UNDERSTANDING AND ADDRESSING ADOLESCENT PREGNANCY

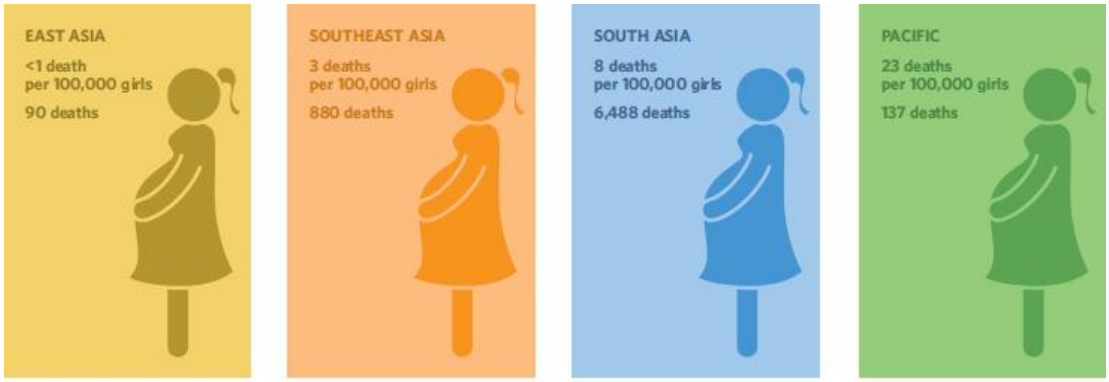
Adolescent pregnancy has profound implications for the health and well-being of young people, and that of future generations. Early pregnancy is associated with higher rates of adverse pregnancy outcomes such as preterm birth, low birth weight, and perinatal mortality, compared with births to adult women. In South and Southeast Asia, the newborn mortality rate is 50% higher among babies born to girls less than 18 years compared to 20-29 year olds, and twice as high for adolescent mothers aged less than 16.

Complications of pregnancy and childbirth remain among the leading cause of death for 15-19 year old girls in this region, resulting in an estimated 7,595 deaths in 2017 (figure 12). Maternal disorders are the leading cause of death of adolescent girls in the Pacific, and the second and third leading cause of death in South Asia and Southeast Asia, respectively. Many pregnant adolescent girls also experience high rates of intimate partner violence, and, in the context of premarital pregnancy, substantial stigma and discrimination.

Maternal disorders are the leading cause of death of adolescent girls in the Pacific, and the second leading cause of death in South Asia

Adolescent pregnancy also has significant socioeconomic consequences for adolescent girls, including lower educational attainment, and limited employment and economic opportunities. These outcomes can perpetuate a cycle of poor health, disadvantage and gender inequality that impacts not only on adolescent girls but also extends to their families and communities. There is very little information about adolescent boys' experience with early pregnancy, although available studies suggest that many young men are unprepared for fatherhood, and lack knowledge and skills related to maternal and child health despite their traditional role as decision-makers in the family.

FIGURE 12. MATERNAL MORTALITY RATE AND TOTAL NUMBER OF MATERNAL DEATHS AMONG GIRLS AGED 15-19 YEARS (2017)



Source: GBD 2017[55]

ADOLESCENT FERTILITY REMAINS HIGH IN MANY COUNTRIES, AND IS INCREASING IN PARTS OF THE REGION

In 2019 there were over 3.7 million births to adolescent girls aged 15-19 years in Asia and the Pacific (table 6**), with India, Bangladesh, Indonesia, Pakistan, China and the Philippines accounting for over 75% of all adolescent births in the region. Countries in the Pacific have among the highest adolescent fertility rates, with the highest rate in the region reported in Marshall Islands (138 births per 1,000 females 15-19 years). In the Pacific, more than 1 in 6 women aged 20-24 commenced childbearing by age 18, compared with 1 in 8 in South Asia, and 1 in 14 in Southeast Asia (figure 13). The lowest rates of fertility and childbearing are in East Asian countries. Data on childbearing among very young adolescents (<15 years) are scarce. Between 2 and 3% of women aged 20-24 gave birth by age 15 in South Asia and the Pacific. Fertility rates for very young adolescents are only available for Bangladesh where the rate is estimated at 10 births per 1,000 girls aged 10-14years (among the highest in the world).

There is very limited data on adolescent pregnancies (as opposed to births) in this region, although an analysis conducted by Guttmacher Institute estimated there

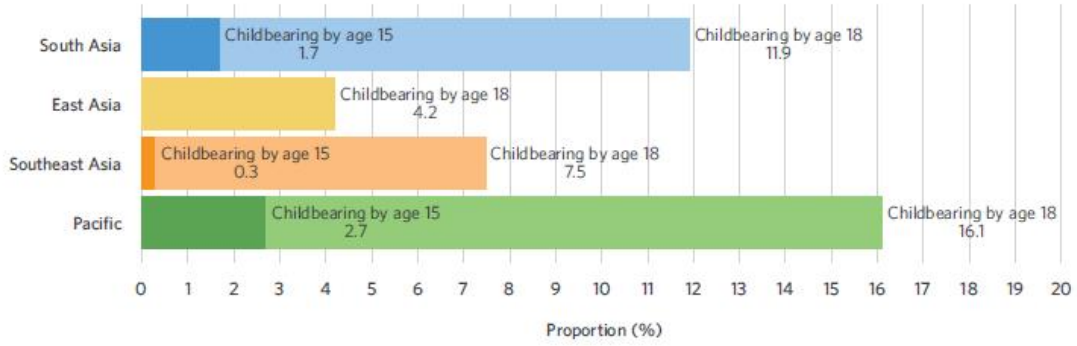
were over 8 million pregnancies to adolescent girls in Asia in 2016, which included 1.2 million miscarriages and 2.4 million induced abortions.64 While adolescent birth rates are low in China (8 per 1,000 girls), a national survey conducted in 2010 suggested that adolescent pregnancies are common. The survey of almost 11,000 unmarried 15-24 year olds found that 17% of sexually active adolescent girls had experienced a premarital pregnancy, of which 91% ended in abortion.

TABLE 6. ADOLESCENT FERTILITY RATE AND TOTAL NUMBER OF ANNUAL BIRTHS TO GIRLS AGED 15-19 YEARS

Region	Country	Births per 1,000 girls 15-19 years	Total number of annual births to girls 15-19 years
South Asia	Afghanistan	69.0	155,388
	Bangladesh	83.0	631,630
	Bhutan	20.2	687
	India	13.2	783,750
	Iran	40.6	109,620
	Maldives	7.8	101
	Nepal	65.1	103,118
	Pakistan	38.8	408,680
	Sri Lanka	20.9	5,838
East Asia	China	7.6	290,616
	DPR Korea	0.3	276
	Mongolia	31.0	4,644
Southeast Asia	Cambodia	50.2	36,495
	Indonesia	47.4	536,094
	Lao PDR	65.4	22,890
	Malaysia	13.4	17,326
	Myanmar	28.5	72,134
	Philippines	54.2	273,981
	Thailand	44.9	95,817
	Timor-Leste	33.8	2,535
	Viet Nam	30.9	159,309
Pacific	Fiji	49.4	1,828
	Kiribati	16.2	81
	Marshall Islands	138.0	381
	Micronesia	13.9	83
	Nauru	69.0	36
	Papua New Guinea	52.7	23,557
	Samoa	23.9	215
	Solomon Islands	78.0	2,652
	Tonga	14.7	74
	Tuvalu	42.0	24
	Vanuatu	49.4	692

Across the region **1 in 10 women** aged 20-24 years (12 million women) commenced childbearing as a child - by the age of 18 (excluding China).

