



Family planning

The adolescent imperative

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Overview

The global response to family planning must put adolescent girls at its centre, with investment and prioritisation at the scale of the HIV pandemic response to urgently accelerate progress. Figures suggest international donors provide more than \$8 billion annually to stop the spread of HIV. By contrast, in 2014, the Family Planning 2020 global partnership had secured just \$1.4 billion to ensure girls and women have access to lifesaving contraceptives.

The scale of the challenge

- Despite progress, more than 16 million adolescent girls become mothers each year, nearly all of whom live in developing countries and are married at a young age.
- The social and economic costs of child motherhood are immense, from heightened risk of maternal and infant illness and death, to premature school dropouts and truncated life opportunities.
- Without an adolescent-responsive approach, the international community will not achieve the Family Planning 2020 goals or Sustainable Development Goals 3 (health and wellbeing) and 5 (gender equality).

Key actions to deliver progress

The global community must:

1. Urgently increase funding and attention to match the scale of the HIV crisis response.
2. Prevent adolescent motherhood by strategically challenging the harmful gender norms that support child marriage.
3. Tailor regional and country strategies to match context-specific adolescent fertility trends.
4. Invest in the future by collecting disaggregated data on adolescents to monitor progress, and prioritising comprehensive sex education as out-of-wedlock pregnancies are set to rise.

Overview and scale of the challenge

Child marriage and adolescent pregnancy is a challenge of international urgency. Of the 20,000 babies born each day to girls under the age of 18 in developing countries (UNFPA, 2017), almost 85% are born to those who are already married (Wodon et al., 2017) (Box 1).

Adolescent pregnancy jeopardises girls' wellbeing and future life chances, especially in the countries where it is most common (Wodon et al., 2017; Loaiza and Liang, 2013; Cherry and Dillon, 2014; Chandra-Mouli et al., 2014; WHO, 2014). Unlike their counterparts in developed countries, girls in countries with the highest adolescent fertility rates are likely to be malnourished, and often lack access to quality maternity care or safe abortion. Complications of pregnancy and childbirth – such as obstetric fistula, which has life-long consequences – are far more common in adolescents than in adults (Braine, 2009), and remain a leading cause of death among adolescent girls (WHO, 2017). Indeed, the maternal mortality ratio for girls under the age of 16 is estimated to be four times higher than that of women in their early 20s (Conde-Agudelo et al., 2005), and maternal conditions were the third largest cause of disability-adjusted life years (DALYs)¹ for girls between the ages of 15 and 19 in 2012 (WHO, 2017).

Adolescent pregnancy is also risky for babies. Neonatal deaths are 50% more common in infants born to mothers under the age of 20 (WHO, 2011), and on average three out of every 100 deaths to children under the age of five can be directly attributed to adolescent childbirth (Wodon et al., 2017). Early motherhood also increases the risk of under-five stunting by 6.3% (ibid.).

While the medical complications of adolescent pregnancy are reducing as girls' access to health care improves, economic and social costs remain largely unchanged. Girls who are married and become pregnant as children are less likely to complete their own education or take on paid employment, and subsequently are unlikely to have the assets to commit to their children's educations. It has been estimated, for example, that 11% of girls in Nigeria, 28% of girls in Egypt, and 32% of girls in Nepal leave school to marry (Wodon et al., 2017). On average, this early school leaving directly leads to a 9% reduction in women's adult earnings. Scaled up, the aggregate impact of child marriage and early school leaving on national economies is large. Lost earnings and productivity attributable to child marriage are estimated to be US\$4.8 billion in Bangladesh and US\$7.6 billion in Nigeria (ibid.). Child marriage also drives higher fertility, which is a problem in the countries that tend to have the highest rates of child marriage. It is estimated that, across the lifespan, girls who marry at 17 will have 17% more children on average than girls who marry at the age of 18 (ibid.). Because population growth impacts gross domestic product per capita, Wodon et al. (2017) calculate that the welfare benefits that could be harnessed by ending child

Box 1: While pregnancy rates are down, absolute numbers remain high and are driven by certain countries

