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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Accelerating progress towards preventing pregnancy among adolescent girls

Report of the Office of the United Nations High Commissioner for Human Rights*

Summary

In the present report, prepared pursuant to Human Rights Council resolution 56/21, the Office of the United Nations High Commissioner for Human Rights examines the issue of adolescent pregnancy through a human rights lens, analysing its multifaceted drivers and interventions that can contribute to its prevention based on existing standards and promising practices.

* The present report was submitted to the conference services for processing after the deadline so as to include the most recent information.

I. Background

1. The present report is submitted pursuant to Human Rights Council resolution 56/21, in which the Council requested the Office of the United Nations High Commissioner for Human Rights to prepare a report on how to accelerate progress towards preventing pregnancy among adolescent girls, in consultation with relevant stakeholders. The report draws on virtual consultations held with adolescent girls, experts from various regions and backgrounds and representatives of civil society organizations and United Nations entities, as well as desk research and 66 submissions received in response to a questionnaire, including from States.[1]

A. Contextual framework

2. Despite progress worldwide in reducing the rate of adolescent pregnancy over the past two decades, this phenomenon, which has devastating consequences for girls' lives, remains a significant global concern. Millions of girls become pregnant and give birth each year before they are physically, emotionally or socially prepared to do so, predominantly in low- and middle-income countries.[2] Preventing adolescent pregnancy is a key element of the Sustainable Development Goals, including indicator 3.7.2.

3. In its resolution 56/21, the Human Rights Council recognized a wide range of intersecting drivers of adolescent pregnancy, including poverty, social exclusion, discrimination, gender inequality, child marriage, sexual violence, limited access to education and health services and inadequate social protection. Adolescent pregnancy is both a cause and a consequence of a range of human rights violations, reflecting the complex interplay of social, cultural, economic and other factors that shape adolescents' lives. When their rights are not respected, protected and fulfilled, adolescents face heightened risks of pregnancy and its consequences, which can even cost them their lives.[3] Adolescents who are pregnant and give birth also face a higher risk of maternal mortality than adult women.[4]

4. As detailed in the present report, the international human rights framework provides a solid foundation for addressing adolescent pregnancy by outlining States' obligations to respect, protect and fulfil the rights of adolescents. In the report, OHCHR examines adolescent pregnancy through a human rights lens, with a focus on its multifaceted drivers and interventions that can contribute to its prevention based on existing standards and promising practices.

B. Alarming and uneven prevalence of adolescent pregnancy

5. An estimated 12.3 million adolescent girls between ages10 and 19 gave birth globally in 2025, representing a 12 per cent decline from 14 million in 2015.[5] Between 2015 and 2025, the global adolescent birth rate among girls between ages 10 and 14 fell, from 1.5 births per 1,000 girls to 1 birth per 1,000, while the rate among girls between ages 15 and 19 declined, from 45.9 births per 1,000 girls to 37.6 births per 1,000.[6] However, the commendable progress made worldwide hides significant disparities in the generally underestimated prevalence of adolescent pregnancy, with global averages concealing substantial differences between and within regions. According to the latest comprehensive regional overview published by the World Health Organization, in 2025, the sharpest declines have occurred in Southern, Central and Western Asia and North Africa, while progress has been slower in Latin America and the Caribbean and in sub-Saharan Africa. Sub-Saharan Africa and Latin

[1] The questionnaire and the submissions received in reply are available from https://www.ohchr.org/en/calls-for-input/2026/call-input-accelerating-progress-towards-preventing-adolescent-girls-pregnancy.
[2] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.
[3] See the submissions.
[4] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.
[5] See https://iris.who.int/server/api/core/bitstreams/45189137-2f10-48e1-ae43-91b0d8ddd120/content.
[6] Ibid.

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America and the Caribbean continue to record the highest adolescent birth rates worldwide, at 101 and 53.2 births per 1,000 girls, respectively. These regional averages obscure substantial variation between countries. For example, in Latin America and the Caribbean, national averages can range from 85.6 to 24.1 adolescent births per 1,000 girls.[7]

6. Every year, an estimated 21 million adolescent girls in low-and middle-income countries become pregnant, and approximately half of those pregnancies are unintended.[8] Data indicate that 55 per cent of those unintended pregnancies end in abortions, which are frequently unsafe, as legal abortion care is often unavailable, contributing significantly to maternal morbidity and mortality.[9] Significant inequalities in contraceptive access and use persist, both between and within countries, with the highest unmet need in low-income countries. In those countries, the unmet need for modern contraception is far higher among adolescent girls between ages 15 and 19 (43 per cent) than among all women of reproductive age (24 per cent).[10]

7. Existing disparities between countries in the same region and within countries are shaped by intersecting factors, such as poverty, race or ethnic origin, Indigenous identity,[11] level of educational attainment and geographical location, as they are by conflict,[12] in which women and adolescent girls face heightened risks and are more exposed to sexual violence and child marriage.[13] For example, in many sub-Saharan African countries, adolescent birth rates among the poorest wealth quintile can be three to five times higher than among the wealthiest quintile.[14] Similarly, the rate of adolescent pregnancy is higher among those with no or limited access to education than among those who have completed secondary school.[15] Progress in reducing adolescent births has been particularly slow among the most marginalized communities, leading to increasing inequality.[16] In Latin America and the Caribbean, which has the second highest adolescent birth rate in the world, adolescent girls of African descent are approximately 50 per cent more likely to become pregnant than their peers, reflecting structural inequalities linked to racism, poverty and social exclusion that disproportionately limit their access to education and labour market opportunities.[17]

C. Data collection and accountability

8. Significant gaps remain in the availability of data on adolescent pregnancy,[18] particularly in countries where birth registration or reporting systems remain incomplete or deficient,[19] leading to an underestimation of the real prevalence of adolescent pregnancy.[20]

[7] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.
[8] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.
[9] See https://www.unfpa.org/adolescent-pregnancy; A/HRC/60/43, para. 24; https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf; and https://www.un.org/development/desa/pd/node/3288.
[10] See https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf; and information from the online consultations.
[11] See https://lac.unfpa.org/en/publications/the-price-of-inequality-socioeconomic-consequences-adolescent-pregnancy-early-motherhood-lac.
[12] See https://www.unescwa.org/publications/gender-snapshot-arab-region-2024.
[13] See https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy; and https://data.unicef.org/topic/child-health/early-childbearing/.
[14] See https://link.springer.com/article/10.1186/s12939-020-01251-y.
[15] See https://www.unfpa.org/adolescent-pregnancy; and https://data.unicef.org/topic/child-health/early-childbearing/.
[16] See https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy; and https://link.springer.com/article/10.1186/s12939-020-01251-y.
[17] See https://lac.unfpa.org/en/publications/the-price-of-inequality-socioeconomic-consequences-adolescent-pregnancy-early-motherhood-lac.
[18] See https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf.
[19] See https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2022_tp_selecting-abr-data-for-sdg-reporting.pdf; https://www.unicef.org/media/62981/file/Birth-registration-for-every-child-by-2030.pdf; and information from the submissions and consultations.
[20] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

