United Nations | Department of Economic and Social Affairs

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

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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.

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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 relationship between fertility and development, and provides substantive support to intergovernmental processes at the United Nations that consider fertility, family planning and development. 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 1990-1995 to 2015-2020, 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 population estimates, which are prepared biennially by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, provide a standard and consistent set of population figures that are used throughout the United Nations system and beyond.

The present report, *World Fertility Report 2019: Early and later childbearing among Young Women,* 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
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 reviews global levels in adolescent fertility from 1990 to 2020, a period that encompasses 25 years of implementation of the Programme of Action of the International Conference on Population and Development, adopted in 1994, the period for achievement of the Millennium Development Goals (MDGs), launched in 2000, and the initial phase for implementation of the 2030 Agenda and achievement of the SDGs, which succeeded the MDGs in 2015.

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." and that "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" than children in general.

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 to adolescents and investing in the human capital of girls as part 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 one of the factors that have a bearing on teenage marriages, pregnancies and births.

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 on fertility[3] had

[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).

drawn attention to social and demographic factors underlying adolescent fertility. The *World Fertility Report 2019* presents the latest analysis of levels and trends in adolescent fertility worldwide over the past 30 years and, wherever possible, disaggregates the available information into two age groups: 15 to 17 years and 18 to 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. The details on data sources for the estimation of fertility and their limitations are 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 in the world with a population of at least 90,000. Chapter III presents adolescent fertility disaggregated into age groups 15-17 and 18-19 for selected countries with available data. Chapter IV presents summary policy considerations.

[4] Childbearing among girls aged 10 to 14 years, a growing concern in many 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 the period 1990-1995 to 2015-2020 are from *World Population Prospects 2019*, the official United Nations publication of population estimates and projections (United Nations, 2019a). The methodology and data sources used in the *World Population Prospects* estimations are described elsewhere (United Nations, 2017b). The data used to disaggregate adolescent fertility into age groups 15-17 and 18-19 years, and selected indicators associated with adolescent fertility, are 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 to 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 women-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. For example, 100 women reaching their 17th birthday at the start of the 3-year window before the survey would contribute 200 women-years to the denominator before they turned 19 years of age, that is, 100 women multiplied by two years from age 17 to 19 years.

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 the levels and trends in family planning among adolescents from World Contraceptive Use 2019 (United Nations, 2019b) would allow to analyse the relationship between family planning and adolescent fertility, and explore how they are related to patterns of early marriage and union formation.

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II. ADOLESCENT FERTILITY FROM 1990-1995 TO 2015-2020

