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World Fertility 2019

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Department of Economic and Social Affairs

Population Division

World Fertility 2019

Early and later childbearing among adolescent women aged 15-19 years

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New York, 2020

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The Population Division of the Department of Economic and Social Affairs provides the international community with timely and accessible population data and analysis of population trends and development outcomes for all countries and areas of the world. To this end, the Division undertakes regular studies of population size and characteristics and of all three components of population change (fertility, mortality and migration). Founded in 1946, the Population Division provides substantive support on population and development issues to the United Nations General Assembly, the Economic and Social Council and the Commission on Population and Development. It also leads or participates in various interagency coordination mechanisms of the United Nations system. The work of the Division also contributes to strengthening the capacity of Member States to monitor population trends and to address current and emerging population issues.

Notes

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The term “country” as used in this report also refers, as appropriate, to territories or areas.

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PREFACE

The Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat is responsible for providing the international community with up-to-date and scientifically grounded information on population and development. The Population Division provides substantive support to the United Nations General Assembly, the Economic and Social Council and the Commission on Population and Development on population and development issues and undertakes regular studies on population levels and trends, including trends of fertility, nuptiality and family planning, changes in population policies and the interrelationships between population and development.

As part of its work on fertility, the Population Division monitors levels and trends in fertility by age of the mother, as well as its proximate determinants, such as marriage and contraceptive use. The Division also collects and analyses information on the linkages between fertility, family planning and sustainable development, and provides substantive support to intergovernmental processes at the United Nations that consider these topics. The Population Division is the designated custodian agency of indicators used for tracking progress toward target 3.7 of the Sustainable Development Goals (SDGs), including indicator 3.7.2, the adolescent birth rate (numbers of births per 1,000 adolescent girls aged 10-14, or per 1,000 young women aged 15-19), and indicator 3.7.1, the percentage of the total need for family planning that is being satisfied with modern contraceptive methods. A custodian agency is a United Nations body or other international organization responsible for developing and recommending international standards and methodologies for monitoring progress toward the achievement of the SDGs. Other responsibilities include compiling and verifying internationally comparable country-specific data and associated metadata, estimating regional and global aggregates and using such data for thematic reporting.

This report presents new estimates of adolescent fertility at ages 15-19, broken down further into age groups 15-17 and 18-19. The period under review, from 1990 to 2020, included the adoption in 1994 and more than 25 years of implementation of the Programme of Action of the International Conference on Population and Development; it also encompassed the entire era of reference for the Millennium Development Goals, from 1990 to 2015, as well as the first five years of the 2030 Agenda for Sustainable Development and its new set of global Goals. The data presented here come mainly from *World Population Prospects 2019*, which presents the latest population estimates and projections published by the United Nations. The analysis also relies on country-specific data from other relevant sources, including the Demographic and Health Surveys.

The present report, *World Fertility 2019: Early and later childbearing among adolescent women aged 15-19 years,* has been issued without formal editing. Responsibility for the report rests with the Population Division.

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FIGURES

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EXPLANATORY NOTES

The following symbols have been used in the tables throughout this report:

A minus sign (-) before a figure indicates a decrease or negative number.

A full stop (.) is used to indicate decimals.

Use of a hyphen (-) between years, for example, 1995-2000, signifies the full period involved, from 1 July of the first year to 1 July of the second year.

An em dash (—) indicates that the magnitude is not zero, but less than half of the unit employed (i.e. is rounded to 0, when in fact it is not 0)

A 0 or 0.0 indicates that the magnitude is zero

Two dots (..) indicate that data are not available or are not reported separately

Numbers and percentages in this table do not necessarily add to totals because of rounding.

References to regions, subregions, development groups, countries or areas:

The designations employed in this publication and the material presented in it do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The term "country" as used in this publication also refers, as appropriate, to territories or areas.

In this report, data for countries and areas are often aggregated in six continental regions: Africa, Asia, Europe, Latin America and the Caribbean, Northern America, and Oceania. Further information on continental regions is available from https://unstats.un.org/unsd/methodology/m49/. Countries and areas have also been grouped into geographic regions based on the classification being used to track progress towards the Sustainable Development Goals of the United Nations (see: https://unstats.un.org/sdgs/indicators/regional-groups/).

The designation of "more developed" and "less developed", or "developed" and "developing", is intended for statistical purposes and does not express a judgment about the stage in the development process reached by a particular country or area. More developed regions comprise all countries and areas of Europe and Northern America, plus Australia, New Zealand and Japan. Less developed regions comprise all countries and areas of Africa, Asia (excluding Japan), Latin America and the Caribbean, and Oceania (excluding Australia and New Zealand).

The group of least developed countries (LDCs) includes 47 countries, located in sub-Saharan Africa (32), Northern Africa and Western Asia (2), Central and Southern Asia (4), Eastern and South-Eastern Asia (4), Latin America and the Caribbean (1), and Oceania (4). Further information is available at http://unohrlls.org/about-ldcs/.

The group of Landlocked Developing Countries (LLDCs) includes 32 countries or territories, located in sub-Saharan Africa (16), Northern Africa and Western Asia (2), Central and Southern Asia (8), Eastern and South-Eastern Asia (2), Latin America and the Caribbean (2), and Europe and Northern America (2). Further information is available at http://unohrlls.org/about-lldcs/.

The group of Small Island Developing States (SIDS) includes 58 countries or territories, located in the Caribbean (29), the Pacific (20), and the Atlantic, Indian Ocean, Mediterranean and South China Sea (AIMS) (9). Further information is available at http://unohrlls.org/about-sids/.

The classification of countries and areas by income level is based on gross national income (GNI) per capita as reported by the World Bank (June 2018). These income groups are not available for all countries and areas.

* For country notes, please refer to: https://population.un.org/wpp/Download/Metadata/Documentation

List of Abbreviations

ABR	Adolescent birth rate at ages 15-19 years
DHS	Demographic and Health Survey
ICPD	International Conference on Population and Development
SDG	Sustainable Development Goal
TFR	Total fertility rate

INTRODUCTION

The 2030 Agenda for Sustainable Development includes 17 Sustainable Development Goals, which established 169 quantifiable targets across the social, economic and environmental dimensions of sustainable development, and a framework of 232 indicators for assessing the global progress toward reaching those targets.[1] Goal 3 calls for ensuring healthy lives and promoting well-being for all at all ages. One of the indicators under target 3.7 on sexual and reproductive health is the adolescent birth rate (ABR). This report presents new estimates of adolescent fertility at ages 15-19, broken down further into age groups 15-17 and 18-19. The period under review, from 1990 to 2020, included the adoption in 1994 and more than 25 years of implementation of the Programme of Action of the International Conference on Population and Development; it also encompassed the entire era of reference for the Millennium Development Goals, from 1990 to 2015, as well as the first five years of the 2030 Agenda for Sustainable Development and its new set of global Goals.