FIGURE 13. PROPORTION OF WOMEN AGED 20-24 WHO GAVE BIRTH AS CHILDREN (BY AGE 15 AND 18)

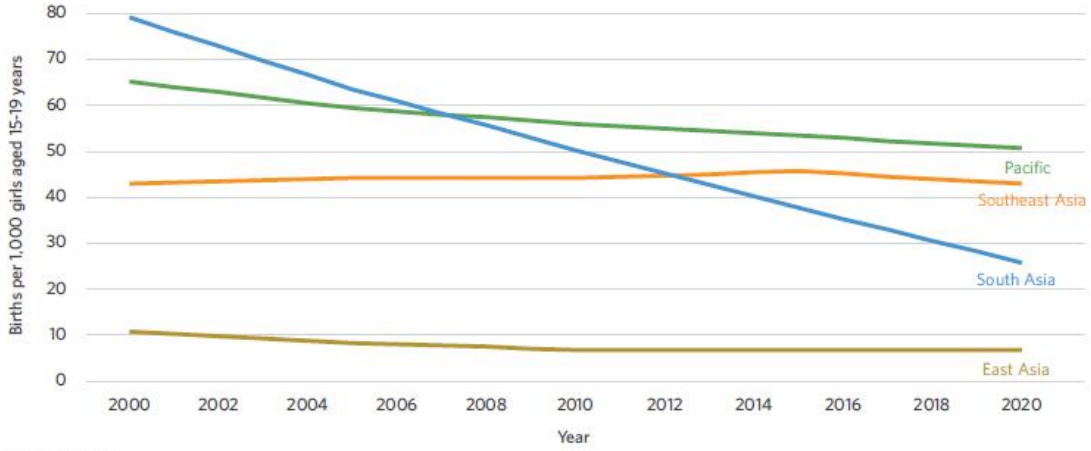


Note: East Asia estimate includes Mongolia only
Source: DHS and MICS

Adolescent fertility rates are now highest in the **Pacific** (51 births per 1,000 girls) and **Southeast Asia** (43 births per 1,000 girls), compared with **South Asia** (26), where there has been a significant reduction in the last two decades, and **East Asia** (7).

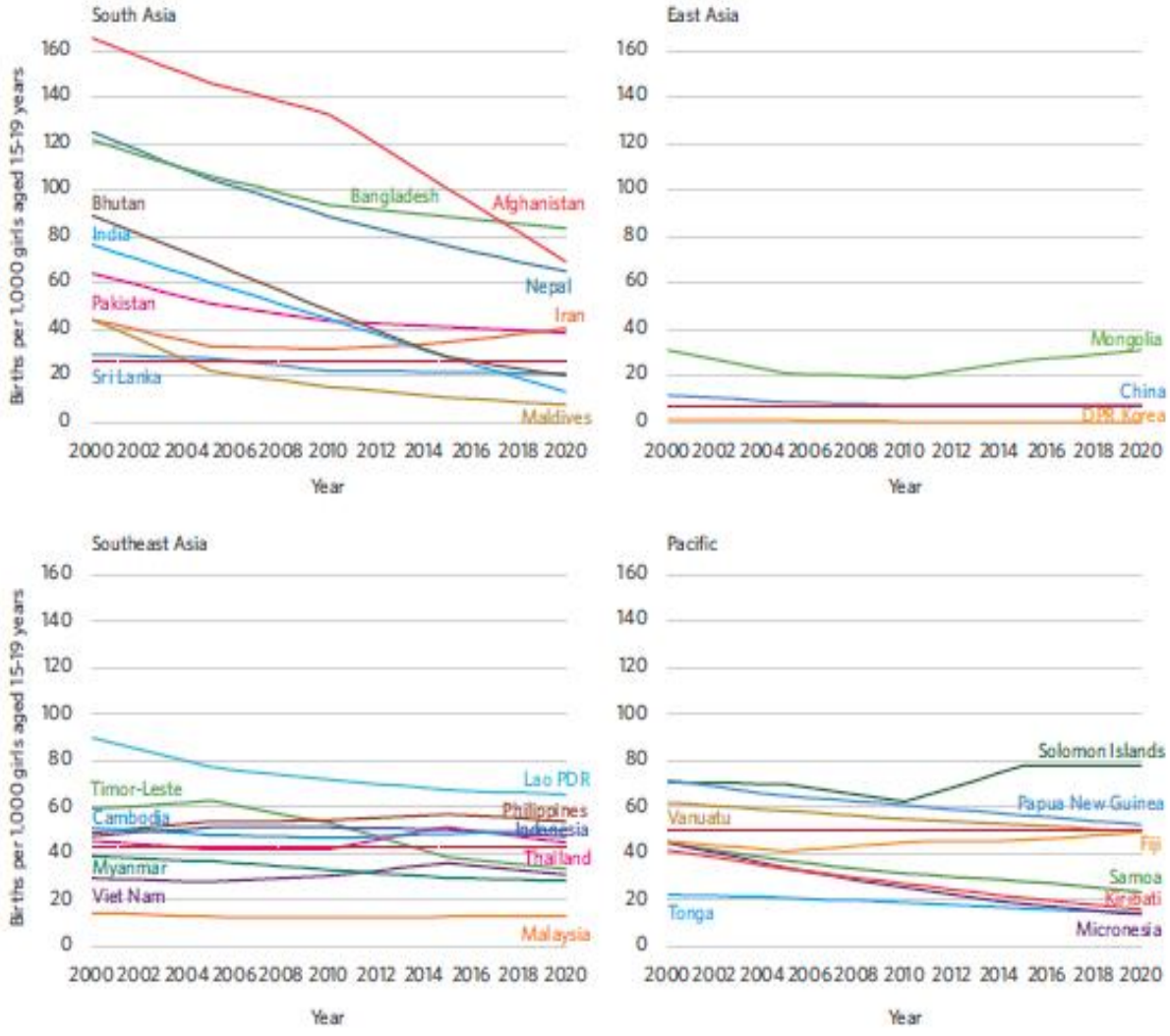
National DHS and MICS estimates of adolescent fertility show fluctuations in rates over the last decade. However, trend data from UNPD indicate that adolescent fertility has declined by more than 60% in South Asia since 2000, most notably in India in the context of falling rates of child marriage (figures 14 and 15). However, fertility rates in Bangladesh, Afghanistan and Nepal remain considerably higher than the sub-regional average. Less progress has been made in the Pacific, where fertility rates have only fallen by around 20% in the last two decades, with increases in the Solomon Islands and Fiji. Overall, there has been no progress in reducing adolescent fertility in Southeast Asia since 2000: despite some progress in Lao PDR, Myanmar and Timor-Leste, rates in the UNPD modelled estimates have increased in the Philippines and Viet Nam, and stalled in Thailand, Cambodia, Indonesia and Malaysia. However, more recent survey and birth registration data has shown a decrease in adolescent pregnancy in the Philippines and Thailand. While rates remain low in East Asia, adolescent fertility has increased by 60% in Mongolia since 2010.