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Many pregnancies remain hidden and underreported due to the stigma and fear associated with consensual sexual activity and sexual violence, as well as criminalization of consensual adolescent sexual conduct and abortion care, further undermining the accuracy of available data.[21]

9. Fragmentation of data is also common: health, education, justice and child-protection systems often operate in silos, preventing the comprehensive analysis of how factors such as school dropout, child marriage and sexual violence intersect and compound the risks for adolescents.[22] Deficient data systems weaken national responses, making it harder to allocate resources appropriately, monitor progress and implement evidence-based interventions for adolescents.[23]

10. Existing gaps in data collection are also problematic in terms of ensuring States' accountability.[24] Evidence-based decision-making should rely on the systematic collection and analysis of robust data. Qualitative methods, such as storytelling, lived experiences and interviews, are as vital as quantitative indicators for understanding realities on the ground and for informing, implementing and evaluating laws, policies and programmes.[25] Health and socioeconomic data, disaggregated by sex, age, disability, race or ethnic origin and other grounds, is essential in order to understand and effectively respond to violations of sexual and reproductive health and rights.[26]

II. Structural drivers of adolescent pregnancy: a human rights-based response

11. Adolescent pregnancy is marked by a convergence of social, cultural, economic and systemic factors, with gender inequality being a central driver.[27] Adolescent pregnancy exposes girls to a cascade of human rights violations that often intersect, including infringements of the rights to life, health, education, work and an adequate standard of living, as well as freedom from violence, exacerbating existing inequalities and perpetuating cycles of poverty and discrimination. Without duly identifying and addressing the root causes of adolescent pregnancy, sustained progress cannot be achieved.

A. Intersecting inequalities and socioeconomic rights gaps

1. Gender norms, power imbalances and harmful practices

12. Harmful gender norms and practices that limit girls' autonomous decision-making and perpetuate inequality, such as child marriage, acceptance of sexual violence and unequal power in relationships, are major drivers of adolescent pregnancy.[28]

[21] See https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf, pp. 82–85; https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content, p. 2; https://www.who.int/publications/i/item/9789240104204, p. 27; and information from the consultations.

[22] Information from the submissions and consultations.

[23] Ibid.; and see https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf.

[24] See https://www.unfpa.org/publications/start-her-unfpa-strategy-reproductive-maternal-and-newborn-health-and-well-being-2025; and the submissions.

[25] Ibid.

[26] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health; Committee on the Rights of the Child, general comment No. 20 (2016) on the implementation of the rights of the child during adolescence; CEDAW/C/GBR/CO/8; and Convention on the Rights of Persons with Disabilities, art. 31.

[27] See https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content; and information from the submissions and consultations.

[28] See https://www.unfpa.org/adolescent-pregnancy; https://www.unfpa.org/child-marriage; https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content; and Committee on the Rights of the Child, general comment No. 20 (2016).

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(a) Child marriage

13. As of 2023, an estimated 640 million girls and women worldwide had been married in childhood.[29] Child marriage contributes to high rates of adolescent pregnancy.[30] About 9 in 10 adolescent births in low- and middle-income countries occur among girls married before the age of 18.[31] Child marriage and informal unions place girls at increased risk of pregnancy, as they have limited autonomy to influence decision-making about contraceptive use and delaying childbearing.[32] In many communities, there is immense pressure on adolescent girls to prove their fertility soon after marriage, leading to unwanted pregnancies.[33]

14. Domestic legal frameworks should clearly establish a minimum age of marriage, without any exception, consistent with international human rights law. According to the Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women, the minimum age limit should be 18 years of age for marriage. Any marriage where at least one of the parties is under 18 years of age is to be considered child marriage and constitutes a harmful practice.[34] The effective prevention and elimination of child marriage, in compliance with international human rights law, require the full enforcement of such legal frameworks.

(b) Gender-based violence

15. Sexual violence is a leading cause of forced adolescent pregnancy but is too often silenced and poorly documented.[35] It is estimated that over 370 million girls and women globally (1 in 8 girls and women) have experienced rape or sexual assault before the age of 18. The prevalence is even higher in conflict-affected settings, where more than 1 in 4 adolescent girls between ages 14 and 17 are exposed to sexual violence.[36] In addition, about 23 per cent of adolescent girls between ages 15 and 19 have already been subjected to physical and/or sexual violence from an intimate partner.[37]

16. Adolescent pregnancy can also increase girls' exposure to violence and exploitation.[38] In many contexts, sexual activity and pregnancy outside of marriage is highly stigmatized and even criminalized, which can lead to girls being forced into child marriage and their being prevented from gaining access to needed support and healthcare services.[39] Pregnant

[29] See https://data.unicef.org/resources/is-an-end-to-child-marriage-within-reach/.

[30] Information from the consultations; and see https://data.unicef.org/resources/child-marriage-latest-trends-and-future-prospects/; and https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

[31] Information from the submissions and consultations; and see https://www.ungeneva.org/en/news-media/news/2025/04/105564/stopping-child-marriage-key-curbing-deadly-teen-pregnancies-who.

[32] See https://data.unicef.org/topic/gender/sexual-and-reproductive-health/; and https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

[33] Information from the submissions and consultations; and see https://www.unfpa.org/sites/default/files/pub-pdf/EN_State%20of%20World%20Population%20report%202025.pdf.

[34] Committee on the Rights of the Child, general comment No. 20 (2016); joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019) on harmful practices; and A/HRC/62/26.

[35] See the submissions; and https://www.unfpa.org/sites/default/files/pub-pdf/EN_SWP22%20report_0.pdf.

[36] See https://www.unicefusa.org/press/over-370-million-girls-and-women-globally-subjected-rape-or-sexual-assault-children-unicef.

[37] See https://www.who.int/publications/i/item/9789240116962; Information from the submissions and consultations.

[38] See https://www.unicef.org/wca/reports/girl-goals-what-has-changed-girls; and https://knowledge.unwomen.org/en/digital-library/publications/2024/09/research-paper-documenting-reproductive-violence-unveiling-opportunities-challenges-and-legal-pathways-for-un-investigative-mechanisms.

[39] Committee on the Rights of the Child, general comment No. 20 (2016); and https://www.icj.org/wp-content/uploads/2023/03/Principles-Report_English.pdf.