A. LEVELS AND TRENDS IN THE ADOLESCENT BIRTH RATE

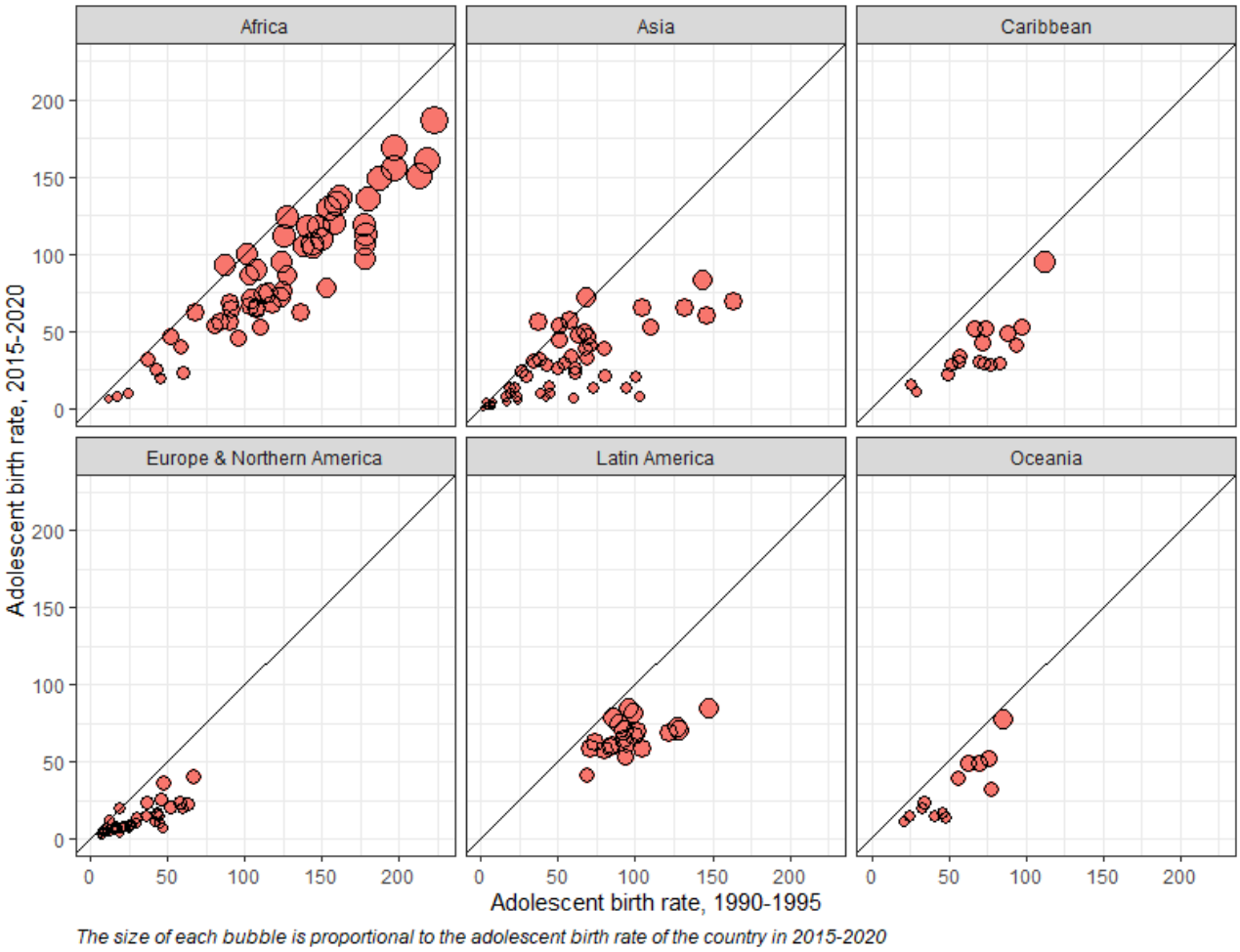
Estimates of adolescent birth rates are available for 2015-2020 for 201 countries or areas with populations of at least 90,000 (United Nations, 2019a). The broad regional patterns of adolescent fertility have not changed much with respect to those documented in previous reports (United Nations, 2013,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

The decline in the adolescent birth rate has been almost universal across major areas 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. Each bubble represents the adolescent birth rates of each country in 2015-2020. The size of the bubbles is proportional to the adolescent birth rate of each country in 2015-2020. The markers under the diagonal line show countries where the adolescent birth rate has declined, and the further below from the diagonal line, the greater the decline in the adolescent birth rate. The decline was particularly remarkable in Asia, particularly in countries that had relatively high initial values of the ABR in 1990-1995, for example in Afghanistan, Armenia, Bhutan, Lao People's Dem. Rep., 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 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, of which 29 were in Africa. For some of these countries, the rate 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 the 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 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 the question of what factors are 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 Certainly, the advent of modern contraceptive methods have helped couples and individuals to avoid unintended pregnancies. Barrier-methods reduced the spread of sexually transmitted infections (STIs) and, by addressing the problem of STIs, have helped in reducing rates of infertility. Also, in countries where access to abortion became an established practice long before the new contraceptives were available, it gave women an alternative to carrying an unintended pregnancy to term (van de Kaa, 2002). Variations in the adoption and spread of birth control practices, among other factors, might explain the convergence of the ABR in 2015-2020 in some countries.

