



# Facing the facts

Adolescent girls and contraception



# In 2015

Cover: Portrait of a young woman at Dakhla Refugee Camp., Algeria, 2003. © UN Photo/Evan Schneider

This page: A classroom of school children in Assiut, Egypt, 2015. © Christina Rizk

- 15 million adolescent girls\* in developing countries gave birth
- 13 million lacked access to contraceptives

\* Throughout this booklet, 'adolescent girls' refers to those aged 15-19, unless otherwise noted.

# Adolescent girls and the right to family planning

The importance of reproductive health, in general, and access to voluntary family planning, in particular, is well established. They are crucial to the entire, interconnected and transformative global development agenda.

The Sustainable Development Goals, to which the world has newly committed, prioritize the needs of those who are most vulnerable and underserved, including young people. Their reproductive choices will have enormous repercussions for the trajectory of their own lives and for the future of their countries.

Yet their unmet need for reproductive health services remains high. Demand for and use of contraception among adolescent girls has increased, but current levels remain remarkably lower than for other age groups.

- Of the 13 million adolescent girls with an unmet need for contraception, about half live in Asia and the Pacific and more than 30 per cent live in sub-Saharan Africa.
- Globally,\* 23 per cent of adolescent girls are married or in union, and 3 per cent are unmarried but sexually active. A substantial majority, 74 per cent, are not sexually active.

- Only about 15 per cent of adolescent girls who are married or in union are using modern contraception (see regional percentages and contraceptive mix in the figure next page).

\*Refers to the weighted average of 156 UNFPA programme countries.

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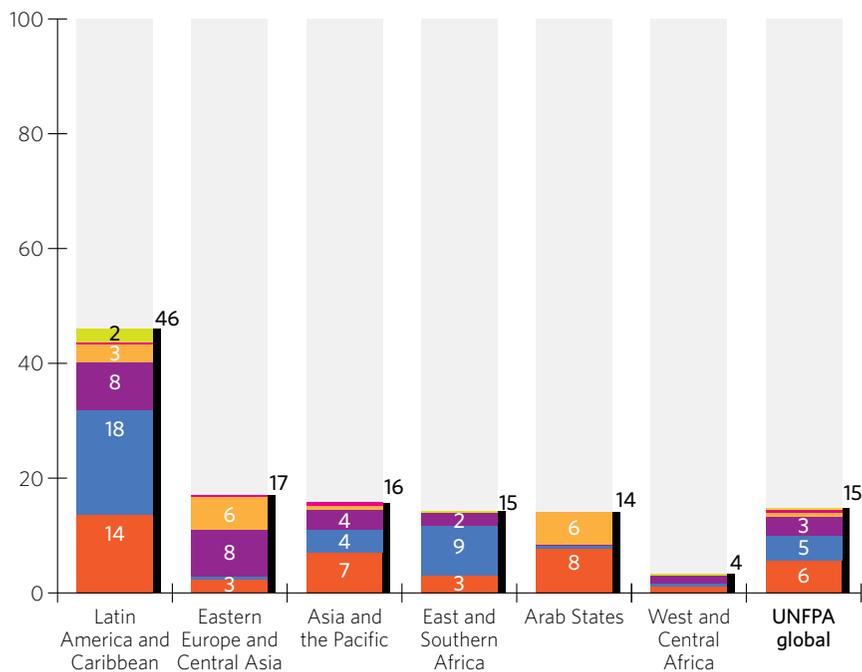
Deura, Nepal.

© UNFPA/Anna Adhikari



## Just 15 per cent of adolescent girls, married or in union, use modern contraception.

Percentage of adolescent girls aged 15-19, married or in union, using modern contraception, by region, 2002-2014, and contraceptive mix.



- Not using any modern method
- Implant
- Sterilization
- IUD
- Male condom
- Injectable
- Pill
- Modern contraceptive prevalence rate

Notes: "UNFPA global" refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database ([unfpaopendata.org](http://unfpaopendata.org)).

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A young mother outside the  
Kinaaba Health Centre.

© UNFPA/Omar Gharzeddine



# What vulnerabilities and barriers do adolescents face?

An unplanned pregnancy or a sexually transmitted infection at an early age can upend health, education, hopes and dreams at a time when girls are full of possibility.