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adolescents and adolescent mothers are also at heightened risk of intimate partner violence, as they may be economically dependent on their partners and have limited power to enjoy safe, respectful and equal relationships.[40]

17. Weak legal and policy frameworks for addressing gender-based violence, including sexual violence, create a culture of impunity for perpetrators, leaving adolescent girls exposed to the sexual violence that can lead to forced pregnancy.[41] States have the obligation to prevent, and protect individuals from, these forms of violence. States are also obligated to investigate and punish acts of sexual violence against adolescents.[42] This includes adopting and enforcing laws criminalizing sexual violence and exploitation, addressing impunity and ensuring effective remedies and survivor-centred responses by law enforcement and justice systems.[43] Comprehensive prevention strategies require addressing harmful gender norms, strengthening child protection systems and ensuring access to health, psychosocial and legal support services for adolescent survivors.[44] Child-friendly complaint mechanisms should be available, in line with international human rights standards. Such mechanisms should be accessible, confidential and safe.

18. While considering a case involving sexual violence, the Committee on the Rights of the Child stated that, in the case of pregnant girls, consideration should be given to the special and differential physical and mental health impact of child pregnancy, the particularly significant risk that pregnancy posed to the lives of girls because of possible complications during pregnancy and childbirth and the potentially serious impact that it could have on their development and their future. It emphasized that denying information about, and access to, abortion care exposed girls to considerable risks to their lives, health and development, effectively forcing them to continue pregnancies or face obstetric emergencies in violation of their rights. The Human Rights Committee has clarified that the right to life also concerns the right to enjoy a dignified life and requires States to address broader social conditions that may threaten that right. Forced pregnancy and motherhood interrupts and hinders the personal, family, educational and professional goals of girls who are mothers and severely restricts their life plans. The Committee considered that the lack of information on sexual and reproductive health, such as on the termination of pregnancy, which prevents a person from taking informed decisions and results in forced pregnancy and forced motherhood, amounts to a violation of the right to seek and receive information.[45]

(c) Stigma, stereotypes and power imbalances

19. Stigma surrounding adolescent sexuality and contraception in the family, including limited child-parent communication and support from parents, from the community or society at large, hampers girls' ability to prevent pregnancy.[46] Adolescent girls cannot always opt for safe sex or the use of contraception, given their limited or unequal decision-making

[40] See https://www.who.int/publications/i/item/9789240116962; https://www.unfpa.org/press/state-world-population-2013-motherhood-childhood; https://doi.org/10.1136/ip-2023-044985; and https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(24)00145-7/fulltext.

[41] See Human Rights Committee, *Susana v. Nicaragua* (CCPR/C/142/D/3626/2019), *Lucía v. Nicaragua* (CCPR/C/142/D/3627/2019), *Norma v. Ecuador* (CCPR/C/142/D/3628/2019) and *Fátima v. Guatemala* (CCPR/C/143/D/3629/2019); and Committee on the Rights of the Child, *Camila v. Peru* (CRC/C/93/D/136/2021).

[42] See, for instance, Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19; and Convention on the Rights of the Child, art. 19.

[43] See Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017).

[44] See Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017); and Convention on the Rights of the Child, art. 39.

[45] Human Rights Committee, *Susana v. Nicaragua*, para. 8.16; *Lucía v. Nicaragua*, para. 8.5; *Norma v. Ecuador*, para. 11.7; *Fátima v. Guatemala*, para. 15.18; and Committee on the Rights of the Child, *Camila v. Peru*, para. 8.5 and 8.7. See also Committee on the Rights of the Child, *Camila v. Peru*, para. 8.14.

[46] Information from the submissions and consultations. See also https://www.unfpa.org/press/new-unfpa-report-finds-30-years-progress-sexual-and-reproductive-health-has-mostly-ignored; and https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

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power vis-à-vis their parents or partners. Furthermore, harmful stereotypes extend into healthcare systems, where pregnant adolescents may face negative or judgmental attitudes in relation to their sexual conduct and discriminatory treatment from health workers, as well as actual or feared breaches of confidentiality, creating additional barriers that discourage them from seeking access to the healthcare that they need.[47] Stigma within the family and the community, discrimination in schools and misinformation, including through digital channels, further deters adolescents from seeking information and services, including contraception.[48]

20. According to international human rights law, States should take all appropriate measures to modify social and cultural patterns of conduct with a view to achieving the elimination of prejudices and practices that are based on stereotyped gender roles.[49] Comprehensive strategies to combat stigma, including through public awareness-raising campaigns, training health providers and educators and creating supportive environments are important for adolescents' exercise of sexual and reproductive health rights;[50] as well as combating and eliminating discriminatory assumptions and stereotyped expectations, such as limiting women's function to mothers and caregivers.[51]

2. Socioeconomic barriers and discrimination

21. Certain adolescent girls face higher pregnancy risks, due to intersecting forms of discrimination and marginalization, as recognized by the Human Rights Council in its resolution 56/21. Poverty, coupled with the absence of social protection and services, such as scholarships, transportation, food programmes or cash transfers, limit access to education, increasing the risk of child marriage, school dropout and adolescent pregnancy.[52] Food insecurity can force girls into harmful and exploitative survival strategies, including child marriage or sexual exploitation.[53] Limited livelihood options and socioeconomic barriers to access to education, such as school fees, long distances to learning facilities, lack of school safety, inadequate sanitation facilities and lack of inclusive education, can reinforce the misperception that marriage is the only possible path.[54] Rural adolescents, for example, face greater barriers to access to education, health services and economic opportunities, further heightening the risks.[55]

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[47] See https://www.who.int/publications/i/item/9789240081765; and information from the submissions and consultations.

[48] Information from the submissions and consultations.

[49] Convention on the Elimination of All Forms of Discrimination against Women, art. 5 (a).

[50] Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 52; and general comment No. 20 (2016), para. 25; and Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, paras. 13 and 31.

[51] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 31; Convention on the Elimination of All Forms of Discrimination against Women, art. 5; Committee on the Elimination of Discrimination against Women, general recommendation No. 25 (2004) on temporary special measures, para. 7; and general recommendation No. 28 (2010) on the core obligations of States Parties under article 2 of the Convention, para. 9; Convention on the Rights of Persons with Disabilities, art. 8; Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016) on women and girls with disabilities, para. 8; Human Rights Committee, general comment No. 28 (2000) on the equality of rights between men and women, para. 5; and *R.K.B. v. Turkey* (CEDAW/C/51/D/28/2010), para. 8.8.

[52] Information from the submissions and consultations. See also https://www.unicef.org/media/172871/file/GPECM%202024%20ARR-compressed.pdf.

[53] See https://wcaro.unfpa.org/en/publications/technical-briefinterlinkages-child-marriage-and-food-insecurity; and information from the submissions and consultations.

