

Indian girl, married at 19

“My husband had the right to decide, and he decided the number of children we should have and whether it would be a boy or a girl.”

Sethuraman et al, 2007

Young women, both married and unmarried, report that men’s attitudes toward contraceptives constitute the largest barrier to their use.¹¹⁰ As girls most often lack agency in their relationships, and “husbands are the ultimate decision makers”,¹¹¹ breaking down men’s resistance to contraception is key to increasing its uptake.¹¹² First, men often want larger families than women.¹¹³ In Indonesia the gap between the number of children men and women want is quite small--only 0.4 (4.3 versus 3.9, based on 2007 DHS data). In Niger, on the

other hand, men want 3.5 more children (on average) than women (12.6 versus 9.1, 2006 figures). The gap in Nigeria is more typical (8.5 versus 6.7, 2003 figures).¹¹⁴

Additionally, men appear to be much less likely than women to approve of contraceptive use in general.¹¹⁵ In Zambia, for example, 30% of women report that they do not use contraceptives because their husbands do not approve.¹¹⁶ In Indonesia, 7.2% of young women report that their husband’s disapproval precludes their use of contraception (2007 data). In Nigeria, Izugbara and Ezech note that “a wife could easily threaten her husband’s sense of control and headship by bringing up the topic of family planning with him”.¹¹⁷

Health worker in Uganda

“Women say their partners want many children and if you ask them to take their

husbands to the health centres to be explained to, the men refuse, saying those are women's things. In African tradition, whatever a man says is what you take."

Mwesigye, 2012

Young married women are therefore often left with a poor choice: attempt to claim the rights that ought to be their own and use contraception secretly – and risk "punishment" – or take their chances at pregnancy. In Nigeria, for example, women report that wives "can use [contraceptives] covertly with great risks to her life if

her use is discovered... She might suffer from his infidelity, him taking a second wife, or divorce."¹¹⁸ In other contexts, using contraceptives can generate considerable intra-household tensions and even violence. In a comparative study on delaying first pregnancies in Bangladesh and India, Sethuraman *et al* cite the example of one young woman, married at 16, who said: "One day I tried to take pills and he caught me and he slapped me."¹¹⁹

Given the importance of men's attitudes to young women's contraceptive use and ultimate fertility patterns, it is very important to understand what drives men's fertility preferences. Fatherhood, like motherhood, is often a valorised role.¹²⁰ Where the partners of young women are young men, it can be the case that "early fatherhood is a welcome affirmation of masculine maturity and strength".¹²¹ This is particularly true in more rural areas. However, it is the case that girls' sexual partners are far more likely to be older men. Across sub-Saharan Africa, for example, husbands are, on average, ten years older than their young brides.¹²² In Nepal, the husbands of married teens are six years older than their wives.¹²³ This age gap is echoed in rural Ecuador; one study found that pregnant teens' partners were six year older – with only 12% of fathers also still in adolescence.¹²⁴ For these men, pregnancy ensures an heir and evidences "manliness".¹²⁵

Bangladeshi woman, married at 19

"He came home and told me, 'Don't use these (pills) anymore.' So I stopped using them."

Sethuraman *et al*, 2007

This age gap also, however, increases the power that men have over their wives. In Nepal, it was found that older men married to younger women are "more likely to be the sole decision-maker about conception and pregnancy when compared to marriages with older women (49% vs. 6%)".¹²⁶ This pattern is also seen in sub-Saharan Africa. Barbieri and Hertrich

found that across 18 countries, the youngest wives – and those with the largest partner age differences – "always have a lower level of contraceptive use... This illustrates their disadvantage in terms of individual decision-making power and in the elaboration of shared conjugal projects."¹²⁷ As mentioned above, polygamy complicates things still further. In these families, the number of wives and children a man has is often key to his social status, providing an additional incentive for men to marry young women who are just beginning their most fertile years.¹²⁸

In some contexts, it appears that it is not so much that men do not approve of contraception, but that women simply do not know whether men approve. For example: "Talking about family planning is a taboo in many Rwandan households; the majority of women have never discussed family planning with their husband."¹²⁹ This lack of communication and intra-household empowerment alone is what most women reported as the largest obstacle to contraceptive use.¹³⁰ Adolescent wives may have a particularly difficult time discussing contraception with their husbands. For example, in Indonesia, more than 40% of women under the age of 20 had never discussed family planning with their husband, compared with 30% of women aged 25–29 (2007 data). This pattern is similar, though less pronounced, in Bangladesh (2007 data). Interestingly, young Indonesian women were three times more likely to report that their husband disapproved of contraception than were their husbands themselves (7.2% versus 2.2%, 2008 data), which points to limited spousal communication as a very important barrier to uptake of contraception. However, given that one in five Indian men, for instance, report that "contraception is women's business and a man should not have to worry about it", many women may find these conversations difficult (2007 DHS data). This is echoed in South Africa, where 28% of young respondents said that even if a girl brought up the subject of contraception, her partner would refuse to discuss it.¹³¹

3.2.3 The impact of gender-based violence

Married Ugandan 17-year-old

"There is no way I would have refused because if I did he would have raped me. So I just agreed."

Wagman et al, 2009

In addition to having little space to negotiate contraceptive use, young women, married or unmarried, often have no power over the nature and timing of their sexual relationships. Sexual coercion and rape are common experiences for many young women; a review of more than a dozen studies found that across the developing world, between 15% and 30% of girls reported that coercion was involved in

their first sexual experience.¹³² In some regions of the world, forced sex is even more common. For example, 40% of adolescent girls in Burkina Faso and Uganda report having been raped,¹³³ and nearly half of young women in the Caribbean reported that their first experience of sexual intercourse was forced.¹³⁴ Both boys and girls report that this is a "normal" part of relationships, "most commonly perpetrated by a boyfriend or husband".¹³⁵

Married girls appear to be particularly vulnerable to sexual violence; physically and socially isolated, they have little recourse to their husbands' demands.¹³⁶ One study found that one-third of young wives reported being forced into marital sex, and 17% of young husbands reported forcing their wives.¹³⁷ Significant age differences between spouses can exacerbate the issue. In Nepal, for example, girls married to men more than five years older were more likely to report coercion.¹³⁸

In some regions of the world, rape and marriage are inexorably intertwined. The practice of "marriage by abduction" is prevalent in the Horn of Africa. Men, to avoid paying bride price, abduct young teens and rape them. "Many times the boy's parents agree to the abduction as they cannot afford the dowry traditionally required in the region. Village elders often serve as mediators between the families and discourage the girls from pressing charges and going to court against their attackers... After she's abducted, the community sees her as if she is married."¹³⁹ Marriage by abduction is very common in Ethiopia: "The prevalence... (is) as high as 92 per cent in Southern Nations Nationalities and Peoples Region (SNNPR), with a national average of 69 per cent."¹⁴⁰

Adolescent boy, Burkina Faso

"If you take her out to eat and drink and she refuses to have sex with you, you can force her because it's not for nothing that you spent your money."

Moore et al, 2007

While both married and unmarried girls are vulnerable to rape, unmarried girls can also face a different sort of sexual coercion – the pressure that comes from transactional sex. Across the sub-Saharan African region, many adolescent girls report trading sex for money or gifts.¹⁴¹ In one study, three-quarters of girls in Ghana, Malawi and Uganda reported that their most recent sexual experience was for money or gifts.¹⁴² These are, however, barbed gifts; they are imbued with power differentials and offered to girls who have little voice to say "no". As Boileau *et al*

noted, girls are "faced with an impossible array of expectations when negotiating sex".¹⁴³ They are considered "seductresses", expected to provide sex for the men who fall for their charms, and regarded as promiscuous if they purchase condoms; they are expected to "behave responsibly" sexually¹⁴⁴ and yet often left to provide for themselves economically.

Girls consistently find themselves in a lose-lose situation. In Ghana, for example, adolescent girls in one study reported considering sex an obligation, not a right.¹⁴⁵ In Uganda, girls whose "parents had difficulty in providing basic necessities such as food, clothing, shoes and soap" viewed sex as a way to obtain not just luxuries, but the basic necessities of life.¹⁴⁶ Similarly, in Kenya, girls participating in a study on sexual scripts noted that sex was just an expectation and that while "yes" got gifts, "no" risked rape.¹⁴⁷ Some girls must buy their own futures. In Cameroon and Liberia, teens who wish to stay in school reported that they were often forced to either have sex with their teachers or with other older men who agreed to pay their fees.¹⁴⁸

3.2.4 The impact of the sexual transition

Unmarried girl, Dominican Republic

"Parents blame their daughters, not their sons. They lose confidence and make you feel guilty."

UNFPA, 2007

20-year-old Ugandan male

"The spread of sexuality nowadays is due to the fact that girls are not serious, they are provocative. It's a disaster."

Boileau et al, 2008

17-year-old African female

"(Abstinence until marriage) is recommended in the village where I am from, it makes our families proud. Only the husband can have his wife (...) but this seems impossible nowadays."

Boileau et al, 2008

Unlike married girls, however, unmarried teens are also caught in the nexus of both a biological and a demographic transition that is exposing them to more frequent premarital sex – in an environment in which contraceptive access is limited by social stigma. Worldwide, the age of puberty is dropping, and the age of marriage is rising, driven by international law and an increasing emphasis on girls' education.¹⁴⁹ These two facts have ushered in a "sexual transition" in which sexuality and marriage are increasingly disassociated.¹⁵⁰

This "global phenomenon, occurring at different paces in different settings", has a variety of implications for adolescents, particularly girls.¹⁵¹ First, in societies in which marriage and sex are tightly linked, it lengthens the period of time in which their sexuality is socially frowned upon – placing them in the untenable position of simultaneously being expected to "service" men and

remain virginal until marriage.¹⁵² Even, and perhaps particularly, girls who are trying to be responsible about their sexuality are condemned for their behaviour. In South Africa, for example, "girls who suggest using or who attempt to use male condoms are considered by both male and female participants to be conducting themselves highly inappropriately and reflecting their loose morals".¹⁵³

The stigma and shame that often surround adolescent sexuality make it difficult for teens to acquire not just contraception, but related information. "A key barrier to access is the perception among young people that such services are not confidential and that their private information will become known, particularly to a parent."¹⁵⁴ Girls are significantly more likely than boys to report that embarrassment or shyness keeps them from acquiring good information.¹⁵⁵ For example, in Ghana, nearly 65% of girls reported that their feelings were a barrier to contraceptive access; as did more than half of girls in Uganda.¹⁵⁶ However, even boys find this situation difficult – reporting that they are embarrassed to keep condoms, as they do not want to be "caught" by friends and family.¹⁵⁷ Teens often find it difficult to talk with one another about sexual matters too. Adolescents in a study in Nepal agreed that their negotiation skills regarding sexual activity were weak, with girls noting that they found it very difficult to discuss sexual matters with their boyfriends.¹⁵⁸

Unmarried teens face an additional burden as well. Whereas married teens who become pregnant most often have husbands and larger communities supportive of their pregnancies, unmarried pregnant girls may have "financially unsupported, and socially unsanctioned pregnancies" that their partners do not want.¹⁵⁹ In the past, it was common for a premarital pregnancy to be rapidly followed by marriage. However, today: "Although there is still social pressure on fathers, it seems to be

much less than in the past for a variety of reasons: social, since elders have less influence on young adults; economic, since many very young fathers have no income and no easy way to pay for the bride price (*lobola*) and to support the new family; geographic, since men might migrate and live far away, so escaping social pressure in the villages."¹⁶⁰ Therefore, to the extent that the sexual transition makes it more likely that young women have premarital

15-year-old Chilean mother

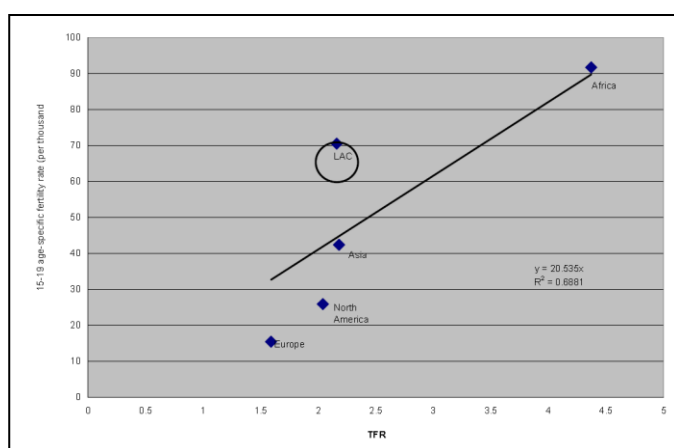
"It's hard to get up the nerve to talk to your parents or teachers about sex; it's embarrassing. And you can't just go to a clinic and ask for birth control, because everyone there knows you."