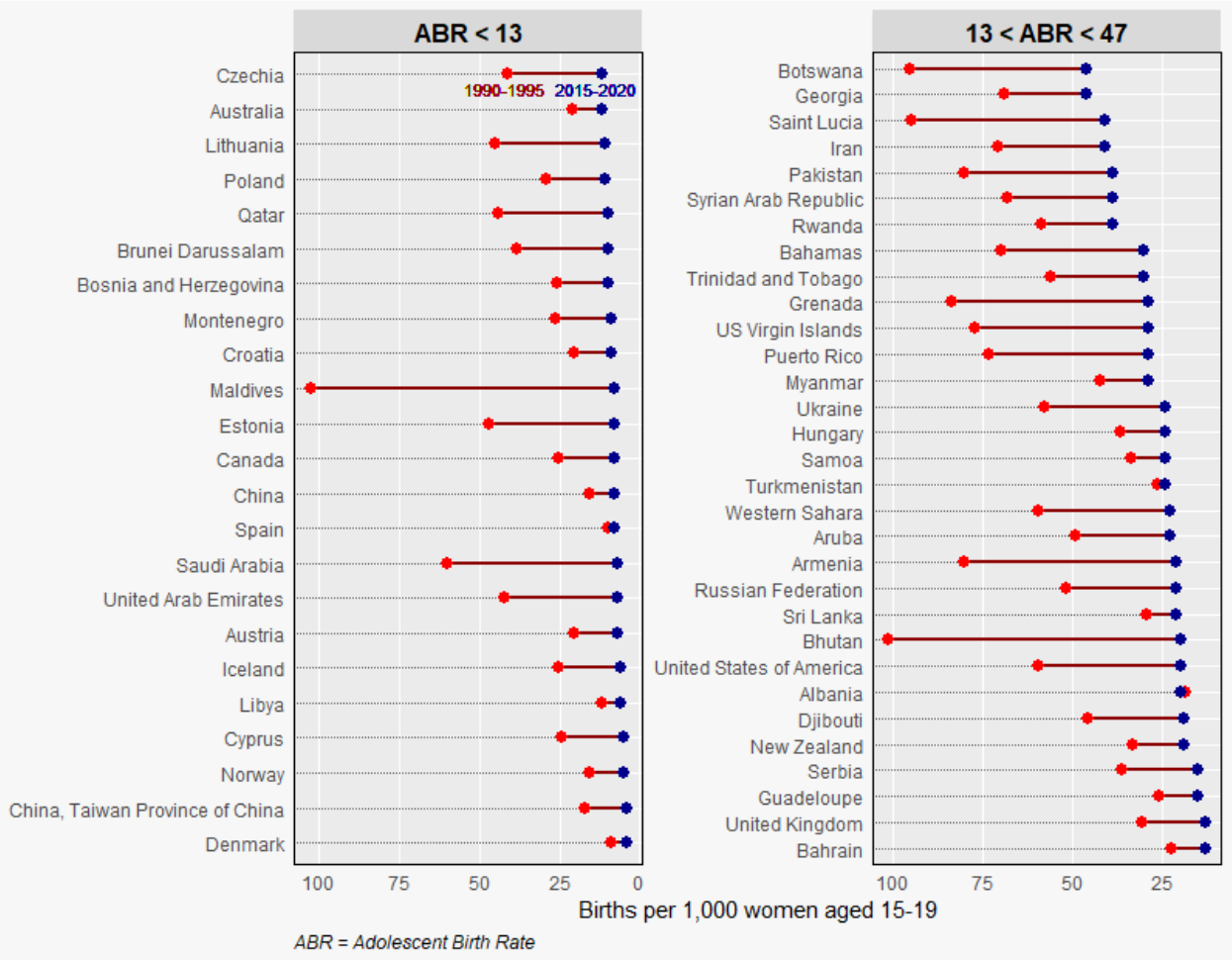
A recent study of the relationship between the adolescent birth rate and socioeconomic indicators shows that variations in the trends in adolescent fertility across countries, between 1990 and 2012, were associated with trends in the growth national wealth, income inequalities, and educational expenditures (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 income 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, and to approach 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 region 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, that had achieved similar levels of adolescent fertility by 2015-2020 (85 births per 1,000 women) despite having a different starting levels of adolescent fertility in 1990-1995 (figure II.2), differences in national wealth, income inequalities and educational expenditures (Santelli et al., 2017). In 2012, the GDP per capita and the national expenditures on education as a percentage of GDP in Nicaragua were lower than Venezuela's, and 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 it having a restrictive abortion policy and lower indicators of socioeconomic development than Venezuela (Mendoza-Cardenal, 2016), amidst the recent political instability there.