[54] Information from the submissions and consultations; https://www.unicef.org/reports/mapping-social-protection-intervention-pathways-address-barriers-girls-education; and https://data.unicef.org/resources/child-marriage-and-education-data-brief/.

[55] Information from the submissions and consultations; and https://www.unfpa.org/adolescent-pregnancy.

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22. Girls with disabilities, girls without family care and those in street situations, girls of African descent,[56] Indigenous girls, Roma girls, those living in informal settlements, migrant and nomadic girls, those living with HIV and gender-diverse adolescents are more exposed to sexual violence and face compounded barriers to access to sexual and reproductive health information and services, increasing the risks of adolescent pregnancy and perpetuating cycles of poverty.[57] In humanitarian and crisis contexts, the risk of child marriage and adolescent pregnancy increases,[58] including among refugees and internally displaced girls who face elevated risks of sexual violence and exploitation.[59]

23. These multiple and intersecting forms of discrimination must be taken into account in efforts to redress disadvantage, exclusion and marginalization, including on the grounds of age, gender, disability, geographical location, race or ethnic origin and other intersecting grounds.[60]

B. Lack of access to quality education

24. Lack of access to quality education is a key driver of adolescent pregnancy. School dropout is both a cause and a consequence of adolescent pregnancy.[61] Pregnant adolescent girls often face exclusion, discrimination and pressure to leave school, which limits their education and, in turn, their future economic empowerment and participation in public life, perpetuating cycles of poverty.[62] Interrupting girls' education constrains their ability to acquire skills and knowledge, leading to higher risks of unemployment and trapping many girls in low-paid, insecure or precarious work.[63] Caregiving responsibilities further restrict their opportunities and economic independence.[64]

25. The absence of legal protections, such as non-expulsion policies and the right to return to school, to support pregnant and parenting students to continue their education during pregnancy and after childbirth and the lack of effective implementation of such policies, compounds the educational and economic consequences of adolescent pregnancy.[65] In their submissions, some States reported having laws and policies that protected adolescent girls' right to education by prohibiting exclusion from school due to pregnancy or parenthood and requiring school retention for pregnant adolescents and re-entry after childbirth. At the same

[56] See https://www.ohchr.org/sites/default/files/documents/issues/racism/en-gender-explainer.pdf.

[57] Information from the submissions and consultations; see A/80/113; Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016); Committee on the Elimination of Racial Discrimination, general recommendation No. 37 (2024) on equality and freedom from racial discrimination in the enjoyment of the right to health; https://www.unfpa.org/swp2024; https://lac.unfpa.org/sites/default/files/pub-pdf/2025-07/Milena_ENG_WEB_DOBLES%20%281%29.pdf; https://www.unfpa.org/minimum-standards; and https://www.unfpa.org/sites/default/files/pub-pdf/makeitmatter.pdf.

[58] Information from the submissions and consultations; and see A/HRC/47/38.

[59] See https://iawgfieldmanual.com; https://www.unicef.org/adolescentkit/media/1946/file/AdolKit-Guide-Understanding-adolescents-humanitarian-contexts-EN.pdf; A/HRC/47/38; and the submissions.

[60] Committee on the Elimination of Racial Discrimination, general recommendation No. 37 (2024); and Convention on the Rights of Persons with Disabilities, art. 7 (3).

[61] See https://data.unicef.org/resources/girl-goals-report/; https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content; Committee on the Elimination of Discrimination against Women, general recommendation No. 36 (2017) on the right of girls and women to education; and information from the submissions and consultations.

[62] See Committee on the Elimination of Discrimination against Women, general recommendation No. 36 (2017); Human Rights Council resolution 56/21; https://data.unicef.org/resources/girl-goals-report/; and information from the submissions and consultations.

[63] Information from the consultations; Committee on the Elimination of Discrimination against Women, general recommendation No. 36 (2017); and https://www.unwomen.org/sites/default/files/2025-03/adolescent-girls-rights-over-30-years-en.pdf.

[64] See https://www.unicef.org/media/153476/file/Five-Game-Changing-Priorities-With-and-For-Adolescent-Girls.pdf; and information from the consultations.

[65] See https://www.unesco.org/en/articles/pregnancy-and-right-education; and information from the submissions and consultations.

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time, States also acknowledged challenges faced in enforcing the existing legal and policy framework due to harmful social norms.[66]

26. United Nations human rights mechanisms have emphasized that, in the context of measures to guarantee the right to education, programmes should be designed and implemented to guarantee the successful schooling of pregnant teenagers and adolescent mothers, including by ensuring that they are not expelled from school and are supported to continue their education.[67]

Comprehensive sexuality education

27. Comprehensive sexuality education is a curriculum-based process of teaching and learning about the emotional, physical and social aspects of sexuality. It is aimed at equipping children and young people with the knowledge, skills and attitudes to empower them to realize their health, well-being and dignity, develop respectful social and sexual relationships and understand and ensure the protection of their rights throughout their lives. Comprehensive sexuality education emphasizes values such as respect, inclusion, non-discrimination, equality, empathy, responsibility and reciprocity. It reinforces healthy and positive values about bodies, sexuality, puberty, relationships and family life.[68]

28. Comprehensive sexuality education has been shown to reduce the rate of adolescent pregnancy, delay the onset of sexual activity and improve adolescents' knowledge about their bodies and reproductive health.[69] Data show that comprehensive sexuality education is five times more likely to be successful in preventing unintended pregnancy and sexually transmitted infections when explicit attention is given to the topics of gender and power, including violence.[70] Some States have reported that ensuring mandatory, comprehensive sexuality education – delivered both in and outside of schools by trained teachers or educators – is central to addressing adolescent pregnancy and promoting a culture of gender equality.[71]

29. Without accurate information about their bodies, relationships and contraception, adolescents are unable to make informed decisions about their sexual and reproductive health.[72] However, in certain countries, sexual and reproductive health and rights are highly politicized, and comprehensive sexuality education is opposed by some sectors of society. At times, the content of sexuality education is inaccurate or even prejudicial, including through the promotion of abstinence as the only contraceptive measures, and thereby not effective in contributing to the prevention of adolescent pregnancy.[73] Limited or lack of accurate and evidence-based information on sexual and reproductive health, as well as misinformation and disinformation, including through digital channels, can further undermine adolescents' knowledge and decision-making.[74]

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66 See the submissions.

67 See Committee on the Elimination of Discrimination against Women, general recommendation No. 36 (2017); E/CN.4/2006/45; and Committee on the Rights of the Child, general comment No. 20 (2016).

68 See https://www.unesco.org/en/health-education/cse; and https://www.who.int/news-room/fact-sheets/detail/comprehensive-sexuality-education.