The Programme of Action noted the importance of addressing issues related to adolescent sexual and reproductive health and substantially reducing adolescent pregnancies. As stated in Chapter 7: "Poor educational and economic opportunities and sexual exploitation are important factors in adolescent child-bearing. In both developed and developing countries, adolescents faced with few life choices have little incentive to avoid pregnancy and child-bearing."[2] Furthermore, the Programme of Action noted that "early marriage and early motherhood can severely curtail educational and employment opportunities of adolescents and are likely to have a long-term, adverse impact on their and their children's quality of life." Moreover, "motherhood at a very young age entails a high risk of maternal death, while children born to young mothers have higher levels of morbidity and mortality".

The Programme of Action also observed that the reproductive health needs of adolescents had been largely ignored by reproductive health services. It recommended actions that governments should take to substantially reduce adolescent pregnancies and to address adolescent sexual and reproductive health issues, including unwanted pregnancies, unsafe abortions and sexually transmitted infections. The MDGs emphasized the importance of expanding access to reproductive health for adolescents and investing in the human capital of girls as a core component of the global development agenda. The SDGs, embedded in the 2030 Agenda for Sustainable Development, elaborated on these and related targets and strategies.

Overall, adolescent fertility has fallen significantly since 2004 (United Nations, 2019; World Bank Group, 2015). However, disparities across and within countries and between population groups indicate that large numbers of young people do not have access to means of controlling their fertility, with important implications for their well-being. The 2030 Agenda recognizes the interdependence between ensuring universal access to sexual and reproductive health-care services and other development goals, including ending poverty in all its forms, as poverty is associated with higher rates of teenage marriage, pregnancy and childbirth.

Addressing the multiple factors underlying adolescent births is indispensable for improving sexual and reproductive health and the social and economic well-being of adolescents. Earlier reports[3] drew attention to the social and demographic factors underlying adolescent fertility. *World Fertility 2019* presents the

[1] A/RES/70/1 and Annex of A/RES/71/313
[2] Paragraph 7.42
[3] See for instance *World Fertility Report 2015* (United Nations, Department of Economic and Social Affairs, 2017a) and *Adolescent Fertility since the International Conference on Population and Development (ICPD) in Cairo* (United Nations, Department of Economic and Social Affairs, 2013).

latest analysis of levels and trends in adolescent fertility worldwide over the past 30 years and, wherever possible, presents disaggregated information pertaining to age groups 15-17 and 18-19 years.[4]

This report is organized in five chapters following this introduction. Chapter I presents a summary of the sources of data and estimation methods. Information about the data sources used for the estimation of fertility, and about their limitations, is provided in *World Fertility Report 2015* (United Nations, 2017a). Chapter II reviews the levels and trends in adolescent birth rates for each country or area with an estimated population of at least 90,000 in 2019. Chapter III presents measures of adolescent fertility separately for age groups 15-17 and 18-19 for countries with available microdata. Chapter IV discusses some policy considerations.

[4] Childbearing among girls aged 10 to 14 years, a continuing concern in selected countries, is the subject of the *World Fertility Report 2017*.

I. DATA SOURCES AND ESTIMATION METHODS

The data used to assess the levels and trends in the adolescent birth rate from 1990 to 2020 are those contained in *World Population Prospects 2019*, the latest set of global population estimates and projections by the United Nations (United Nations, 2019a). The methodology and data sources that underlie these estimates have been described elsewhere (United Nations, 2017b). The data used to measure adolescent fertility levels separately for age groups 15-17 and 18-19 years, and other selected indicators associated with adolescent fertility, were drawn from the Demographic and Health Surveys (DHS), which provide internationally comparable information for 78 countries and areas.

Adolescent fertility is measured by the adolescent birth rate, which is the annual number of births to women aged 15-19 years of age per 1,000 women in that age group. The numerator consists of the number of births tabulated according to the age of mother at the time of the birth during the 3-year period before the survey. The denominator consists of the number of woman-years of exposure to childbearing in the 3 years before the survey. The denominator takes into account both the number of women in the survey and the amount of time each woman spends at ages 15-19 in the 3-year window prior to the survey.

This report does not address the extent to which adolescent birth rates may be diminished due to recourse to abortion in these ages. Using data on levels and trends in family planning among adolescents from *World Contraceptive Use 2019* (United Nations, 2019b) makes it possible to analyse the relationship between family planning and adolescent fertility and to explore how these are related to patterns of early marriage and union formation.

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II. ADOLESCENT FERTILITY: TRENDS OVER TIME

A. ADOLESCENT BIRTH RATE FROM 1990 TO 2020

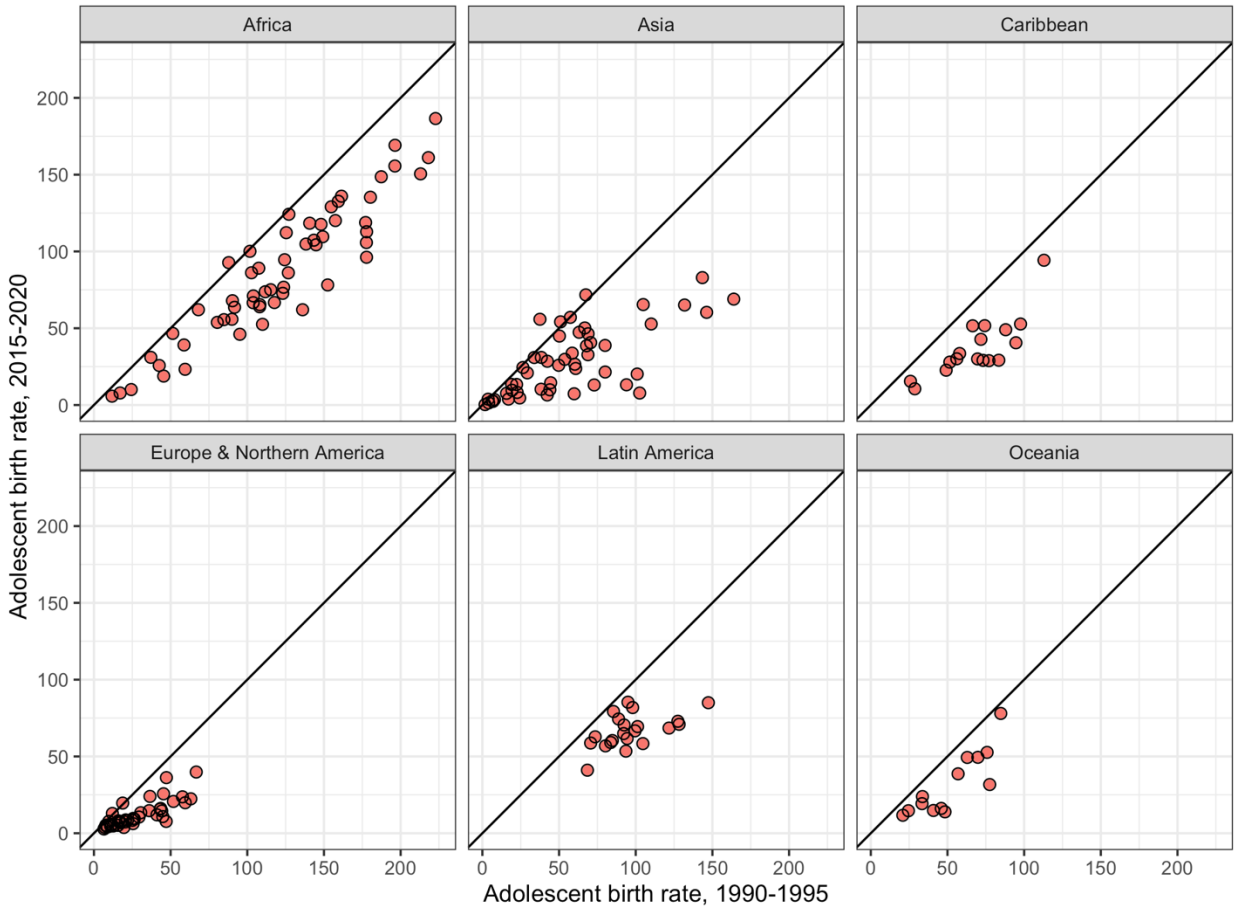
Estimates of the adolescent birth rate are available for 2015-2020 for 201 countries or areas with populations of at least 90,000 (United Nations, 2019a). The broad regional patterns of adolescent fertility have not changed much with respect to those documented in previous reports (United Nations, 2013, 2017a). In 2015-2020, Africa had the highest levels of the ABR, followed by Asia and Latin America and the Caribbean. The lowest levels were observed in Europe and Northern America, followed by Oceania. Exceptions were noted for a few countries in Africa with relatively low levels of adolescent fertility: Algeria, Libya and Tunisia.