Estrada, 2009

births, rather than conceptions,⁺⁺⁺⁺ it also places an additional social burden on girls and their children, who may be less likely to complete their education and more likely to live in poverty.¹⁶¹

The Latin American sexual transition is unfolding somewhat differently from those in other regions of the world. On the one hand, and as discussed above, there is an increasing dissociation between sexual activity and marriage, leaving an increasing number of young women to raise their babies not with the help of a partner, but with their mothers.¹⁶² On the other hand, and as Figure 22 shows, Latin America “is moving away from the stylized link between fertility at early ages and the total fertility rate”, a fact which is causing considerable concern and has important ramifications for programming.¹⁶³ While the total fertility rate in Latin America has fallen and continues to fall, the adolescent fertility rate has actually climbed in five out of eleven countries. This suggests that family planning programming needs to do more than merely include adolescents – it needs to target them.

Figure 22: Relationship between adolescent fertility and total fertility



Source: Rodríguez, 2011

Ironically, while unmarried teens face greater barriers than their married peers to acceptance of their sexuality, there appear to be positive health benefits to this sexual transition. First, unmarried teens are having sex later and less frequently, as they are not subject to marital obligations; this significantly reduces their risk of pregnancy.¹⁶⁴ Second, unmarried adolescents are more likely than married adolescents to use modern contraceptives.¹⁶⁵ In India, for example, only 6.9% of married teens reported using contraceptives in the 2006 DHS; this is compared with 25.3% of unmarried teens. In Sierra Leone, the ratio was even higher: 1.2 to 20.5 (2008 data). Despite the fact that “failure rates for adolescents (are) about 25% higher than those for older women”, due to the fact that teens tend to use less reliable methods less reliably,¹⁶⁶ and despite the fact that research indicates that most adolescents do not start using contraceptives until about one year after their sexual debut,¹⁶⁷ unmarried girls are still better protected against pregnancy and disease than their married peers.¹⁶⁸

⁺⁺⁺⁺ Lloyd (2005) notes, the “overall level of premarital childbearing across all developing countries remains very low” (p 530), but it is increasing in some regions, notably southern Africa and South America. Country income level appears to be a key differentiating factor, with premarital births actually decreasing in low- and lower-middle income countries, and increasing in those that are upper-middle income.

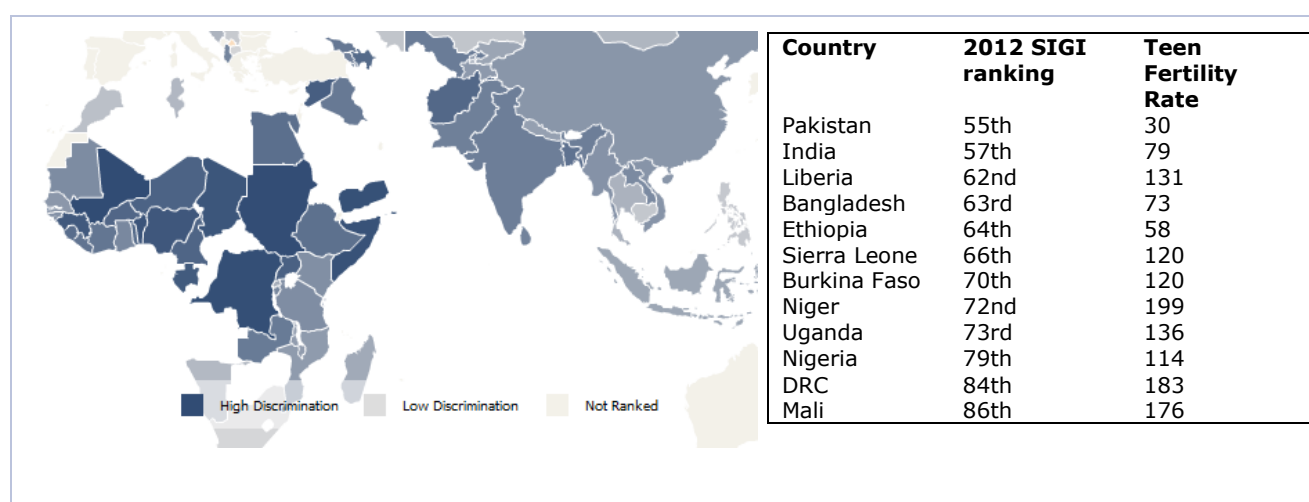
3.3 Socio-cultural norms and practices

The impact of the broader cultural milieu and social institutions on young women's reproductive behaviour cannot be overstated.¹⁶⁹ It shapes what adolescents themselves want, and determines how their families and communities push them. Throughout much of sub-Saharan Africa and South Asia, motherhood is often simply seen as what girls are "for"; their social value is firmly rooted in their capacity for reproduction.¹⁷⁰ "Women's main role is to give children to their husband's family."¹⁷¹ This has a series of cascading impacts on the way girls are treated, and whether they are ultimately able to control their own bodies and lives. Their births are often not celebrated, their education is frequently not prioritised, and they may be subject to dangerous cultural traditions such as female genital mutilation (FGM) and child marriage.

3.3.1 The Social Institutions and Gender Index (SIGI)

A useful way of capturing, on a quantitative level, the influence of social institutions on girls' lives is the Organisation for Economic Co-operation and Development (OECD)'s Social Institutions and Gender Index (SIGI). The SIGI uses 12 indicators, ranging from son preference to family law that allows child marriage, to women's freedom of movement. As figure 23 shows, social institutions in sub-Saharan Africa and South Asia are very discriminatory towards women.¹⁷² Of the 86 countries ranked in 2012 – and of the countries we identified in the introduction to this report as having the highest adolescent fertility rates – all are in the bottom half.

Figure 23: Women's comparative disadvantage as captured by the SIGI



3.3.2 The impact of child marriage

Child marriage, defined by the UN Convention on the Rights of the Child (UNCRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) as marriage before the age of 18, is illegal in most of the world and has declined over the past few decades.¹⁷³ Despite this, however, the institution of child marriage still drives adolescent pregnancy in the developing world; nine out of ten births to teens are to married teens.¹⁷⁴ Furthermore, every year there are another 10 million child brides, who, as Figure 24 shows, are often from the poorest families.¹⁷⁵ Because dowries often rise as girls become older – and become better educated – there is "a strong incentive in favour of early marriage".¹⁷⁶

Ugandan girl

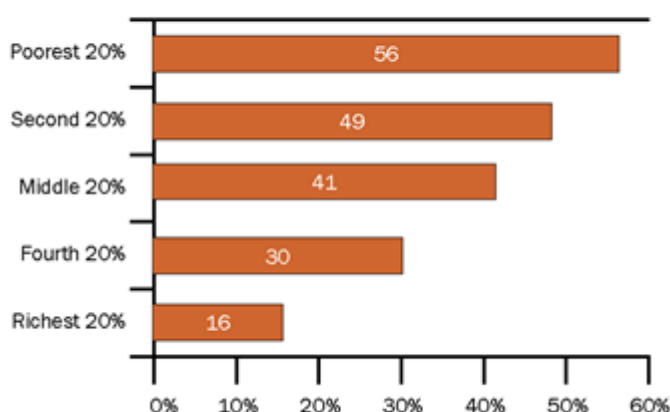
"If a girl does not marry at 14 or 16 years, it becomes a curse to the family."

Sekiwunga and Whyte, 2009

As mentioned above, most young wives are married to men who are substantially older than them – and have little say over the matter, as it is often their fathers' "inalienable right to choose husbands" for them.¹⁷⁷ As "bargaining power within the household is influenced by generation and family status (including status related to polygamy and age differentials), control of income and assets, age at marriage, (and) level of education",¹⁷⁸ these girls then have little access to decision-making power within their marital homes.¹⁷⁹ For example, in Northern Nigeria, more than 90% of young married women aged 15–24 reported that their husbands had sole authority over whether they could access healthcare.¹⁸⁰ In parts of sub-Saharan Africa, where polygamous marriages are common, men deliberately seek out young girls so that they can teach them to be good wives.¹⁸¹

Figure 24: Likelihood of child marriage by wealth quintile

Percentage of women aged 20-24 who were married or in union before age 18, by wealth index quintile (1987-2006).



Source: PLAN, 2011

3.3.3 The impact of education

Indian mother

"We can't let our daughters go to school. We need them in the home. They are our hands and feet!"

Van der Gaag, 2011

Education has repeatedly been found to affect both the age of sexual debut and contraceptive use. For girls and boys alike, teens who are in school are less likely to have sex and more likely to use contraception.¹⁸² On average, each additional year of girls' education has been found to increase contraceptive uptake and reduce fertility by 10%¹⁸³ – with women's education ultimately being the "single most powerful correlate of contraceptive use and fertility decline".¹⁸⁴ Pooling DHS data across 17 Least Developed Countries in sub-Saharan Africa paints a compelling picture of how large this impact can be: girls with the highest level of education had an adolescent birth rate of 47, while girls with no education had a rate that was more than four times higher, at 192.¹⁸⁵

A primary vehicle for this difference, at least in South Asia and sub-Saharan Africa, may be the relationship between girls' education and child marriage. Girls who stay in school are much less likely than their peers to marry early.¹⁸⁶ One study found that compared with girls with no education, girls who stayed in school for ten years were likely to marry six years later.¹⁸⁷ The relationship is, of course, bi-directional. In Nigeria, 69% of unmarried adolescent girls are still in school – compared with only 2% of their married peers.¹⁸⁸ As McQueston *et al* note, however, this relationship does not necessarily imply causality. "Early marriage is most common in countries with very low levels of educational attainment. Thus, girls are likely to experience a gap between the end of their school and marriage, even if they marry very early by Western standards".¹⁸⁹

Ethiopian leader

"We prefer to send boys to school. A girl never finishes her journey. She humiliates her parents."

Tafere and Camfield, 2009

Education gives girls options; in addition to promoting self-responsibility, it lets girls imagine and plan their own futures.¹⁹⁰ Where girls are "raised to be fearful and ignorant regarding sexuality and reproduction, to be submissive and obedient, to be fatalistic, and to accept the established order of the male and adult dominance",¹⁹¹ school can increase young women's autonomy and decision-making skills and further their options for economic independence, with lifelong impacts on their fertility choices.¹⁹²

Education matters in other ways as well. For example, men who are more educated are more likely to use contraception, which is key, given that in many families men are the sole decision-makers with regard to fertility.¹⁹³ Furthermore, a higher overall level of women's education impacts the contraceptive uptake – and fertility rates – of whole communities.¹⁹⁴ Finally, the education of mothers-in-law can have a significant impact on the timing of young women's first birth. Even controlling for age of marriage, in rural Bangladesh it was seen that mothers-in-law who were more educated had daughters-in-law who delayed childbearing, suggesting a greater acceptance of family planning.¹⁹⁵

10-year-old Bangladeshi girl

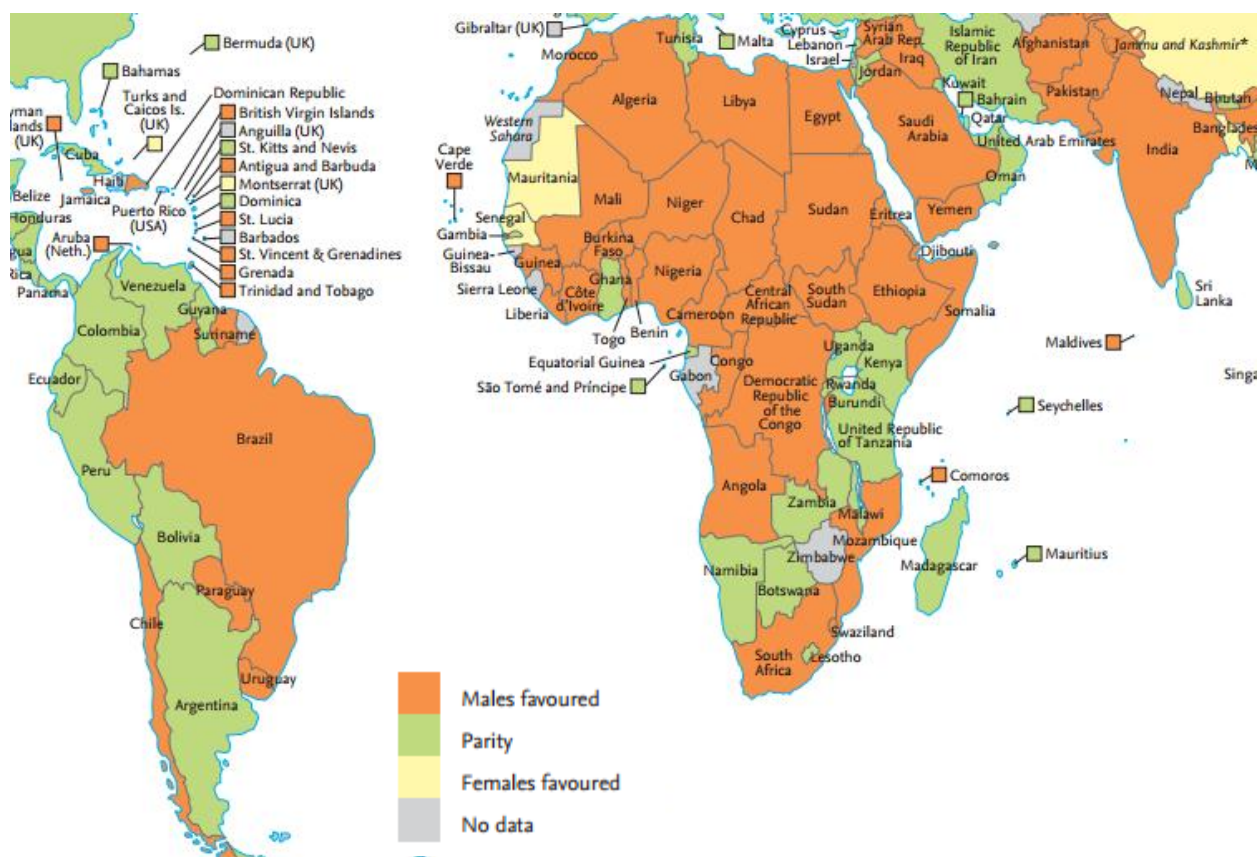
"If I get an education, people will honour me and my parents will be proud".