FIGURE 14. ADOLESCENT FERTILITY RATES 2000-2020 (MODELLED ESTIMATES)



Source: UNPD[292]

FIGURE 15. TRENDS IN ADOLESCENT FERTILITY RATE BY COUNTRY, 2000-2020 (MODELLED ESTIMATES)



The dotted line indicates the sub-regional adolescent fertility rate for 2020

Source: UNPD[292]

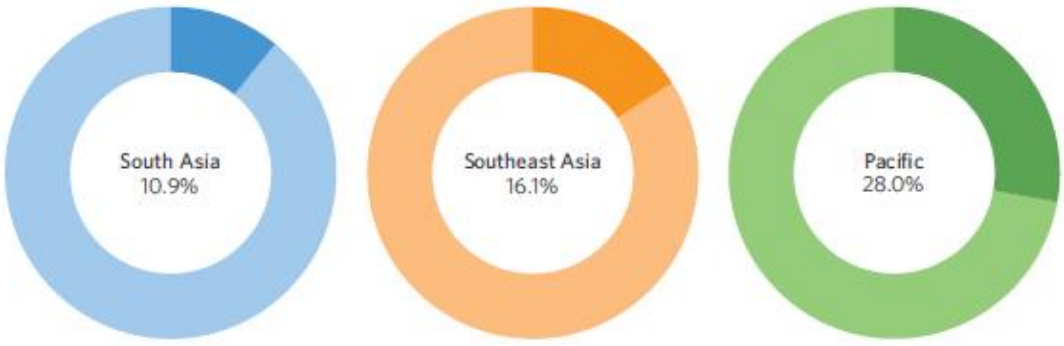
A SIGNIFICANT NUMBER OF ADOLESCENT PREGNANCIES ARE UNINTENDED, PARTICULARLY IN COUNTRIES WITH HIGH AND/OR INCREASING FERTILITY RATES

Not all adolescent pregnancies are intended or wanted. Unintended births are distinct to unintended pregnancies (which have several outcomes including birth, spontaneous and induced abortion), with the Guttmacher institute estimating unintended pregnancies to account for 43% of all adolescent pregnancies. In this region (excluding East Asia) there were **around 440,000 unintended births to adolescent girls in 2019, accounting for around 1 in 8 of all adolescent births (figure16). The percentage of births** that were unintended ranged from 4% in Pakistan and Afghanistan, to over 60% in Marshall Islands, with more than a quarter of births mistimed or unwanted in the Pacific.

In contrast to countries in other regions, in the Pacific, the proportion of births that were unintended is higher among adolescents aged 15-19 years than young women aged 20-24 years (appendix). Unintended births among adolescents age 15-19 years are also high in high fertility settings, such as Bangladesh (22%) and Nepal (20%) and in countries where fertility rates have increased, including the Philippines (29%) and Solomon Islands (33%).

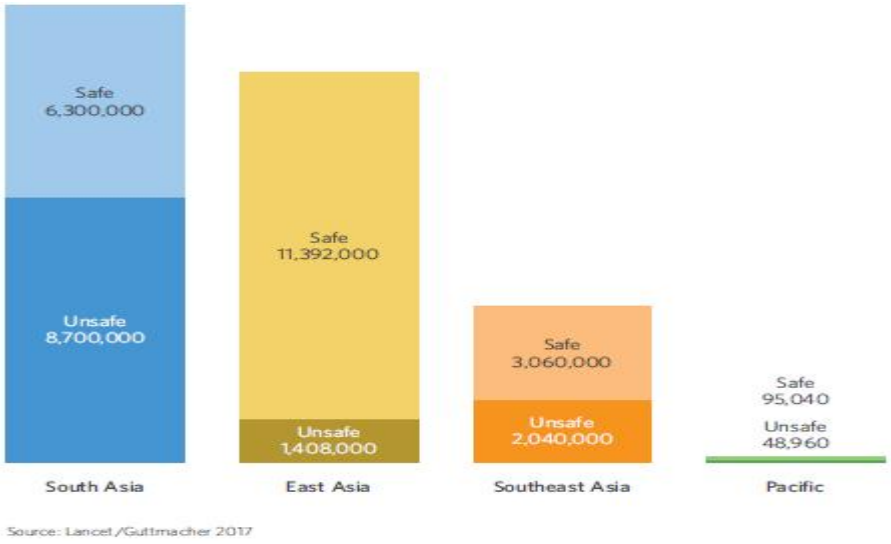
Unintended pregnancy, particularly if it occurs outside of marriage, can have substantial consequences for young people including stigma, social isolation, school expulsion, forced marriage, and in some cases violence and suicide. **It is estimated that 65% of all unintended pregnancies in Asia, and 38% in the Pacific end in induced abortion,** which, in settings where legal abortion is highly restricted and the majority are unsafe, can lead to considerable morbidity and mortality.

FIGURE 16. PROPORTION OF BIRTHS TO 15-19-YEAR-OLD GIRLS THAT WERE UNINTENDED



Source: DHS and MICS

FIGURE 17. TOTAL NUMBER OF SAFE AND UNSAFE ABORTIONS IN 2014 AMONG WOMEN AGED 15-49 YEARS

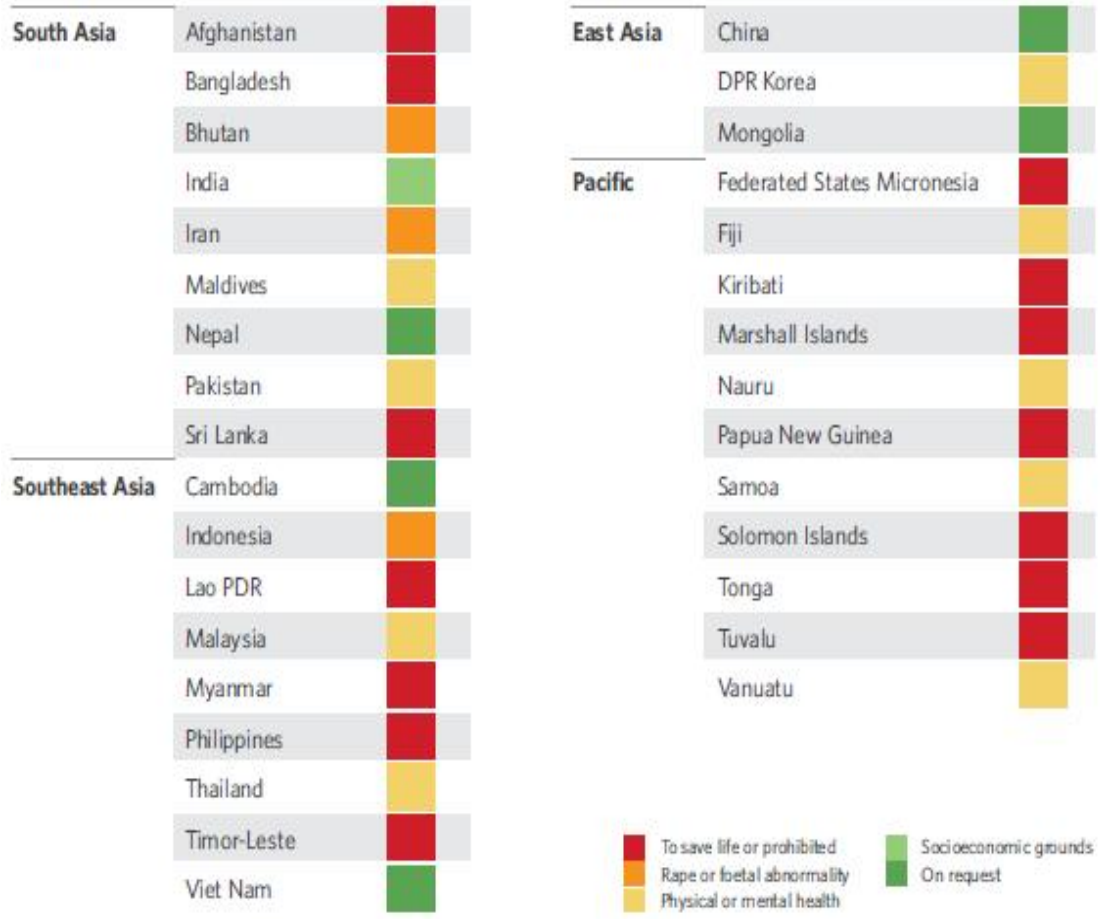


Data on induced abortion are limited, particularly for the Pacific. In 2014, an analysis conducted by the Guttmacher Institute estimated that the total number of induced abortions among women 15-49 years was 12.8 million in East Asia, 15.0 million in South Asia, 5.1 million in Southeast Asia, and 144,000 in Oceania (including Australia and New Zealand). Unsafe abortions accounted for 58% of all induced abortion in South Asia, 40% in Southeast Asia, and 34% in the Pacific (although this includes data form Australia and New Zealand where safe abortion is more accessible)(figure 17). In Asia, almost 5 million women aged 15-49 years were treated for complications of unsafe abortion, and there were 5,400 deaths (6% of all maternal deaths).