A decline in the adolescent birth rate has been almost universal across regions and countries. The bubbles in Figure 1 show the adolescent birth rates for countries or areas in 2015-2020 compared to the levels of 1990-1995, grouped by region. The markers under the diagonal line show countries where the adolescent birth rate has declined: the further below from the diagonal line, the greater the decline in the adolescent birth rate. Some of the largest declines occurred in Asia, particularly in countries that had relatively high values of the ABR in 1990-1995: for example, Afghanistan, Armenia, Bhutan, Lao Peoples Democratic Republic, Nepal, Pakistan, State of Palestine and Yemen (United Nations, Department of Economic and Social Affairs, 2019a).

Rapid fertility declines were observed in all the major regions depicted in figure II.1. Of the 77 countries and areas where adolescent fertility declined by more than 50 per cent between 1990-1995 and 2015-2020, 28 were in Asia, 28 in Europe, 8 in Africa (Algeria, Botswana, Djibouti, Eritrea, Libya, South Sudan, Tunisia and Western Sahara), 7 in the Caribbean (Aruba, Bahamas, Grenada, Martinique, Puerto Rico, Saint Lucia and the United States Virgin Islands), four in Oceania (Guam, Kiribati, Micronesia and New Caledonia), and two in Northern America (Canada and the United States).

In 2015-2020, adolescent fertility was still relatively high, with 80 births or more per 1,000 adolescent girls aged 15-19 years, in 34 countries, including 29 in Africa. For some of these countries, the ABR exceeded 140 per 1,000, including six in Africa (Angola, Chad, Equatorial Guinea, Mali, Niger and Mozambique), four in Latin America and the Caribbean (Dominican Republic, Nicaragua, Panama and Venezuela), and one in Asia (Bangladesh).

Figure II.1. Adolescent birth rate at ages 15-19, by country and region, 2015-2020 versus 1990-1995



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019a).

B. Pace of change in the adolescent birth rate

The pace of decline in adolescent fertility and comparisons with the decline in total fertility have been reported elsewhere (United Nations, 2012; United Nations, 2013, 2017). This report examines trends in 104 countries that had similar levels of the adolescent birth rate in 2015-2020 and assesses the pace of decline across countries. The countries shown in figure 2 are those where the adolescent birth rate changed by at least 5 births per 1,000 women between 1990-1995 and 2015-2020. A number of countries with similar levels of adolescent fertility were located in different regions, for example, Botswana and Georgia, Brunei Darussalam and Qatar, Estonia and Maldives, Myanmar and Puerto Rico, and Bhutan and the United States. Others were located in the same region, for example, Brazil and Uruguay; Croatia and Montenegro; Ethiopia and Ghana; and Nicaragua and Venezuela.

These comparisons raise questions about the factors associated with the convergence of the ABR in 2015-2020 among countries that were further apart in the level of ABR in 1990-1995.[5] The advent of modern contraceptive methods helped couples and individuals to avoid unintended pregnancies. Barrier methods reduced the spread of sexually transmitted infections (STIs) and, therefore, helped to reduce rates of infertility. Also, in countries where access to abortion became an established practice before modern contraceptives were available, women had an alternative to carrying an unintended pregnancy to term (van de Kaa, 2002). Variation in the adoption and spread of birth control practices, among other factors, might explain the convergence of the ABR in 2015-2020 for some countries.