Brown, 2012

Despite this, girls' education continues to be undervalued in many developing countries. As Figure 25 shows, most of the world's out-of-school girls live in sub-Saharan Africa, which also has some of the highest rates of adolescent fertility.¹⁹⁶ In fact, the gender gap in secondary education appears to be widening in this region; the gender parity index (GPI) dropped from 0.82 in 2000 to 0.79 in 2008, with even more significant drops in the GPI for upper-secondary schooling (from 0.83 in 1999 to 0.77 in 2008).¹⁹⁷ The

most disadvantaged young girls are worst affected: the poorest girls are 3.5 times more likely than the wealthiest girls to be deprived of an education.¹⁹⁸

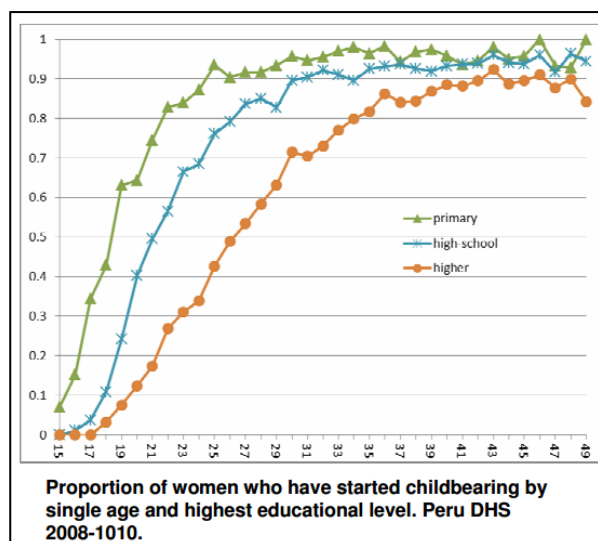
Figure 25: Gender parity in primary schools



Source: UNESCO, 2012

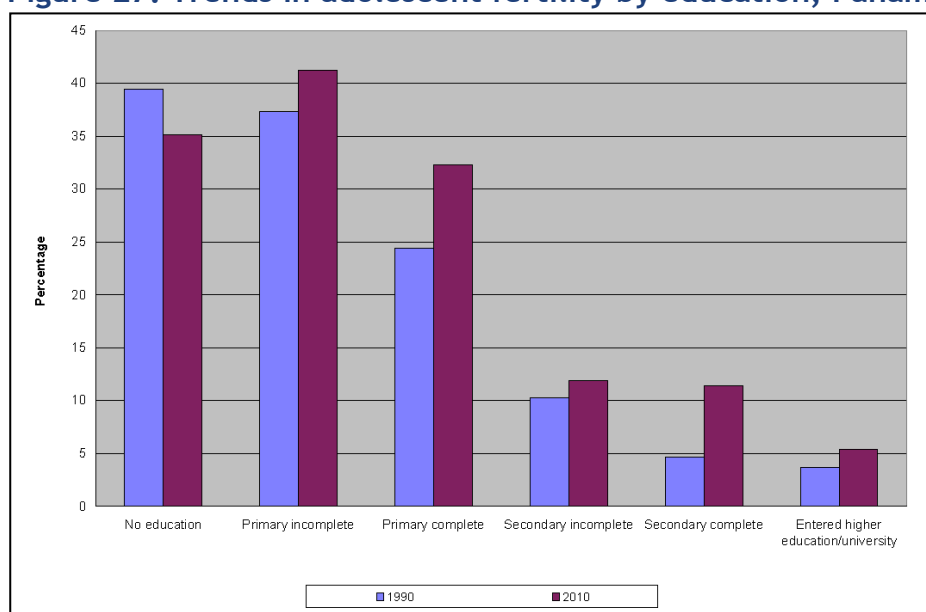
While patterns between education and adolescent fertility are largely consistent throughout most of the world, Latin America seems to be bucking the general trend. On the one hand, the most easily observed pattern matches that seen elsewhere. In fact, Näslund-Hadley and Binstock note: “the relationship between adolescent childbearing and education levels – whether measured in terms of school attendance, enrolment, or completion – appears to be stronger in LAC than in other parts of the world”.¹⁹⁹ However, while across sub-Saharan Africa and South Asia it is common for girls to leave school before pregnancy, often preparatory to marriage, Näslund-Hadley and Binstock found that in Peru and Paraguay, most girls were still in school when they became pregnant. Two-thirds subsequently dropped out, either because they were doing poorly in school and viewed their pregnancies as a convenient reason to leave or because they found the quality of education to be so low as to be meaningless for their future employment. While it remains the case that education and age at first birth are closely related (see Figure 26), there are significant chicken-or-egg questions regarding directionality. Furthermore, this relationship hides another equally troubling pattern that is emerging throughout Latin America. Recent census data indicate that early motherhood is on the rise for all teens, regardless of their position in the educational system (see Figure 27).²⁰⁰ Latin America is already the most economically unequal region in the world, and persistent lack of economic opportunity – even for those who complete their education – leaves the poorest in particular to decouple their fertility decisions from their schooling.²⁰¹

Figure 26: Impact of education on age at first birth, Peru



Source: Rivera, 2011

Figure 27: Trends in adolescent fertility by education, Panama



Source: Rodríguez, 2011

3.3.4 The impact of son preference

Ethiopian Orthodox Christian Priest

"The difference between a boy and girl starts at birth. When women express their pleasure at the birth of a child, a baby boy gets seven ululations, while a baby girl gets only three."

Van der Gaag, 2011

Young Ugandan male

"When a man leaves a boy, then he is sure of the continuity of his blood."

Beyeza-Kashesy et al, 2010

In many cultures, particularly in South and South East Asia, there is a strong preference for sons, which means that many young married girls can ill afford to use family planning until they have produced a male heir. This is reflected in local proverbs, ranging from Vietnam's "One son is children, two daughters are none" to Nepal's "To raise and care for a daughter is like taking care of somebody else's garden".²⁰² As mentioned above, son preference has been found to be an important driver of contraceptive use, particularly for newly married women.²⁰³ In Bangladesh, for example, where "the desire that the first child be a boy is highly cherished among couples", mothers who already had one son were 60% more likely to use contraceptives than those who did not.²⁰⁴ In India, "53 percent of women with two daughters and no sons are using contraception, compared with 77 percent of women with two sons and no daughters".²⁰⁵

Son preference is not limited to Asia. While African cultures are myriad and highly varied, son preference is prevalent in many regions where patriarchy is deeply rooted.²⁰⁶ In Uganda, for example, a group of adolescents and young adults agreed that "girls are mainly valued as income because they bring in bride price or dowry, which the boys will use to get wives".²⁰⁷ Among the Yoruba of Nigeria, a boy child is described as a woman's "seat"; until she has a son, a wife remains a visitor in her husband's home – a custom which illuminates the lack of worth accorded to adult women, not just girls.²⁰⁸

3.3.5 The impact of polygyny

Polygyny^{*****} is still common in several sub-Saharan African countries; in some regions of Nigeria, Uganda and Sierra Leone, for example, nearly one-third of all married women are in polygamous marriages.²⁰⁹ Polygyny has a variety of impacts on adolescent fertility. First, as mentioned above, men's status in polygamous cultures can be tied to the number of wives and children they have.²¹⁰ Subsequent wives are most commonly adolescents who are allowed no objections to the marriage and have little voice within it. However, given that the production of sons is of vital importance vis-à-vis status between co-wives and ultimate control over husbands' wealth, polygyny incentivises adolescent pregnancy – even for girls.²¹¹

3.3.6 The impact of religious values and traditions

Evidence on the links between religious values and traditions and contraceptive use is quite limited. Studies suggest, though, that religion can influence girls' sexual and contraceptive behaviour, both directly and indirectly. In some areas, the influence of religious values on family planning is fairly broad and indirect. In Swaziland, for example, "Religious beliefs emphasize the spiritual importance of progeny",²¹² while for some Muslim women, "Accepting the births that occur is not fatalism; rather, it signifies humility".²¹³ In predominantly Catholic Chile, where adolescent pregnancy rates have been rising recently, Claudia Dides, Director of the Gender and Equity Programme of the Chilean chapter of the Latin American School of Social Sciences (FLACSO), noted that the Education Ministry "has been a bastion of conservative thinking in sex education matters. I'd even venture that (ministry authorities) have been remiss in their duty to Chile's young people, because of their ideological beliefs".²¹⁴

In other areas, however, the impact is more direct. Catholic Manila has, since 2000, had a legal prohibition against the distribution of contraceptives at all health clinics that receive municipal funding.²¹⁵ In Honduras, a 2009 Supreme Court ruling banned all distribution of emergency contraceptives – and a great many other Latin American countries have "regulation that is not uniform",²¹⁶ as emergency contraceptives are still often believed to be

***** Polygyny is the form of polygamy that specifically refers to unions in which there is one man and more than one wife.

abortifacients^{§§§§§} – even by providers. Similar religious barriers are seen in Africa, where 20% of the population is Catholic; in Uganda, women who attended church-funded clinics were found to be less likely to use modern contraceptive methods than those who attended other types of clinic.²¹⁷

Whether direct or indirect, the impact that religious values have on contraceptive use in some countries is marked. Across sub-Saharan Africa, from Ghana to Lesotho to Tanzania, between one-quarter and one-half of women report that their religion negatively impacts their contraceptive use.²¹⁸ In Pakistan, almost 30% of women report that they do not use contraception because conception is “up to God” (2007 data); and in Bangladesh, nearly 12% of women under the age of 30 report that their religion prohibits the use of contraceptives (2007 data). Religious beliefs matter to men too. In Pakistan, more than one-quarter of all men report that their religious beliefs prevent them from using contraception (2007 data).

3.4 Cognitive barriers

Kenyan mother

“... how can I talk about sex to my own daughters? It is not possible. I am a Christian.”

Kangara, 2005

Many adolescents have little understanding of reproduction. They often do not understand how their bodies work, how pregnancy occurs, how to prevent pregnancy, or where to get contraceptive supplies.²¹⁹ They tend to rely on “rumours” and myths spread through peer networks, and have more mis-information than they do facts.²²⁰ This is reflected in the rates of unplanned and mis-timed pregnancy—which, while lower than the rates of planned pregnancy, are unnecessarily

high. In sub-Saharan Africa, data indicate that at least one in three adolescent pregnancies were unplanned or mis-timed²²¹ – ranging from a low of 10% in Niger to a high of 80% in South Africa.²²² In Central America, figures ranged from one-third to one-half.²²³ Premarital sex and pregnancy is less common in Asia, though evidence suggests that it is becoming more common.²²⁴

3.4.1 Sex education at home

Evidence indicates that in many cultures, parents provide little sexuality education, as they “feel uncomfortable to give sexual training to their children and teenagers”.²²⁵ The situation is complicated by the fact that many parents never received adequate information regarding sexuality and reproduction themselves, and are thus unable to teach their children.²²⁶ The end result is that many teens do not rely on their parents for information. In Iran, for example, adolescents ranked their parents and families in last place as a source of sexual information.²²⁷ This was also true in Nigeria²²⁸ and Ethiopia.²²⁹ There is evidence that girls are particularly unlikely to turn to their parents for information on sexuality. In the Amhara region of Ethiopia, while few teens reported that their parents gave them information, girls were significantly less likely than boys to turn to their parents (1.3% versus 4.4%).²³⁰

In part, this reflects cultural taboos about discussing sexuality cross-generationally.²³¹ “Our background as Africans dictates that you don’t talk about sex at home.”²³² It is also, however, driven by a mistaken belief that teaching children and teenagers about sexuality will encourage them to experiment at a young age.²³³ This can lead parent-led conversations to focus on stigmatising themes,²³⁴ creating “an atmosphere of fear, shame, and embarrassment among young people, thereby inhibiting their attempts to obtain the information and services they need”.²³⁵

African adolescent girl

“Talking to elders about it (sex) is not possible, so I usually get my information during discussions with friends from my group and also from the radio.”