Data on induced abortion among adolescents are scarce, particularly for unmarried adolescents. Analysis from 2008 estimated that women under the age of 25 accounted for 34% of all unsafe abortions in Asia (excluding East Asia) (11%among 15-19 year olds and 23% among 20-24). Smaller studies have suggested that in settings where abortion is legal, rates of induced abortion are higher among married, better educated and wealthier adolescents. However in settings where abortion is highly legally restricted, substantial stigma, social pressure, isolation and community sanctions are drivers of unsafe abortion among unmarried girls. In one of the few recent studies from the Pacific, 71% of women accessing post-abortion care in Papua New Guinea (where abortion is highly legally restricted) were aged 15- 24 years, and 39% were unmarried.

There are an estimated **3.6 million** unsafe abortions each year among women aged **15-24 years** in Asia (excluding East Asia).

FIGURE 18. ABORTION LEGISLATION



Source: World Abortion Laws[73], UNFPA 2020[399] for DPRK, Fiji, Maldives.
Note: Lao conflicting laws/guidelines on exemptions

Abortion is more likely to be unsafe (conducted by unskilled providers and/or using unsafe methods) in settings where it is highly legally restricted. Fourteen countries only permit abortion to save a woman's life or prohibit it all together; and an additional three countries only allow abortion in the case of rape, incest or foetal abnormality (figure 18).

In addition to legal restrictions, there may also be regulations that prevent some people from accessing government services (such as migrants) or requirements for parental or spousal consent that may prevent young people from seeking care. Even where abortion is more legally accessible, it often remains highly stigmatized which inhibits young people accessing safe services, or delay seeking post-abortion care for complications. Adolescents are more likely to delay seeking an abortion, resort to unsafe providers or unsafe methods, and delay seeking help for complications. Consequently, adolescent and unmarried young women are also at higher risk of abortion-related morbidity and mortality in some settings.

EARLY PREGNANCY OCCURS IN THE CONTEXT OF LOW USE OF EFFECTIVE CONTRACEPTION AND HIGH UNMET NEEDS, PARTICULARLY IN COUNTRIES WITH HIGH AND/OR INCREASING FERTILITY RATES

Use of modern methods of contraception among currently married young women varies considerably in the region (figures 19 and 20), but less than 60% are using an effective method in all countries, with the exception of Thailand. Modern contraceptive prevalence is lowest in South Asia and the Pacific: fewer than 15% of married 15-24 year olds are currently using a modern method in Afghanistan, Pakistan, Maldives, Kiribati, Nauru and Tuvalu. Fewer married adolescents are using modern contraception compared with women aged 20-24 years (appendix).

Around 20% of 15-19-year-old girls who are married or sexually active and want to avoid pregnancy rely on less effective traditional methods of contraception.

Many adolescents and young women rely on less effective, short-acting methods (condoms, pills) and traditional methods, with the use of highly effective long-acting reversible methods low in many countries.

Misconceptions about contraception and its side effects are a common reason for

reliance on traditional methods and discontinuation of modern methods in this age group. Inconsistent and incorrect use are also commonly reported, contributing to contraceptive method failure and unintended pregnancy.

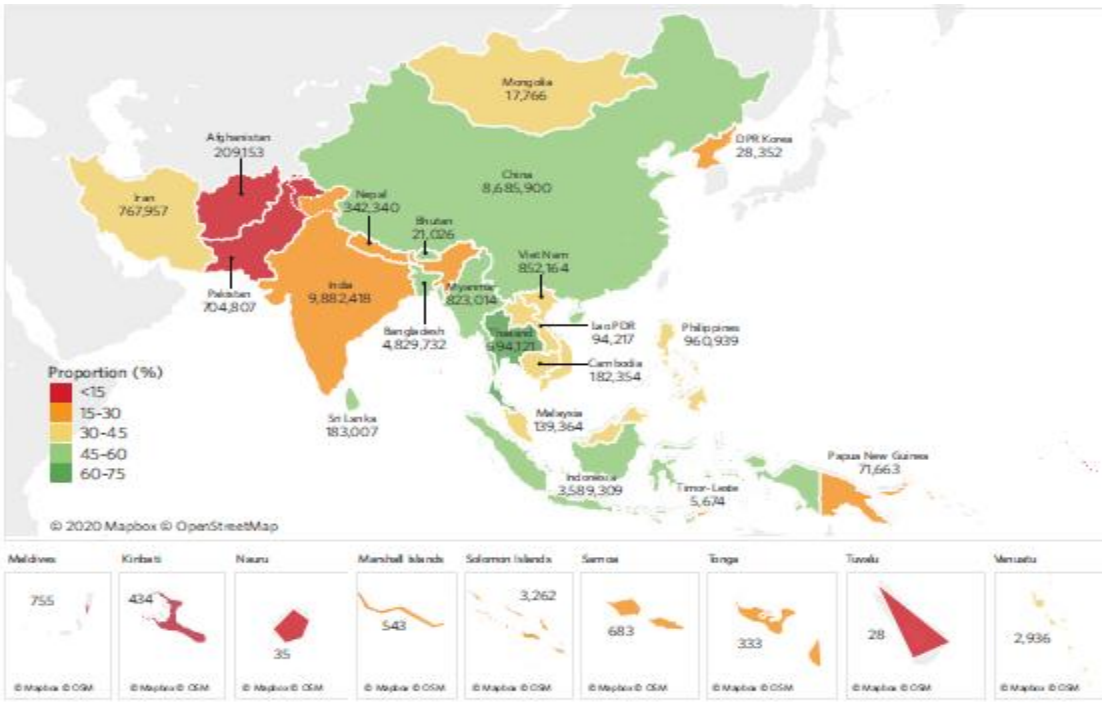
34 million young women aged 15-24 years have an unmet demand for modern contraception.

Almost 1 in 3 (31%) of young women aged 15-24 years who have a need for family planning do not have their demand satisfied by modern methods (figures 21 and 22, country level estimates detailed in the appendix). The unmet demand for modern contraception is highest in South Asia and the Pacific, where almost half of all 15-24 year olds with a demand for family planning are not using an effective method. Among married women, adolescents aged 15-19 years have less satisfied demand than young women aged 20-24 years (figure 23).