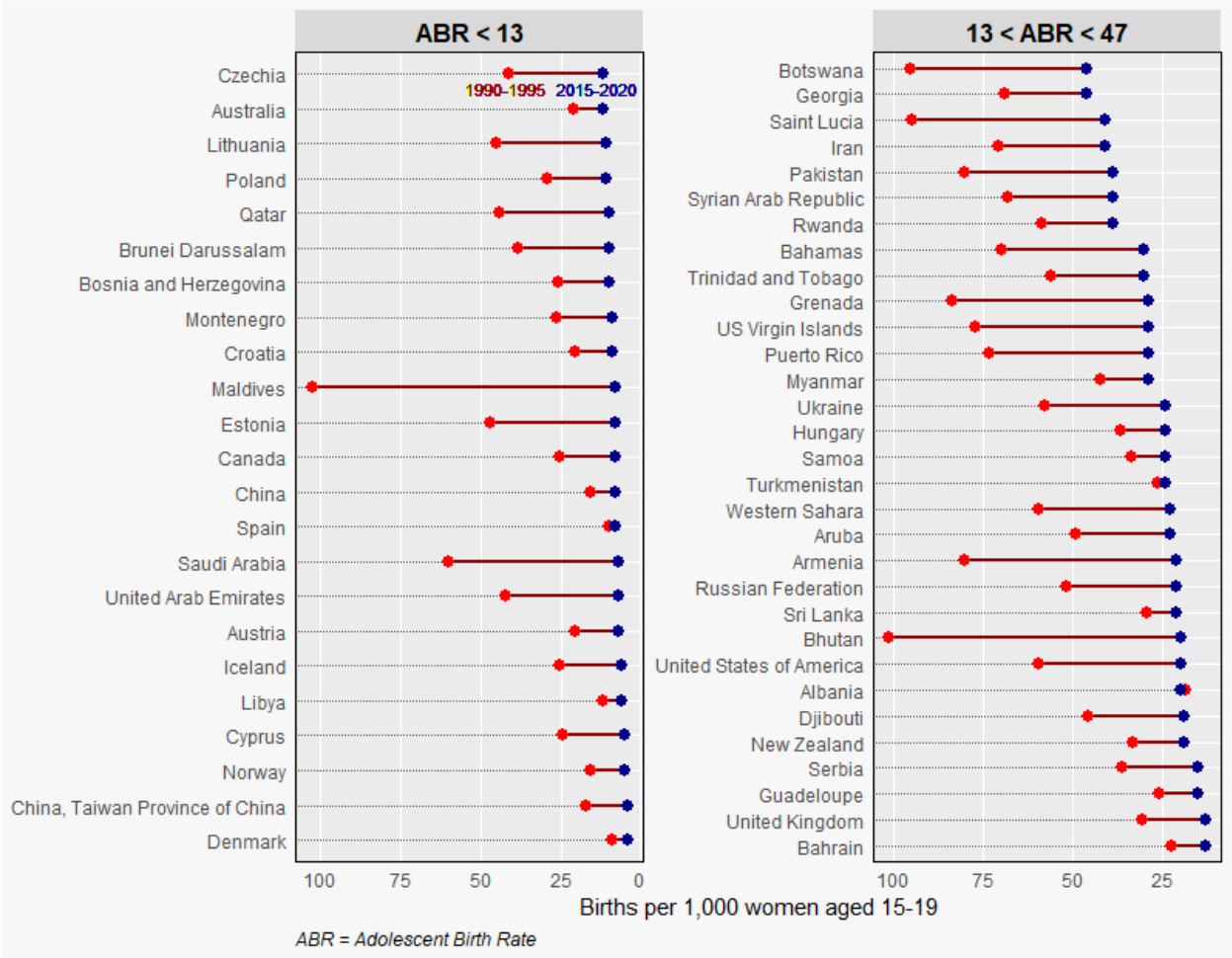
A recent study of the relationship between the adolescent birth rate and socioeconomic indicators shows that national trends in adolescent fertility between 1990 and 2012 were associated with trends in per capita gross domestic product (GDP), income inequality and educational expenditures (Santelli et al., 2017). For example, Namibia and Sudan had similar levels of adolescent fertility in 2015-2020 (64 births per 1,000 women), despite Sudan's lower levels of per capita GDP and expenditures on education. However, Sudan had significantly lower income inequality in 2012 than Namibia (Santelli et al., 2017). The improvements in income inequality in Sudan appear to have been an important contributing factor to the decline in adolescent fertility there, bringing it close to the level for Namibia. This is also broadly consistent with the fact that the largest declines in the adolescent birth rate occurred in the three regions (using World Bank designations) with the lowest income inequality in 1990: Europe and Central Asia, Middle East and North Africa and South Asia. In sum, reductions in poverty and income inequality, among other factors, may account for the convergence of adolescent birth rates in 2015-2020 among some countries that had disparate adolescent birth rates in 1990-1995.

Another example is that of Nicaragua and Venezuela, which had achieved similar levels of adolescent fertility by 2015-2020 (85 births per 1,000 women) despite having different starting levels of adolescent fertility in 1990-1995 (figure II.2), as well as differences in per capita income, income inequality and educational expenditures (Santelli et al., 2017). In 2012, both GDP per capita and national expenditures on education as a percentage of GDP were lower in Nicaragua than in Venezuela, while income inequality was slightly lower in Venezuela than in Nicaragua. In 1990-1995, the adolescent birth rate in Nicaragua was considerably higher (147 births per 1,000 women) than in Venezuela (95 births per 1,000 women). Yet, by 2015-2020, the adolescent births rates in the two countries had converged to 85 per 1,000 women. The pace of decline in the adolescent birth rate in Nicaragua was faster despite its restrictive abortion policy and lower indicators of socioeconomic development compared to Venezuela (Mendoza-Cardenal, 2016), amidst the recent political instability there.

Other cases seem to point to factors such weak governance or civil conflict in countries such as Libya, Myanmar, Rwanda and Zimbabwe. The variation in the pace of decline of adolescent fertility reflects the diversity and complexity of these factors, even within the same region (Hanafi, 2014; Mendoza-Cardenal, 2016; Avellaneda and Dávalos, 2017; Camila and others, 2017).