Boileau et al, 2008

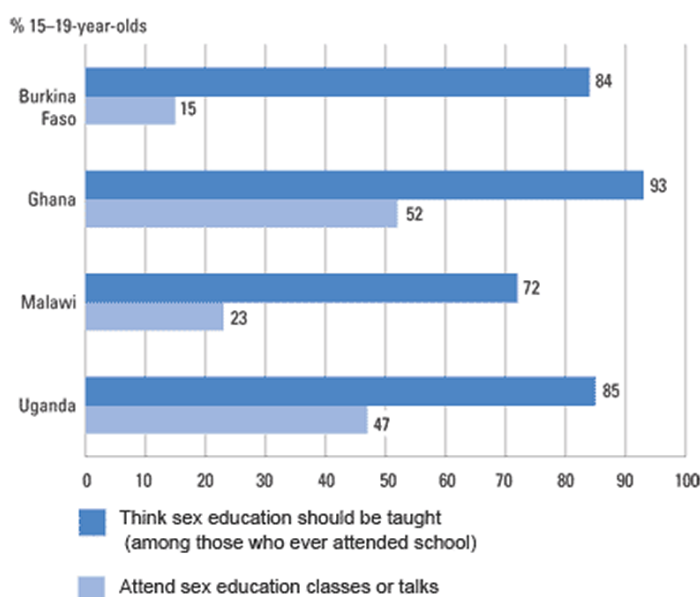
§§§§§ Abortifacients are substances which cause the abortion of an established pregnancy. Mifepristone (RU-486) is a common modern medication used to induce abortion.

3.4.2 Sex education at school

School-based sexuality education is, on average, wanted and well-liked by adolescents.²³⁶ As Figure 28 shows, the vast majority of adolescents in four sub-Saharan African countries support having sexuality education as part of the school curriculum, though less than a third have actually had a class.²³⁷ Furthermore, despite the fact that adults worry that explicit information will encourage early sexual activity, young adolescents believe that this is not the case.²³⁸

Implementation problems often interfere with the effectiveness of sexuality education at school. Even in countries with laws mandating such education, the roll-out is slow and quality can be low.²³⁹ In India, since 2007, six states have banned the co-curricular sex education programme that had been implemented in 150,000 schools across the country – a worrying development given that less than 20% of Indian teens were aware of at least one method of contraception.²⁴⁰ Another study revealed that non-specialist teachers found the subject uncomfortable and avoided it.²⁴¹ In Nigeria, there are also concerns about the timing of sexual education, which is taught at both the junior secondary and senior secondary level. However, students enrolled in JSS had more unintended pregnancies than older students, suggesting that even waiting till junior secondary school is too late.²⁴² This is echoed by Biddlecom *et al*, who note that in Burkina Faso, for example, less than one-third of girls aged 12–14 are enrolled in school – meaning that school-based sexuality education would miss the majority of girls unless it was delivered in primary school.²⁴³

Figure 28: Teens who think school-based sex education is a good idea versus those who have had such education



Source: Boonstra, 2007

The tone and content of sex education classes can also be problematic. Teachers are often embarrassed and poorly prepared.²⁴⁴ This leads many adolescents to conclude that classes are “too technical, negative and moralistic”, leaving them to get information from peers and the media instead.²⁴⁵ In Ghana, for example, the ABC (‘abstinence’, ‘be faithful’, ‘condoms’) campaign has emphasised abstinence over other family planning methods. This has resulted in “lacunae among sexually active youth in their familiarity with the available tools that can be used for adequate protection”.²⁴⁶ Girls are particularly disadvantaged in co-ed sex education classes; they become shy and quiet, out of fear that the boys will tease them.²⁴⁷ Out-of-school adolescents, who are more likely to be female and older, have even more limited access to

accurate sex education, with those in Uganda noting that they get “information on sexuality through ‘rumours’”.²⁴⁸

Ecuadorian teacher

“... if they teach those issues at school, students will know how to protect themselves and they will go out and have sex with everybody”.

Goicolea, 2009

Latin American girl, gave birth at 15

“We had a sexual education class. They told us that if we had unprotected relations we could get AIDS, sexually transmitted diseases... but no one explained to us why. They always explained everything as taboo.”

Näslund-Hadley and Binstock, 2010

Kenyan teacher

“I think we should let young people talk about these things among themselves because personally, I cannot talk about sex to young people.”

Kangara, 2005

3.4.3 Content of adolescents’ knowledge

Adolescents’ lack of information about reproductive health and sexuality often leads to problematic misunderstandings. In the Amhara region of Ethiopia, for example, while nearly all teens knew that unprotected sex could lead to HIV infection, less than 45% knew that pregnancy could also result.²⁴⁹ Similarly, in Central America, almost one in three adolescents did not know that pregnancy could occur the first time a girl had sex.²⁵⁰ This ratio is similar to that found in India, where one in four girls did not know that pregnancy could occur mid-cycle, and many girls did not know that a missed period could signal pregnancy.²⁵¹ This could explain why studies have found that, on average, teens do not begin using contraception until one year after they become sexually active.²⁵² Another factor can be seen in several sub-Saharan African countries, where adolescents were very likely to report that they did not know where to obtain contraceptives.²⁵³ In India, girls were particularly limited “in accessing advice about contraception and sexual health, with 57.6% of males stating they have good access to advice they need compared to only 39.3% of females”.²⁵⁴

Even when teens know about conception and contraception, their information can best be described as fragmented.²⁵⁵ For example, in a study of four sub-Saharan African countries, it was found that less than one-third of teens, and less than 10% of Burkinabe teens, had a level of knowledge that was detailed enough to prevent pregnancy.²⁵⁶ Similarly, a Ugandan study found that a third of male teens, and half of female teens, did not know that condoms can only be used once,²⁵⁷ while in Malawi, only a quarter of sexually active girls had all the key facts on correct condom use.²⁵⁸ Biddlecom *et al* reported that less than half of boys in their study in Ghana knew that girls had a fertile phase.²⁵⁹

Indian girl, married at 17

“I used to take family planning pills, but irregularly. I had fear that after taking those pills, I will become infertile and no one will look after me...”

Sethuraman *et al*, 2007

In Nigeria, a study on unmet reproductive health needs found that three times more adolescents knew where to get contraceptives than were willing to use them – fear being the primary barrier to use.²⁶⁰ Adolescents reported concerns that condoms could come off, get stuck, and damage a woman’s reproductive system²⁶¹ (see box below for a discussion on condom use). Others were concerned that hormonal contraceptives permanently reduce women’s fertility, and were even capable of causing sterility or death.²⁶² In Lesotho, for example, 25% of young female respondents believed that contraception caused cancer.²⁶³ In Nigeria, more than 40% of youths thought that the chemical in contraceptives could damage

reproductive systems.²⁶⁴ Mis-information given by adults can also magnify adolescents' fears. In South Africa, for example, preachers reportedly told girls that contraceptive use "punctures and spoils the eggs", and mothers apparently refused to allow their daughters to use birth control for fears that they would become permanently sterile.²⁶⁵

Two females in Malawi

"When we get sick because of using pills, at the hospital we are told that the pills have clotted in the intestines and in the uterus and the organs are rotting."

"If a man sleeps with a woman who is taking contraceptives, its power renders him weak (impotent)."

Chipeta et al, 2010

Many adolescents do not believe that modern methods of contraception are effective. This may be due to the fact that teens have failure rates significantly higher than those of older women. In part, this is because teens use less effective methods than older women – condoms instead of tubal ligation, for example. The fact that "contraceptive methods are available at health facilities but without adequate information" also significantly impacts effectiveness.²⁶⁶ Another key observation, however, is that women who are less than 100% committed to contraceptive use are more prone to incorrect use. As one

study notes, "Women who have mixed feelings about oral contraceptives are prone to using them inconsistently, and inconsistent use can in turn exacerbate negative feelings by increasing the likelihood of irregular bleeding."²⁶⁷ Cognitive barriers to contraceptive use are clearly multi-layered, interfering even with the efficacy of those adolescents who have sought them out and are using them.

Box 2: Condom use

Given the misinformation and fear that many adolescents in the developing world have about hormonal methods of contraception, condoms would seem to offer a practical way for young women to reduce the risk of pregnancy. Evidence, however, indicates that uptake is far from universal. In South Africa, slightly less than half of all young women, and slightly more than half of all young men, report having used a condom the last time they had sex (Burgard and Kusunoki 2009). Less than one-third of young women report consistent use.

There are several reasons why young women use condoms less than young men. First, age-disparate relationships reduce use. Overall, similarly aged partners have been found to use condoms about 2.5 times more than partners with an age gap of five years or more (Bankole *et al*, 2007). Second, long-term relationships in general, and marriage in particular, reduces uptake (Evans 2009; Burgard and Kusunoki 2009).

Due to the high incidence of HIV in Africa, condom use is often associated with disease prevention rather than pregnancy prevention (Burgard and Kusunoki 2009). This leads men to either mistrust women who ask them to use a condom – or to blame women for mistrusting them (Marston and King 2006). As women in one Nigerian study noted, if a woman asks her partner to use a condom, then "he might suspect her of promiscuity, which could lead to negative repercussions for her" (Nigerian Urban Reproductive Health Initiative (NURHI) 2011, p 6).

As mentioned earlier, given adolescents' tenuous knowledge and inconsistent contraceptive use – as well as their particular vulnerability to coerced sex – many have a real need for emergency contraceptives. This form of contraception, which can be taken up to five days after unprotected sex, prevents conception by delaying ovulation. However, while post-coital options have the potential to expand adolescents' contraceptive options, very few adolescents even know they exist, much less how they work and where to get them from. For example, in a study on contraceptive knowledge among teens in Angola, Freitas found that only 2% had heard of emergency contraception.²⁶⁸ Similarly, in their study of female adolescent street-hawkers in Nigeria, Attahir *et al* found that less than 1% knew about emergency contraceptives, and of those, none had correct knowledge about how they worked.²⁶⁹ Finally, in a population of teen mothers in South Africa, Ehlers found that while a quarter knew about emergency contraceptives, only 10% knew that they actually prevented pregnancy.²⁷⁰ Even providers often misunderstand the details of how emergency contraceptives work,²⁷¹ confusing them with mifepristone, which causes abortion. However, emergency contraceptives, unlike

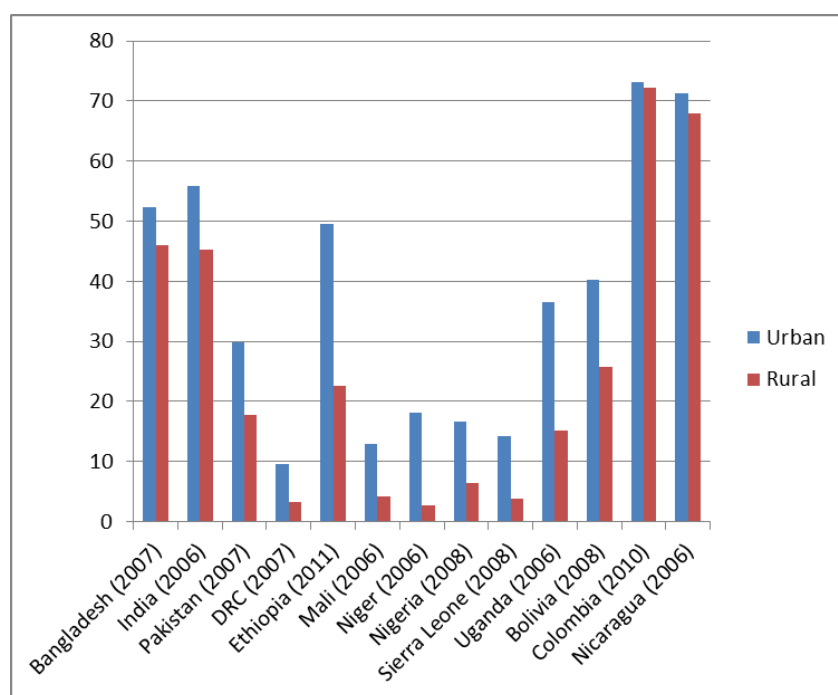
“abortion pills”, do not interfere with embryonic development and will not cause the abortion of an established pregnancy.²⁷²

3.5 Geographic barriers

Geographic inaccessibility to contraceptive services is clearly critical – knowledge without access is ineffective. However, the relationship between access and location is complex. While urban women tend to have better access to reproductive health services and contraceptives than rural women, urban adolescents often struggle with lack of access due to socio-cultural factors, many of which we discussed in the preceding sections.