FIGURE 19. PREVALENCE OF MODERN CONTRACEPTIVE USE AMONG MARRIED YOUNG WOMEN, AND TOTAL NUMBER OF MODERN CONTRACEPTIVE USERS

Source: DHS and MICS

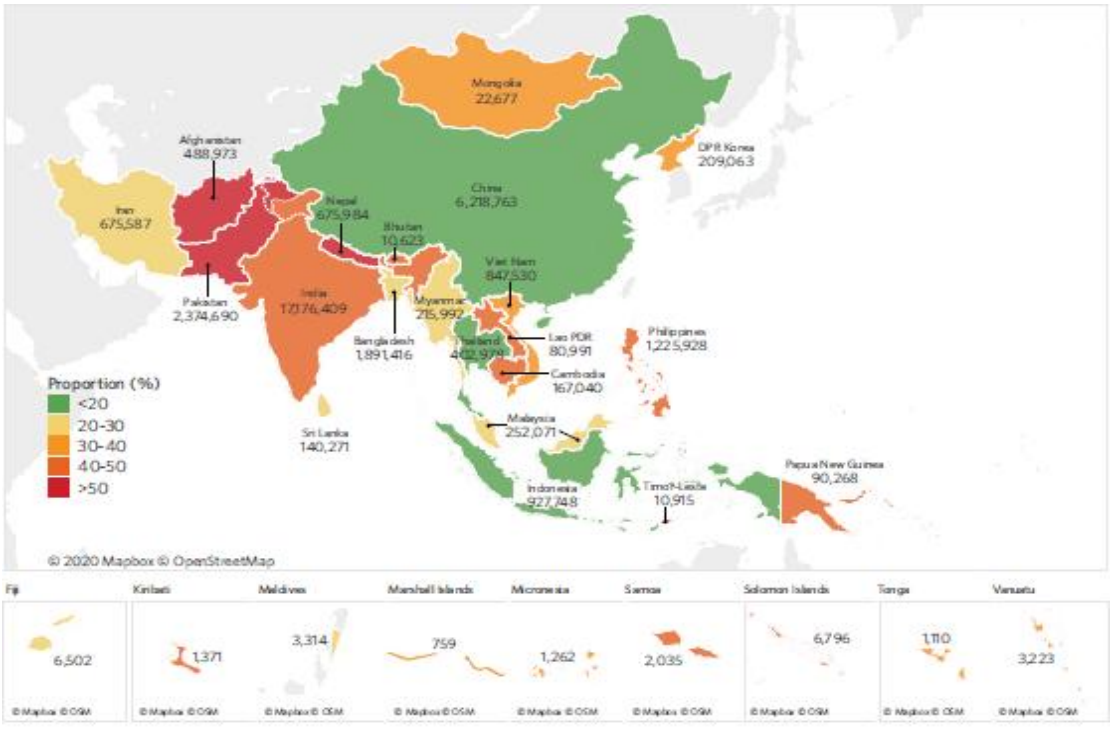
FIGURE 20. TOTAL NUMBER AND PROPORTION OF MARRIED WOMEN 15-24 YEARS CURRENTLY USING A MODERN METHOD OF CONTRACEPTION



Source: DHS and MICS

Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

FIGURE 21. TOTAL NUMBER AND PROPORTION OF 15-24-YEAR-OLD WOMEN WHOSE DEMAND FOR FAMILY PLANNING IS NOT SATISFIED BY MODERN METHODS



Source: GBD 2017

Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

FIGURE 22. TOTAL DEMAND FOR FAMILY PLANNING AMONG 15-24-YEAR OLD WOMEN, AND PROPORTION AND TOTAL NUMBER WHOSE DEMAND IS MET AND UNMET BY MODERN METHODS

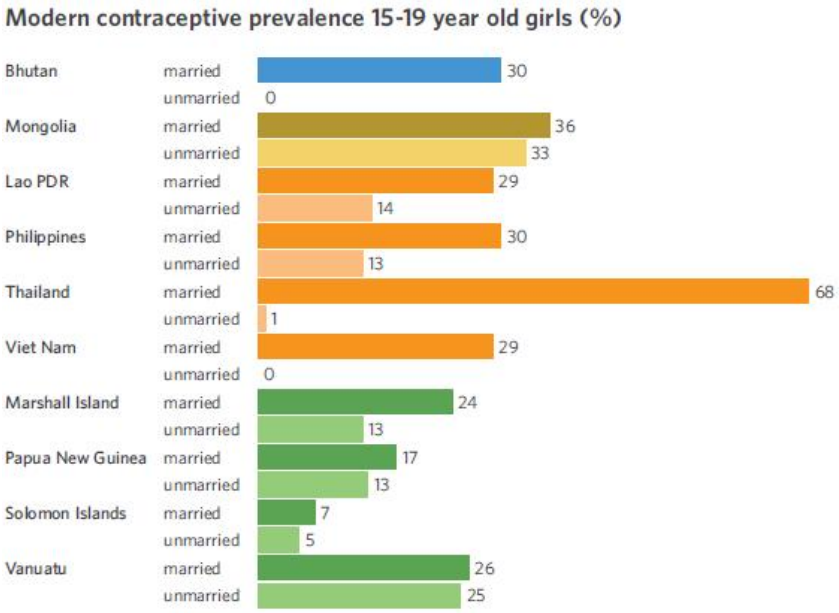
FIGURE 23. PROPORTION OF MARRIED WOMEN AGED 15-24 WHOSE DEMAND FOR FAMILY PLANNING IS SATISFIED BY MODERN METHODS BY AGE GROUP

Note: East Asia estimate is for Mongolia only.
Source: DHS and MICS.

There is limited information about contraceptive use by sexually active unmarried adolescents, but available data demonstrate the use of modern methods is low (figure 24). In all countries with available data, **fewer than 1 in 4 sexually active adolescent girls aged 15-19 years are currently using a modern method**, and, with the exception of India, less than half have their demand for family planning satisfied with modern methods.

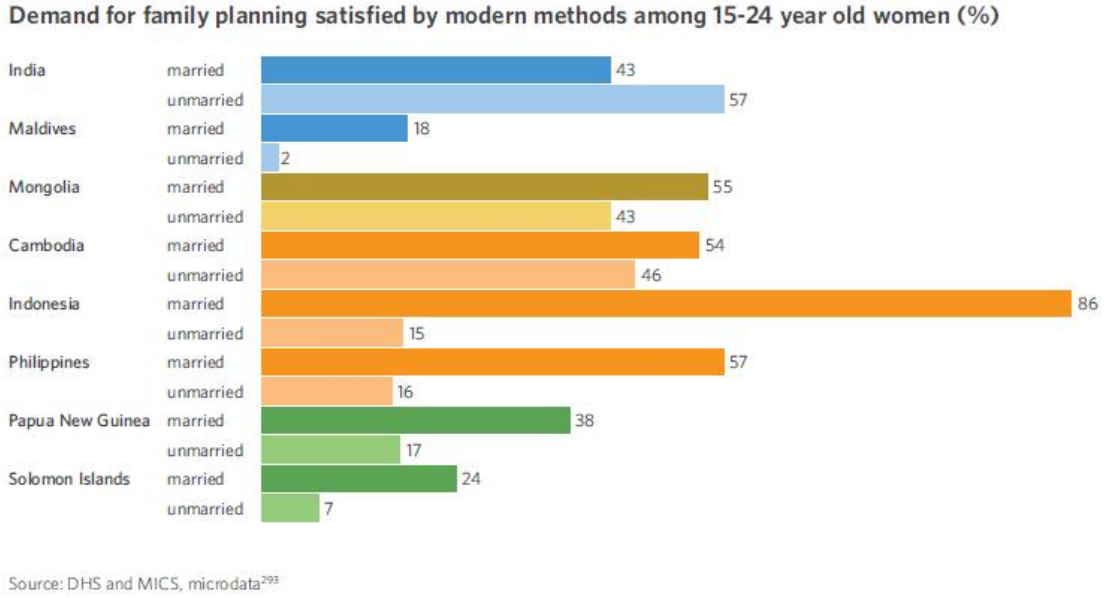
Use of modern contraception and demand satisfied are particularly low among unmarried sexually active women in those countries where adolescent fertility rates have not declined or are increasing, including the Philippines, Thailand, Mongolia, Vietnam, and Solomon Islands, suggesting that very poor access to contraceptive services among this group is an important contributor to increasing fertility rates.

