PREVENTING EARLY PREGNANCY: WHAT THE EVIDENCE SAYS

The Preventing early pregnancy: What the evidence says? in Developing Countries presents the evidence to design national policies and strategies. It contains recommendations on action and research for preventing:

- **early pregnancy**: by preventing marriage before 18 years of age; by increasing knowledge and understanding of the importance of pregnancy prevention; by increasing the use of contraception; and by preventing coerced sex

- **poor reproductive outcomes**: by reducing unsafe abortions; and by increasing the use of skilled antenatal, childbirth and postnatal care.

These guidelines are primarily intended for policy-makers, planners and programme managers from governments, nongovernmental organizations and development agencies. They are also likely to be of interest to public health researchers and practitioners, professional associations and civil society groups.

They have been developed through a systematic review of existing research and input from experts from countries around the world, in partnership with many key international organizations working to improve adolescents’ health. Similar partnerships have been forged to distribute them widely and to support their use.

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**INTERVENTIONS MUST AIM TO:**

**Prevent early pregnancy**
1. Reduce marriage before age 18
2. Foster understanding and support for preventing early pregnancy
3. Increase the use of contraception among adolescents
4. Reduce coerced sex among adolescents

**Prevent adverse reproductive outcomes**
5. Reduce unsafe abortion among adolescents
6. Increase access by adolescents to skilled prenatal, childbirth and postnatal care
Over 30% of girls in developing countries marry before 18 years of age; around 14% do so before the age of 15. Early marriage is a risk factor for early pregnancy and poor reproductive outcomes. Furthermore, marriage at a young age perpetuates the cycle of under-education and poverty.\(^1\)

WHO’s recommendations for preventing early marriage are informed by 21 studies and project reports as well as the conclusions of an expert panel. The studies were conducted in Afghanistan, Bangladesh, Egypt, Ethiopia, India, Kenya, Nepal, Senegal and Yemen, among others. In some of these studies and projects, the primary outcome was delaying the age of marriage. In others, this outcome was secondary to school retention, knowledge and attitudes, or sexual behaviour. The research supports actions to prevent early marriage.

What can policy-makers do?

**PROHIBIT EARLY MARRIAGE.**

In many places, laws do not prohibit marriage before the age of 18. Even in places where they do, these laws are not enforced. Policy-makers must put in place and enforce laws that ban marriage before 18.

**KEEP GIRLS IN SCHOOL.**

Around the world, more girls are enrolled in school than ever before. Educating girls has a positive effect on their health, the health of their children, and that of their communities. Also, girls in school are much less likely to be married at an early age. Sadly, school enrolment drops sharply after five or six years of schooling.\(^2\) Policy-makers must increase formal and non-formal educational opportunities for girls at both primary and secondary levels.

**INFLUENCE CULTURAL NORMS THAT SUPPORT EARLY MARRIAGE.**

In some parts of the world, girls are expected to marry and have children in their early or middle teenage years, well before they are physically or mentally ready to do so. Parents feel pressured by prevailing norms, traditions and economic constraints to marry their daughters at an early age. Community leaders must work with all stakeholders to challenge and change norms around early marriage.

What can researchers do?

- Build evidence on the types of interventions that can result in the formulation of laws and policies to protect adolescents from early marriage (e.g. public advocacy).
- Gain a better understanding of how economic incentives and livelihood programmes can delay the age of marriage.
- Develop better methods to assess the impact of education and school enrolment on the age of marriage.
- Assess the feasibility and existing interventions to inform and empower adolescent girls, their families and their communities to delay the age of marriage, and assess the potential of taking interventions to scale.

Worldwide, one in five women has a child by the age of 18. In the poorest regions of the world, this rises to over one in three women.³ Teen pregnancies are more likely to occur among poor, less educated and rural adolescents.⁴

WHO’s recommendations for preventing early pregnancy are informed by two graded systematic reviews, three ungraded studies, as well as the conclusions of an expert panel. The studies in the systematic reviews included those conducted in developing countries (Mexico and Nigeria) as well as those conducted among poorer socio-economic populations in developed countries. Collectively, the studies demonstrate reductions in early pregnancy among teen girls exposed to interventions that included sexuality education, cash transfer schemes, early childhood education and youth development, as well as life skills development. One study showed a reduction in repeat pregnancies as a result of an intervention that included home visits for social support.