69 Ibid.; and information from the consultations.

70 See https://www.unesco.org/en/health-education/cse.

71 See the submissions.

72 See https://www.unesco.org/en/articles/international-technical-guidance-sexuality-education-evidence-informed-approach, p. 12; https://unesdoc.unesco.org/ark:/48223/pf0000377963, p. 9; and information from the consultations..

73 Information from the consultations; and https://www.unesco.org/en/articles/international-technical-guidance-sexuality-education-evidence-informed-approach, p. 29.

74 Committee on the Rights of the Child, general comment No. 25 (2021), para. 104; https://infodemiology.jmir.org/2025/1/e83747; https://www.unesco.org/en/articles/journey-towards-comprehensive-sexuality-education-global-status-report, p. 10; https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content, p. 2; and information from the submissions and consultations.

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30. Comprehensive sexuality education should be available and accessible to all adolescents. [75] Comprehensive sexuality education should be inclusive, unbiased, evidence-based, scientifically accurate, human rights based and age-appropriate; it should be part of the mandatory school curriculum and reach out-of-school adolescents.[76] Educational materials should not perpetuate harmful or discriminatory stereotypes.[77] Teachers and other professionals should be adequately trained to provide comprehensive sexuality education and ensure that young people are involved in developing such education programmes.[78] Sexual and reproductive health education should include self-awareness and knowledge about the body, including the anatomical, physiological and emotional aspects, and should be accessible to all children, including girls and boys. It should include content related to sexual health and well-being and be designed in a manner through which children are able to gain knowledge regarding reproductive health.[79]

C. Inadequate health systems

31. Shortcomings within health systems can be a barrier to preventing adolescent pregnancy. Limited availability of adolescent-friendly sexual and reproductive services, stock-outs of contraceptives, provider bias and judgmental attitudes, high costs, long distances to facilities, poor referral networks and lack of school-based health services all contribute to adolescent pregnancy.[80]

1. Lack of accessible adolescent-friendly services

32. Inadequate safeguards for confidentiality and privacy, including the lack of private spaces and fear of disclosure to parents, partners or schools, can deter adolescents from seeking care.[81] Service quality and accessibility barriers, including inconvenient operating hours conflicting with school scheduling, lack of access for persons with disabilities and language barriers, as well as discriminatory treatment and stigma, can further limit access.[82]

33. Comprehensive sexual and reproductive health services, including for adolescents, are grounded in four essential elements of the right to health, which States are obligated to guarantee: availability, accessibility, acceptability and quality. Availability implies ensuring sufficient health facilities, trained healthcare providers, medicines and contraceptives. Accessibility requires removing barriers so that services are non-discriminatory, physically reachable, economically affordable and accompanied by clear, accurate health information.

[75] Committee on the Rights of the Child, general comment No. 20 (2016), para. 59; Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 63; Committee on the Rights of the Child, general comment No. 15 (2013), para. 69; and https://www.ohchr.org/en/documents/tools-and-resources/compendium-comprehensive-sexuality-education.

[76] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 63; Committee on the Rights of the Child, general comment No. 20 (2016), para. 61; and A/65/162, para. 16.

[77] Committee on the Rights of the Child, general comment No. 20 (2016) para. 28; Committee on the Rights of the Child, general comment No. 15 (2013), para. 9; and A/65/162, para. 33.

[78] A/54/38/Rev.1, chap. I., para. 18; Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 13; Committee on the Rights of the Child, general comment No. 20 (2016), para. 37 (e); and A/HRC/32/32, para. 113 (d).

[79] Committee on the Rights of the Child, general comment No. 15 (2013), para. 59; and general comment No. 4 (2003) on adolescent health and development in the context of the Convention, para. 26.

[80] Information from the submissions and consultations; https://www.unicef.org/esa/media/15076/file/UNICEF-Adolescent-and-Young%20Mothers-Investment-Case-2024.pdf; and https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

[81] See https://www.unesco.org/en/articles/early-and-unintended-pregnancy-education-sector-evidence-review-and-recommendations; https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content; and information from the submissions and consultations.

[82] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016); https://www.unicef.org/lebanon/media/5711/file/AG_Access_to_PHC.pdf; and see submissions.

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Acceptability means that care is respectful and culturally appropriate, sensitive to adolescents' needs, upholding confidentiality, supporting informed decision-making and protecting against harmful practices and gender-based violence. Quality demands that services are scientifically and medically sound, with evidence-based standards, skilled professionals and safe medicines and facilities.[83]

34. Adolescents' exercise of their sexual and reproductive health and rights requires access to information and confidential services. The Committee on the Rights of the Child has recommended that all adolescents have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person. This includes information on family planning and contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections, counselling, maternal health services and menstrual health.[84] The Committee on Economic, Social and Cultural Rights also noted that adolescents should have access to information about the risks of early pregnancy, regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality.[85] Health services should employ trained personnel who fully respect the rights of children to privacy and non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive services and free contraception, as well as HIV-related care and treatment.[86]

35. Crises, such as armed conflict, environmental disasters or public health emergencies, displace communities, undermine access to sexual and reproductive health services and even destroy healthcare facilities, further aggravating existing disadvantages and risks. Such crises can also cause disruptions to the supply chains for contraceptives and other sexual and reproductive health commodities, create insecurity that hampers access to health facilities, limit the availability of clinical management of rape services and create administrative and documentation barriers that prevent displaced adolescents from acquiring access to national health support systems.[87]

36. However, in such contexts, States' international human rights obligations in relation to sexual and reproductive health remain in place.[88] The Minimum Initial Service Package for Sexual and Reproductive Health[89] developed by the Inter-Agency Working Group for Reproductive Health in Crisis should be incorporated into all humanitarian preparedness and response plans to ensure the timely delivery of essential sexual and reproductive health services, including those tailored to the needs of adolescents.

(a) Restrictive legal and policy frameworks

37. A key area of concern is barriers to access to sexual and reproductive health services by adolescents. Many States worldwide impose a minimum legal age or third-party authorization requirements that restrict adolescents' access to services such as contraception, HIV testing and safe abortion care. The Committee on the Rights of the Child has recommended that there be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or

[83] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016); and general comment No. 14 (2000).

[84] Committee on the Rights of the Child, general comment No. 20 (2016), para. 59.

[85] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016).

[86] Committee on the Rights of the Child, general comment No. 3 (2003) on HIV/AIDS and the rights of the child, para. 20.

[87] See A/80/360; Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013) on women in conflict prevention, conflict and post-conflict situations; A/HRC/47/38; https://esaro.unfpa.org/sites/default/files/pub-pdf/2025-05/Annual%20Report%20(2024%20-%202025)%20amended_1.pdf; https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20HAO%20Report%202025%20F1%20(Dec%204%202024).pdf; and S/2025/389.