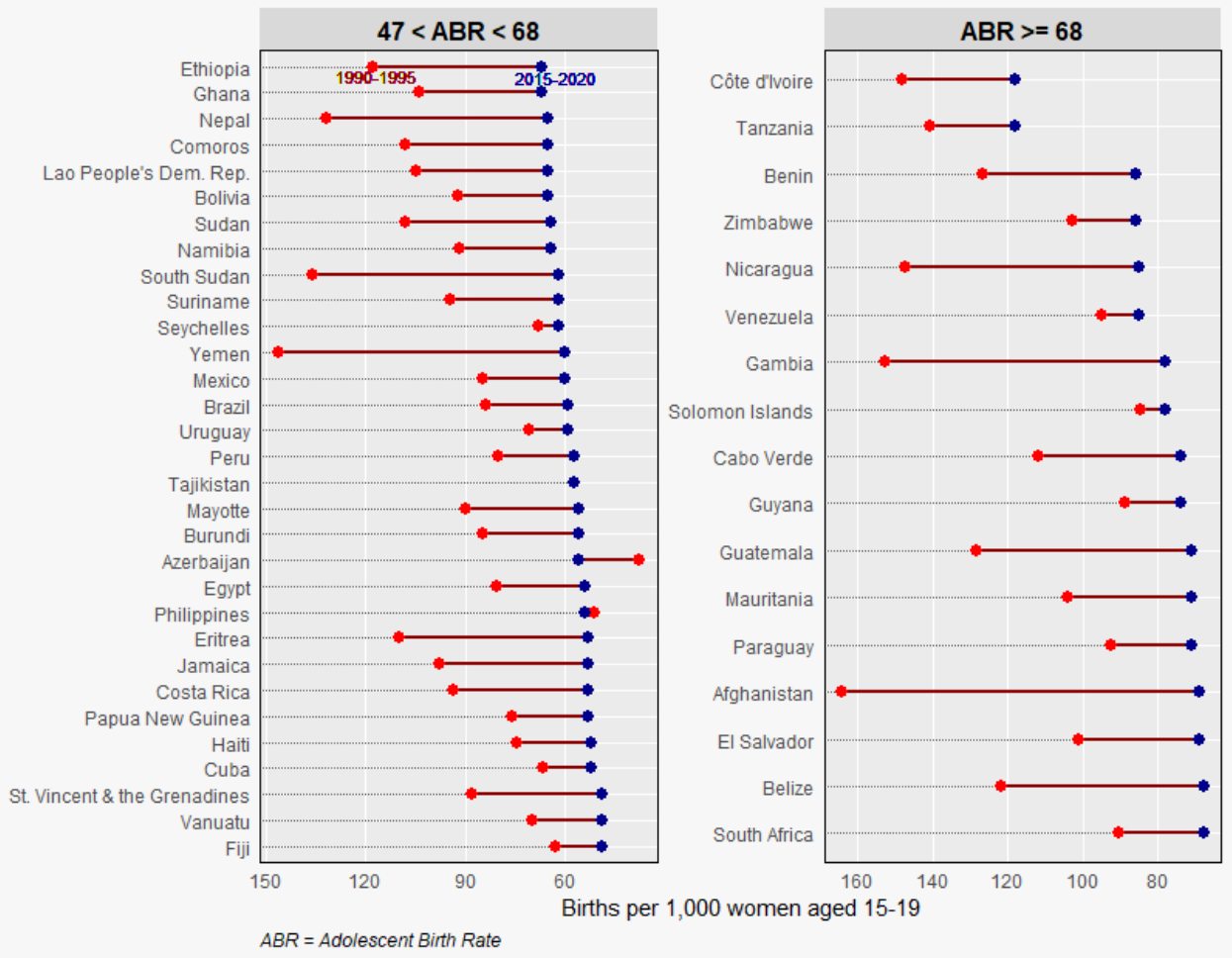
[5] One of the factors to consider is the history of family planning services in each country. Family planning is one of the 10 great public health achievements of the twentieth century, on a par with such accomplishments as vaccination and advances in motor vehicle safety (Centers for Disease Control and Prevention (CDC), 1999).

Figure II.2. Trends in the adolescent birth rate at ages 15-19 from 1990-1995 to 2015-2020 among countries with similar levels of adolescent fertility in 2015-2020 (in descending order by level in 2015-2020)



Note: Adolescent Birth Rate (ABR).
Source: United Nations, Department of Economic and Social Affairs, Population Division (2019a).

Figure II.2 (continued)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019a).

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III. ADOLESCENT FERTILITY: DIFFERENCES BY AGE

A. ADOLESCENT BIRTH RATE AT AGES 15-17 AND 18-19

Indicators of sexual and reproductive health of adolescents are commonly based on the age group from 15 to 19 years, a legacy of data collection practices and policies that limited the sample selection or questions on reproductive health to women in the main reproductive ages (15-49 years). While data pertaining to the age group 15-19 years are useful for the regional and global monitoring of trends, they do not enable a detailed assessment of sexual and reproductive behaviour in relation to adolescent development, puberty and the legal age of majority. Limiting the study of sexual and reproductive behaviour to adolescents aged 15-19 omits the lived experience of girls under age 15 at the time of the survey. Often, the indicators of sexual and reproductive health and behaviour before age 15 are based on responses to retrospective questions by older women, whose experience may be far removed from the current situation of adolescents. The global decline in the age of menarche, the rising age at marriage and changing societal values present a widening window for sexual activity among young adolescents (National Research Council and Institute of Medicine, 2005; Prentice et al., 2010; Pathak et al., 2014; Song et al., 2015).

Adolescent fertility is a different phenomenon when it occurs at different development periods in the lives of young people. The needs and challenges of girls aged 14 years or younger are markedly different from those aged 15-17 or 18-19 and vary according to the regional, socio-economic and cultural context. Girls who begin sexual activity at young ages take longer to initiate contraceptive use and are less likely to use contraception to avoid pregnancy (Guleria et al., 2017). It is likely that the relatively low rates of contraceptive use at first sex among young adolescents are due to lack of information and restrictions on contraceptive use (Finer and Philbin, 2013). Girls who become pregnant before the age of 18 are susceptible to heightened risks of health complications, which can be severe among girls younger than age 15 and extend also to their new-borns (World Health Organization, 2011).

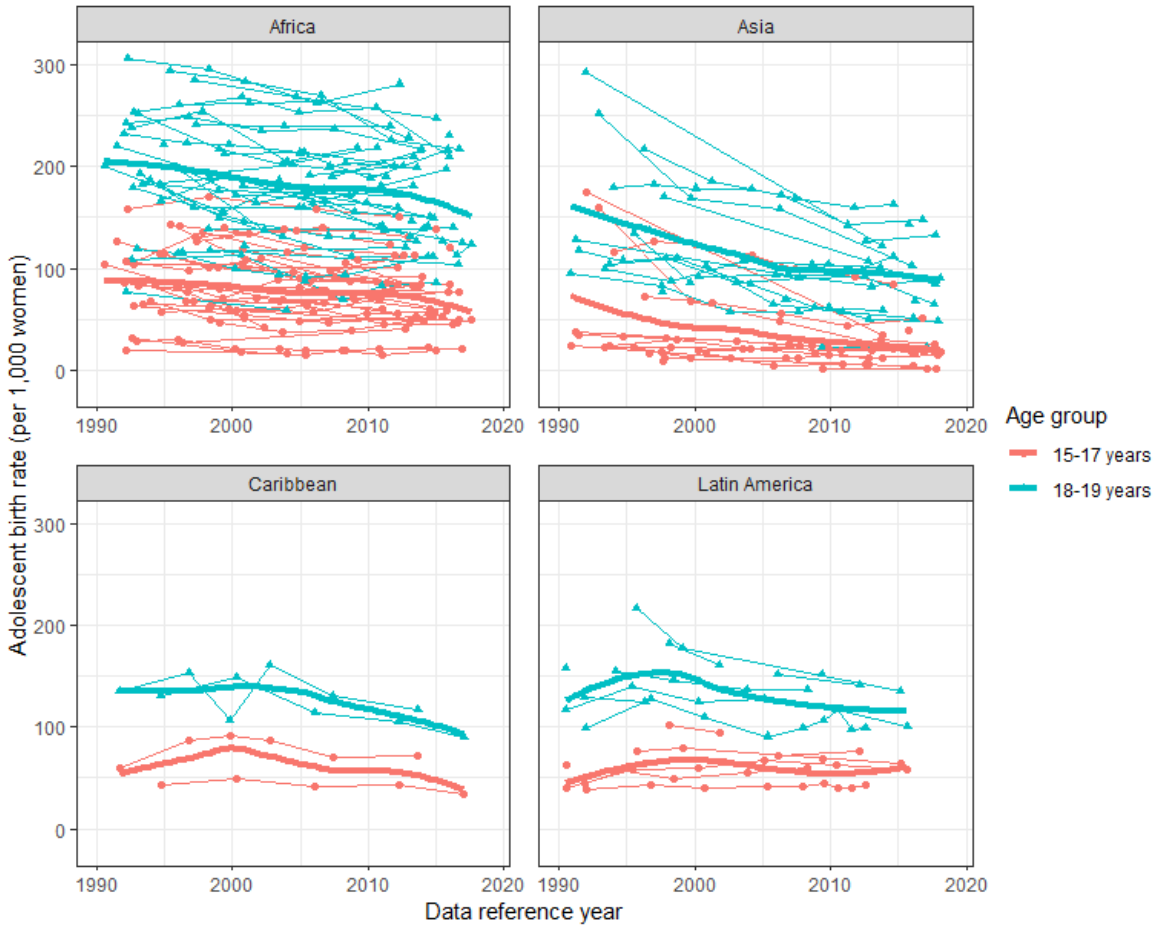
Breaking the period of adolescence into three age categories (ages 10-14, 15-17 and 18-19) has been proposed, based on the physiological readiness of the female body for childbearing, cognitive capacities, normative expectations and legal requirements governing the transition to adulthood (Dixon-Mueller, 2008). Many adolescents, including those who experience menarche early, will not necessarily be physically mature until ages 15-17. Even then, many may lack knowledge of sexual and reproductive health or, even if they have such information, may not have the capacity to act on it.