**What can policy-makers do?**

**SUPPORT PREGNANCY PREVENTION PROGRAMMES AMONG ADOLESCENTS.**

Early pregnancies occur because of a combination of social norms, traditions and economic constraints. At the same time, there continues to be resistance to sexuality education. Policy-makers must give strong and visible support for efforts to prevent early pregnancy. Specifically, they must ensure that sexuality education programmes are in place.

**What can individuals, families and communities do?**

**EDUCATE ALL ADOLESCENTS ABOUT SEXUALITY.**

Many adolescents become sexually active before they know how to avoid unwanted pregnancies and sexually transmitted infections. Peer pressure and pressure to conform to stereotypes increase the likelihood of early and unprotected sexual activity. In order to prevent early pregnancy, curriculum-based sexuality education must be widely implemented. These programmes must develop life skills, provide support to deal with thoughts, feelings and experiences that accompany sexual maturity and be linked to contraceptive counseling and services.

**BUILD COMMUNITY SUPPORT FOR PREVENTING EARLY PREGNANCY.**

In some places premarital sexual activity is not acknowledged and there is resistance to discussing meaningful ways of addressing it. Families and communities must be engaged and involved in efforts to prevent early pregnancies and sexually transmitted infections, including HIV.

**What can researchers do?**

- Build evidence of the effect of interventions to prevent early pregnancy including those that increase employment, school retention, education availability, and social supports.
- Conduct research across socio-cultural contexts to identify feasible and scalable interventions to reduce early pregnancy among adolescents.

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Even in places where contraceptives are widely available, sexually active adolescents are less likely to use them than adults.\(^5\)

WHO’s recommendations for increasing the use of contraception are informed by 7 graded and 26 ungraded studies conducted in 17 countries, as well as the conclusions of a panel of experts. Some focused exclusively on increasing condom use, while others examined increasing the use of hormonal and emergency contraceptives. In some, increasing contraception was a primary outcome whereas in others it was secondary. Some studies focused exclusively on health system actions (such as over-the-counter or clinic provision of contraceptives) while others focused on community and stakeholder engagement to increase contraceptive use. Collectively, these studies demonstrate that contraceptive use can be increased as a result of actions directed at multiple levels - policies, individuals, families, communities and health systems.

**What can policy-makers do?**

**LEGSILATE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES.**

In many places, laws and policies prevent the provision of contraceptives to unmarried or younger adolescents. Policy-makers must intervene to reform policies enable all adolescents to obtain contraception.

**REDUCE THE COST OF CONTRACEPTIVES TO ADOLESCENTS.***

Financial constraints can adversely impact contraceptive use among poorer adolescents. To increase use, policy-makers should consider reducing the financial cost of contraceptives to teens.

**What can individuals, families and communities do?**

**EDUCATE ADOLESCENTS ABOUT CONTRACEPTIVE USE.**

Adolescents may not be aware of where to obtain contraceptives and how to use them appropriately. Efforts to provide accurate information about contraceptives must be combined with sexuality education.

**BUILD COMMUNITY SUPPORT FOR CONTRACEPTIVE PROVISION TO ADOLESCENTS.**

There is resistance to the provision of contraceptives to adolescents, especially those who are unmarried. Community advocacy is needed to remove this barrier.

**What can health care providers do?**

**ENABLE ADOLESCENTS TO OBTAIN CONTRACEPTIVE SERVICES.**

Often, adolescents do not seek contraceptive services because they are afraid of social stigma or being judged by clinic staff. Health service delivery must be made more youth-friendly.

**What can researchers do?**

- Build evidence on the effectiveness of different interventions to increase contraceptive use.
- Understand how gender norms affect contraceptive use.