[88] See Committee on the Elimination of Discrimination against Women, general recommendation No. 30 (2013).

[89] See https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations.

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authorization.[90] The requirement for third-party authorization acts as a barrier to healthcare, as it discourages adolescents from seeking needed services in order to avoid seeking parental consent, which may result in rejection, stigmatization, hostility or even violence.[91]

38. The Committee on the Rights of the Child recommended that legal frameworks recognize adolescents' increasing responsibility for decisions affecting their lives. The Committee also encourages States to consider the introduction of a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services, irrespective of age.[92]

(b) Criminalization

39. Another problematic aspect of some legal frameworks is the criminalization of consensual sexual activity, which can deter adolescents from seeking health services and can lead to unjust prosecution and further stigmatization. The Committee on the Rights of the Child has urged States to decriminalize consensual sexual activity between adolescents of similar ages.[93] The Committee has also considered that abortion should be decriminalized in all cases involving child pregnancy and that access to safe abortion services and post-abortion care for pregnant girls should be ensured, particularly in cases where there is a risk to the life or health of the mother and cases involving rape or incest.[94] This includes, but is not limited to, ensuring access to abortion care for girls or adolescents who become pregnant as a result of sexual violence.[95]

2. Financial barriers

40. The direct costs of sexual and reproductive health services, including consultation fees and the cost of contraceptives and transportation to health facilities, can be prohibitive for adolescents, particularly those from low-income households. These obstacles disproportionately affect the most marginalized adolescents, especially those facing multiple and intersecting forms of discrimination, reinforcing existing inequalities.[96]

41. Chronic underfunding of sexual and reproductive health services was also reported as undermining efforts to ensure adequate access to services that are necessary to prevent adolescent pregnancy,[97] as was a lack of transparency and accountability in the disbursement of funding for prevention across multiple sectors. In line with international human rights standards, States Parties to the International Covenant on Economic, Social and Cultural Rights are bound to take steps, to the maximum of their available resources, with a view to progressively achieving the full realization of the rights established in the Covenant, including the right to health.[98]

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[90] Committee on the Rights of the Child, general comment No. 20 (2016), para. 60; Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 41; https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy; and information from the submissions and consultations.

[91] See A/HRC/32/32; and information from the submissions and consultations.

[92] See Committee on the Rights of the Child, general comment No. 12 (2009) on the right of the child to be heard; and general comment No. 20 (2016), para. 39.

[93] Committee on the Rights of the Child, general comment No. 20 (2016), para. 12; and general comment No. 24 (2019) on children's rights in the child justice system, para. 40.

[94] Committee on the Rights of the Child, general comment No. 20 (2016), para. 60; and *Camila v. Peru*, para. 9. See also Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 34, 40 and 57; Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017), para.18; and Human Rights Committee, general comment No. 36 (2018) on the right to life, para. 8.

[95] See Human Rights Committee, *Susana v. Nicaragua*, *Lucía v. Nicaragua*, *Norma v. Ecuador* and *Fátima v. Guatemala*.

[96] Information from the submissions and consultations; and see https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf; and https://iris.who.int/server/api/core/bitstreams/b951006d-c82a-450f-b511-8e9bd6efc2a4/content.

[97] Information from the consultations.

[98] International Covenant on Economic Social and Cultural Rights, art. 2; and see Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016).

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42. Existing systemic shortcomings at the national level have been exacerbated by declining global donor support, with a significant drop in sexual and reproductive health funding in 2025 and 2026, resulting in reduced service availability, commodity shortages and weakened health systems.[99] Cuts to international aid have disrupted service delivery, supply chains and health workforces, particularly in sub-Saharan Africa. These disruptions have led to contraceptive shortages, staff layoffs and significant unmet needs among adolescent girls. These cuts have been coupled, in some cases, with requirements that limit funding to organizations labelled as "promoting abortion", having an impact on funds for contraception, maternal health, the treatment of infectious diseases, humanitarian aid and human rights programmes at large. As reported, these constraints put women's and girls' health at risk, disrupting care and cutting off essential sexual and reproductive health services, potentially increasing the rate of adolescent pregnancies.[100]

43. With regard to foreign assistance and policy, the Committee on Economic, Social and Cultural Rights has stated that States Parties to the International Covenant on Economic, Social and Cultural Rights that are not able to comply with their obligations and that cannot realize the right to sexual and reproductive health due to a lack of resources, must seek international cooperation and assistance. States that are in a position to do so must respond to such requests in good faith and in accordance with their international commitments.[101] The Committee further noted that States' international assistance should not impose restrictions on information or services existing in donor States, draw trained reproductive healthcare workers away from recipient countries or push recipient countries to adopt models of privatization.[102] States should ensure that their international agreements dealing with intellectual property or trade and economic exchange do not impede access to the medicines, diagnostics or related technologies required for prevention or treatment of HIV/AIDS or other diseases related to sexual and reproductive health.[103] In lending, international financial institutions' policies should also reflect obligations related to the right to health.[104]

III. Impactful initiatives to prevent adolescent pregnancy

44. Over the past two decades, States across all regions have undertaken efforts to reduce adolescent pregnancy rates and to ensure access to sexual and reproductive health services. Although political and socioeconomic contexts vary, information gathered for the present report, including through the submissions received and the consultations undertaken, confirms that efficiently addressing the complex challenge of adolescent pregnancy requires a rights-based and multisectoral approach. Interventions combining an enabling legal environment, education (including comprehensive sexuality education), adequate health services, community engagement, empowerment strategies and economic support are among the most effective measures for reducing adolescent pregnancy and improving girls' health, educational attainment and socioeconomic outcomes. Confronting structural inequalities related to poverty, gender, race, disability, geographical location, among other forms of disadvantage, and how those inequalities intersect is essential for designing targeted strategies for the adolescents most at risk. Programmes that actively keep adolescents

[99] See https://pmnch.who.int/news-and-events/news/item/20-10-2025-snap-survey-conducted-by-pmnch-reveals-global-funding-crisis-threatening-health-and-rights-programs-for-women-children-and-adolescentshttps; https://pmnch.who.int/news-and-events/news/item/09-02-2026-women-s-children-s-and-adolescents-health-in-2026-from-crisis-management-to-system-correction; https://www.healthdata.org/research-analysis/health-financing; and the submissions.

[100] See https://www.guttmacher.org/report/evidence-for-ending-global-gag-rule; and https://reproductiverights.org/resources/fact-sheet-the-global-gag-rule-and-human-rights/.

[101] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000); and general comment No. 22 (2016).

[102] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016).

[103] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000). See also A/HRC/11/12.