- 16 million girls between the ages of 15 and 19 give birth each year (Blum, 2015). 7.3 million of those births are to girls under the age of 18 (UNFPA, 2017).
- 95% of adolescent births take place in low- and middle-income countries (UNFPA, 2017).
- 84% of children born to mothers under the age of 18 are attributed to child marriage – and while the rate of child marriage is declining in most countries, the number of child brides is continuing to rise due to growth in the population of adolescent girls (Wodon et al., 2017).
- 777,000 girls under the age of 15 became mothers in 2016 (Woog and Kågesten, 2017). This was at great risk to themselves, as mothers under the age of 16 are four times more likely to die than mothers in their 20s (Conde-Agudelo et al., 2005).
- Half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of the Congo (DRC), Ethiopia, India, Nigeria and the United States (Blum, 2015).
- In all countries, the girls most likely to become mothers are poorer, less educated and live in more rural areas (Loaiza and Liang, 2013).
- In developing countries, adolescent pregnancies are not necessarily unwanted.
- Only a third of pregnancies to girls under the age of 15 were unplanned, due to pressures from in-laws and social norms that associate motherhood with social status (Woog and Kågesten, 2017).
- Only half of pregnancies to girls aged 15-19 were unintended (ibid.).

marriage could reach US\$566 billion in 2030. And another US\$100 billion could be recouped through the impact of reducing child mortality and child stunting (ibid.).

The solution: key actions to deliver progress

If the international development community is to achieve Sustainable Development Goal (SDG) 3 on health and wellbeing for all, and SDG 5 on gender equality (UN SDGs, 2017), it is essential that adolescent-responsive family planning and services are put at the heart of global efforts.

Relatively simple and cost-effective approaches – such as improving girls' physical access to contraception – are a necessary first step to delivering global progress in

adolescent pregnancy, but existing evidence shows these alone are far from sufficient.

We argue that four key actions could support the progress that is so urgently needed.

1. Secure international funding and commitments that are commensurate to the scale of the challenge

The current investments and approach to tackling adolescent fertility are woefully inadequate. There needs to be a coordinated, multi-pronged attack on the scale that the world has dedicated to stopping the spread of HIV over the past two decades.

There were nearly half a million new HIV infections among children under the age of 15 in 2000. By 2015, the number of new child infections had dropped to 150,000 – a decline of 70% (UNAIDS, 2016a; 2016b). The fall in adult infections was also significant, at 40% between 1997 and 2015 (*ibid.*). By contrast, adolescent fertility rates have not fallen nearly as fast: between 2000 and 2015, the rate fell only 21% on a globally.²

Progress against HIV has been driven by unprecedented global financial support, with US\$19 billion committed in 2015 alone, including US\$7.53 billion in donor government funding and US\$618 million from private philanthropic funders (AVERT, 2017). While analogous figures are not available for work to reduce child marriage and adolescent pregnancy, given the number of actors and diversity of programming, it is clear that funding is much lower. In 2014, for example, the Family Planning 2020 global partnership (FP2020) secured a considerably more modest US\$1.4 billion in bilateral donor funding.³

Certainly, the trends are very different; the global focus on the HIV pandemic was initially spurred by rapidly rising infection rates and very high mortality rates. However, while there is still much to be done, the numbers today are less dramatic; there were 2.1 million new infections globally in 2015 and a total of 36.7 million people living with HIV (UNAIDS, 2016).⁴ By contrast, child marriage – which accounts for at least of 75% of adolescent pregnancies⁵ – affects 15 million girls annually. Globally it is estimated that 700 million women and 150 million men were married as children (Girls not Brides, 2017).⁶ As noted, a new report on the economic costs of child marriage by the World Bank and the International Center on Research on Women (Wodon et al., 2017) finds that the costs of not intervening are staggering – especially given the effects on individual and national fertility rates. Both the absolute number of people affected by adolescent pregnancy and the multi-dimensional effects on individuals, families, communities and economies warrants the type of attention that the HIV response rightfully galvanised, and still merits.

Also clear from the HIV prevention and response initiatives is the need for a synchronised strategy on adolescent pregnancy that integrates access to contraceptives with regionally tailored information,

awareness-raising and social-norm communication-change approaches. Tackling adolescent pregnancy – like tackling the child marriage that almost always precedes it – requires a focus on the social norms that place value on the girls' ability to produce children, and which deprive them of their rights to be active agents in shaping their own futures (Chandra-Mouli et al., 2014; Patton et al., 2016; Harper et al., 2017; UNICEF, 2017).

2. Adopt a strategic and context-sensitive approach to challenge the norms that support child marriage

The data speaks for itself: the best way to prevent child motherhood is to prevent child marriage and the harmful gender norms that underpin it (Harper et al., 2017; Wodon et al., 2017). Programming lessons from diverse contexts suggest that how best to do this varies considerably, and depends not only on marriage and fertility dynamics over time but also on government commitment, resourcing and governance approaches and the resonance of communications messaging.