Yet many face high barriers to obtaining contraceptives: Laws and policies may restrict their access. In many regions, adolescent girls, who often marry much older husbands, have limited power to negotiate contraceptive use and family planning. Adolescent girls may not feel comfortable visiting family planning clinics – even those that are intended to be youth friendly.

- Adolescents and youth systematically experience less informed choice. Lack of education or money may reduce their ability to access health information or services. Living in rural areas can also restrict options.
- The unmet need for family planning is highest among adolescents: 23 per cent compared to 15 per cent for women ages 30-34.
- Adolescent girls without schooling are about three times more likely to give birth than those with a secondary education or higher.

- Only 24 per cent of Ethiopian adolescent girls using modern contraceptives were informed about possible side effects. The figure is 35 per cent for Nigerian girls.

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Seila, 16, is pregnant with her first child. She dropped out of school to work on her family's farm in Tbong Khmum Province.

© UNFPA Cambodia





# Higher hurdles for unmarried, sexually active girls

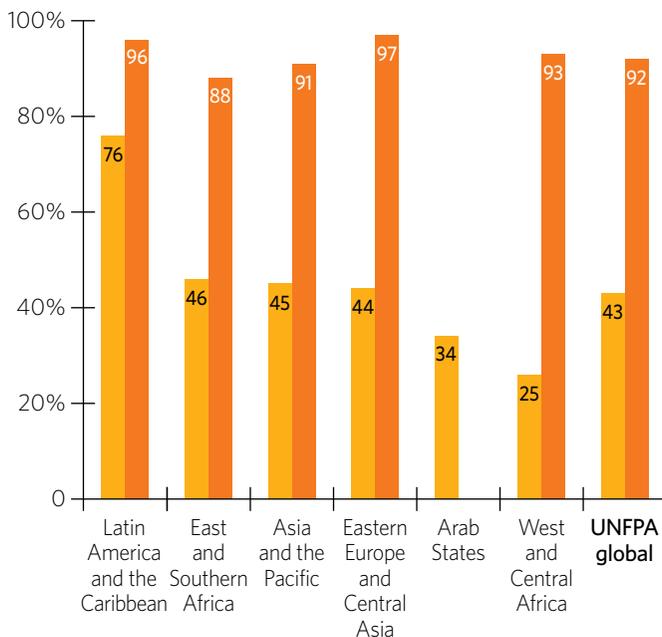
The vast majority of sexually active adolescent girls in developing countries are married, and most reproductive health surveys track only this group. Some countries do not acknowledge sex outside of marriage, nor do they collect data on the contraceptive needs of unmarried women, including adolescent girls.

But a human rights perspective – and international commitments – insists that the reproductive rights of unmarried girls be fulfilled. Sexually active unmarried girls aged 15-19 have the highest demand for contraception of any age group. They often face added stigma in accessing contraception and more severe consequences from this lack.

- In three out of five developing regions (Asia and the Pacific, East and Southern Africa, and West and Central Africa), the unmet need of sexually active, unmarried girls for contraception is about double that of their married counterparts.
- About 41 per cent of unmarried sexually active girls use modern methods of contraception. Condoms account for nearly 70 per cent of their total usage.

## Sexually active, unmarried adolescent girls have more than twice the total demand for contraception compared to their married counterparts.

Total demand for contraception among adolescent girls by region, latest data, 2002-2014.

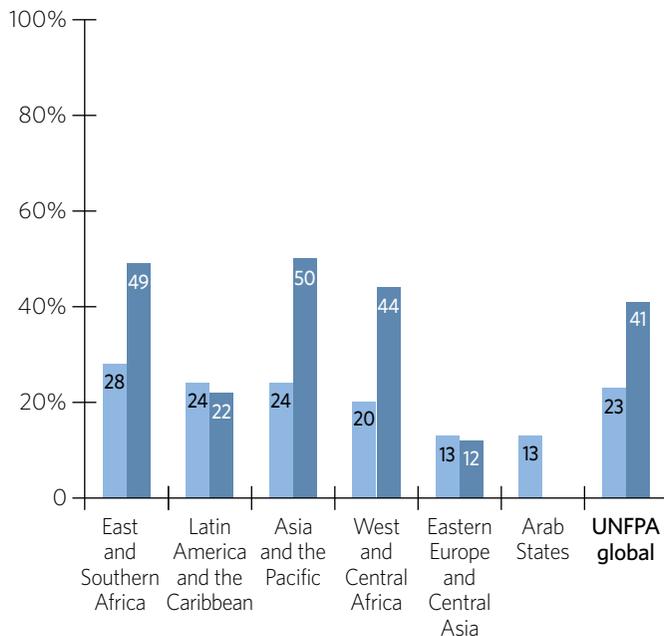


■ Total demand for contraception, currently married

■ Total demand for contraception, unmarried and sexually active

## Their level of unmet need for contraception is also high.

Rate of unmet need among adolescents by region, latest data, 2002-2014.