FIGURE 24. CONTRACEPTIVE USE AMONG MARRIED VERSUS SEXUALLY ACTIVE UNMARRIED WOMEN



†† Data for this chart are drawn from UNPD World Contraception Use 2020. For some countries, estimates provided are from the micro-data of available national DHS and MICS surveys and not otherwise available in published reports. Estimates for unmarried adolescents may be based on small non-representative samples.

FIGURE 24. CONTRACEPTIVE USE AMONG MARRIED VERSUS SEXUALLY ACTIVE UNMARRIED WOMEN (CONTINUED)



MANY PREGNANT ADOLESCENTS DO NOT RECEIVE ADEQUATE MATERNAL CARE

The majority of pregnant adolescent girls in the region were attended at least once by a skilled antenatal care provider (table 7). However, the proportion of adolescent girls who delivered with a skilled birth attendant or in a health facility is low in several countries, most notably in Bangladesh, where only 42% were attended by a skilled provider, and 36% delivered in a health facility. Access to skilled postnatal care is considerably lower: less than half of girls received postnatal care in Afghanistan, Bangladesh, Pakistan, Indonesia, Lao PDR, Timor-Leste, Kiribati and Papua New Guinea.

There is little information concerning the quality of, or adolescents' satisfaction with maternity care. A recent study published in The Lancet examining mistreatment of women in health facilities during labour in four countries (including Myanmar) found that more than a third of women experienced physical or verbal abuse, stigma or discrimination. Adolescent girls were almost twice as likely as women over the age of 30 to experience mistreatment. Other studies from the region have highlighted the need to improve postnatal care for adolescent mothers (and their partners) to help them transition to parenthood. Postnatal support not only needs to focus on high quality care to avoid the poor health outcomes associated with adolescent pregnancy, but also needs to include psychosocial support delivered with compassion and empathy to help young parents rapidly adapt to their new adult roles. Repeat pregnancy among adolescents is common, and associated with adverse outcomes. Therefore, there is a critical need for high quality postnatal and post-abortion contraceptive counselling and services for this group.

TABLE 7. PROPORTION OF 15-19 YEAR OLDS WHO RECEIVED MATERNAL HEALTH CARE (%)

Region	Country	Antenatal care (at least 1)	Skilled birth attendant	Facility birth	Postnatal care
South Asia	Afghanistan	58.4	53.6	51.5	30.8
	Bangladesh	64.4	41.8	36.1	33.9
	Bhutan	96.0	58.2	57.2	
	India	80.8	85.5	83.9	63.0
	Maldives	99.1	100.0	96.8	89.5
	Nepal	88.0	68.7	68.1	52.7
	Pakistan	84.2	70.2	67.4	48.0
	Sri Lanka	99.2	99.3	99.8	99.8
East Asia	Mongolia	100.0	100.0	100.0	90.9
Southeast Asia	Cambodia	95.7	91.4	85.9	82.0
	Indonesia	95.0	77.0	72.0	76.6
	Lao PDR	74.7	56.4	57.0	37.9
	Myanmar	80.0	60.8	37.3	53.0
	The Philippines	90.5	85.9	79.2	83.0
	Thailand	98.5	99.4	99.4	80.1
	Timor-Leste	79.6	57.8	44.5	30.3
	Viet Nam	90.7	86.9	85.8	82.6
Pacific	Kiribati	91.5	78.1	70.8	49.2
	Marshall Islands	95.7	93.5	82.8	62.8
	Nauru	95.5	90.6	95.7	
	Papua New Guinea	81.4	61.1	60.6	47.1
	Samoa	94.5	86.4	85.6	61.4
	Solomon Islands	95.0	88.2	87.8	61.7
	Tonga	92.3	99.0	100.0	89.9
	Tuvalu		100.0	100.0	
	Vanuatu	76.5	92.5	92.7	78.0

Source: DHS and MICS

THE CONTEXT AND DRIVERS OF ADOLESCENT PREGNANCY ARE COMPLEX

Early childbearing is generally more common among less educated, rural and poorer adolescents (figure 25), and is also higher in countries with increased levels of societal gender inequality. However, the context and drivers of adolescent pregnancy are complex, inter-related and context-specific. A summary of the individual, interpersonal, family, community and societal factors that contribute to early and unintended pregnancy in the region is provided in figure 28. **The majority of adolescent births occur within the context of marriage and early union, and in South Asia traditional child marriage remains among the most significant drivers of early childbearing.** Socio-cultural pressure to prove fertility soon after marriage, son preference, and the limited decision-making autonomy of married adolescent girls, contributes to poor access to, and low use of, contraception and high rates of fertility in these settings (table 8). Additionally, a significant proportion of married adolescent girls experience physical and/or sexual intimate partner violence, which is associated with an increased risk of unintended pregnancy.

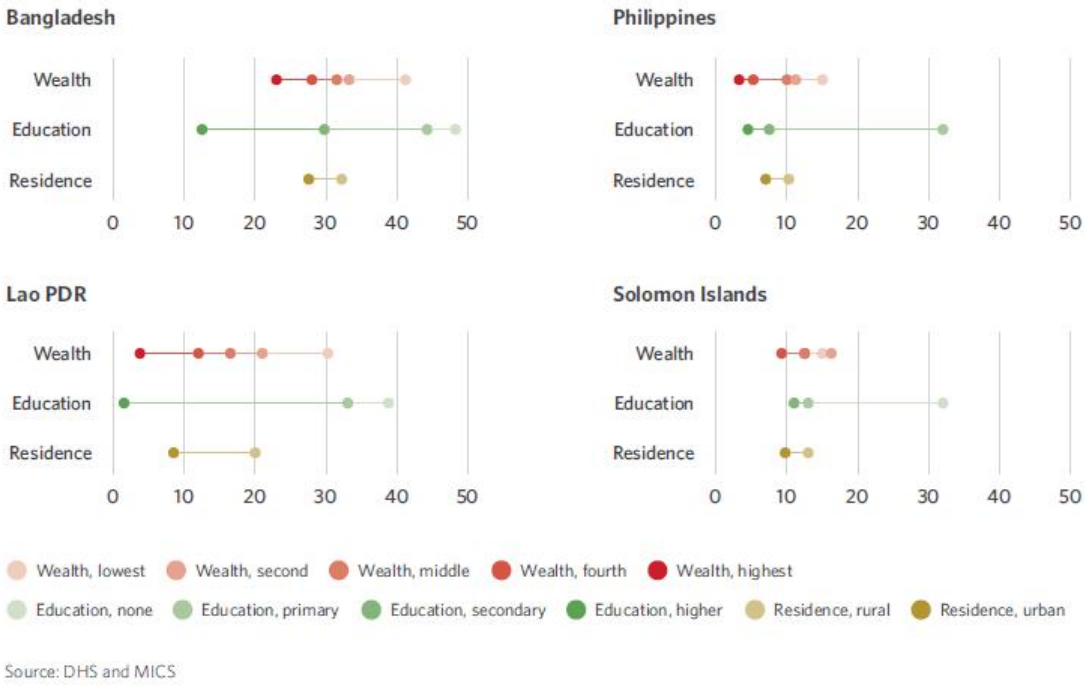
> "He [husband] didn't want a baby either. But my father- and mother-in-law wanted one right away, and said we couldn't use birth control."
>
> (20-year-old woman, Nepal)