By age 18 or older, most adolescents are likely to have developed capacities or competencies to make informed decisions about their sexual and reproductive health. In most countries, the age of majority is 18 years, which is also the minimum legal age for women to marry without parental consent in most (158) countries. This suggests that legally independent adolescents aged 18 and 19 may face fewer constraints in accessing sexual and reproductive health-care services than girls and boys below 18 years of age. In most developing countries (146), adolescent pregnancy often occurs within the context of child marriage, abetted by state or customary law allowing girls younger than age 18 to marry with the consent of parents or other authorities. With parental consent, girls under age 15 can marry in 52 countries, although in many cases it is not a question of consent but rather that the parents have arranged the marriage. In 23 countries, adolescents below age 18 are permitted to marry legally without special permissions (Arthur et al., 2018). In such settings, many girls will have already become pregnant by the time they reach the age of 18 to 19 years old.

The in-depth study of sexual and reproductive health among adolescents clearly requires an analysis by age that goes beyond the conventional age group from 15 to 19 years. While research findings indicate that in most countries childbearing is rare among girls below age 15, in some countries, including Angola, Bangladesh, Cameroon, Gabon, Kenya, Liberia, Malawi, Mali, Niger, Nigeria, Tanzania and Uganda, between 7 and 15 per cent of girls have had a child before age 14 (World Health Organization, 2007; Finer and Philbin, 2013; Neal and Hosegood, 2015; MacQuarrie et al., 2017).

Adolescents below age 18 are generally not considered "adults" unless the applicable law indicates that majority status is attained earlier (UNICEF, 1989). Nevertheless, the term "women" is applied to them to be consistent with the conventional definition and calculation of the adolescent birth rate.

Figure III.1. Adolescent birth rates at ages 15-17 and 18-19 over time, by region and country, 1990-2018



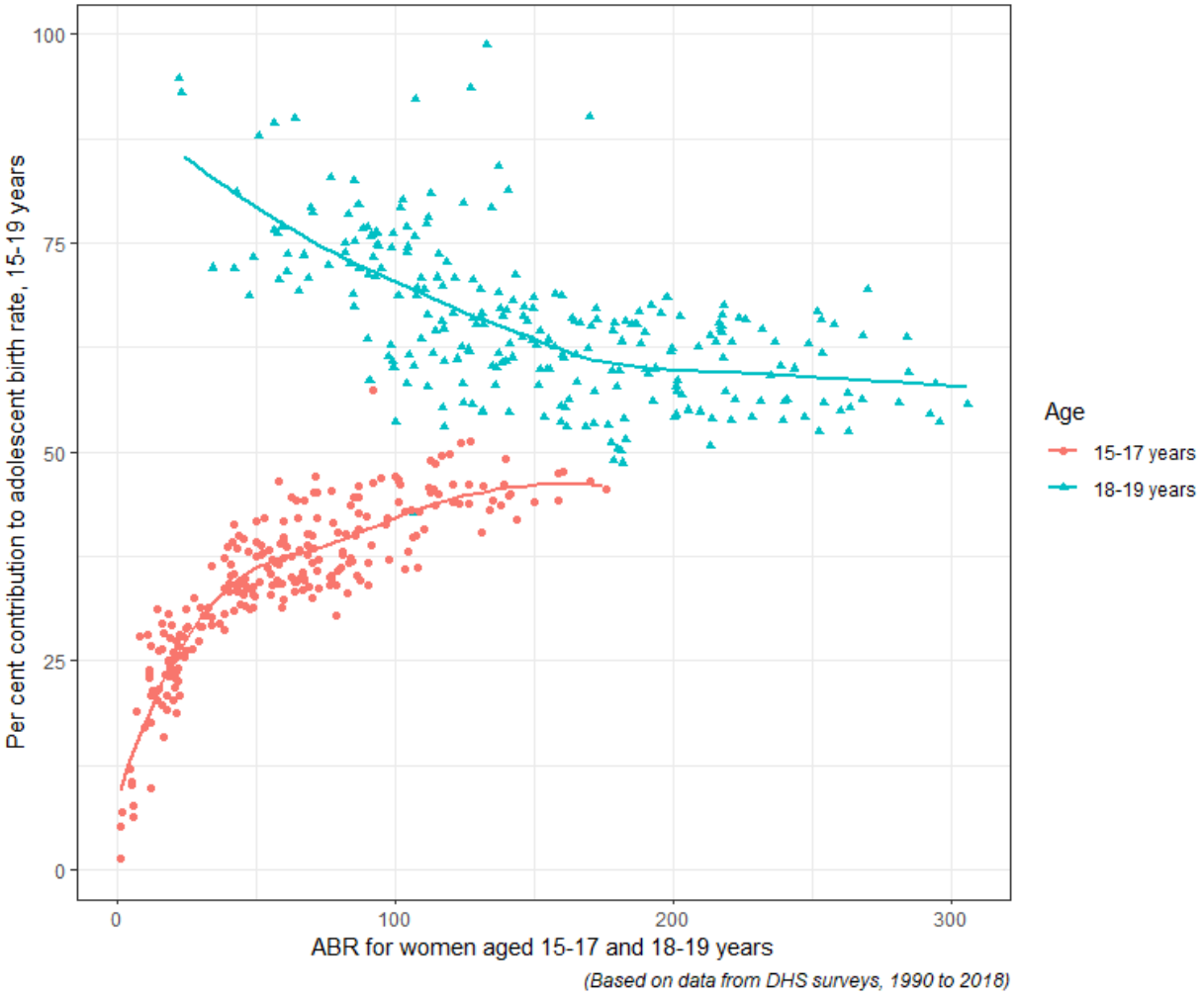
The data analysed in this chapter are derived from the Demographic and Health Surveys (DHS), which enable the analysis of adolescent fertility rates in two separate age groups: 15-17 years and 18-19 years. Individual-level records from the DHS are available since 1990 for 250 surveys from 75 countries. For the period 1990-1995, data are available for 46 surveys from 39 countries. For the most recent period, starting from 2010, they are available for 71 surveys from 56 countries. Twenty-nine countries have data for both the earlier and most recent period. Fifty-seven per cent of the data come from Africa, 30 per cent from Asia and 11 per cent from Latin America and the Caribbean.

