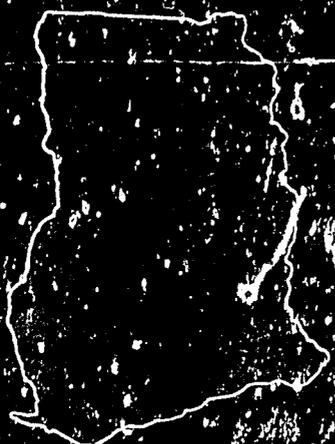


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SOME  
IMPLICATIONS  
OF EARLY  
CHILDBEARING  
IN GHANA

BY BEN GYEDJ GARBRAM

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## INTRODUCTION

Adolescence, the period covering ages 10 to 19, is a time of critical biological and psychological changes: adolescents are past childhood but have not yet entered adulthood. For Ghana's older adolescents (aged 15-19), biological changes are likely to coincide with social transitions and stresses, including sexual awareness. Though adolescents have become a significant segment of the sexually active population in Ghana, their needs regarding information, health care, and family planning are often ignored.

In 1985, the 1.4 million adolescent males and females aged 15-19 constituted 10.4 percent of Ghana's population. Because of Ghana's rapid population growth and young age distribution, this group will become an even larger proportion of the overall population. If current trends continue, their numbers will rise to 2.4 million by 2000, about 11 percent of the total population.

Ghana's young people are the country's future, and their increasing sexual activity has long-reaching implications. This booklet will summarize research findings on teenage sexuality and early childbearing which affect both the long-term welfare of individual female adolescents and the Ghanaian society as a whole, including:

- The reasons adolescent fertility is high.
- The health risks to both mother and child from adolescent pregnancy.
- The social and economic disadvantages inflicted on young persons when faced with an unwanted pregnancy.
- The suspected high incidence of sexually transmitted diseases (STDs) among adolescents, particularly in urban areas.
- The lack of adequate family life education programmes.

**WHY IS  
ADOLESCENT  
FERTILITY  
HIGH?**

Births to adolescents accounted for 11 percent of Ghana's births in 1979-1980. There are several reasons why this number is so high.

First, adolescents form an important component of all females of reproductive age (15-49). Because of Ghana's high population growth rate, the number of adolescent females aged 15-19 is growing faster than the number aged 20-49. In 1985 there were

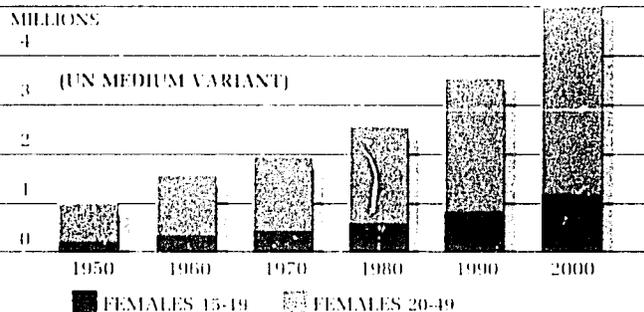
713,000 females aged 15-19; this number is expected to increase to 1.2 million by the year 2000. (See Chart 1)

Second, women marry at a relatively young age in Ghana. Although there has been a slight increase in the age at first marriage for Ghanaian women, the latest available information indicates that this age is 19, compared with 21 in Morocco, 23 in England and Wales, and 25 in Sri Lanka and Japan. Only about 67 percent of Ghanaian females aged 15-19 have never been married, in contrast with 95 percent in Tunisia and France, 96 percent in Canada, and 99 percent in Japan and Sweden. (See Chart 2)

Third, the traditional desire in Ghana for large families is still very strong. Young couples are pressured by both the extended family and society to have children during the first year of marriage. There is, therefore, a strong relationship between early marriage and the high level of adolescent fertility.