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* Conditional recommendation
Girls in many countries are pressured into having sex, often by family members. In some countries, over a third of girls report that their first sexual encounter was coerced.

WHO’s recommendations for reducing coerced sex are informed by two graded studies, six ungraded studies or reviews of laws, and the collective experience and judgment of an expert panel. The studies and reviews were conducted in Botswana, India, Kenya, South Africa, Tanzania and Zimbabwe. Collectively, these studies suggest that actions to influence community and gender norms can have positive effects on the ability of girls to resist coerced sex and on the attitudes of men and boys towards coerced sex.

**What can policy-makers do?**

**PROHIBIT COERCED SEX.**

In many places, law enforcement officials do not actively pursue perpetrators of coerced sex and it is often difficult for victims to seek justice. Policy-makers must formulate and enforce laws that prohibit coerced sex and punish perpetrators. Victims and their families must feel safe and supported when approaching the authorities and seeking justice.

**What can individuals, families and communities do?**

**EMPOWER GIRLS TO RESIST COERCED SEX.**

Girls may feel powerless to refuse unwanted sex. Girls must be empowered to protect themselves, and to ask for and obtain effective assistance. Programmes that build self-esteem, develop life skills, and improve links to social networks and supports can help girls refuse unwanted sex.

**INFLUENCE SOCIAL NORMS THAT CONDONE COERCED SEX.**

Prevailing social norms condone violence and sexual coercion in many parts of the world. Efforts to empower adolescents must be accompanied by efforts to challenge and change the community and gender norms that condone coerced sex.

**ENGAGE MEN AND BOYS TO CRITICALLY ASSESS NORMS AND PRACTICES.**

Men and boys may view gender-based violence and coercion as normal. They should be supported to critically look at the negative effects of this on girls, women, families and communities. This could persuade them to change their attitudes and refrain from violent and coercive behaviours.

**What can researchers do?**

- Build evidence on the effectiveness of laws and policies aimed at preventing sexual coercion.
- Assess how laws and policies are formulated, enforced and monitored in order to understand how best to prevent the coercion of adolescent girls.

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An estimated 3 million unsafe abortions occur globally every year among adolescent girls 15-19 years of age. Unsafe abortions contribute substantially to maternal deaths and to lasting health problems.

WHO’s recommendations for reducing unsafe abortions are informed by the collective experience and judgment of an expert panel. There were no studies that could be used to provide evidence to inform the panel’s decisions.

**What can policy-makers do?**

**ENABLE ACCESS TO SAFE ABORTION AND POST-ABORTION SERVICES.**

Policy-makers must ensure that adolescent girls have access to safe and legal abortion services, as well as to appropriate post-abortion care, regardless of whether the abortion itself was legal. Adolescent girls who have had abortions must be offered post-abortion contraceptive information and services.

**What can individuals, families and communities do?**

**INFORM ADOLESCENTS ABOUT WHERE THEY CAN OBTAIN SAFE ABORTION SERVICES.**

When faced with an unwanted pregnancy, adolescent girls may turn to illegal or unsafe abortions. All adolescent girls must be informed about the dangers of unsafe abortion, about safe abortion services that are legally available, and about where and how they can obtain these services.

**INCREASE COMMUNITY AWARENESS OF THE DANGERS OF UNSAFE ABORTION.**

There is very little public awareness of the scale and tragic consequences of withholding legal and safe abortion services. Families and community leaders must be made aware of these consequences and build support for policies to enable adolescent girls to access abortion and post-abortion services.

**What can health systems do?**

**IDENTIFY AND REMOVE BARRIERS TO SAFE ABORTION SERVICES.**

Even where abortions are legal, adolescents are often unable or unwilling to obtain safe abortions because of unfriendly health workers and burdensome clinic policies and procedures. Managers and health service providers must identify and overcome these barriers so that adolescent girls can obtain safe abortion services, post-abortion care, and post-abortion contraceptive information and services.