B. Trends in adolescent fertility at ages 15-17 and 18-19

Figure III.1 shows the levels and trends in adolescent birth rates among women aged 15-17 years (in red) and 18-19 years (in blue) by region from circa 1990 to circa 2018. Each thin line on the chart represents the trend for an individual country, while each bold line shows the average trend for countries in the region. As expected, birth rates among older adolescents aged 18-19 tend to be higher than among younger adolescents aged 15-17. A comparison across regions shows that birth rates for women aged 15-17 years in several African countries were higher than or equal to those for older adolescents aged 18-19 years in Asia, Latin America and the Caribbean (Annex table A.1). Not only are birth rates among adolescent women aged 15-17 and 18-19 years higher in Africa than in the other regions, but also there are large variations among African countries. The wide variations in levels of adolescent fertility in Africa correspond to large variations in the gross enrolment ratio for girls at the lower secondary school level and underlying early and recurrent pregnancy among adolescents, including a high prevalence of child marriage and early sexual initiation (African Union, 2015; El Nagar et al., 2017; High-Level Meeting on Ending Child Marriage in West and Central Africa, 2017).

The contributions of adolescent fertility at ages 15-17 and 18-19 are depicted as a percentage of the adolescent birth rate for ages 15-19 years (Figure III.2). The countries shown are listed in annex table A.2. The percentage contribution of the adolescent birth rate at ages 15-17 was positively associated with the rate for women in that age range: in countries where the adolescent birth rate at ages 15-17 was high, the contribution of those ages to the ABR for ages 15-19 also tended to be high. This percentage was below 50 per cent with few exceptions, including Bangladesh in 1996 and 1999 and the Dominican Republic in 1999. Conversely, the percentage contribution attributed to ages 18-19 tended to be high when the ABR at those ages was low. In 16 countries (Armenia, Azerbaijan, Cambodia, Egypt, India, Jordan, Kazakhstan, Kyrgyzstan, Maldives, Philippines, Republic of Moldova, Rwanda, Tajikistan, Timor-Leste, Uzbekistan and Viet Nam), the contribution of the birth rate at ages 18-19 to the ABR for ages 15-19 was 75 per cent or above (Annex table A.2).

Figure III.2. Percentage contribution of adolescent birth rate (ABR) at ages 15-17 and 18-19 to the ABR at ages 15-19 years, by level of ABR at ages 15-17 and 18-19, 1990-2018



IV. SOME POLICY CONSIDERATIONS

Levels and trends of adolescent fertility depend on the opportunities and constraints that young women face in different contexts. Staying in school longer, especially beyond primary school, and having access to reproductive health-care services and information, particularly before adolescents become sexually active, tend to keep adolescent fertility low. The absence of such opportunities is reinforced in many settings by poverty, which further constrains the decisions or choices that young women make or that are made for them. Early marriage is the most common factor associated with adolescent fertility, since most first births among young women occur within marriage. Conception before marriage and large age differences between partners are common among adolescents in many developing countries. Some research suggests that large age gaps are markers of gendered power dynamics at the individual, household and societal levels (Kolk, 2015) that are almost invariably not in favour of young women.

Innovative approaches to providing reproductive health care attuned to the needs of adolescents include programs that respect young women's privacy and discretion, as well as counselling tailored to the unique needs of young people. Cross-national research on adolescent fertility suggests varied factors associated with the levels and trends in adolescent birth rates. Among them, political and cultural differences inform public policies that either discourage sexual activity or deem teenage sexuality as developmentally appropriate (Schalet, 2000; Carpenter, 2005), with consequences for contraceptive use, pregnancy, and pre- and post-natal health care. Settings where premarital sexual activity is stigmatized, and where stigmatization is viewed as a means of preventing teenage pregnancy, tend to be less effective in promoting contraceptive use (Furstenberg Jr, 2016).

Low levels of adolescent fertility are prevalent in countries that have adopted pragmatic policies and strategies to avoid teenage pregnancy and parenthood, including the promotion of sex education and contraceptive use through mass media and schools (Jones et al., 1985; Weaver et al., 2005). Even in developed countries, research has identified a need to expand comprehensive sex education programs and access to sexual health services, including contraception.

The increased penetration of mobile phones in developing countries, even among younger people, is providing agencies, countries and health experts with a direct channel of communication to improve family planning and health programmes (USAID Bureau for Africa, 2012; Babalola and others, 2017a; Ippoliti and L'Engle, 2017; Babalola and others, 2017b). However, although mobile phones have become an indispensable communication tool all over the world, the associated cost may exclude very poor young women from receiving family planning information. This situation may be exacerbated by the digital divide between men and women that persists in many countries: in 2019, women were 26 per cent less likely than men to use mobile internet services in low- and middle-income countries, where cost and illiteracy remain the greatest barriers to owning and using a mobile phone (GSM Association, 2019).

In sum, the common thread in reducing adolescent childbearing is to provide young women with access to the information, services and support that they need to navigate their sexuality and avoid pregnancy. Reducing teenage pregnancy and childbearing will require policies and strategies to address these and other drivers of adolescent fertility. While many countries have national policies and curricula that support comprehensive sex education in schools (Woog and Kågesten, 2017), the quality of such education is often unknown.

To live up to the pledge that no one will be left behind, the international community will need to support the advancement of young girls and adolescent women and to ensure they are granted the right to determine

freely their choice of a partner and of the number and spacing of their children. The exercise of such rights can make a critically important contribution to advancing young women's health and living conditions and thereby to realizing the aspirations of the 2030 Agenda for Sustainable Development, including the achievement of its Sustainable Development Goals.