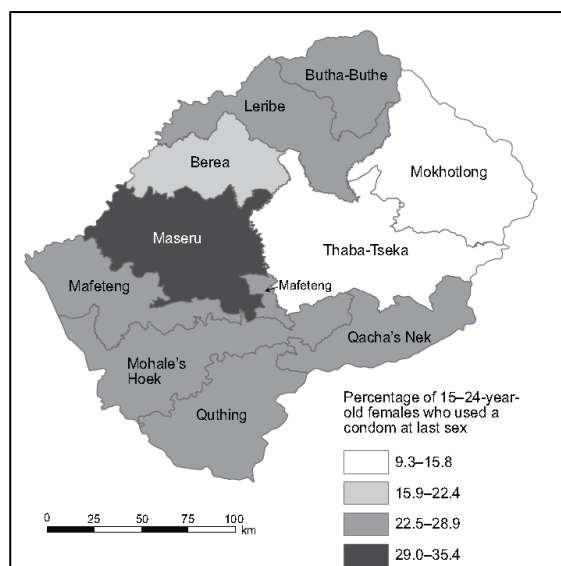
Irrespective of their age, women who live furthest from clinics use contraceptives less than those for whom access is more convenient.²⁷³ From Myanmar to Ghana to Bolivia, ease of physical access to family planning clinics matters.²⁷⁴ As Figure 29 shows, while India, Bangladesh, Colombia and Nicaragua are closing the gap, the rural-urban divide remains acute across sub-Saharan Africa, as well as in Pakistan and Bolivia.

Figure 29: Women's use of modern contraceptives, by residence location



Source: DHS data

Geographic access varies considerably, however, even within countries. For example, in countries that are only just beginning to use modern contraceptive methods, such as Mali, urban areas have the first and best access to contraceptives.²⁷⁵ In other countries – Nigeria, for example – geographic access to contraceptives is limited for whole regions (the Islamic north in this case), though admittedly this is as much because of cultural reasons as geographic reasons (see Figure 30).²⁷⁶ Often considered too young to need contraceptives, adolescents face an added burden of access. In Ethiopia, for example, three-quarters of teens in the Amhara region reported that clinics were too far for them to conveniently use.²⁷⁷ Embarrassment and fear of being found out can mean that even those in urban areas with good access “prefer to receive care in facilities away from their own neighbourhoods”.²⁷⁸

Figure 30: Young women's use of condoms at most recent sex, Nigeria, by region

Source: Weiner, 2010

Married girls have “far more constrained access to medical care compared to unmarried girls”.²⁷⁹ In a study on the experience of married adolescents in Northern Nigeria, they were more likely to be concerned about distance, privacy, and permission.²⁸⁰ In Burkina Faso, Population Council research found that young brides were “constrained by time, limited mobility, and lack of access to health centres”.²⁸¹ Female sequestration is a problem in many countries. In Afghanistan and Pakistan, for example, women who are isolated at home often lack access to both contraception and education.²⁸² This isolation is not merely a rural phenomenon; in Nigeria, affluent, urban men “increasingly reinvent it [purdah] as a symbol of elitism and as a means of insulating their wives”.²⁸³

3.6 Economic barriers

Given that teens in developed countries often complain that contraceptives are too expensive, it should come as no surprise that those in developing countries frequently cite cost as a significant barrier to consistent use.²⁸⁴ Adolescents “frequently lack their own source of income or control over their finances to be able to afford contraceptives”.²⁸⁵ Married girls are again even more disadvantaged, as “girls are financially dependent on their husbands and therefore lack the power to make demands upon them... Ultimately, they cannot leave because they cannot repay their high dowry.”²⁸⁶

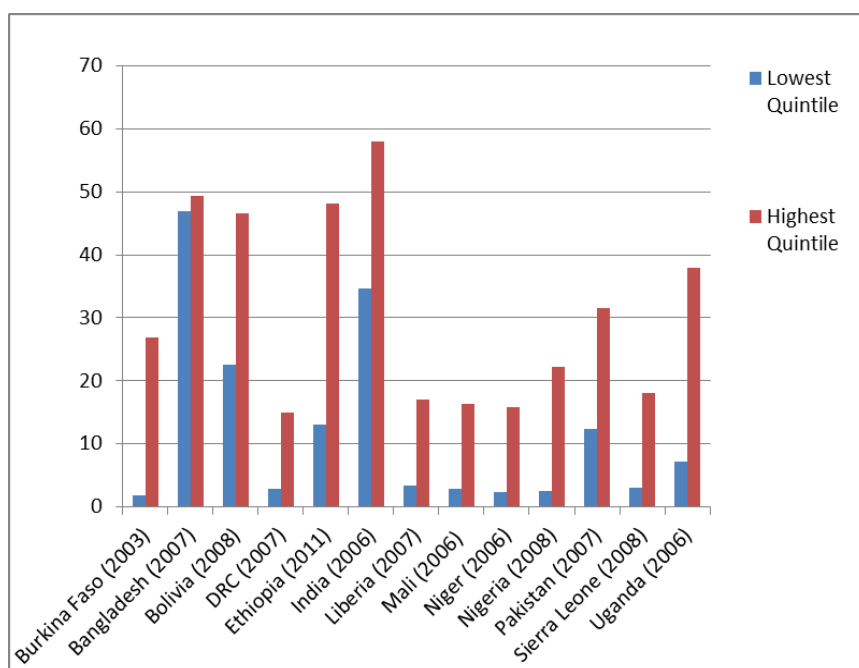
Adolescents may be particularly vulnerable to costs related to both distribution venue and specific methods. Public versus private sector distribution has important ramifications for the costs of contraceptives.²⁸⁷ As more countries move towards private distribution systems, the poorest people may have greater difficulty acquiring contraception, which is a cause for concern. Nanda *et al* note that in South Africa, this is a problem for the distribution of emergency contraceptives, which are available at pharmacists, but are not, as a dedicated product, available at public facilities: “cost seems to be a barrier and it is difficult to convince stakeholders of its importance” to the public sector.²⁸⁸

Adolescents may be particularly susceptible given that their need for privacy may encourage them to purchase contraceptives in private shops rather than be seen in public clinics. In Ghana, for example, a privately purchased three-pack of condoms – the least expensive form of contraception – cost more than the minimum daily wage.²⁸⁹ In Nigeria, the pill (when

purchased at a pharmacy) can cost up to \$19.50 a year, which is nearly 8% of individual annual income.²⁹⁰ There are also method-specific cost concerns. Adolescents are particularly likely to use short-term methods, such as condoms (DHS data). While these methods may be the least expensive in terms of cost per use, they are actually the most expensive in terms of cost per couple-year of protection,*****²⁹¹ which may partially explain why teens are so inconsistent about contraceptive use.

It should be noted that poverty is a powerful predictor of contraceptive use for married women, regardless of their age. While disaggregated statistics are not available for adolescents, as Figure 31 shows, in almost all countries, the poorest women have lower rates of contraceptive use than the wealthiest women. This problem is particularly acute in countries in which contraceptive use is nascent. It is important, however, to understand that these differences do not imply that cost itself is necessarily a barrier to use. The poorest women also have less demand for family planning. On average, they have less education, are more likely to live in rural areas, and are more constrained overall by the socio-cultural disadvantages mentioned above.

Figure 31: Married women's use of modern contraceptives, by wealth quintile



Source: DHS data

***** Cost per couple-year of protection (CYP) is a measure of the cost of preventing pregnancy during one year for one couple.

3.7 Administrative barriers

Ugandan local leader

"Safe motherhood is entirely for grown-up women, and this leaves behind the adolescents."

Sekiwunga and Whyte, 2009

Public clinic provider, South Africa

"Sometimes you won't even mention [EC], like, say you look at the client and she is 18 years old – so you'd rather not mention it because you are trying to make them use a condom so that they won't come back with HIV."

Nanda et al, 2009

There are a variety of administrative barriers to adolescents' use of contraception. Some of these are at the clinic or service delivery point level. For example, adolescents may find the clinics' opening hours inconvenient, want separate hours just for teens, or prefer walk-in appointments.²⁹² Wait times at clinics are often long, which many adolescents report as difficult for them. Furthermore, many providers are reluctant to provide contraceptives to adolescents, believing that to do so would encourage early sexual activity (this is discussed in more detail below).²⁹³

In many places, service links at clinics appear to be very weak. Rwandan women reported that when they are at clinics for other healthcare services, few providers spontaneously bring family planning into the conversation.²⁹⁴ Given the overlapping nature of the causes and solutions, and the large funding stream aimed at HIV, the links between HIV-related care and family planning are particularly weak.²⁹⁵ In fact, there is evidence in South Africa that providers are reluctant to mention emergency contraception to adolescents because they perceive it to lower girls' use of condoms.²⁹⁶

Furthermore, the forms of readily available contraception in some countries are not appropriate for adolescent use. In India, for example, family planning policies, messages and clinics emphasise female sterilisation, which alone accounts for 85% of "modern" contraceptive use.²⁹⁷ As a permanent method, the procedure is not appropriate for adolescents who merely wish to delay their first pregnancy. This, in large part, accounts for the fact that "only a third of Indian adolescents who wish to practice contraception are able to do so".²⁹⁸ Adolescents in other countries wishing to delay their first pregnancy face similar barriers. Where family planning is "geared to women who already have children, there is little opportunity or even acceptability, for newly-weds to access contraceptive services".²⁹⁹ In Burkina Faso, for instance, even where contraception was well accepted as a means to space children, providing it to women without a "socially accepted sexual life" was not viewed positively.³⁰⁰ Finally, many clinics find it difficult to keep contraceptive supplies in stock, which makes it difficult for young people to acquire them.³⁰¹

There are also real and perceived legal restrictions, based on age, parity and marital status, that make it difficult for teens to obtain reproductive care. In Indonesia, for example, legislation explicitly targets family planning services towards married couples.³⁰² In Honduras, the Supreme Court recently upheld a law that bans emergency contraception – even in the case of rape. In Manila, as mentioned earlier, municipal clinics have been barred since 2000 from offering family planning services. The Supreme Court recently refused to hear a case in which a group of poor women sued the city over their lack of access to contraceptives.

These real legal barriers are joined, particularly in the minds of adolescents, by a host of perceived legal barriers. In Zambia, for example, all sexually active women and men, regardless of age or marital status, are allowed access to contraceptive services and information. However, in practice young people have restricted access because they do not understand the law. Similarly, in Tanzania, teens who had had an abortion thought "that only pregnant women or women who had given birth in the past were allowed to attend family planning (FP) clinics".³⁰³

There are barriers to funding as well. For example, the United States President's Emergency Plan for AIDS Relief (PEPFAR), one of the largest donors for the health sector in sub-Saharan African countries, focuses narrowly on abstinence, and does not fund programmes that

distribute condoms in school or to students under the age of 14.³⁰⁴ Programmes targeted at adolescents are not unique in facing funding barriers. Global funding for family planning has “halved since 1995: from US\$ 723 million in 1995 to US\$ 338 million in 2007”.³⁰⁵ A 2010 survey designed to assess the integration of community-based family planning into local maternal and child health programmes found that funding was a critical barrier, impacting the supply of commodities as well as staffing.³⁰⁶

3.8 Barriers related to quality of care

South African nurse

“It’s her secret, and it’s a scandal for nurses to know.”