- Unmet need for contraception, currently married
- Unmet need for contraception, unmarried and sexually active

Notes: 'UNFPA global' refers to the weighted average of 156 UNFPA programme countries.

Source: UNFPA global open database ([unfpaopendata.org](http://unfpaopendata.org)).

# Declining rates of adolescent births, but increasing numbers

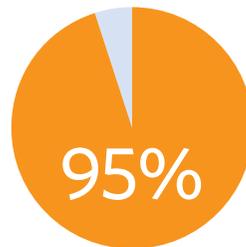
During the last 25 years, significant progress has been made in reducing adolescent childbearing, especially between 1990 and 2000. This is important because adolescent girls are much more likely to die in childbearing than women aged 20-24. And children born to adolescent mothers face heightened risks of mortality, undernourishment and school dropout.

Declines in the adolescent birth rate have been almost universal across regions and countries (except in the Arab States). Reductions occurred amid increasing school participation, rising demand for contraception and falling rates of child marriage.

Nevertheless, an additional 4 million adolescent births are projected by 2035, with almost all of the increase coming from sub-Saharan Africa. This rapid projected increase is mainly due to high levels of fertility combined with a large proportion of the population entering their childbearing years.

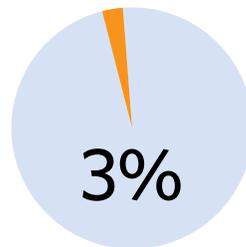
The projected trends in adolescent births closely track the numbers of sexually active adolescent girls with an unmet need for contraception.

- In 2015, more than 15 million adolescent girls gave birth, a number projected to rise to more than 19 million by 2035, if current patterns remain unchanged.
- Sub-Saharan Africa has made the least progress in reducing adolescent births. In 2012, there were 118 births per 1,000 adolescent girls, slightly lower than the rate in 1990 of 123 births.
- By 2035, the adolescent births in sub-Saharan Africa are projected to account for about half of those globally.



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95 per cent of the world's births among adolescents occur in developing countries.

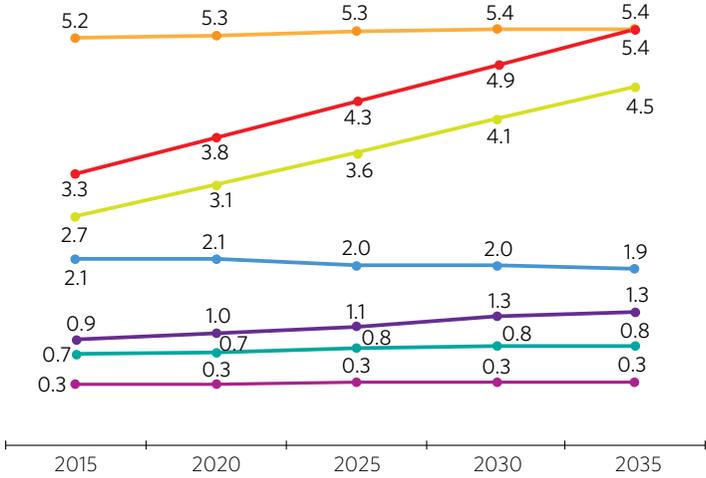


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Only 3 per cent of adolescent girls are unmarried and sexually active.