Focus on changing gender norms by targeting the decision-makers who shape girls' fertility

Direct messaging about gender norms works well in some contexts⁷ – especially where messages can be crafted to simultaneously tackle child marriage and adolescent pregnancy, by working to convince husbands and marital families to delay pressuring for pregnancy. Here, it is critical that programming helps to grow girls' self-confidence and their ability to communicate, but also works with the husbands, families and communities who too often see girls solely as wives and mothers.

In Ethiopia's Amhara region, which has long had the country's highest rate of child marriage (27.2%)⁸ and the lowest average age at first marriage (15.1 years),⁹ concerted efforts on the part of the government and non-governmental organisations (NGOs) have seen rates of adolescent pregnancy plummet in recent years. While 11.6% of Amhara girls had begun childbearing as adolescents in 2011, by 2016 that rate was down to 8.3% (Central Statistical Agency [Ethiopia] and ICF International, 2012; 2016). This progress is all the more remarkable given that the national rate climbed slightly from 12.4% to 12.5% over that same period due to large increases in other regions.¹⁰ Amhara's success in reducing its adolescent pregnancy rate is the result of both declines in child marriage and improvements in girls' contraceptive use. Both have been driven by strong government programming (Box 2), combined with norms-based approaches shaped around Pathfinder International's (2006) early research on the causes and consequences of child marriage, and implemented through programmes such as the Population Council's Berhane Hewan (Erulkar and Muthengi, 2009) and Care's TESFA (Towards Improved Economic and Sexual Reproductive Health Outcomes for Adolescent Girls) (Edmeades et al., 2014).

Care's TESFA programme in Ethiopia, for example, aimed to improve the lives of married adolescent girls through a curriculum designed to push 'gate keepers' (such as husbands and in-laws, as well as community and religious leaders) to rethink gender norms, and to support girls to learn about sexual and reproductive health and develop livelihoods skills. An evaluation found the programme to be effective on several fronts (Edmeades et al., 2014). Married girls not only developed close friendships that supported them to aspire to futures beyond motherhood, but they also grew closer to their husbands, who began sharing decision-making and chores with them. Girls' uptake of contraception increased by 27% (with the full support of their husbands) and, in many communities, child marriages began to be cancelled as married girls raised their voices together about the ways in which the practice had negatively impacted their own lives (Box 3).

The spill-over effects of investing in girls' schooling cannot be underestimated

Sometimes tackling child marriage and the underlying gender norms is best approached indirectly, not explicitly, convincing parents to support their daughters' schooling. This is especially true in contexts where direct approaches may elicit a backlash (Omoeva et al., 2014; Girls not Brides, 2017a) and is well supported by Wodon et al.'s (2017) recent calculation that each additional year of secondary school reduces the risk of child marriage by 4 to 6 percentage points.

As home to the world's largest population of adolescents¹¹ – as well as the country accounting for the largest absolute numbers of child marriages¹² – India is central to the fight against adolescent pregnancy. Fortunately, it is making considerable (but largely unrecognised) progress: between 2005 and 2015, its adolescent fertility rate fell 54% (from 51 per 1,000 adolescent girls to 23 per 1,000) (World Bank, 2017). And progress appears to be accelerating. Between 2005 and 2010, India's adolescent fertility rate fell 29%; between 2010 and 2015 it fell 35% (ibid.).

In India, where marriage is still quickly followed by pregnancy and the most common form of contraception remains female sterilisation (UNDESA, 2015), progress towards reducing adolescent pregnancy appears primarily the result of campaigns to keep older adolescent girls in school. Even in an environment where gender norms remain highly discriminatory and broader gender messaging is weak, such campaigns have resulted in reductions in child marriage that are far greater than those seen in neighbouring Bangladesh (Box 4). A decade ago, 47% of Indian girls were married before the age of 18. Now this figure is only 27% (Government of India, 2007; 2017).

In the 2004-2005 school year, only 45% of Indian girls enrolled in secondary school (9th and 10th grades) and only 25% of girls enrolled in senior secondary school (11th and 12th grades). A decade later, in the 2014-2015 school year, those figures were 79% and 54% respectively (Government of India, 2016). Indeed, Indian girls are now just as likely to attend secondary school as boys (ibid.).