[104] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000); and A/HRC/40/57.

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engaged in school or educational endeavours, while addressing gender norms and providing comprehensive sexuality education, are particularly impactful.

45. Set out below are some of the promising practices in various regions reported to address adolescent pregnancy. At their centre lies an emphasis on access to health services and meaningful adolescent participation, while ensuring protection from harm, including the damage caused by child marriage and sexual violence.

46. One country in South-East Asia reportedly recognized adolescent pregnancy as a national public health and development priority, prompting the adoption of a stronger legal and policy framework aligned with international commitments on sexual and reproductive health and rights. In 2016, the Government enacted a law establishing binding obligations for national and local authorities to prevent adolescent pregnancy through coordinated multisectoral action. The law and the national strategy are structured around five mutually reinforcing pillars: delivering school-based sexuality education; engaging with families and communities; strengthening adolescent-friendly health services; providing social protection, welfare and educational support for pregnant adolescents and young parents; and improving data collection and knowledge management.

47. This law was adopted in response to rising adolescent pregnancy rates during the preceding decade, and the Government recognized that fragmented, sector-specific responses were insufficient. The law explicitly mandated coordinated action across the health, education, social welfare and community systems. To institutionalize this approach, a national committee chaired by the Prime Minister was established, supported by five subcommittees aligned with each strategic pillar.

48. According to information provided to OHCHR, substantial progress following those reforms and sustained legislative, policy and programmatic investments. Between 2012 and 2022, the national adolescent birth rate among girls between ages 15 and 19 declined, from 53.4 to 18 births per 1,000 girls, while the rate among girls between ages 10 and 14 fell, from 1.8 to 0.8 births per 1,000 girls. Complementary measures to uphold pregnant adolescents' right to education and prevent school dropout, including counselling services, national hotlines and locally implemented prevention initiatives, have reached large numbers of young people.[105]

49. In one Latin American country, a range of measures were reportedly implemented to ensure accessible services and to equip adolescents with the knowledge and skills to manage their sexual and reproductive health. In 2003, a national sexual and reproductive health programme was established by law, laying the foundation for national policies to promote sexual and reproductive health, including among adolescents. In 2006, the country adopted a law on comprehensive sexuality education, introducing mandatory sexuality education across all educational institutions and levels nationwide. In 2014, the Civil Code was amended to enable adolescents from the age of 13 to gain access to health services without parental consent, including contraception, legal abortion care and mental healthcare.

50. Between 2017 and 2023, the country implemented a national, intersectoral policy aimed at reducing adolescent pregnancy through comprehensive sexuality education, improved access to contraception and coordinated action across the health, education and social sectors across 12 provinces with high adolescent birth rates. Core components included the provision of health counselling in schools and community settings, expanded access to contraceptive methods, capacity-building for teachers and health professionals and targeted measures to prevent sexual abuse and forced pregnancy. The programme also engaged with boys to challenge harmful gender norms.

51. Complementing the public health response, efforts to empower adolescents were also advanced by the country's feminist movement. Ongoing communication campaigns have reportedly played a key role in enabling young people to make informed decisions, seek services and claim their rights. In 2013, the adolescent birth rate stood at 66.8 per 1,000 girls between ages 15 and 18. By 2022, that rate had declined to 25.8, representing a 61.38 per cent reduction. The country has also reduced mortality and morbidity rates associated with unsafe

[105] Information from the consultations.

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abortion, following the legalization of abortion care in 2020. In 2021, the country recorded zero adolescent deaths resulting from unsafe abortion. Continued political and financial commitment is essential to sustain and institutionalize these gains.

52. In one West African country, notable progress has reportedly been achieved in improving adolescent sexual and reproductive health outcomes. The information received indicates that one factor distinguishing that country is its long-standing enabling policy environment, shaped by national champions who have sought to prioritize sexual and reproductive health and gender equality.

53. Efforts have been undertaken there to address child marriage in particular. In 2016, a campaign of zero tolerance of child marriage was launched, with the aim of transforming harmful social norms and creating a protective environment for children and their communities. In 2018, a national multisectoral strategy on adolescent sexual and reproductive health was adopted, promoting sexuality education for both in-school and out-of-school young people, supporting its integration into the national education system and providing age-appropriate curricula. The adolescent birth rate declined, from 130 per 1,000 girls in 2001 to 77.2 per 1,000 girls in 2020. Over the same period, the prevalence of child marriage fell, from 39 per cent to 31 per cent, and the proportion of girls between ages 15 and 19 who had undergone female genital mutilation decreased, from 12 per cent in 2001 to 2 per cent in 2012.[106] In 2021, the parliament expanded the legal grounds for access to safe abortion care, adopting reportedly one of the most progressive legal frameworks on abortion in the region, which is, according to the information received, expected to contribute to further progress in preventing adolescent pregnancy. The law benefited from political support, as well as strong advocacy by national civil society organizations.

54. In one Western European country, a strategy to reduce adolescent pregnancy was implemented between 1999 and 2010. The strategy was, according to the information received, a whole-of-government, multi-agency programme, anchored in strong national leadership and sustained investment, involving the health, education and social services and the local authorities. It combined strengthened comprehensive sexuality education in schools, improved access to effective contraception through adolescent-friendly sexual health services, awareness-raising campaigns engaging with adolescents and parents and coordinated support services for young parents. The interventions were underpinned by local-level delivery structures, including local teenage pregnancy coordinators and partnership boards, to tailor implementation to community needs.

55. The implementation of the strategy resulted in a substantial – approximately 72 per cent – decline in adolescent birth rates between 1998 and 2021, from 46 births per 1,000 girls between ages 15 and 17 to 13, reflecting sustained reductions across diverse areas of the country and in more deprived communities. According to the information received, this illustrates how evidence-based policy, long-term political commitment, effective management structures and routine monitoring and review can achieve measurable reductions in adolescent pregnancy at scale, offering lessons for policymakers on the importance of integrated, adequately resourced, and locally responsive strategies. However, challenges persist, with national adolescent birth rates remaining higher than other countries in the region, in particular among marginalized communities.[107]

IV. Conclusions and recommendations

A. Conclusions

56. **Adolescent pregnancy remains a complex global challenge, deeply rooted in structural inequalities, including restricted access to sexual and reproductive health services and information. As demonstrated above, it is both a cause and a consequence of human rights violations, disproportionately affecting marginalized girls. The challenges associated with the prevention of adolescent pregnancy are exacerbated in**

[106] See https://www.healthdata.org/sites/default/files/2025-05/PIIS0140673625005033.pdf.
[107] Information from the consultations.