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

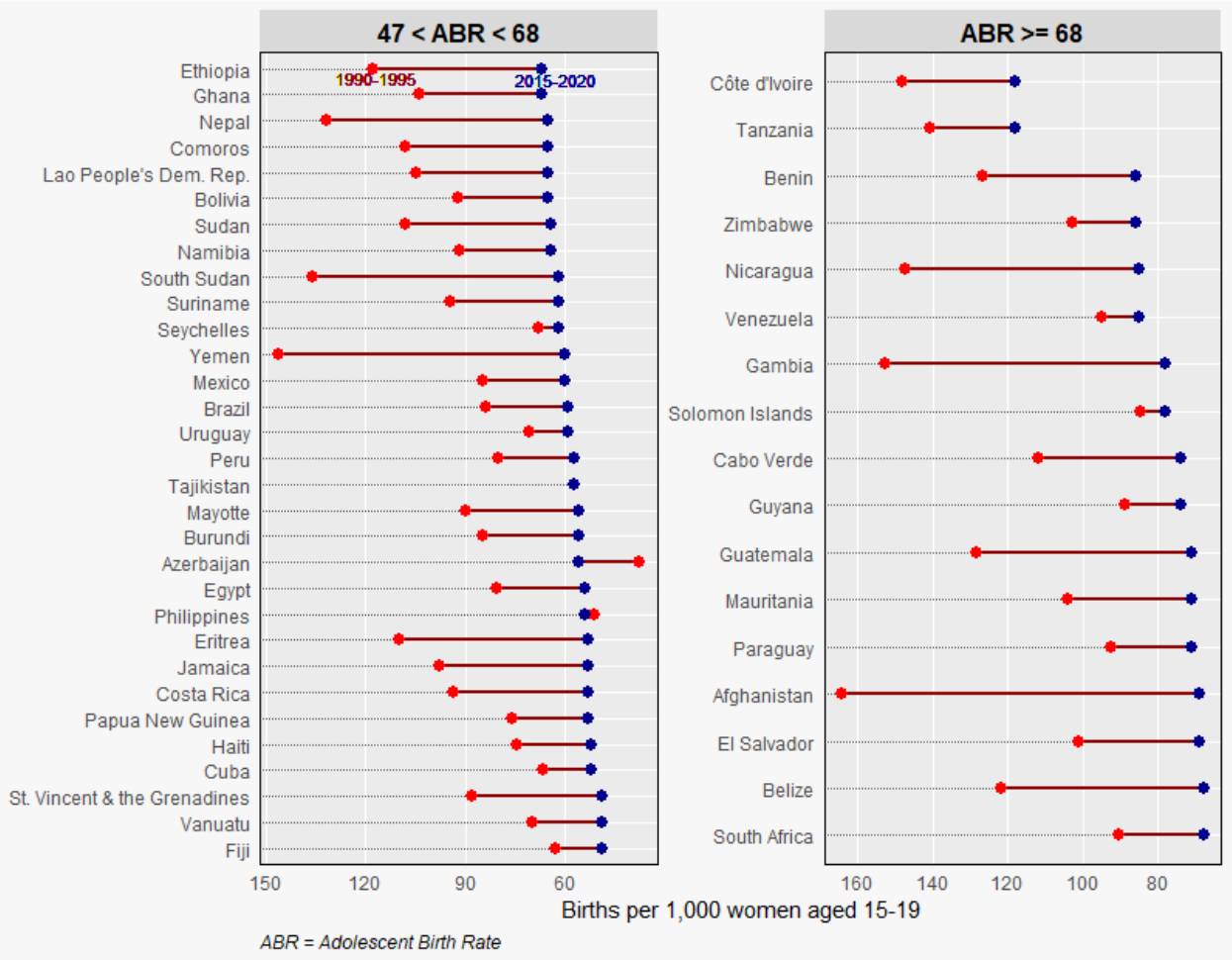
[5] One of the factors to consider is the history of family planning services in each country. Family planning is one of the 10 great public health achievements of the twentieth century, on a par with such accomplishments as vaccination and advances in motor vehicle safety (Centers for Disease Control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

Figure II.2. Tends in adolescent birth rates 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 AT AGES 15-19

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 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 regional and global monitoring purposes, they do not enable a detailed assessment of sexual and reproductive behaviour in relation to adolescent development, puberty and its cultural significance, and legal age of majority. Limiting the study of sexual and reproductive behaviour to adolescents aged 15 to 19 omits the lived experience of girls under 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 might 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, their susceptibility to pregnancy and low gynaecologic age[6] (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 or younger are markedly different from those aged 15 to 17 or 18 to 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 they 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 to using contraception (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 15 and extend to new-borns (World Health Organization, 2011).