Box 2: Tackling sexual and reproductive health challenges at scale: Ethiopia's innovative platforms

The Ethiopian government has created a number of innovative platforms that are successfully reducing adolescent fertility, especially in communities where they are supported by strong NGOs. Its Health Extension Programme, which deployed its first workers in 2005, has trained tens of thousands of female high school graduates to provide primary health care at the community level. One of four key packages of care that health extension workers deliver is family planning, which is free to all girls and women (WHO and Global Health Workforce Alliance, 2008).

The Women's Development Army grew out of the Health Extension Programme. It organises local women into groups of one leader and five members that meet regularly (almost daily in some locations) to discuss a wide variety of health-related topics, including both child marriage and family planning. In some communities, these Armies have been instrumental in monitoring girls at risk of child marriage (especially where they have been supported by gender-focused NGOs), and even having those marriages called off. They are also central to efforts to make sure that girls attend school on a daily basis and access health services (Jones et al., 2016a; 2016b).

Box 3: Covering all the bases with TESFA

TESFA's success was driven by its engagement not just with girls – who often have no ability to make decisions about their own lives – but also by its work with husbands, in-laws and religious leaders. Girls reported that, in the past, mothers-in-law would 'nag their sons' about the need for a baby immediately after marriage. If young wives did not fall pregnant then their mothers-in-law would 'characterise her as a mule' and urge her son to divorce her. Now, however, after efforts to help villagers see that they should 'have a planned number of children that considers the economic capacities of their families', girls no longer have to take contraception secretly. Indeed, one married girl said that, while in the past 'even to be seen in the health centre itself was assumed as a crime, currently, our husbands are by our side, they remind us to go to the clinic'.

Source: Jones et al. (2016a; 2016b).

While India's push to keep girls in school has necessarily been multi-faceted and diverse, conditional cash transfers to parents of girls are increasingly common, with a recent review finding more than 20 schemes across the country (Sekher and Ram, 2015). These programmes, which grew out of the state of Haryana's Apni Beti Apni Dhan (ABAD) (Our Daughter, Our Wealth), have been found to have significant impacts on both girls' enrolment and the time they are given to study. An evaluation of ABAD found that for girls over the age of 15 – those most at risk of both child marriage and adolescent motherhood – being an ABAD beneficiary increased their probability of enrolment by 23% (Nanda et al., 2014). Programmes such as the state of Bihar's Cycle Scheme, which provides girls attending 9th grade with a free bicycle, have also helped to significantly improve girls' access to secondary school (by as much as 30%) (Muralidharan and Prakash, 2013).

3. Tailor regional and country strategies to match context-specific adolescent fertility trends

Programmatic efforts to curb adolescent pregnancies need to be tailored, informed by data on adolescent fertility trends over time. Existing data underscores that it is essential to keep attention focused on all those developing countries in which child motherhood remains common – including those where adolescent fertility rates remain high (e.g. Bangladesh); fertility rates have fallen, but absolute numbers remain large because of population size (e.g. Ethiopia and India); progress has stalled in the last decade (e.g. Brazil and Indonesia); and in which rates are low but climbing (e.g. Viet Nam and the Philippines) (see Box 5 and Figure 1).

Box 4: Slower progress in Bangladesh

Home to one of the world's largest populations of young mothers, Bangladesh lags far behind India in terms of reducing child marriage and adolescent fertility – despite its Female Secondary School Stipend programme.

In Bangladesh 59% of girls are still married before aged 18 – a rate more than double that of India, and only marginally lower than that two decades ago. Bangladesh's adolescent fertility rate is 3.5 times higher than India's (83 vs 23 per 1,000 adolescent girls).

While much of the difference between India and Bangladesh appears resistant to education, it is also the case that Bangladesh has been slower to make progress towards keeping girls in school through the higher-secondary level. Barriers to girls' education are clear starting in 9th grade (secondary school). Looking only at the public schools that enrol the poorer girls who are more likely to marry and become mothers as children, the gender parity index for 9th and 10th grade grades is only 0.76.

Source: BANBEIS (2015).

4. Prepare for the future by investing in adolescent-sensitive data to monitor progress and provide comprehensive sex education to match demographic transitions

The global community needs to better prepare for the future. This includes investing in adolescent-sensitive data to track progress and in comprehensive sex education, given likely demographic transitions whereby premarital sexual activity becomes common as child marriages decline.