TABLE 8. PROPORTION OF MARRIED ADOLESCENT GIRLS 15-19 YEARS WHO CAN REFUSE SEX WITH THEIR HUSBAND, AND WHO ARE INVOLVED IN DECISION-MAKING (%)

Region	Country	Autonomy contraception	Autonomy sex	Autonomy health care	Autonomy visiting friends
South Asia	Afghanistan			40.9	41.8
	Bangladesh			48.9	43.6
	India			60.7	58.7
	Maldives	78.5	65.7	80.9	96.5
	Nepal	88.1	88.7	26.9	19.3
	Pakistan	77.5	41.3	23.6	18.8
	Sri Lanka			80.1	81.9
Southeast Asia	Cambodia			89.2	95.3
	Indonesia	87.6		83.4	81.8
	Myanmar			69.7	81.1
	The Philippines	91.7	83.9	95.1	92.1
	Timor-Leste	94.2	45.6	90.9	88.3
Pacific	Kiribati			45.8	35.4
	Marshall Islands			64.8	60.8
	Samoa			85.5	82.1
	Solomon Islands			82.6	72.3
	Tonga			79.6	67.5
	Vanuatu			73.2	76.4

Source: DHS and MICS

FIGURE 25. PERCENTAGE OF GIRLS AGED 15-19 YEARS WHO HAVE COMMENCED CHILDBEARING, BY WEALTH, EDUCATION AND RESIDENCE, SELECTED COUNTRIES (%)



Source: DHS and MICS

However, **not all adolescent births that occurred in marriage were conceived in marriage.** In Southeast Asian countries, where adolescent fertility rates are increasing or have stalled, up to a third of adolescent births among ever-married 20-29 year old women were conceived prior to marriage (figure 26). Unlike adolescent pregnancies within the context of traditional forms of child marriage, these premarital pregnancies are more common in urban areas, and among girls from wealthier households in Indonesia, the Philippines and Vietnam (figure 27).

FIGURE 26. PROPORTION OF ADOLESCENT PREGNANCIES AMONG EVER-MARRIED / IN UNION WOMEN AGED 20-29 THAT WERE CONCEIVED PRIOR TO MARRIAGE / UNION (%)

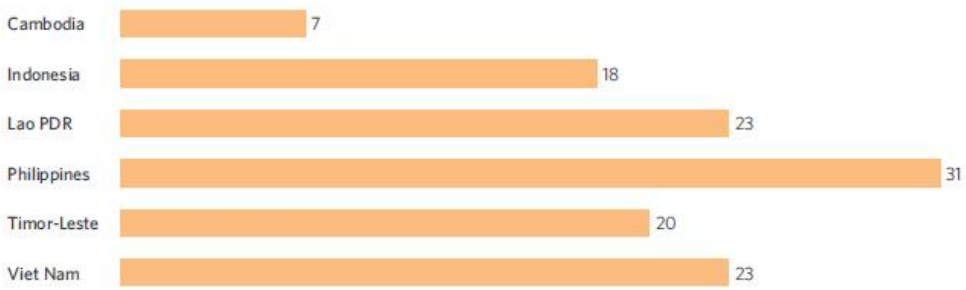
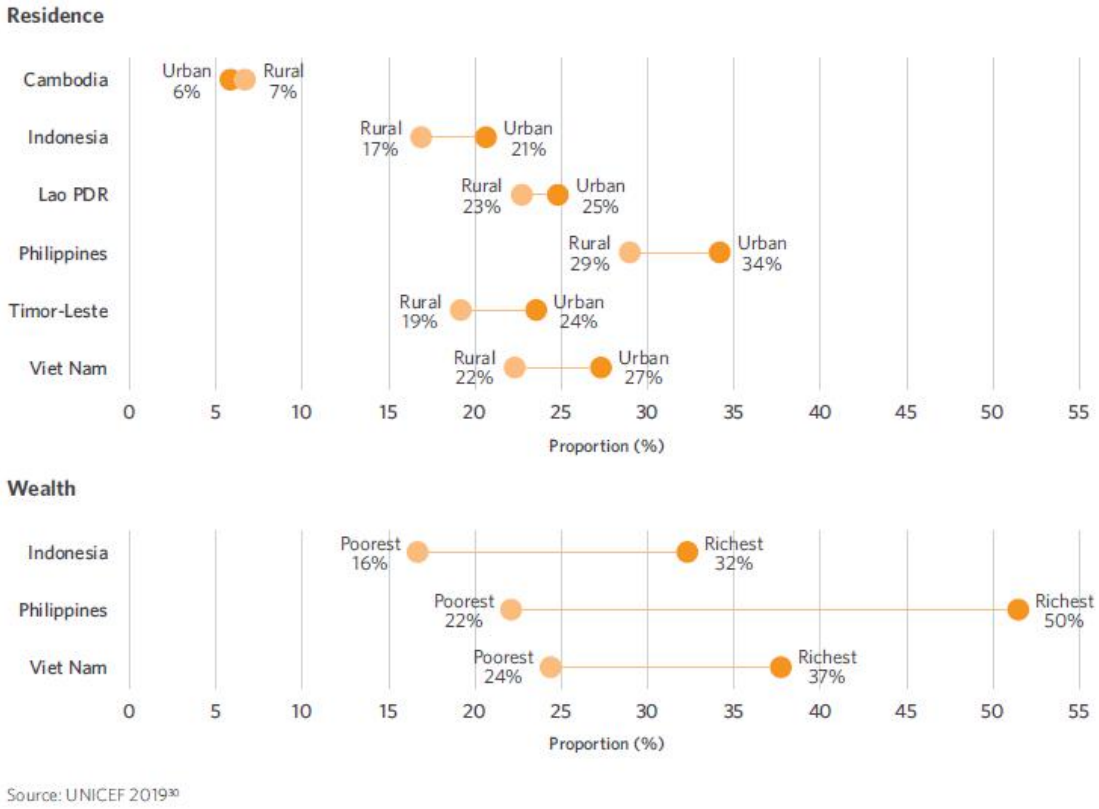