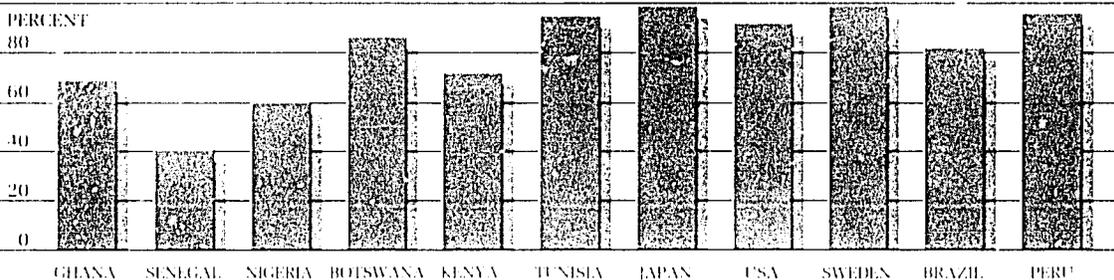
Finally, by the late 1970s, general improvements in health and nutrition had reduced the average age at which Ghanaian girls begin to menstruate to 15 years of age. Menstruation brings with it earlier sexual maturity and increased biological capacity to have children.

**CHART 1  
GHANAIAN FEMALES OF REPRODUCTIVE AGE, 1950-2000**



SOURCE: *World Population: The 1980s - Estimates and Projections as Assessed in 1981*, United Nations, New York, 1986.

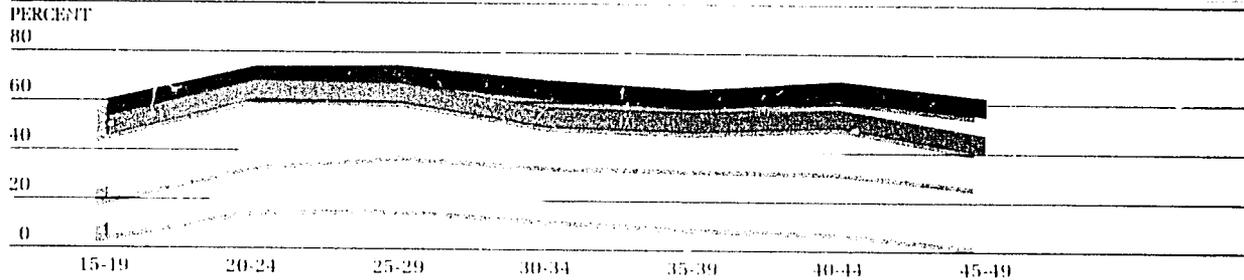
**CHART 2  
NEVER-MARRIED ADOLESCENTS AGED 15-19 (SELECTED COUNTRIES, 1976-1982)**



SOURCE: Gyepe-Gabnah, B., *Adolescent Fertility in Sub-Saharan Africa*, Boston: The Pathfinder Fund, 1985, p. 6-7, and Senderowitz, I and Panman, J.M. "Adolescent Fertility: Worldwide Concerns" in *Population Bulletin*, Vol. 40, No. 2, April 1985, Washington, D.C.: Population Reference Bureau.

CHART 3

GHANAIAN WOMEN WHO HAVE HEARD OF OR USED CONTRACEPTION BY AGE, 1980



Meanwhile, in spite of recent slight increases in the use of modern contraceptives, the proportion of females using contraception is still low. Available data indicate that only 12 percent of female adolescents have ever used efficient contraception. (See Chart 3)

■ HEARD OF ANY METHOD	■ EVER USED ANY METHOD
▨ HEARD OF ONE OR MORE EFFICIENT METHODS	▨ EVER USED ONE OR MORE EFFICIENT METHOD

SOURCE: Extracted from Ghana Fertility Survey, 1979-1980. Accra: Central Bureau of Statistics, 1980.

PREMARITAL  
SEXUAL  
ACTIVITY

Traditional Ghanaian culture generally encourages chastity before marriage. As a result, the rate of premarital childbearing was, until recently, relatively low in Ghana. Even in the late 1970s, only 5 percent of females who had been married for five or more years reported premarital births compared with about 20 percent in Kenya.