Wood and Jewkes, 2006

Finally, barriers related to quality of care are also of significant concern. For many healthcare providers, “[sexual and reproductive health] SRH-care is scarcely addressed, communication training is not given, neither are medical ethics and attitudes discussed”.³⁰⁷ This lack of training appears obvious to adolescents seeking family planning products and information, and is their main concern with regard to quality of care.³⁰⁸ In Kenya, Lao PDR and Zambia, almost half of providers indicated that they were unwilling to provide contraceptives to adolescents.³⁰⁹ In Uganda, most providers were unwilling to provide contraceptives to young people, though short-acting methods were seen as acceptable for married teens.³¹⁰ Girls in South Africa reported that providers’ attempts to scold and stigmatise them often deterred them from seeking care.³¹¹ Similarly, in Malawi, nearly 20% of girls said that their privacy was not respected or that they were treated badly when they were trying to access contraceptives.³¹²

Lack of provider *knowledge* – rather than attitudes – is particularly glaring for emergency contraception. As one South African informant notes, “While the contraception market is consumer driven, the marketing of emergency contraception would need to be aimed at health care workers” who, in some settings, remain largely ignorant of its existence.³¹³ For example, healthcare providers who deal with post-exposure HIV prophylaxis for survivors of sexual assault “had not been trained in EC provision because they were considered to be working outside of ‘contraception provision’”.³¹⁴

4 Conclusions

Reducing adolescent pregnancy requires urgent policy attention, but attention that is also balanced. On the one hand, as McQueston *et al* note, donors and governments “should adopt a rights-based approach to adolescent fertility and shift their focus from the proximate to distal causes of pregnancy, including human rights abuses, gender inequality, child marriage, and socioeconomic marginalization”.³¹⁵ They, and others, correctly observe that where progress has been made on these fronts, fertility has tended to fall naturally. On the other hand, as Cleland *et al* point out, “reductions in fertility in almost all poor countries have happened in the presence of comprehensive family-planning programmes”.³¹⁶ Our review of the evidence on adolescent fertility and family planning needs suggests that a two-pronged approach is necessary. Such an approach would seek to empower girls and shift social institutions while also promoting an environment which, from local communities to international donors, enables and supports access to contraceptives for all, whether adolescent boys and girls or adult men and women.

For Kabeer, empowerment is “the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them”.³¹⁷ In this vein, empowering girls and women presents several unique challenges. First, as Malhotra observes, the family itself is the central locus of girls’ disempowerment. While the broader culture and social institutions work to constrain girls’ options, the family most often serves as the first and most significant mediator for their impacts on girls’ lives.³¹⁸ Second, while empowering any group requires transforming institutions, empowering girls and women requires reworking the patriarchal structures that permeate society.³¹⁹

The barriers girls face in controlling their fertility are many and varied; they are intertwined, and inexorably steeped in these patriarchal gender relations. Solutions are similarly complex. There is a need for multi-faced strategies that enable and encourage girls to chart their own futures, and choose motherhood only if and when they are ready. We set out our recommendations to achieve this in the table that follows, in Section 5. With few exceptions, these strategies are closely interlinked, often serve multiple purposes, and are not necessarily focused on fertility. However, they are rooted in the recognition that girls’ ability (or lack thereof) to make decisions about when or if they become mothers is highly dependent on how girls view their position in society – and how society in turn views them.

Socio-cultural shifts, for example, are required in order to view girls as more than vehicles for reproduction. Harmful traditions that encourage child marriage, condone gender-based violence, and place girls in the untenable position of being solely responsible for the outcome of sexual activity – while lacking the decision-making power to control it – need to be ended. Girls need to be educated for their futures as independent, economically productive members of society. They need to understand their legal rights, and be given spaces where they can practice speaking up to claim those rights. At the same time, boys and men need to be brought squarely into the middle of these transformations, so that they have a vested interest in ensuring that their wives/ partners and daughters will live in a world different than that of their mothers and their grandmothers. Finally, given that fears and concerns about different contraceptive methods are widespread, all adolescents – not just girls – need accurate information and practical knowledge about reproduction and contraception, and access to the methods they choose.

To complement this critical long-term approach, we also need “quick-win” strategies. Cultural shifts take time – time that the millions of adolescent girls at risk for pregnancy this year do not have. Having allowed family planning budgets to shrink and rhetoric for teens to focus on abstinence, the international development community urgently needs to understand that in the developing world, adolescent pregnancy is heavily driven by child marriage. Advocating abstinence in this context is misguided and the evidence shows that it is rarely effective in bringing down adolescent fertility rates. Given that “money talks”, particularly in terms of national budgets, there is a need for stronger advocacy to heighten awareness around the

developmental value of investing in girls' empowerment. Evidence suggests that "the proportion of people living in poverty in 45 countries would have fallen by a third if the crude birth rate had decreased by five per thousand in the 1980s".³²⁰ Keeping girls in school pays even more. For example, it is estimated that the Asia-Pacific region alone is losing more than \$30bn a year as a result of gaps in education.³²¹ Communities and families, on the other hand, care about the faces around them – and yet most are unaware that early childbearing is dangerous for mothers and babies.³²² Clearly, investments in community education are also urgently needed.

5 Recommendations

In order to chart their own futures and choose motherhood only if and when they are ready, girls need to be empowered along five key dimensions. In this final section of the report, we identify key policy and programme measures that could help support girls' empowerment in these five areas, highlighting quick-win opportunities as well as a number of good practice examples from developing countries. Additional details about empowerment opportunities and good practice examples from existing programmes can be found in Table 1 in Appendix 2.

1. Socio-cultural empowerment

To empower girls to make their own reproductive decisions, there is a need for fundamental cultural shifts, including most importantly around the following:

- **Child marriage** must be urgently tackled, as it risks locking adolescent girls into relationships in which they have limited voice to shape their reproductive health choices and which may also subject them to gender-based violence. Programmes supporting parents to cover schooling costs, and incentivising girls with longer-term rewards for completion, have significantly reduced the incidence of child marriage. There is solid evidence that such initiatives are affordable and feasible, even in low-income contexts.
- Other harmful traditions that limit girls' value to reproduction demand urgent and more strategic programme attention. These include: **son preference**, which encourages early and higher fertility; **dowry**, which encourages parents to invest in girls' marital futures rather than their education; and **lack of inheritance rights**, which deprives girls of productive assets and leaves them economically dependent on their husbands/ partners.
- As part of this process, we must **rework the gender stereotypes that underpin sexual relationships** so that men see girls and women as more than objects of sexual gratification, and girls and women are able to refuse sexual relations. This longer-term goal will require diverse programming that includes altering the gendered images to which children are exposed and developing initiatives for boys in which they learn about gender equality and "new masculinities".

Quick win

Recognising that attitudinal changes about family planning are among the most difficult to effect, it is vitally important that whole communities are targeted. Evaluation evidence indicates that the participation of religious and community leaders is required and large-scale media campaigns can be useful. Interventions must be culturally sensitive and designed around local norms, but convey two key messages: 1) pregnancies that are too early are dangerous; and 2) pregnancies that are too closely spaced are dangerous. Where communities can learn that both mothers and babies have better short-term and longer-term outcomes, they are less likely to encourage early childbearing.

Source: Nazeer and Taylor, 2011; USAID, 2005a, 2008; Sethuraman et al, 2007; Erulkar and Muthengi, 2007

Good practice example

Ethiopia's *Berhane Hewan* ("Light for Eve") works with communities to delay girls' marriage. Girls are offered fee waivers, school supplies, small cash payments, health and reproductive training, and access to mentors in exchange for continuing their education and delaying marriage. Community education programmes engage leaders and parents in dialogue about the impacts of harmful practices, such as child marriage and FGM. Rigorous evaluation has shown extremely positive impacts.

Source: Erulkar and Muthengi, 2007

- As the sexual transition unfolds, and marriage and sexuality become increasingly disconnected, **behavioural change communication initiatives** also need to address cultural attitudes (including those of service providers) which place the social burden/stigma of sexual activity on girls alone. Boys and men's responsibility for reproduction needs to be acknowledged, as do girls' attempts to deal maturely with their sexuality.

2. Educational and economic empowerment

In order for girls and women to be seen as actors beyond their reproductive capacities, educational and economic empowerment is vital. Interventions need to support girls and young women to make contributions to their families and communities that move beyond the traditional domestic sphere, as follows:

- **Girls need to be prepared with a solid education through secondary school** to increase their intra-household bargaining power and enable them to make their own reproductive decisions. This will involve ensuring that the youngest girls start school on time – so that they do not reach “marriageable age” before they finish primary school – as well as ensuring that young mothers have a chance to combine parenthood and education. Demand-side programmes such as cash transfers and school feeding schemes have proven successful in keeping girls in school in diverse middle- and low-income countries.
- Adolescent girls also need **access to vocational training and credit** to allow them entry to the job market and to increase their capacity to earn and control an independent income. Girls need specific skill sets, including computer literacy and financial education, and entry into savings schemes. Existing programmes have helped younger girls delay marriage and increased the earnings of working girls.

Quick win

Where the appeal of increasing girls' and women's power is limited by tradition, economic messages often have more immediate impact. Behavioural communication change efforts need to work with messages such as “each extra year of schooling your daughter receives can boost her wages up to 20%”. Governments can also be targeted with messages about the positive spill-over impact of girls' education on GDP.

Source: World Bank, 2011; UNFPA, 2005; Esteve-Wolart, 2004

Good practice example

The Female Stipend Programme in Bangladesh was begun in 1994. Targeting rural girls aged 11–14, the programme provides a stipend for those who 1) stay in school and pass exams, and 2) delay marriage until the age of 18. The stipend is paid directly to girls, increases with their grade level, and is sufficient to cover all educational expenses. It currently reaches 2.3 million girls a year and has been the driving force behind the fact that it only took Bangladesh 15 years to achieve gender parity in lower secondary school.

Source: Lloyd and Young, 2009; Grown, 2006; Herz and Sperling, 2004

3. Interpersonal empowerment

Space for girls within their natal families to voice their own opinions – and have them heard – is critical. Girls also need support to exercise agency in their marital families/sexual relationships, including the right to refuse sex, the right to use contraception, and the right to space pregnancies.

Good practice example

Tuseme, a programme started by the Forum for African Women Educationalists, uses drama and other creative means to help girls learn to identify and solve problems in their lives. Across sub-Saharan Africa, 80,000 children have benefited from the programme, which teaches girls negotiation skills and gives them a safe space to practice speaking out for what is important to them.

Source: Lloyd and Young, 2009

- Girls' rights to refuse marriage and demand education need to be recognised by the adults in their lives. To help girls become comfortable speaking out, access to **safe spaces** with strong networks of peers to support them and mentors to inspire them is critically important. Throughout the developing world, girls' clubs have had remarkable success in helping girls to help one another, with some girls even seeking out local magistrates to help their friends delay marriage and stay in school.
- Joint decision-making about family planning is key, and needs to be supported by **behavioural change communication** efforts so that couples learn to negotiate sex and contraception, recognising them for what they are – areas of joint responsibility. Adolescent girls' clubs have been successful at strengthening girls' resolve regarding these discussions; other programmes have jointly targeted husbands and wives.

4. Legal empowerment

Legal harmonisation is required to reduce inconsistencies between national laws and international standards, especially those regarding children's rights.

- A necessary though admittedly insufficient first step is **enacting laws that will prevent the worst abuses of girls' rights**. Specifically, laws need to recognise girls' rights to: education, freedom from violence, refuse child marriage, and use contraception.
- Existing laws recognising girls' rights also require active **enforcement and monitoring**, including eliminating exceptions for religious law or local custom, which often undermine girls' legal empowerment.
- **Human rights education** is essential in order to raise awareness among girls about their rights and options. This will enable them to know when their rights are being violated, and potentially encourage them to report violations.
- At the same time, **boys and men need to be taught about human rights and how they apply to the girls and women in their lives**. They specifically need to learn to recognise that freedom from sexual coercion and control over fertility are inviolable rights for all people.
- **Adolescents require full legal access to contraceptives**. In places where custom or law makes it difficult for teens to acquire contraception, legal codes must be altered and related community education campaigns undertaken.
- To lead on effective legal enforcement, healthcare professionals and other community leaders require tailored information and capacity strengthening opportunities, as well as the provision of professional incentives.

Good practice example

In effect since 2007, the South African Children's Act gives children over the age of 12 full rights to reproductive healthcare, including access to contraceptives, information and HIV testing. The Act states that all people must sell condoms to children over the age of 12, as well as tell them where they can obtain free condoms. Furthermore, it allows schools to distribute condoms free of charge to all students over the requisite age and grants all children, regardless of age, the right to access health information.

Source: Han and Bennish, 2009

5. Practical empowerment

Finally, many adults – parents, teachers and healthcare providers – are uncomfortable with adolescent sexuality; this significantly impacts the information that adolescents have at their disposal to make good decisions regarding their fertility. In order to address these information deficits, the following actions are urgently needed:

- It is vital that adolescents be given practical knowledge about reproduction and contraception. Appropriately timed, school-based **sex education**, which can delay sexual debut and increase contraceptive use, is a necessity. Community-based clinics, which can target even out-of-school teens as well as offer family planning as part of an integrated care plan, are also critical.
- Adolescent access to contraceptives is limited by both geography and cost. Teens are also deterred by their own embarrassment and providers who stigmatise their behaviour. A variety of programmes, from **vouchers that provide free SRH care, to door-to-door health providers that target girls isolated at home** have shown a positive impact on contraceptive uptake.
- Given the high rates of coerced sex – and the limited availability of safe abortion – greater effort needs to be made to make girls and healthcare providers aware of **emergency contraception**. Community awareness programmes built around media campaigns and peer educators have proven effective in “getting the word out”. Training pharmacists in provision has also been successful.