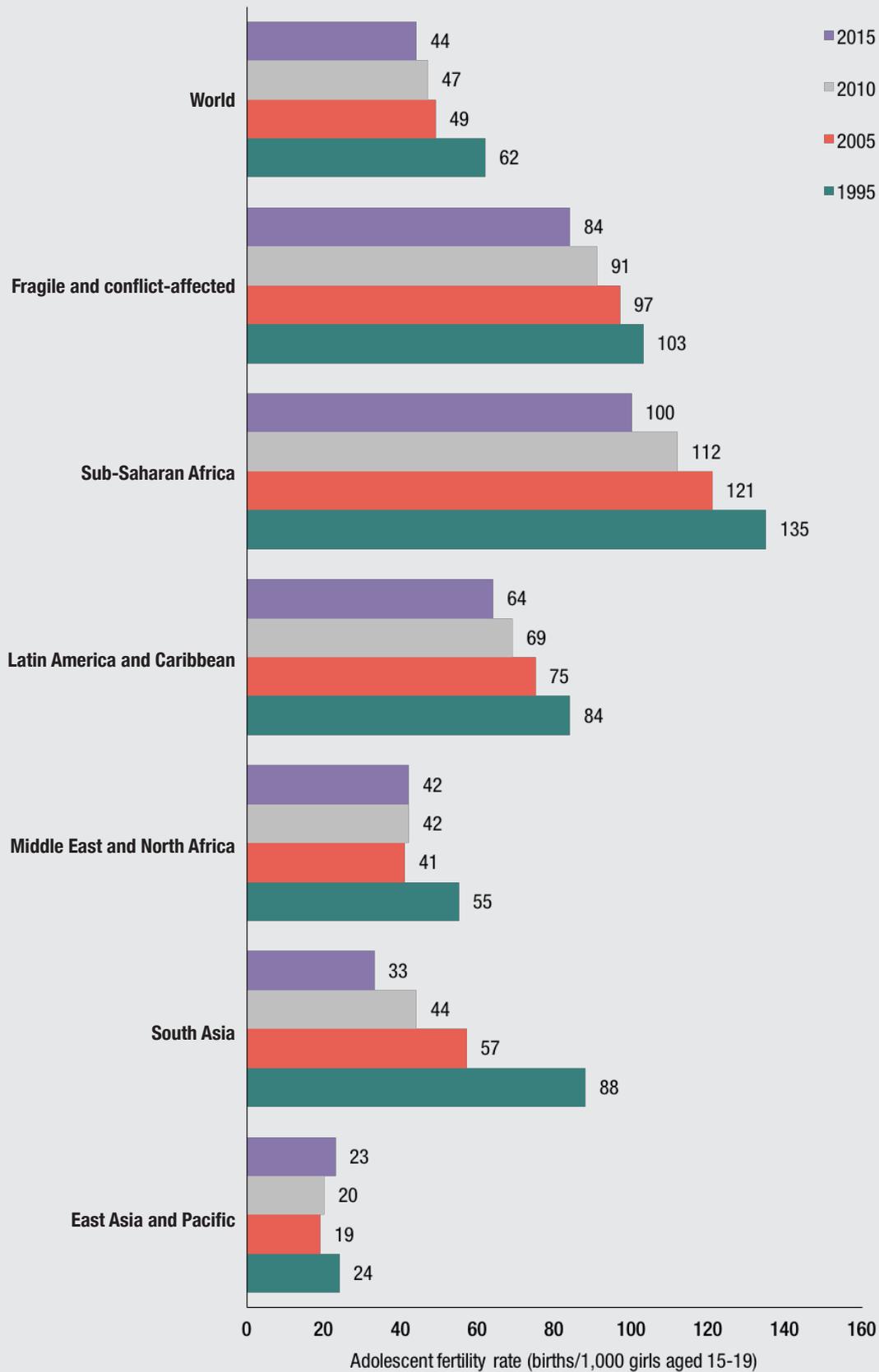
To better monitor progress and stay abreast of emerging trends, robust age-disaggregated data on adolescent fertility is essential. Despite the fact that