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conflict and other crisis settings. The consequences for adolescent girls' health and lives are severe, with long-term socioeconomic disadvantages perpetuating cycles of poverty and discrimination. Underreporting of adolescent pregnancies, limited disaggregated data, limited institutional capacity, the politicization of adolescent sexual and reproductive health, persistent underfunding of sexual and reproductive health services and the absence of effective and confidential complaint mechanisms, all hinder the ability to respond effectively to the needs of adolescents. Restrictive legal frameworks, including the criminalization of consensual sexual activity between adolescents of similar ages and abortion care, continue to undermine prevention efforts.

57. **The promising practices highlighted above demonstrate that adolescent pregnancy is preventable when addressed through multisectoral, rights-based approaches that combine access to quality education, including comprehensive sexuality education, accessible and adolescent-friendly health services, community engagement, adolescent empowerment and targeted social protection. Laws and policies proved effective in supporting the reduction of adolescent pregnancy include those that eliminate child marriage, establish adequate protection mechanisms for children who are victims of sexual violence, guarantee access to confidential and youth-friendly information and services without third party consent, subsidize contraceptives, and decriminalize abortion care and consensual sexual conduct between those close in age. There is also the need for sustained political commitment, adequate financing and the meaningful participation of adolescents in designing and implementing policies that affect their lives.**

58. **Effectively addressing adolescent pregnancy should become a priority for all, which might in some situations mean treating it as a national emergency. It requires States to comply with their human rights obligations to respect, protect and fulfil the right to sexual and reproductive health of all adolescents, moving beyond siloed approaches towards sustainable, coordinated, evidence-based action. As some participants in the consultations said: "A girl child should never have to bear and raise another child."**

B. Recommendations

59. **To prevent adolescent pregnancy and to uphold the rights of adolescent girls, States should:**

Legal and policy reform

(a) **Establish and enforce a minimum age of marriage of 18 years of age, in accordance with international human rights law and standards, taking all measures necessary to prevent child marriage;**

(b) **Taking into account the recommendations of United Nations human rights mechanisms, remove legal and policy barriers that restrict adolescents' access to sexual and reproductive health services, including third-party consent requirements, age-of-consent restrictions for contraception and sexual and reproductive health information and the criminalization of close-in-age consensual adolescent sexual activity. Abortion should be decriminalized and legally accessible to adolescents in line with international human rights law and standards;**

(c) **Engage with adolescents meaningfully and safely in programme design, policy advocacy and monitoring and evaluation, promoting youth leadership and protection from reprisals;**

Education systems

(d) **Ensure universal access to free, quality and inclusive primary and secondary education and implement nationwide policies guaranteeing the continuation of schooling during pregnancy and re-entry after childbirth, while eliminating stigma and discrimination against pregnant students and adolescent mothers;**

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(e) **Elaborate and implement comprehensive sexuality education programmes provided by trained teachers and professionals as part of the mandatory school curriculum, also available to out-of-school adolescents, designed to address gender norms, power dynamics and digital misinformation;**

Social protection

(f) **Expand targeted social protection measures, such as cash transfers, scholarships and food programmes, for girls at high risk of pregnancy and integrate adolescent pregnancy prevention into national poverty reduction, gender equality and child protection strategies;**

(g) **Guarantee that community-based support programmes for adolescent parents ensure the ability to continue their education and access to health services and socioeconomic opportunities;**

Health systems

(h) **Ensure and strengthen confidential, affordable, accessible and adolescent-friendly sexual and reproductive health services providing a full range of contraceptive methods, respectful maternal healthcare and mental health support;**

(i) **Use the best efforts to address all financial, geographical and attitudinal barriers to access to sexual and reproductive health services, including by relying on evidence-based approaches to address bias and stigma;**

(j) **Ensure the adequate funding of sexual and reproductive health services through sustained domestic financing, including by mitigating the impact of decreasing international funding;**

Underserved and marginalized adolescents

(k) **Prioritize outreach to adolescents who have been left behind, including those in remote or conflict-affected areas;**

(l) **Ensure the accessibility and inclusivity of information and interventions, guaranteeing that they are multilingual and designed with an intersectional lens;**

(m) **In humanitarian and crisis settings, integrate adolescent sexual and reproductive health services and education continuity into emergency preparedness and response plans;**

Changing harmful social norms

(n) **Launch sustainable public awareness-raising campaigns and community dialogues to challenge harmful gender norms, including pressure for early motherhood, address stigma surrounding contraception and adolescent sexuality and actively engage with boys, men, parents and community leaders in these efforts;**

(o) **Ensure training on non-judgmental, rights-based approaches for health providers and educators;**

Gender-based violence prevention and response

(p) **Strengthen the prevention of and response to gender-based violence, including sexual violence, intimate partner violence and online exploitation;**

(q) **Guarantee accessible, survivor-centred and child-friendly reporting mechanisms, alongside a full range of trauma-informed services and sexual and reproductive healthcare, including prophylactic treatment, safe abortion care, psychological support and emergency contraception;**

Data and accountability

(r) **Invest in robust data systems, using a human rights-based approach, that collect qualitative and quantitative data, disaggregated by age, race or ethnic origin,**

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disability and other intersecting factors, to address unreported pregnancies and un-registered births;

(s) **Establish confidential, child-friendly complaint mechanisms to report cases of violence;**

International assistance and foreign policy

(t) **Adopt foreign policies that prioritize gender equality and sexual and reproductive health services, including those tailored to adolescents' needs;**

(u) **Provide international assistance inclusive of sexual and reproductive health services and information.**

60. **In their oversight and accountability role, national human rights institutions should:**

(a) **Monitor State compliance with obligations related to adolescent health, education and non-discrimination and investigate complaints of school expulsion of pregnant girls, denial of sexual and reproductive health services, violations of privacy and confidentiality and gender-based violence**;

(b) **Issue public reports and recommendations on systemic barriers to the prevention of adolescent pregnancy, advocate for law and policy reform, support and encourage human rights education and guidance to schools, health providers and local authorities and foster the establishment of child- and adolescent-friendly complaint mechanisms that are accessible, confidential, and safe**.

61. **Civil society organizations and youth-led organizations play an essential role in monitoring, advocacy and ensuring participation in policymaking. They should receive the necessary support to do so and engage as follows:**

(a) **Advocate for rights-based legal reforms to prohibit child marriage, guarantee quality education and sexual and reproductive health access and monitor the implementation of national policies and budgets affecting adolescents**;

(b) **Engage in community-based sexual and reproductive health information and referrals, also targeted at out-of-school and marginalized adolescents, and implement programmes that challenge harmful gender norms by engaging with parents, boys, men and community leaders**;

(c) **Facilitate the establishment of sustainable safe spaces, peer-led education and support networks for pregnant and parenting adolescents to empower young people and foster lasting behavioural change**.

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