A disaggregation 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, and social 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 age 15 to 17. Even then, many of them may lack the knowledge on sexual and reproductive health or, if they have such information, they might 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 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 18 to marry with the consent of parents or other authorities. Girls under age 15 can marry with parental consent in 52 countries, although in many cases it

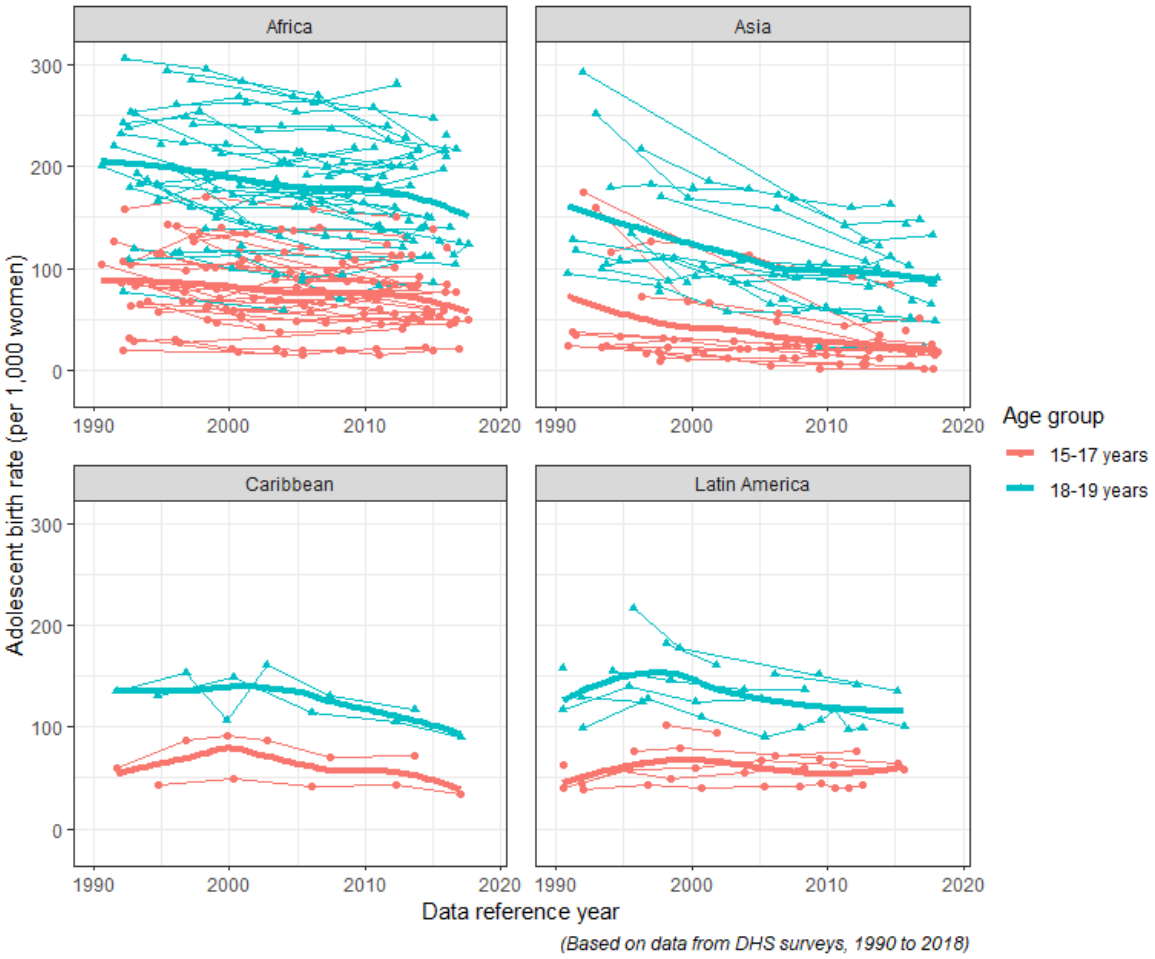
[6] Gynaecologic age is defined as age in years at conception minus age at menarche and it is an indicator of physiological maturity. Heightened risks of complications from pregnancy occur among girls with a low gynaecological age (less than or equal to 2 years).