FIGURE 27. PREMARITAL ADOLESCENT CONCEPTIONS AMONG 20-29-YEAR-OLD WOMEN BY RESIDENCE AND WEALTH STATUS



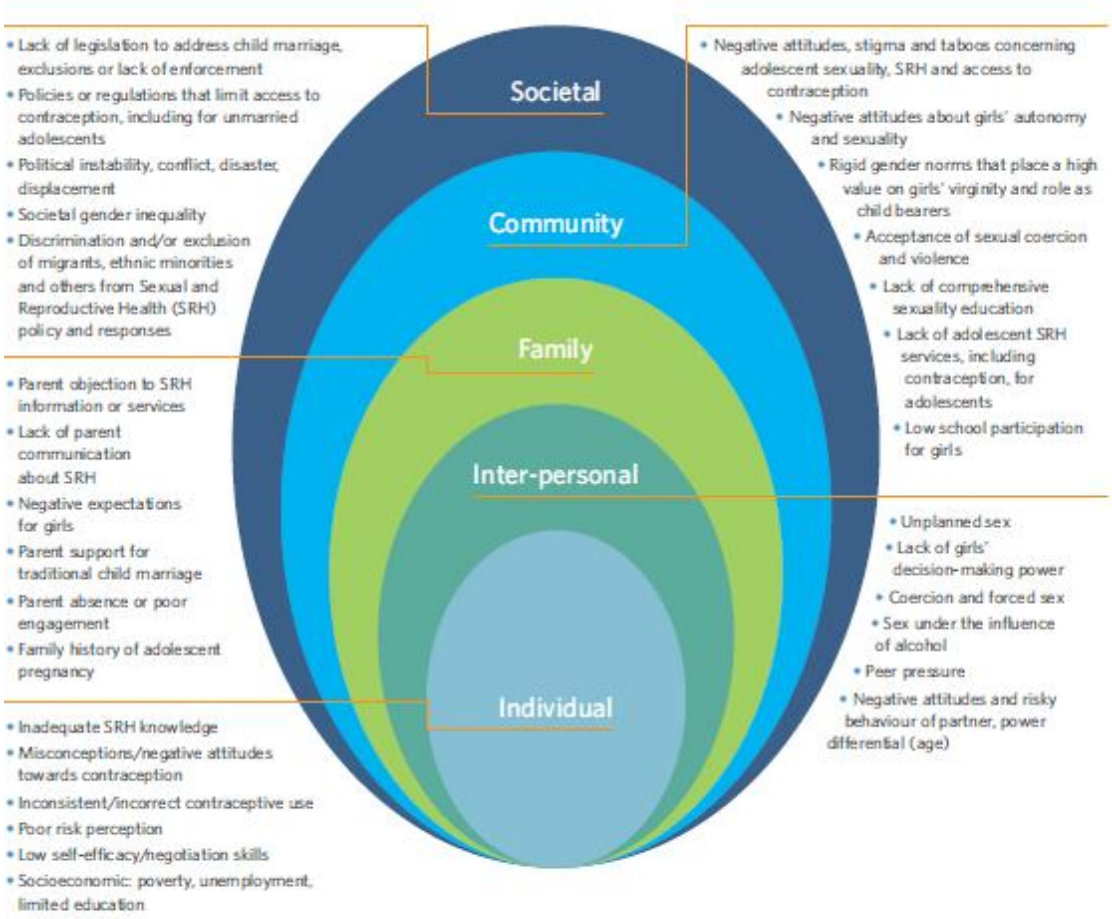
Source: UNICEF 2019[30]

In many Southeast Asian countries, lack of comprehensive sexuality education, limited access to quality contraception services, considerable socio-cultural disapproval of adolescent sexuality, harmful gender norms, and policy and regulatory barriers are major contributors to low use of contraception and girls' limited agency to negotiate safe and consensual sex. There has been a particular neglect of the needs of unmarried sexually active adolescents, which is likely to have contributed to the lack of progress.

> **"For us, condoms are too expensive but I only found that the long-term contraception injection was free after I already had my baby"**
>
> (Young woman, Thailand)

> **"I was 15 years old going on 16 when I had my first child. It was never my intention.....I had a boyfriend, he was a bit older than me. He took me out. I was already a bit drunk from work. We drank more. We never meant for this to happen. It was out of control."**
>
> (Young adolescent mother, Thailand)

FIGURE 28. DRIVERS OF ADOLESCENT PREGNANCY



Source: UNFPA / UNICEF 2018[94], UNFPA 2013[99], Chung 2018[100]

Marginalized girls are at particular risk of early and unintended pregnancy. Young female sex workers face considerable barriers to accessing quality, non-judgmental SRH services, including contraception, and report high rates of pregnancy, repeat pregnancy and abortion. Higher rates of adolescent pregnancy are also reported among some ethnic groups, particularly in the context of rigid gender norms that promote early childbearing. Exclusion from universal health care policies, poor access to SRH services, conservative sociocultural norms, stigma and discrimination also contribute to high rates of pregnancy among refugee and migrant adolescents in the region.

STRATEGIES TO ADDRESS ADOLESCENT PREGNANCY AND ASSOCIATED HARMS

Addressing adolescent pregnancy requires a comprehensive, youth-centred, multisectoral approach to respond to the interrelated drivers of early pregnancy, and reduce associated adverse outcomes for girls and their infants. Key is the meaningful engagement of young people to understand the factors contributing to pregnancy and identify effective approaches that respond to their needs and take into account their agency. Priority strategies recommended by WHO101 include interventions to:

- Prevent child marriage
- Prevent early pregnancy through comprehensive sexuality education, improved education participation of girls, and economic and social support programmes
- Increase the use of effective contraception
- Reduce sexual violence
- Prevent unsafe abortion
- Increase access to and quality of maternal health care

Recent studies of interventions to prevent pregnancy from this region are limited, but indicate that a combination of multiple strategies can reduce pregnancy and increase the use of effective contraception. These include comprehensive sexuality

education, improved access to and quality of youth-friendly SRH counselling and services, immediate postpartum contraceptive counselling, use of voucher programmes to increase uptake of contraception, strategies to address community-level norms and barriers that contribute to child marriage and/or limit access to SRH services, and approaches to improve school participation among girls. Much of the current evidence has focused on preventing adolescent pregnancy in the context of traditional arranged child marriage. There is a need for further research to understand the other pathways and drivers of adolescent pregnancy, and evaluations of strategies to prevent pregnancy, particularly in Southeast Asia and the Pacific, where fertility rates have stalled or are increasing.

A summary of key UN agency strategies, regional initiatives, and global evidence of effective approaches, is provided in box 7.

BOX 8. KEY STRATEGIES TO PREVENT ADOLESCENT PREGNANCY AND POOR HEALTH OUTCOMES

- **Supportive policy and legislative environment:**
  - Legislation that prohibits forced marriage before the age of 18 years for girls and boys
  - Legislation to prevent sexual violence, including within marriage
  - Remove legislative and regulatory barriers to contraceptive services, including limits based on age, parent consent, or marital status
  - Include adolescents and contraceptive services in universal health coverage schemes
  - Ensure inclusion of marginalised adolescents, including migrants, young people with disabilities and those in humanitarian settings
- **Address family and community attitudes, norms and barriers:**
  - Educate and mobilise families, communities and leaders to address harmful cultural, religious and gender norms that promote non-consensual early marriage and/or stigmatise sexually active unmarried adolescents, including through use of mass media
  - Build community support for adolescent SRH services, including contraception
  - Engage parents to improve support for adolescent SRH and increase parent-adolescent communication
  - Engage boys and men to address harmful gender norms that limit girls' agency and contribute to sexual violence and coercion
- **Improve school participation**
  - Increase girls' secondary school participation, including cash transfers for girls most at risk / in the context of low education participation
- **Empower adolescent girls**
  - Life-skills training, including CSE, and livelihood / employment opportunities
  - Safe spaces
- **Improve access to comprehensive sexuality education**
  - Improve coverage and quality of comprehensive sexuality education (for both in-school and out-of-school adolescents), with a focus on building communication and negotiation skills, gender equality, consent and agency, and addressing myths and misconceptions about contraception
- **Increase access to and quality of SRH services, including contraception**
  - Ensure availability of a range of contraceptives, including emergency contraception
  - Promote dual method use (effective modern method and condom use) to prevent unintended pregnancy and STIs
  - Provide competency-based training of providers in non-judgmental contraceptive counselling and services for adolescents
  - Implement and monitor national AFHS standards
  - Remove policies and regulations that require mandatory parental or spousal consent for contraception and comprehensive abortion care
  - Consider voucher schemes or other financing mechanisms to increase uptake and reduce financial barriers
  - Improve the provision and quality of postpartum and post-abortion contraceptive counselling and services
- **Improve support for pregnant adolescents and young parents:**
  - Increase access to post-abortion care, and comprehensive safe abortion where legal
  - Improve access to and quality of maternity care
  - Improve access to and quality of postnatal care, including to increase psychosocial and other supports for young parents
  - Support return to, or continuation of, education
  - Life-skills training and livelihood / employment opportunities
- **Strengthen data and research** to inform policies and programmes, particularly understanding the context of adolescent pregnancy outside traditional child marriage, and the needs of sexually active unmarried adolescents