One reason for low premarital pregnancy was the observance of puberty rites for girls, an effective mechanism in controlling premarital adolescent fertility. These rites, which signify the attainment of adulthood and marriageable age, were supposed to follow shortly after the girl's first menstruation but in practice were usually delayed until the girl was considered physically mature. Thus, for instance, a girl who starts menstruating at age 15 could have her puberty rites postponed to age 16. Marriage usually followed

soon after the puberty rites.

Modern lifestyles and other social changes, including urbanisation and increasing female education, have reduced the incidence of these puberty rites and extended the time period between physical maturity and marriage. One result appears to be an increase in sexual activity among unmarried adolescents. These factors, particularly education, have changed the scope of the adolescent pregnancy problem.

Sexual activity among unwed adolescents has increasingly become a problem, particularly in the urban areas, where about a third of Ghanaians live and where a greater proportion of adolescents tend to dwell. A large number of unmarried adolescents engage in sexual relations within an environment of inadequate contraceptive and counselling services.

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## HEALTH RISKS OF EARLY PREGNANCY

The natural consequence of sexual activity without use of contraceptives is pregnancy. And pregnancy among adolescents is a problem that seems to be increasing. Although adolescents aged 15-19 constitute less than 10 percent of married females of reproductive age, they contributed about 20 percent of all pregnancies seen at the Korle-Bu Teaching Hospital Antenatal Clinic in 1985.

Ghanaian society still does not consider adolescent pregnancy within marriage a serious social problem, partly because of a lack of appreciation of the negative consequences of early childbirth. Although adolescents are generally healthier than the adult population, their risk of suffering from pregnancy-related medical problems is higher. A study of Ghanaian adolescents from 1980 to 1985 confirmed that the rates of iron-deficiency anaemia and eclampsia

(pregnancy-induced high blood pressure accompanied by seizures) are higher for the adolescent mother. (See Chart 4)

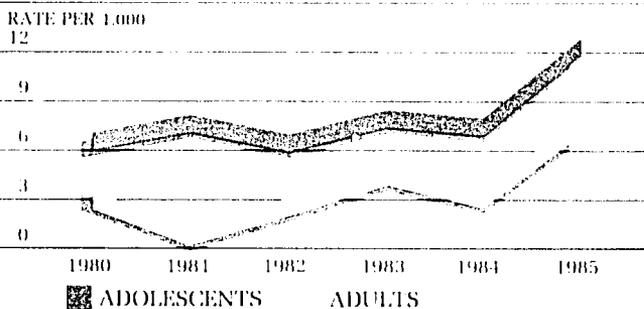
Maternal mortality is also much higher for teenage mothers. According to the World Health Organization (WHO), pregnancy-related deaths "are the main cause of death in 15- to 19-year-old females. . . . Death rates from causes related to abortion and delivery are particularly high in girls below 18 years of age." Researchers have recently found that the main cause of maternal death among adolescents who delivered at Korle-Bu Teaching Hospital between 1983 and 1985 was septicaemia, arising from septic abortion.

Adolescent pregnancy outside of marriage has added risks. The difficulty of combining schooling and childbearing appears to have contributed to a heavy reliance on potentially dangerous illegal abortions, a problem found most often among secondary school girls from urban areas. Complications associated with illegal abortions have serious public health implications because they raise maternal mortality and morbidity and divert limited health resources. A 1968-1969 study at Korle-Bu Teaching Hospital found that 41 percent of the hospital's blood supply was used to treat abortion complications. Medical researchers indicate that this pattern still persists in the major hospitals.

Early pregnancy poses problems not only for the adolescent but for her child as well. The higher rates of premature birth and low birth weight suffered by infants of adolescent mothers often contribute to long-term mental and physical handicaps or to the death of the infant.