Box 5: Global progress hides surprising variability

- **South Asia, driven by India, has seen the most progress.** India's adolescent fertility rate is down by 65% in the last two decades. Bangladesh, while improving, has seen its rate drop by only 27% in the same period.
- **Latin America and sub-Saharan Africa are making slow, steady progress** at reducing adolescent fertility but there are significant variations within regions. In Latin America, rates in Honduras are down 29% in the last decade, compared to only 11% for Brazil, the region's most populous country. In Africa, Ethiopia and Rwanda have seen tremendous progress (down 40% in the last decade). Nigeria and the DRC, by contrast, have seen more marginal improvements (13% and 6% respectively in the last decade).
- **The Middle East and North Africa have seen progress stall.** While rates were lower in 2015 than they were in 1995, they were higher than in 2005. This story is primarily driven by Iraq, which has seen its adolescent fertility rate climb nearly 30% since 2000. Egypt, the region's most populous country, had a 2015 rate that was only 6% lower than that in 2000.
- **East Asia has not only seen progress stall, but significantly reverse.** While its adolescent fertility rate in 2015 was marginally lower than that in 1995, it was higher than that in 2005 – with reversals accelerating since 2010. Rates in Viet Nam and the Philippines have climbed the most (up 32% and 16% respectively in the last decade).
- **The world's fragile and conflict-affected states face a significant adolescent-fertility burden, and progress is not uniform.** Rates in Afghanistan, South Sudan and Sudan have plummeted (by 45%, 41% and 35% respectively in the last decade), while rates in Iraq have climbed (up 14% since 2005).

Note: Rates of improvement are authors' own calculations using World Bank data.

Figure 1: Adolescent fertility rates in low- and middle-income countries, by region, over time



Source: World Bank (2017).

pregnancy is more dangerous for adolescent girls than adult women – and that adolescent girls (married and unmarried) are less likely to use contraception than adult women (Hindin and Kalamar, 2017) – the core indicators used by the FP2020 global partnership that emerged out of the London 2012 Family Planning Summit are insufficiently adolescent-sensitive (Track 20 Monitoring Progress in Family Planning, 2017). While FP2020 calls for tracking the adolescent fertility rate on an annual basis, they make no attempt to track the number of girls versus older women using modern contraceptive methods, having decision-making over contraception or being forced into unsafe abortions. By tracking only the ultimate outcome (adolescent births), rather than proximate outcomes (such as girls' use of contraception), we are depriving ourselves of the information we need to better shape programming to girls' needs. Eliminating adolescent pregnancy requires age-disaggregated data to inform tailored programming for girls.

Moreover, obscured by aggregate global figures, there are disturbing patterns of stalling – and even reversing – progress in adolescent fertility. And these patterns are likely the harbinger of things to come, unless adequate resources are dedicated now to 'getting ahead of the curve'. For example, births to girls in East Asia and the Pacific increased between 2005 and 2015 – effectively erasing the progress made by the region between 1995 and 2005 (World Bank, 2017). Indeed, since 2010, the region's teen birth rate has actually increased (ibid.). Viet Nam's adolescent fertility rate is up 32% since 2005 (from 30 to 39), and the Philippines' rate is up 16% (from 53 to 63) (ibid.). These increases are related, not to child marriage – which is comparatively rare in both countries – but to increased premarital sexual activity in environments where adolescents' access to sexual and reproductive health (SRH) education and health care is minimal because of the stigma associated with sexuality (especially for girls). This double disadvantage is what also drives Latin's America's stubbornly high rates of adolescent pregnancy (Box 6).

As the age of first marriage continues to climb around the world, improving adolescents' access to comprehensive sexuality education (CSE) has taken on new urgency. Indeed, belying the concerns of parents, who are often worried that even discussing sexuality with teens is tantamount to 'showing the deer which way to run' (Hong et al., 2009), research from around the world has found that CSE – especially if delivered in a non-stigmatising manner in early adolescence – delays teens' sexual debut, reduces both the frequency of sex and the number of sexual partners, improves contraceptive use, and decreases adolescent pregnancy (IPPF, 2016; UNESCO, 2015; UNESCO, 2009; Andrade et al., 2009; Fonner et al., 2014; Haberland and Rogow, 2015). It can also reduce gender-based violence (critical given that forced sex is especially common amongst adolescents), and intergenerational sex (in which girls are especially powerless to negotiate for

safer sex) (Haberland and Rogow, 2015). Governments have taken note of these findings, and a 2015 review by the United Nations Population Fund (UNFPA) found that an increasing number of countries had national policies or curricula to support CSE that meet international standards (UNESCO, 2015).