is not consent that the parents provide, but rather they arrange the marriage. In 23 countries, Adolescents below the age of 18 are permitted to be legally married without requiring and 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 a disaggregation by age that goes beyond the conventional age group 15 to 19. While research findings indicate that in most countries childbearing is rare among girls below 15 years, in some countries, including Angola, Bangladesh, Cameroon, Gabon, Kenya, Liberia, Malawi, Mali, Niger, Nigeria, Tanzania and Uganda, 7 to 15 per cent of girls have had a child by the age of 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 "women", unless the applicable law indicates that majority is attained earlier (UNICEF, 1989). Nevertheless, the term 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 disaggregation adolescent fertility rates into two age groups: 15 to 17 years and 18 to 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. Levels and trends in adolescent fertility

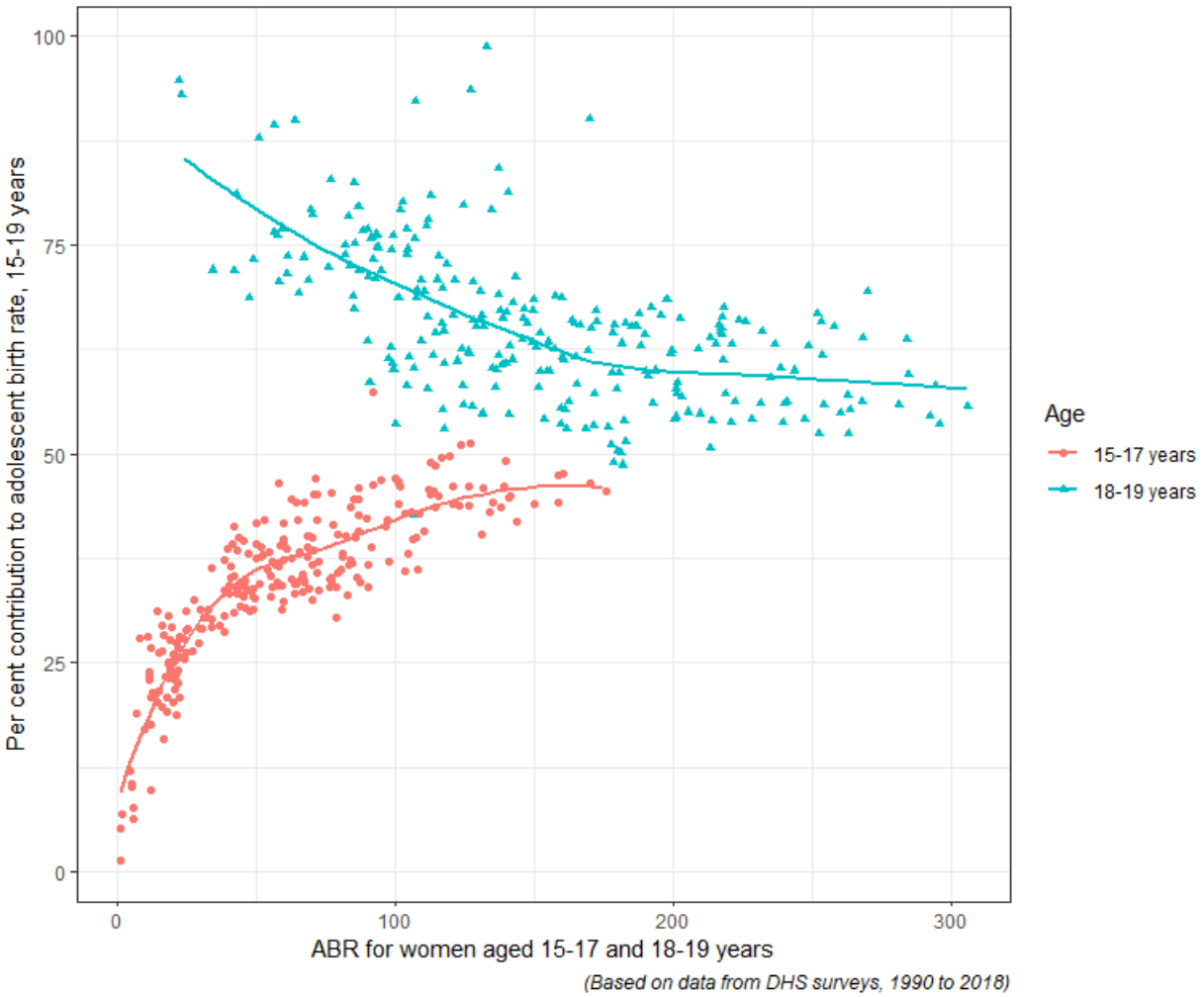
Figure III.1 shows the levels and trends in adolescent birth rates among women aged 15 to 17 years and 18-19 years by region from circa 1990 to circa 2018. Each line on the chart represents trends for a country and the bold lines show the trends in the average adolescent birth rate for all countries in each region and each age group. As expected, the average birth rates among older adolescents aged 18-19 are higher than among younger adolescents. A comparison across regions shows that birth rates for women aged 15 to 17 years in several African countries were higher than or equal to those for older adolescents aged 18 to 19 years in Asia and 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 Asia and Latin America and the Caribbean, but also there are large variations among African countries in the birth rate at those ages. The wide variations in adolescent fertility in Africa correspond to large variations in the gross enrolment ratio for girls at the lower secondary school level, though there are smaller variations in the proportion of the population living in rural areas in African than in other regions.7 The high birth rates in Africa signal the persistence of contextual factors undergirding early and recurrent pregnancy among adolescents, including 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 significance of adolescent fertility among adolescent women aged 15-17 is shown by its component contribution to the adolescent birth rate for all women aged 15-19 years (Figure III.2). The countries shown in figure 4 are listed in annex tables A.2. The contribution of the adolescent birth rate among adolescent women aged 15-17 to the total ABR (15-19) is positively associated with the rate for women aged 15-17: in countries where adolescent birth rates among adolescent women aged 15-17 are high, the contribution of their birth rate to ABR is high compared to countries where adolescent birth rates among such women are low. However, only in Bangladesh in 1996 and 1999, and the Dominican Republic in 1999 did the contribution of the 15-17-year-old birth rate exceed 50 per cent. Conversely, even where birth rates among women aged 18-19 are low, such women contribute large proportions to the ABR, reflecting the shifting composition of the population toward the older segment of adolescents. 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 of adolescents aged 18-19 to the ABR was 75 per and above (Annex table A.2). In each of these 16 countries, the proportion of adolescents among women in the reproductive age group (15-49 years) decreased between 1990-1995 and 2015-2020. However, in a calculation not shown here, in seven of these countries (Azerbaijan, Cambodia, Jordan, Philippines, Tajikistan, Timor-Leste and Viet Nam), there was an increase in their estimated number of births. These data suggest that as adolescent fertility declines in populations with a decreasing segment of young adolescent women aged 15 to 17 years, the contribution of their birth rate to the ABR will decrease. A similar pattern of concentration of adolescent births among