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ANNEX TABLES

Table A.1. Adolescent birth rate for age groups 15-17, 18-19 and 15-19, by region, country or area, 2010-2017

Region, country or area	Period	Reference year	Adolescent birth rate (per 1,000)		
			Ages 15-17	Ages 18-19	Ages 15-19
Africa					
Angola	2015 - 2016	2014	120.4	231.2	162.5
Benin	2011 - 2012	2011	55.1	152.2	93.8
Burundi	2016 - 2017	2015	20.3	124.4	58.2
Cameroon	2011	2010	85.7	189.9	126.5
Chad	2014	2014	139.2	247.2	179.1
Comoros	2012	2011	40.4	120.9	70.1
Congo	2011 - 2012	2010	112.2	200.3	147.2
Côte d'Ivoire	2011 - 2012	2011	101.1	171.4	128.7
Dem. Republic of the Congo	2013 - 2014	2012	84.5	215.3	138.0
Egypt	2014	2013	21.6	111.3	56.4
Gabon	2012	2011	84.9	159.4	113.4
Gambia	2013	2012	49.2	146.2	88.0
Ghana	2014	2013	53.0	111.5	76.3
Guinea	2012	2011	113.5	201.0	146.2
Kenya	2014	2013	59.4	150.5	96.1
Lesotho	2014	2013	57.1	149.3	94.2
Liberia	2013	2012	112.8	209.4	149.3
Malawi	2015 - 2016	2014	83.9	209.0	135.7
Mali	2012 - 2013	2011	131.4	228.3	171.6
Mozambique	2011	2010	123.0	240.0	166.6
Namibia	2013	2012	51.9	126.3	82.3
Niger	2012	2011	149.9	281.2	205.8
Nigeria	2013	2012	82.0	180.6	121.6
Rwanda	2014 - 2015	2014	18.6	85.5	44.7
Senegal	2017	2016	49.8	124.0	77.5
Sierra Leone	2013	2012	81.2	199.4	125.0
South Africa	2016	2015	49.8	104.1	71.1
Togo	2013 - 2014	2013	47.7	138.5	84.3
Uganda	2016	2015	76.6	217.1	131.3
United Republic of Tanzania	2015	2014	77.2	216.3	132.2
Zambia	2013 - 2014	2012	91.6	217.7	141.2
Zimbabwe	2015	2014	59.1	197.6	110.0

Region, country or area	Period	Reference year	Adolescent birth rate (per 1,000) Ages 15-17	Ages 18-19	Ages 15-19
Asia					
Afghanistan	2015 - 2016	2016	38.7	143.2	77.8
Armenia	2015 - 2016	2015	4.7	51.0	24.0
Bangladesh	2014	2013	83.9	162.4	113.4
Cambodia	2014	2013	20.6	111.7	57.4
India	2015 - 2016	2014	18.0	101.7	51.4
Indonesia	2017	2016	18.5	65.2	36.1
Jordan	2017 - 2018	2016	14.1	47.5	26.9
Kyrgyzstan	2012	2011	5.8	107.1	44.4
Maldives	2016 - 2017	2016	0.8	22.3	9.9
Myanmar	2015 - 2016	2015	16.0	67.0	36.4
Nepal	2016 - 2017	2017	51.2	147.4	88.2
Pakistan	2017 - 2018	2017	18.1	90.0	45.5
Philippines	2017	2016	24.8	84.7	46.9
Tajikistan	2017	2016	1.2	132.9	54.3
Timor-Leste	2016	2015	17.2	88.2	41.9
Turkey	2013 - 2014	2012	11.4	59.2	28.8
Yemen	2013	2012	34.1	121.3	67.2
Europe					
Albania	2017 - 2018	2016	6.7	42.9	20.4
Latin America and the Caribbean					
Colombia	2015 - 2016	2014	57.8	100.2	74.6
Dominican Republic	2013	2012	71.1	117.5	89.8
Guatemala	2014 - 2015	2014	64.8	135.9	91.6
Haiti	2016 - 2017	2016	33.6	90.1	54.8
Honduras	2011 - 2012	2011	77.0	140.8	100.5
Peru	2012	2011	43.7	99.3	64.1

Source: Demographic and Health Surveys

Table A.2. Percentage contribution of adolescent birth rate (ABR) at ages 15-17 and 18-19 to ABR at ages 15-19, by region, country or area, 2015-2020

Region, country or area	Survey year	Percentage contribution to ABR at ages 15-19	
		Ages 15-17	Ages 18-19
Africa			
Angola	2015 - 2016	43.9	56.1
Benin	2011 - 2012	35.5	64.5
Burkina Faso	2010	32.4	67.6
Burundi	2010	18.8	81.2
Cameroon	2011	40.2	59.8
Chad	2014	45.9	54.1
Comoros	2012	33.8	66.2
Congo	2011 - 2012	46.0	54.0
Côte d'Ivoire	2011 - 2012	46.4	53.6
Dem. Rep. of the Congo	2013 - 2014	36.9	63.1
Egypt	2014	22.8	77.2
Ethiopia	2011	33.3	66.7
Gabon	2012	44.8	55.2
Gambia	2013	32.8	67.2
Ghana	2014	41.7	58.3
Guinea	2012	45.4	54.6
Kenya	2014	37.3	62.7
Lesotho	2014	36.6	63.4
Liberia	2013	45.2	54.8
Malawi	2015 - 2016	37.3	62.7
Mali	2012 - 2013	45.7	54.3
Mozambique	2011	43.8	56.2
Namibia	2013	37.8	62.2
Niger	2012	44.1	55.9
Nigeria	2013	40.1	59.9
Rwanda	2014 - 2015	25.0	75.0
Senegal	2015	38.1	61.9
Sierra Leone	2013	37.7	62.3
Togo	2013 - 2014	34.0	66.0
Uganda	2011	34.1	65.9
United Rep. of Tanzania	2015	34.7	65.3
Zambia	2013 - 2014	38.9	61.1
Zimbabwe	2015	31.5	68.5
Asia			
Afghanistan	2015 - 2016	28.8	71.2
Armenia	2010	9.9	90.1
Bangladesh	2014	43.8	56.2
Cambodia	2014	21.9	78.1
India	2015 - 2016	20.9	79.1
Indonesia	2012	26.6	73.4
Jordan	2012	27.2	72.8
Kyrgyzstan	2012	7.8	92.2
Myanmar	2015 - 2016	26.6	73.4
Nepal	2011	31.8	68.2
Pakistan	2012 - 2013	26.1	73.9
Philippines	2013	31.5	68.5
Tajikistan	2012	5.9	94.1

Region, country or area	Survey year	Percentage contribution to ABR at ages 15-19	
		Ages 15-17	Ages 18-19
Yemen	2013	29.3	70.7
Latin America and the Caribbean			
Colombia	2015 - 2016	46.5	53.5
Dominican Republic	2013	46.9	53.1
Guatemala	2014 - 2015	42.0	58.0
Haiti	2012	38.5	61.5
Honduras	2011 - 2012	45.5	54.5
Peru	2012	40.0	60.0

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