Despite commitments, however, adolescents' access to quality CSE remains limited (IPPF, 2016; UNESCO, 2015; Anderson et al., 2013). First, programmes are often not delivered until secondary school by which time many

Box 6: Virtual stasis in Brazil

In 1960, the first year for which internationally comparable figures are available, the adolescent fertility rate in Brazil was 92 per 1,000 adolescent girls – compared to a global average of 87 (World Bank, 2017). In 2015, Brazil's rate was 67 and the global average was 44. Indeed, especially when compared to its fellow BRICS, Brazil's lack of progress is remarkable (Russia=23, India=23 and China=7) (ibid.). The country's relatively static adolescent fertility rates are all the more alarming given that births to girls between the ages of 10 to 14 appear to be rising, as those to girls between 15 and 19 years are falling (Vaz et al., 2016).

Adolescent pregnancy in Brazil appears increasingly driven by the country's (and the region's) growing problem with informal unions between teenage girls and older men. Around 36% of Brazilian girls are in a union before the age of 18, and around 11% before the age of 15 (Girls not Brides, 2017b)ⁱ. In terms of absolute numbers of girls 'married' before the age of 15, one study ranks Brazil as fourth in the world (UNICEF (2014), cited in Taylor et al., 2015).

Recent research has emphasised the centrality of gender norms to both child unions and adolescent pregnancy. It has found that especially for the lower-income girls who see education as unattainable, motherhood is viewed as a sign of independence and social status (Heilborn and Cabral, 2011; Taylor et al., 2015; Béhague, 2017). It also notes that Brazil and Latin America in general have been left out of global discussions about child marriage, which have tended to include actors from South Asia and sub-Saharan Africa, where rates have historically been the highest (Taylor et al., 2015).

Two other underlying drivers of high adolescent fertility rates in Brazil are also worth noting. First, it is lagging behind its upper-middle-income peers in terms of education. Of adolescents aged 15 to 17, only 48% of boys and 60% of girls were enrolled in high school in 2012 (IBGE, 2013). Second, it appears to have chosen to forgo tracking child marriage – the last national data appears to have been collected in 2006.

Notes: i) This data – which Girls not Brides sourced from UNICEF's report State of the World's Children 2016 – is over a decade old.

teens are already sexually active and many more have permanently left school, missing the curriculum entirely. The import of this gap is significant, as the same girls who are most at risk of dropping out of school are also most at risk of adolescent pregnancy. Second, the majority of sexuality education that is offered to adolescents is not adequately comprehensive. It tends to focus on

biology and how pregnancy happens, rather than on the interpersonal dynamics that would help young people – especially girls, who are socialised to be acquiescent – to negotiate not only safer sex, but also broader relationships. It also too often fails to deliver the kinds of practical advice that teenagers need and want (Box 7).

Box 7: Vietnamese adolescents want more in-depth sexuality education

In Viet Nam, our research finds that school-based sexuality education revolves around ‘safe sex, ovulation, and menstruation’ and does not provide the ‘deeper and more detailed’ information that teens preferred (Jones et al., 2015). Adolescents told us that they wanted classes and lessons with ‘pictures as examples ... and videos to help us understand the situation better’. They also asked for help understanding their feelings. ‘Sometimes love and friendship could be mistaken a little bit,’ reported one. We have ‘strange feelings when standing next to a friend of the opposite sex,’ added another.

Vietnamese teens’ concerns are echoed across the East Asian region. Alarmed by the country’s growing abortion and HIV rates (both concentrated in young people aged 15-24), the Chinese government recently published a series of textbooks for primary school students that focuses on gender norms – and provides the graphic context that Vietnamese teens want. Unfortunately the government was forced to recall the entire series, due to parental outrage that might have been prevented had the government messaged parents about the importance of comprehensive sexuality education (Huang, 2017).

Box 8: Fertility rates only tell part of the story

- The adolescent fertility rate does not capture the total adolescent pregnancy rate because of the number of girls who have abortions. In some countries, such as Viet Nam – where the average woman has 2.5 abortions in her lifetime – this number is very large (Tuoitrenews Breaking News, 2014).
- It is estimated that 3 million adolescents resort to unsafe abortions each year – with adolescents more likely than older women to have later and unsafe abortions.
- We can expect the number of adolescents seeking unsafe abortions to rise over the next four years because of the policy – and funding – priorities of the Trump administration in the US. Research has found that the ‘Mexico City’ gag rule, which prohibits any organisation accepting US funds from promoting abortion, also limits access to contraception, thus driving up abortion rates (Bendavid et al., 2011).