Good practice example

In Nicaragua, a programme distributed nearly 30,000 vouchers, good for free SRH services, to poor adolescents, at schools, markets and going door-to-door in disadvantaged neighbourhoods. More than half of sexually active girls redeemed their vouchers for contraceptives, STI treatment, counselling, and pregnancy testing. Evaluation showed that girls’ odds of seeking care nearly doubled under the programme.

Source: Meuwissen et al, 2006a, b, c

- ¹ WHO, 2012c
- ² WHO, 2012c; WHO, 2008b
- ³ WHO, 2012c
- ⁴ WHO, 2008b
- ⁵ WHO, 2012a
- ⁶ *Ibid*; WHO, 2008b
- ⁷ World Bank Data, 2012
- ⁸ WHO, 2012a
- ⁹ WHO, 2012b; Conde-Agudelo *et al*, 2004; Patten *et al*, 2009
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Annex 1: Methods and data

A.1 Sources and methodology

This report is based on an in-depth review of secondary literature. Online databases were used to identify the key literature. Search terms were built into a matrix that took into account age, geography and subject. For example, age was captured with "adolescent", "teen", "teenaged", "early" and "young". Geography was used to compensate for the fact that the United States is over-represented in the teen pregnancy literature – and included terms for region, such as "Africa" and "South Asia", as well as country-specific searches for those locations which DHS data indicated had very high adolescent fertility rates, such as Nigeria and Pakistan. Subject search terms ranged from "pregnancy" to "contraception" to "marriage". The literature on adolescent pregnancy is vast. While every attempt was made to do inclusive searches, it is beyond the scope of this paper to thoroughly review the entire body of work. Specific omissions were unintended.

Data, except where otherwise indicated, are from the DHS database.³²² Where country reports were utilised, the year is noted. Where some, but not all, countries in a region were chosen for presentation, it reflects either the age of the data, the magnitude of adolescent fertility, or the country's overall impact on regional population growth. Where countries are omitted in specific graphics and discussion, it reflects lack of data.

A.2 Data limitations

While DHS datasets are rich and valuable, covering a plethora of issues, establishing longitudinal trends and enabling comparative understandings, they are somewhat limited for the purpose of studying adolescent pregnancy.³²² First, the surveys do not include adolescents younger than 15, who represent a sizeable minority of mothers in some countries. Their experiences are effectively lost. Second, and far more importantly, where adolescent girls are disaggregated from "all women of reproductive age", they are

lumped together in a single category – teens aged 15 to 19. This leaves researchers with no ability to ascertain differences and identify patterns between and among different cohorts of adolescents. Given the biological, emotional and social growth that takes place during adolescence, this aggregation is highly problematic. The sexual, marital and reproductive experiences of 13-year-old girls forcibly married to older men have little in common with those of 16-year-old teens engaging in transactional sex or those of 19-year-old women happily married to age-mates. From a programming perspective, it is vital to disentangle life trajectories – and the data do not yet allow this.

There is also a lack of evaluative data. As WHO noted in its 2009 review and McQueston *et al* noted in their 2012 analysis, there are a plethora of programmes aimed at increasing adolescent demand for, and community support of, contraception. However, most evaluations, while positive, are only short-term, leaving us to guess whether they leave long-term impacts.³²² Many interventions are also multi-sectoral and multi-method, which means that disentangling results is difficult at best.³²² For multi-pronged programmes and projects, it is important to ascertain their relative contribution – and where they leave their most long-lasting imprints – on knowledge, attitudes or behaviours.³²² Finally, many of the programmes designed to improve community support provide anecdotal evidence only, which is valuable, but difficult to translate and scale up.

Annex 2: Empowerment opportunities for adolescent girls and good practice examples

Empowerment dimension	What needs to change	Recommended policy and programme measures	Good practice examples of possible empowerment measures
1. Socio-cultural	Medium- to long-term actions		
	To empower girls to make their own reproductive decisions, there is a need for fundamental cultural shifts, including working towards:		
	<p>1) An end to child marriage, which risks locking adolescent girls into relationships in which they have limited voice to shape their reproductive health choices; and which may also subject them to gender-based violence, with its own reproductive health implications.</p>	<ul style="list-style-type: none"> Alternate paths for girls' future security need to be developed and disseminated (see also "education" below). Given that child marriage is often driven by poverty, parents need to understand the long-term reasons to delay marriage and be given the short-term help that makes the delay possible. 	<ul style="list-style-type: none"> Ethiopia's Berhane Hewan ("Light for Eve") works with communities to delay girls' marriage. Girls are offered fee waivers, school supplies, small cash payments, health and reproductive training, and access to mentors in exchange for continuing their education and delaying marriage. Community education programmes engage leaders and parents in dialogue about the impacts of harmful practices, such as child marriage and FGM. Rigorous evaluation has shown extremely positive impacts.³²² In Ethiopia, girls' advisory committees have been established in nearly 4,000 schools. They work with parents and community leaders to keep girls in school and delay marriage.³²² In India, the Haryana state government's <i>Apni Beti Apna Dhan</i> programme provides cash incentives to families who have daughters that reach 18 before marriage.³²²

	<p>2) An end to other harmful traditions that limit girls' value to reproduction, namely:</p> <ul style="list-style-type: none"> a) son preference, which encourages early and higher fertility b) dowry, which encourages parents to invest in girls' marital futures rather than their education c) lack of inheritance rights, which deprive girls of productive assets and leave them economically dependent on their husbands/ partners. 	<ul style="list-style-type: none"> • Because it encourages parents to save for marriage, rather than invest in education, dowry needs to be outlawed and laws enforced. • Inheritance laws need to recognise the rights of girls to inherit property. Access to land and other assets opens options for girls that buy them a level of economic independence that is not reliant on marriage. 	<ul style="list-style-type: none"> • India's <i>Balika Samridhi Yojana</i> programme makes periodic payments to girls in exchange for staying in school and delaying marriage.³²²
	<p>3) The gender stereotypes that underpin sexual relationships need to be altered:</p> <ul style="list-style-type: none"> a) In order to reduce gender-based violence, masculinities need to be reshaped to allow for female voice and decision-making. Men need to know that sex is not something that women are obligated to give them, or risk violence/ abuse. b) To reduce transactional sex, men must see girls as more than objects of sexual gratification and girls must have a real way to say "no". 	<ul style="list-style-type: none"> • Curricula need to be designed with gender dynamics in mind. Girls and women need to be portrayed in stronger roles that move beyond domesticity; boys and men need to be shown in caring, respectful roles. • Gender-based violence needs to be seen as a social rather than private problem, with fully enforceable laws enacted and supported. 	<ul style="list-style-type: none"> • Brazil, the Maldives and Vietnam, among others, have added imagery to textbooks that show men in nurturing roles and girls playing with "boys' toys".³²² • In South Africa, the "Boys Talk" programme is working with adolescent boys to reduce the pull of a "macho" culture. Using both adults and peer mentors, boys get the chance to talk about sex and virginity.³²² • A variety of programmes, including Program H and <i>Yaari-Dosti</i> in India and <i>Addis Birhan</i> in Ethiopia, are working to develop a "gender-equitable" masculine ideal. The programmes aim to reduce gender-based violence, promote dialogue between men and women, and increase men's buy-in to family responsibilities.³²² Initial evaluations are very positive.
	<p>4) As the sexual transition unfolds, and marriage and sexuality become increasingly disconnected, communities need to stop placing the social burden/stigma of sexual activity on girls alone. Boys/men's responsibility for reproduction needs to be acknowledged, as do girls' attempts to maturely deal with their sexuality.</p>	<ul style="list-style-type: none"> • Reproductive healthcare needs to target adolescents to drive up demand, and provide supportive care once girls enrol. Messages need to praise girls for taking positive steps to protect their futures rather than denigrating them for engaging in sexual activity. 	<ul style="list-style-type: none"> • In Mexico, a USAID-funded project worked to train pharmacists to provide more adolescent-friendly services. Evaluation showed that trained providers were judged by teens to be more interested in their FP concerns, more trustworthy, friendlier, and made them feel more comfortable overall. Furthermore, trained providers were much more likely to give very clear instructions on how the provided method should be used.³²²

Quick wins

Recognising that attitudinal changes about family planning are among the most difficult to effect, it is vitally important that whole communities are targeted. The participation of religious and community leaders is required and large-scale media campaigns can be useful. Interventions must be culturally sensitive and designed around local norms.

- Health messages can be “quick wins”. Cultural shifts are possible, but take time. Focusing on immediate benefits to mothers – and particularly babies – is a way to increase community buy-in. All families and communities need to understand that:
 - 1) pregnancies that are too early are dangerous, for mothers and babies.
 - 2) pregnancies that are too closely spaced are dangerous, for mothers and babies.
- Health messages need to target broad audiences, as girls are rarely in a position to delay pregnancy themselves. Messages need to emphasise contraception is not just about preventing births, but timing them.
- In Pakistan, a USAID program called Family Advancement for Life and Health has trained 1,600 prominent community members to spread the word that early marriage is dangerous for girls’ futures on many levels. Parents are largely unaware that early marriage and early fertility is a health concern, and have been very receptive to delaying once they understand the risks.³²²
- In Mali, the Ministry of Health, with USAID funding, is working with local and religious leaders to promote contraceptive use and birth spacing. Calling for dialogue between husbands and wives, leaders are speaking from mosques trying to improve women’s access to family planning services.³²²
- In Bangladesh, media messages and community education programmes have emphasised the relative likelihood of adolescents giving birth to smaller, less well-nourished babies. Mothers and mothers-in-law have responded particularly well to this message.³²²
- Supported by Pathfinder International, community leaders in India are working with newlyweds and their parents to understand the health benefits of delaying the first pregnancy, as well as spacing subsequent pregnancies.³²²

Medium- to long-term actions

2. Education/ economic ³²²

In order for girls and women to be seen as actors beyond their reproductive capacities, they need to be allowed to make contributions to their families and communities that move beyond the traditional domestic sphere.

To that end, **girls and women need economic opportunities, such as training and access to credit and assets**, which enable their independence and allow them to add financial value to their families.

Girls need to be prepared with a solid education through secondary school so as to help them make their own reproductive health choices and to increase their intra-household bargaining power and capacities.

- Girls need to start school "on time". Where girls' entry into school is delayed, which is common in the poorest countries, they reach "marriageable age" before they transition to secondary school.
- Demand-side interventions such as cash transfer programmes, educational scholarships and school feeding schemes have been shown to keep girls in school. Two broad approaches seem effective:
 - 1) Those that are ostensibly gender neutral, but which ultimately demonstrate that girls' education is particularly responsive to variables such as cost and quality, as the benefits of girls' education are seen as comparatively low by many families.
 - 2) Those that specifically target girls.
- Where girls' access to education is constrained by fear of violence, lack of mobility and time poverty, providing female teachers or establishing girls-only spaces can help reach the most disadvantaged.
- Where menstruation and lack of school sanitary facilities discourages adolescent girls from regular attendance – and raises their risk of dropping out – simple interventions like building separate toilets and providing sanitary pads can improve attendance .
- Pregnant girls and young mothers need access to education as well. With appropriate supports, pregnancy and parenting does not have to end a girl's schooling.
- In Burkina Faso, providing school meals for girls significantly increased their enrolment rate, as did establishing "satellite schools" that allowed the youngest girls to start their education on time.³²²
- Mexico's *Oportunidades* offers poor families monthly stipends to keep their children in school. The stipends are for boys and girls and rise with the age of the child. Brazil's *Bolsa Familia* offers a similar incentive. Programme impacts are significantly higher for girls than boys, despite the fact that gendered effects were not intended.³²²
- The Female Stipend Programme in Bangladesh was begun in 1994. Targeting rural girls aged 11–14, the programme provides a stipend for those who 1) stay in school and pass exams, and 2) delay marriage until the age of 18. The stipend is paid directly to girls, increases with their grade level, and is sufficient to cover all educational expenses. It currently reaches 2.3 million girls a year and has been the driving force behind the fact that it only took Bangladesh 15 years to achieve gender parity in lower secondary school.³²²
- In Ethiopia, more than 35,000 poor, urban girls have participated in *Biruh Tefsa* (Bright Future), a programme which recruits door-to-door in slum areas and specifically targets domestic workers and girls engaged in wage labour. The programme provides basic literacy, financial skills, and health education and varies its hours to ensure that all working girls have access.³²²
- In India, assigning female teachers to small, rural schools increased girls' attendance by 50%.³²²
- In Uganda, as well as several other sub-Saharan African countries, projects are underway to facilitate girls making their own sanitary pads out of low-cost, indigenous materials.³²² While initial results on a similar project in Nepal were not encouraging, it should be noted that menstrual-

Adolescent girls need to have access to the vocational training and credit that allows them entry to the job market – and increases their capacity to chart their own futures.