**What can researchers do?**

- Identify and assess interventions that reduce barriers to the provision of safe and legal abortion services in multiple socio-cultural contexts.
- Build evidence on the impact of laws and policies that enable adolescents to obtain safe abortion and post-abortion services.

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7 *Women and health: Today’s evidence, tomorrow’s agenda.*
In some countries, adolescents are less likely than adults to obtain skilled care before, during and after childbirth.8

WHO’s recommendations for increasing the use of skilled antenatal, childbirth and postpartum care are informed by one graded study, one ungraded study, existing WHO guidelines and the collective experience and judgment of a panel of experts. The studies were conducted in Chile and India. One intervention was a home visit programme for adolescent mothers. Another was a cash transfer system contingent upon health facility births. Collectively, these studies suggest that interventions to increase the use of skilled antenatal, childbirth and postpartum care can result in improved health outcomes for mothers and newborns.

What can policy-makers do?

EXPAND ACCESS TO SKILLED ANTENATAL, CHILDBIRTH AND POSTNATAL CARE.

Policy-makers must develop and implement legislation to expand access to skilled antenatal care, childbirth care and postnatal care, especially for adolescent girls.

EXPAND ACCESS TO BEmOC AND CEmOC.

Basic emergency obstetric care (BEmOC) and comprehensive emergency obstetric care (CEmOC) can be life-saving interventions. Policy-makers must intervene to expand access to these emergency services, especially for pregnant adolescent girls.

What can individuals, families and communities do?

INFORM ADOLESCENTS AND COMMUNITY MEMBERS ABOUT THE IMPORTANCE OF SKILLED ANTENATAL AND CHILDBIRTH CARE.

Lack of information is an important barrier to seeking services. It is important to disseminate accurate information on the risks of not obtaining skilled care.

What can health systems do?

Ensure that adolescents and their families and communities are well prepared for birth and birth-related emergencies.

Pregnant adolescents must get the support they need to be well prepared for birth and birth-related emergencies including creating a birthing plan. Birth and emergency preparedness must be an integral part of antenatal care.

BE SENSITIVE AND RESPONSIVE TO THE NEEDS OF YOUNG MOTHERS-TO-BE AND MOTHERS.

Adolescent girls must receive skilled - and sensitive - antenatal and childbirth care and, if complications arise, they must have access to emergency obstetric care.

What can researchers do?

• Build evidence to identify and eliminate barriers that prevent the access to and use of skilled antenatal, childbirth and postnatal care among adolescent girls.
• Develop and evaluate interventions that inform adolescents and stakeholders about the importance of skilled antenatal and childbirth care.
• Identify interventions to change health services for improving access to and use of skilled antenatal and childbirth care by adolescent girls; tailor antenatal, childbirth and postnatal services to adolescents; expand the availability of BEmOC and CEmOC; and improve birth and emergency preparedness for adolescents.

Approximately 16 million adolescent girls between 15 and 19 give birth every year. Babies born to adolescent mothers account for roughly 11% of all births worldwide; 95% of them occur in developing countries. For some of these young women, pregnancy and childbirth are planned and wanted, but for many others they are not. There are several factors that contribute to unplanned and unwanted pregnancies in adolescence. Adolescents may be under pressure to marry and to bear children early, or they may have limited educational and employment prospects. Some do not know how to avoid a pregnancy, while others are unable to obtain condoms and contraceptives to do so. Adolescents may be unable to refuse unwanted sex or to resist coerced sex. Those that do become pregnant are less likely than adults to be able to obtain legal and safe abortions to terminate their pregnancies. They are also less likely than adults to obtain skilled prenatal, childbirth and postnatal care.

Childbirth at an early age is associated with greater health risks for the mother. In low- and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among adolescent girls aged 15 to 19. Unwanted pregnancies may end in abortions—often unsafe abortions. In 2008, there were an estimated 3 million unsafe abortions among 15 to 19 year-olds.

The adverse effects of adolescent childbearing also extend to the health of their infants. Perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged 20 to 29. The newborns of adolescent mothers are also more likely to have low birth weight, with the risk of long term effects.

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