Conclusions and recommendations

The costs of child marriage and too-early motherhood are not only borne by girls and their children, but also by communities, rippling through economies and reverberating across generations. Donors and other development actors need to scale up efforts urgently to meet need.

We suggest that they model their efforts on the actors who spearheaded the global campaign against HIV/AIDS. By scaling up funding and developing a synchronised strategy that paired investments in ‘hardware’ interventions such as condoms and anti-retrovirals, with investments in ‘software’ interventions such as communication and norm-change initiatives, HIV actors managed to turn the tide on new infections in less than two decades. Actors fighting to prevent child marriage and child motherhood, and reach the FP2020 and health- and gender-focused SDGs, can do the same. To achieve this, at least four key priorities need to be delivered.

1. Ensure scaled up funding and global commitments to tackle adolescent pregnancies

Funding and policy prioritisation for tackling adolescent pregnancies needs to be urgently scaled up in line with the scale of the challenge. This will require significantly higher investments than those secured under FP2020 to date – possibly a fivefold increase if the lessons from the HIV pandemic response are indicative – so that meaningful and expedited progress towards the FP2020 and SDG goals can be achieved.

2. Re-double efforts to prevent child marriage and underlying gender norms

A key entrypoint to driving down adolescent pregnancy rates is investing in politically and culturally savvy approaches to change gendered norms that equate girls’ value with marriage and motherhood. Be careful to tackle harmful gender norms strategically – either directly (through information and awareness-raising with girls, their partners, in-laws and parents) or indirectly (by investing in girls’ education) where explicit messaging may elicit a backlash.

3. Develop regionally tailored approaches that speak to the divergent trends in child marriage and adolescent fertility across and within regions

While large investments in sub-Saharan Africa and fragile-state contexts remain imperative given the overall higher rates of child marriage and adolescent fertility, regions that are seeing slow progress or even reversals (as is the case with Latin America and East Asia) also demand attention if global goals are to be achieved. And although South Asia, and especially India, has seen significant progress over the last decade, a major investment in programming to harness and build upon this progress is similarly essential, given the absolute numbers of girls and families impacted.

4. Prepare for the future by investing in age-disaggregated data and comprehensive sex education

To track progress for adolescents at regional, national and sub-national levels, investing in age-disaggregated data collection around adolescent fertility and reproductive and sexual health services uptake is essential. Supporting the roll out of comprehensive sexuality education for all adolescents is also critically important now –but also due to future need. The global community needs to pay particular attention to demographic transitions already underway in Southeast Asia, where recent increases in adolescent fertility are driven by premarital sexual activity, coupled with social norms that limit adolescents’ access to sexuality education and contraception.

Notes

- 1 Disability-adjusted life years (DALYs) are a measure of the years of healthy life lost due to ill-health, disability or premature death. They estimate the gap between current health status and an ideal health status, with the entire population living to an advanced age free of disease and disability. For a specific health condition, DALYs are calculated as the sum of the years of life lost (YLL) due to premature death plus disability (YLD) for people living with the health condition (see <http://apps.who.int/adolescent/second-decade/section3/page4/dalys.html>).
- 2 Author's own calculations, using World Bank data.
- 3 www.familyplanning2020.org/about
- 4 www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf
- 5 The most common figure given for the proportion of adolescent pregnancies due to child marriage is 90%. However, Wodon et al. (2017), calculate the proportion as three in four adolescent pregnancies are due to child marriage and 84.4% of children born to adolescent mothers were born as a result of child marriage.
- 6 www.girlsnotbrides.org/about-child-marriage
- 7 Erulkar and Muthengi (2009); McQueston et al. (2012); Edmeades et al. (2014); Chandra-Mouli, et al. (2015); Haberland (2015); Svanemyr et al. (2015); Oringanje et al. (2009); Smith et al. (2016).
- 8 At the time of Ethiopia's last census in 2007, 27.2% of Amhara girls aged 15-19 were already married.
- 9 According to the 2011 Demographic and Health Survey, the median age at first marriage for all Amhara women aged 20-49 was 15.1 years (Central Statistical Agency and ICF International, 2012).
- 10 For example, the adolescent fertility rate in the Afar region climbed from 15.1% to 23.4% between 2011 and 2016 (Central Statistical Agency [Ethiopia] and ICF International, 2016).
- 11 In 2011, just over 20% of the world's 1.2 billion teenagers lived in India (UNICEF India, 2011).
- 12 According to the latest government figures, 26.8% of Indian girls were married as children (Government of India, 2017).

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