- Girls need to be taught skill-sets that allow for entrance to the labour market. These can be as simple as cooking or sewing skills, or as complicated as computer literacy.
- Girls need financial literacy skills.
- Older girls need access to the credit that allows them to open a business of their own.
- In Kenya, a group of donors led by the Population Council supports the local *Binti Pamoja* ('Daughters United') Centre, which runs a programme to teach financial literacy, vocational skills and life skills, including those related to reproductive health. Thousands of girls have benefited from the safe space, education, and social networks provided through the programme. Similar programmes have been implemented in regions of Kenya and Nigeria that are plagued by high rates of child marriage.³²²
- In Bangladesh, *Kishori Abhijan* ("Adolescent Girls' Adventure") has provided livelihood skills, including vocational training and access to savings and credit programmes, to 15,000 teen girls. Evaluation found that the programme helped the youngest girls delay marriage and helped working girls earn higher incomes, without impacting their school attendance.³²²

Quick wins

Where the appeal of increasing girls' and women's power is limited by tradition, **economic messages have immediate impact. When education can be "sold" as a way to maximise family earnings – and local and national GDP – buy-in is more significant.**

- While numbers are notoriously difficult to come by, arguments to persuade governments of the value of empowering girls and women could include:
 - 1) in India it has been estimated that the total economic output of the country would increase by 8 per cent if the ratio of female to male workers were increased by only 10 per cent per capita³²²;
 - 2) a study which found that educational disparities between 1960 and 1992 may have cost South-East Asia and sub-Saharan Africa 1% a year compared with East Asia.³²²
- For families, persuasive messaging could include: each extra year of schooling for a girl can boost her wages by up to 20%.³²²

A variety of international and pan-national organisations and initiatives are working to keep governments focused on girls' education.

- Started in 1994, UNICEF's African Girls' Education Initiative was the first broad push to get girls across Africa in school. More than 180 project strategies were used to improve girls' attendance.³²²
- The World Bank has been involved with girls' education for decades, with 22% of the projects funded between 1990 and 2005 relating to improving girls' educational outcomes.³²² Most recently, its Adolescent Girls Initiative, launched in 2008, is promoting the "transition of adolescent girls from school to productive employment... in low-income and post-conflict countries".³²²
- The Girls Count report, entitled *New Lessons: The power of educating adolescent girls*, looks at frameworks and policies that encourage girls' education.
- In Ethiopia, Pathfinder has worked with community leaders who see the relationship between fertility and poverty to encourage contraceptive use throughout their villages. Men, who were initially more hesitant, are now asking for contraception, alongside their wives.³²²

3. Familial/inter-personal	<p>In order to reduce child marriage and keep girls in school – both of which are “silver bullets” in terms of reducing adolescent pregnancy – girls need to have voice within their natal families to speak for their futures.</p> <ul style="list-style-type: none"> Measures which support girls’ participation and voice need to be deployed. Girls need safe spaces where they can learn to feel strong and speak for themselves. Girls need to develop strong networks of peers to support them, and have access to role models to inspire them. In India, girls’ collectives, supported by UNICEF, are helping girls learn to speak for themselves and demand education rather than marriage. Across Andhra Pradesh, girls are helping each other by involving their school headmasters, the police and village priests in stopping marriages.³²² <i>Tuseme</i>, a programme started by the Forum for African Women Educationalists, uses drama and other creative means to help girls learn to identify and solve problems in their lives. Across sub-Saharan African, 80,000 children have benefited from the programme, which teaches girls negotiation skills and gives them a safe space to practice speaking out for what is important to them.³²² The Population Council’s <i>Abriendo Oportunidades</i> programme in Guatemala helps Mayan girls build social support networks and connects them to mentors. The curriculum focuses on self-esteem and life-planning and includes education on reproductive health. Not only are girls becoming more confident through their participation, but the young leaders in particular are challenging community assumptions regarding gender roles, opening space for the next generation of girls’ voices.³²² Pathfinder has worked with successful Ethiopian women to show girls in remote areas what is possible in their own lives if they stay in school. It has also trained thousands of adolescents as peer educators, so that they can convey to other teens the importance of finishing school.³²²
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	<p>Where reproductive decision-making rests in the hands of men, or mothers-in-law, girls and women are powerless to control their futures.</p> <p>Girls need to have voice in their marital families/sexual relationships – this includes the right to refuse sex and the right to use contraception.</p>	<ul style="list-style-type: none"> Wives and husbands need to learn to talk to one another. Wives need to learn to speak up. Husbands need to learn to listen. 	<ul style="list-style-type: none"> In India, the Better Life Options programme focused on life-skills training, teaching girls vocational skills, basic living skills (nutrition, self-protection), leadership, etc. At the end of the programme, girls were more likely to leave their villages to obtain healthcare, discuss family planning with their husbands, and use contraception.³²² In India, community leaders have worked with young married couples about how to negotiate sex and contraception.³²²
<p>4. Legal</p>	<p>A necessary, though admittedly insufficient, first step is enacting laws that will prevent the worst abuses of girls' rights. Specifically, legal harmonisation is required in that national laws need to be built around international standards with regard to child marriage and compulsory school attendance. Perhaps even more importantly, existing laws, which are multitudinous, need to be enforced – with exceptions for religious law or local custom eliminated.</p>	<ul style="list-style-type: none"> The minimum age for marriage needs to be set at 18 in all countries, with consent of both parties required. Laws regarding marriage need to be uniformly enforced. The police need to take violations seriously and religious figures need to verify the ages of partners and speak out when they have concerns. 	<ul style="list-style-type: none"> Laws raising the legal age of marriage have been passed around the world. Most countries now set that age at 18 for both girls and boys – though many, particularly in the developing world, still have much lower age limits for girls.
	<p>In order for girls to know that they have rights and options, they need to specifically be taught about both their human rights and the legal codes that impact their lives. This will enable them to know when their rights are being violated, and encourage them to report. They need to know their rights re:</p> <ol style="list-style-type: none"> 1) right to education 2) right to be free of violence 3) right to refuse child marriage 4) right to use contraception. 	<ul style="list-style-type: none"> Girls' clubs, schools and other community organisations, including religious organisations, need to educate girls about their rights. 	<ul style="list-style-type: none"> All of the clubs and programmes mentioned in this table frame their work within a human rights perspective and work to teach girls about their rights.
	<p>Given that girls cannot effectively claim space that is already totally occupied, boys and men need to specifically be taught about human rights and how they apply to girls and women. They need to know that freedom from sexual coercion and control over fertility are inviolable rights for all people.</p>	<ul style="list-style-type: none"> Boys' clubs, schools and other community organisations, including religious organisations, need to educate boys about human rights and their relationship with gender. 	<ul style="list-style-type: none"> See above for example of boys' and men's programmes that have this focus.

Adolescents need full legal access to contraceptives.

In places where custom or law makes it difficult for teens to acquire contraception, legal codes need to be altered and community education campaigns need to be undertaken. Healthcare professionals and other community leaders need to be targeted with information.

- In effect since 2007, the South African Children's Act gives children over the age of 12 full rights to reproductive healthcare, including access to contraceptives, information and HIV testing. The Act states that all people must sell condoms to children over the age of 12, as well as tell them where they can obtain free condoms. Furthermore, it allows schools to distribute condoms free of charge to all students over the requisite age and grants all children, regardless of age, the right to access health information.³²²
- In Chile, after a decade of protest and contentious legal battles, regulations support providing contraceptives, free of charge, to all adolescents over the age of 14, without parental consent.³²² This includes emergency contraception (EC), and specifically allows minors under the age of 14 to access EC before their parents are informed.³²²

5. Practical knowledge and access

It is clear that most adults – parents, teachers and healthcare providers – are uncomfortable with adolescent sexuality. This has significantly impacted the information that adolescents have at their disposal to make good decisions regarding their fertility.

To address the fact that most adolescents have more mis-information than they do information, it is vital that they be given practical knowledge about reproduction and contraception.

- Sex education in schools is a necessity. Evidence overwhelmingly proves that teaching children about sexuality does not encourage experimentation and that comprehensive programmes can actually delay sexual debut, reduce both the frequency of sexual activity and the number of sex partners, and increase contraceptive use.
- Sex education needs to be offered in the community in order to reach out-of-school adolescents and their families.
 - 1) Health clinics should offer family planning services to adolescents who are there for other reasons.
 - 2) Health clinics should run outreach programmes aimed at those who are unaware that they need services.
 - 3) Media campaigns have the potential to reach whole communities, encouraging both behavioural and attitudinal shifts.
- Evidence for school-based sexuality education is mixed – largely owing to its uneven implementation and its typical focus on abstinence. UNESCO's 2009 Technical Guidance Paper calls for four components: 1) information on sexuality, contraception, pregnancy, human rights, gender-based violence, etc.; 2) exploration of values, attitudes and social norms, with a focus on risk-taking and decision-making; 3) interpersonal and relationship skills, including communication, negotiation and refusal; and 4) personal responsibility.
- In Mexico, a concerted communications campaign was able to position pregnancy care as a shared responsibility of the entire community. Using media ranging from T-shirts to videos, the programme was able to double knowledge about family planning.³²²
- In Ghana, Pathfinder and the African Youth Alliance trained youth as peer educators and to distribute condoms. Targeting was particularly innovative; all youth involved had to be employed in a trade or a location that attracted other young people.³²²
- In India, a programme provided SRH care and information for married teens, and their family and community members. Results indicated increased uptake of family planning services as well as better knowledge about pregnancy.³²²
- In China, a community-based intervention that encouraged young people to use contraception and offered counselling and information was able to significantly impact contraceptive use. Adolescents and young adults enrolled in the programme were 14.6 times more like to use to family planning than those not enrolled.³²²

Adolescent access to contraceptives is limited by both geography and cost. Teens are also deterred by their own embarrassment and providers who stigmatise their behaviour.

To address these concerns, **adolescents need supportive, affordable access to contraceptives.**

- Where girls' mobility is restricted, health services should go to girls.
- Schools have a "captive audience" of adolescents – this makes them a logical place to initiate clinic referrals as well as to distribute contraceptives.
- Vouchers can drive up demand for contraceptives by removing cost as a barrier, and by encouraging teens to come to a clinic for information.
- In Burkina Faso, the *Mères-Educatrices* Project goes door-to-door, visiting married teen girls, to ensure that they have access to information on reproductive health and supporting them in their first pregnancies. Given the restrictions placed on these young wives, the *meres-educatrices*, who are themselves young mothers, travelled in pairs, so that one could engage the gate-keeper and another the teen. A newer phase of the programme targets girls at risk for early marriage, teaching them about reproductive health and human rights. Young educators have also worked closely with community and religious leaders to teach them about the dangers of early pregnancy and marriage.³²²
- In Nigeria, where purdah keeps many young women strictly confined to their homes, Pathfinder trained traditional beauticians to offer both contraceptive counselling and contraceptives.³²²
- In South Africa, schools that choose to distribute condoms have found that when they are provided in ways that minimise adult gate-keeping and maximise adolescent privacy, supplies disappear quickly.³²²
- In Nigeria, formal networks between schools and health clinics have shown promise. Adolescents were more likely to use condoms and healthcare services, and less likely to have sexually transmitted infections (STIs).³²²
- In Nicaragua, a programme distributed nearly 30,000 vouchers, good for free SRH services, to poor adolescents, at schools, markets and going door-to-door in disadvantaged neighbourhoods. More than half of sexually active girls redeemed their vouchers for contraceptives, STI treatment, counselling, and pregnancy testing. Evaluation showed that girls' odds of seeking care nearly doubled under the programme.³²²

	<p>Given the high rates of coerced sex – and the limited availability of safe abortion – greater effort needs to be made to make girls and healthcare providers aware of emergency contraception.</p>	<ul style="list-style-type: none"> • Girls, parents, teachers and healthcare providers need to be aware of emergency contraception (EC) and know how it works; particular care needs to be paid to poorer, rural areas. • Clinics need to provide EC on demand, without parental permission. • Over-the-counter providers, such as pharmacies, need to display information openly, so that girls know the products are available – and issue EC on demand. • There is a need to address mis-information regarding the safety of ECs, even within the healthcare community. 	<ul style="list-style-type: none"> • In Cameroon, adolescent mothers are being trained on EC, and sent out into their communities to raise awareness about it.³²² • In India and Bangladesh, TV and other media campaigns were able to quickly raise awareness of EC.³²² • In Venezuela, Paraguay and Pakistan, social marketing has been able to quickly raise awareness of EC.³²² • In Africa, pharmacists are being trained to provide information on ECs. This is key in that out-of-school adolescents are particularly likely to use pharmacies.³²²
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