The risks of early pregnancy are substantially reduced with good ante- and

**CHART 4**  
**ECLAMPSIA RATES AMONG ADOLESCENTS**  
**AND ADULT ANTENATAL CLINIC PATIENTS**  
**KORLE-BU TEACHING HOSPITAL, ACCRA, 1980-1985**



SOURCE: Extracted from Ampofo, D.A. "Dimensions of Adolescent Pregnancy in Korle-Bu Teaching Hospital, 1983-1985," paper presented at the Ghana National Conference on Population and National Reconstruction, University of Ghana, April 1986.

postnatal care. But the bulk of adolescents do not receive adequate medical attention, increasing their risk of developing complications. For unmarried adolescents these medical risks are aggravated by social disapproval and potential lack of familial support during pregnancy. These women are more likely than married women to lose their babies.

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**SOCIAL  
CONSEQUENCES  
OF EARLY  
PREGNANCY**

The social and economic disadvantages of early childbirth for mother and child are enormous. Early pregnancy in part contributes to the rate at which females drop out of elementary and particularly secondary schools, as evidenced by the low proportion of females in Ghana's schools. In 1970, there were 121 male students for every 100 female students aged 6-14 enrolled in regular school. This contrasts markedly with the male female ratio of the same group as they entered secondary school. In 1976-1977, there were 203 male students for every 100 females in secondary form 1. By the time these young people reached form 5, in 1980-1981, the number of male students had increased to 230 for every 100 female students.

In Ghana's changing social environment, educational attainment has become a measure of status for males and females, displacing the traditional indicators of lineage, age, sex, and fertility. By interrupting education, early pregnancy and childbirth restrict future opportunities for social and economic advancement. Although not officially required to withdraw from school, most pregnant girls do so voluntarily, ensuring at least a temporary and usually permanent halt to their education. Career



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opportunities are then cut off. Those who do not choose illegal abortion are forced into premature marriage; or else must bear their child outside marriage.

Problems associated with adolescent childbearing are especially acute for the poor. The very poor and very young mother is likely to be severely overburdened, especially when she is unwed and the child unwanted. Such children usually suffer from malnutrition, infections, and parasitic diseases. These conditions tend to negatively affect the physical and intellectual development of the children, and the effects persist into adolescence. Thus adolescent pregnancy increases the risk that the pattern will be repeated in the next generation, establishing or reinforcing the cycle of deprivation.

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## SEXUALLY TRANSMITTED DISEASE

Along with pregnancy, sexual activity brings with it the risk of sexually transmitted diseases (STDs). STDs are a leading cause of miscarriage, infertility among both men and women, and blindness in newborns.

Like abortion, the incidence of STDs in Ghana is believed to be high among sexually active adolescents, though the actual level is not known. What is particularly disturbing about the high incidence of STDs among adolescents is that certain STDs have been found to be insensitive to antibiotics. In addition, the presence of Acquired Immune Deficiency Syndrome (AIDS) in Ghana poses an even graver threat to those exposed to STDs.

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## FAMILY LIFE EDUCATION

Information on sex and reproduction is a key element in stemming the frequency of adolescent fertility. Ghanaian adolescents have very limited access to programmes offering family life education or counselling. Traditional systems for teaching adolescents about sex and reproduction are rapidly becoming inadequate for disseminating useful up-to-date information. At present, no far-reaching structure has been designed and put in place as a substitute. For example, the Ministry of Education's plans for incorporating family life education into the curricula of secondary schools and teacher training colleges have yet to come to fruition because appropriate mate-



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rials, though under development, are not yet available.

Nonetheless, some services are available to adolescents. The various participating agencies of Ghana's Family Planning Programme provide services and counselling in accordance with their individual objectives. The Committee on Christian Marriage of the Christian Council of Ghana provides counselling, but mainly for married adults; the Catholic Secretariat gives lectures in secondary schools on family life education; government hospitals and clinics, the Planned Parenthood Association of Ghana, and the Ghana Family Planning Programme provide family planning services, in addition to counselling services and lectures on family planning, to all those who visit their clinics regardless of age and marital status.