# Projections for adolescent births closely track levels of unmet need.

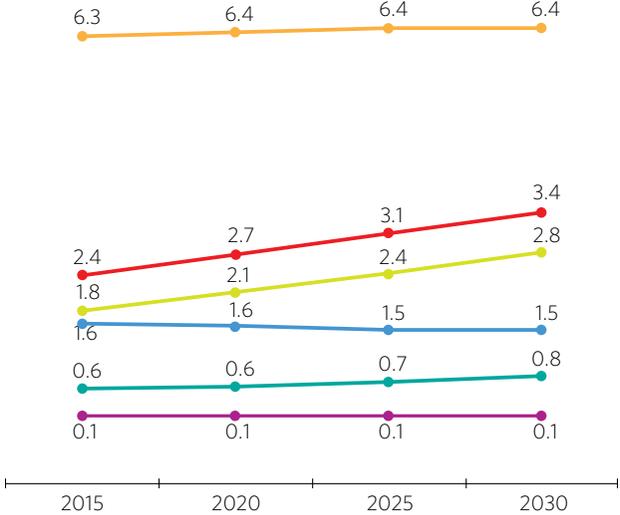
Projections for the number of live births (in millions) to adolescents aged 15-19, selected regions, 2015-2035.



- Asia and the Pacific
- East and Southern Africa
- West and Central Africa
- Latin America and the Caribbean
- Arab States
- Non-UNFPA
- Eastern Europe and Central Asia

Notes: 'Non-UNFPA' refers to countries in which UNFPA does not have a programme (mostly developed countries).  
 Source: UNFPA analysis based on data from the United Nations Population Division.

Number in millions of adolescent girls, married, and unmarried but sexually active, with an unmet need for family planning, 2015-2030.



- Asia and the Pacific (excluding China)
- East and Southern Africa
- West and Central Africa
- Latin America and the Caribbean
- Arab States
- Eastern Europe and Central Asia

Source: UNFPA analysis based on Demographic and Health Survey and Multiple Indicators Cluster Survey data.

# Aspects of inequality: Wealth, education and location

In all developing regions, women in rural areas, in poor households, and with no or low levels of education have lower levels of contraceptive use. But these disparities are heightened among adolescents.

Trend analysis reveals, however, that interventions are reaching disadvantaged groups: In all developing regions, with the exception of West and Central Africa, the percentage of demand for family planning that was satisfied has climbed faster among more vulnerable groups. East and Southern Africa has experienced the fastest rise, particularly among disadvantaged groups.

Examining demographic disparities and social and economic inequalities in family planning is critical to designing evidence-based programming that reaches those in greatest need.

- The adolescent birth rate for those in the poorest 20 per cent of the population is about triple that of those in the wealthiest quintile.
- In West and Central Africa, adolescents living in rural areas are more than two times as likely to give birth as their urban counterparts (167 versus 77 births per 1,000 women aged 15-19).

- The largest inequality related to education is found in Latin America and the Caribbean. Births to adolescent girls with no education are close to four times higher than for girls with secondary or higher education (234 versus 63 live births).



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Children attend class at a local school.  
Dili, Timor-Leste. © Ron Haviv/VII

# How can we accelerate progress?

Ensuring that adolescent girls have the means to decide the number, timing and spacing of their children is essential to protecting their basic human rights to health, life and equal opportunity.

It can also help their countries realize rapid progress. Many of the countries where contraceptive needs are highest are transitioning from a state of high mortality and fertility to one of lower mortality and fertility. In such countries, a window of opportunity for a 'demographic dividend' is opening – but its realization will occur only if young people are healthy, productive and empowered.

Empowering young women, through access to essential reproductive health services, can help countries realize the advantage of having a larger proportion of people in their working years and accelerate progress towards sustainable development.

Collecting and analysing data is crucial to identifying strategic responses in this regard. Data analysis clarifies, for example, that we need to reach out to underserved girls, especially those in rural areas and poor households. It reveals also that education is crucial. Girls who avoid early pregnancies have more educational opportunities, and girls who attend school are more likely to use contraception.

Moving forward will require significant political and financial commitments. However, expanding access to contraceptive options is a prerequisite to securing the human rights of adolescent girls and achieving Sustainable Development Goals Goals 1 (Ending poverty), 3 (Good health and wellbeing) and 5 (Gender equality).

*“Increasing access to modern contraception among adolescent girls is a crucial starting point for improving their long-term health.”*

UNFPA Executive Director, Dr. Babatunde Osotimehin





This brochure, conceptualized and edited by Janet Jensen and designed by Mary Marques, is based on data and analysis of a major UNFPA report entitled *Universal Access to Reproductive Health: Progress and Challenges*. It was written by Edilberto Loaiza (Senior Monitoring and Evaluation Adviser) and Mengjia Liang (Monitoring and Evaluation Analyst) and published by UNFPA in 2015.



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