[7] See (United Nations, Department of Economic and Social Affairs, 2018; UNESCO Institute of Statistics, 2019)

18–19-year-olds was reported in the United States, where they contributed 72 per cent of all pregnancies among young women aged 15–19, amidst the rapid decrease in adolescent fertility between 1990 and 2013 (Kost et al., 2017).

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, beyond primary school, and having access to reproductive health 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 together constrain the decisions or choices that young women make, or that are made for them. 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 the 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 provide reproductive and health services attuned to the needs of adolescents, include programs that respect the young women's privacy and discretion, as well as counselling that is 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) affect contraceptive use, pregnancy, and pre- and post-natal health care. Settings where premarital sexual activity is stigmatized and 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 the access to sexual health services, including contraception.

The increased penetration of the mobile phone in developing countries, and to even younger generations, is providing agencies, countries and health experts with a new 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). Although mobile phones have become an indispensable communication tool all over the world, the cost of owning a mobile phone might exclude poorer young women from receiving family planning information. Also, a significant digital divide persists between men and women in many countries, largely because of the structural inequalities in many societies. In 2019, women were 26 per cent less likely than men to use mobile internet services in low- and middle-income countries (GSM Association, 2019). For many people, including young women in low- and middle-income countries, cost and illiteracy remain the greatest barrier 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 unknown in many of them.

To live up to the pledge to leave no one behind, the international community is called upon to support the advancement of young girls and adolescent women to ensure they are granted the right to determine freely the choice of partner and the number and spacing of their children. The exercise of this right can make a critically important contribution to advancing young women's health and living conditions and thereby to realize the aspirations of the 2030 Sustainable Development Agenda, 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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