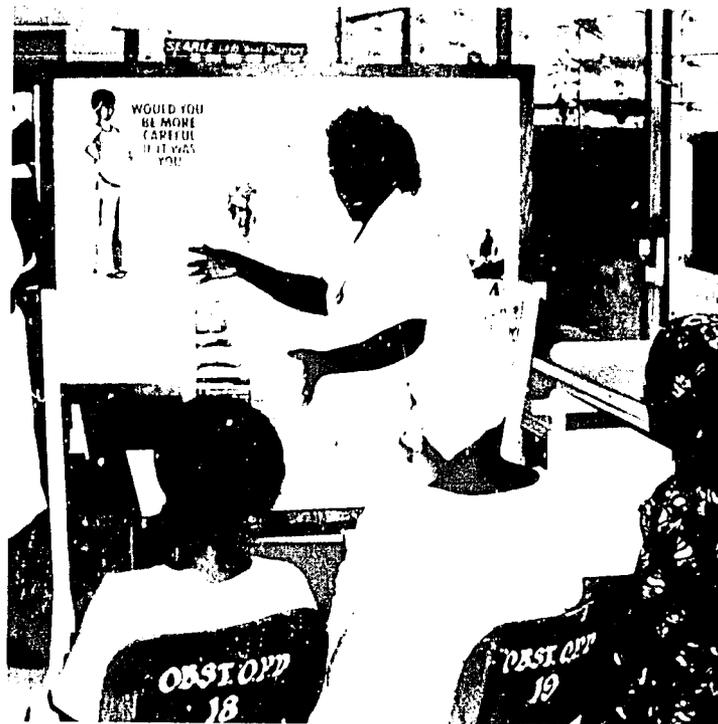
## MALE ADOLESCENTS

This booklet has focussed mainly on female adolescents. However, the health, social, and economic consequences of early sexual activity among male adolescents may be just as severe. The negative effects of STDs among male adolescents, for instance, are just as bad as those of females. In addition, if a young man is believed to have impregnated a girlfriend, enough pressure may be exerted on him to abandon school or enter into an unwanted early marriage. Problems such as these also tend to compromise the future social advancement and job prospects of male adolescents. Thus any family life education programme for adolescents should be addressed to both females and males.

## POLICY IMPLICATIONS

Current and comprehensive information on Ghanaian adolescent sexual behaviour and its implications is lacking. Available evidence and the experience of researchers working in this field, however, indicate that the problems of adolescent sexuality and reproduction are of potentially immense proportions. Dealing with these problems will demand careful planning, financial resources, and a strong commitment on the part of Ghanaian policymakers, private health care and family planning service providers, religious groups, and youth organizations.

As they develop appropriate policies, Ghanaian leaders may want to address the following questions:



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1. Should research be supported to obtain current and comprehensive information on reproductive health behaviour of adolescents and on implications of early pregnancy and childbirth to provide a data base to guide policy formulation?
2. Should pregnant students and adolescent mothers be encouraged to continue their education?
3. Should the family life education programme, as developed by the Ghana Ed-

*CONTINUED ...*

### *POLICY IMPLICATIONS CONTINUED . . .*

ucation Service for adolescents in pre-university institutions, be extended to cover out-of-school adolescents regardless of marital status?

4. Should clinics and other contraceptive service providers develop special programmes to reach certain groups of sexually active adolescents, such as students and married adolescents?
5. What strategy should be adopted to encourage later childbearing?
6. How can contraceptives be made more accessible to sexually active adolescents to help check unwanted pregnancies, illegal abortions, and the spread of STDs?
7. Should public health campaigns against STDs include contraceptive advice and services?

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### **CONCLUSION**

The potential waste of the nation's human resources through early childbearing demands that these policy issues be explored. Not only are the consequences of adolescent fertility grave for the individual, but they have implications for Ghanaian society as well. Early marriage and childbearing, in conjunction with Ghanaian preferences for large families, inhibit a reduction in the country's rapid rate of population growth.

Thus, attention given to solving the problem of adolescent fertility works on two levels: it works toward the advancement of the individual while enhancing society's chances for a higher standard of living.



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