

In Focus

REACHING NEWLYWED AND MARRIED ADOLESCENTS

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In most of the world, family planning programs have had great success in slowing population growth and in improving the status of women's reproductive health. Yet in many countries, these programs tend to reach older women, often after they have had their desired number of children.¹ Even as family planners encourage women to plan their family size and to adequately space births, the youngest married couples, particularly those in which the wife is still an adolescent under the age of 19, are often overlooked.² The majority of births to adolescents in developing countries occur within wedlock,³ despite some evidence that premarital births are on the rise,^{4,5,6} making newlywed and married couples an important group to receive reproductive health information and services.

How many adolescents are married and bearing children?

The following data highlight marriage and childbearing statistics for young women, because most young men postpone marriage and parenthood until their 20s or later.⁶

- Data from 46 Demographic and Health Surveys (DHS) showed that about half of young women age 18 have married or entered a union in most countries in sub-Saharan Africa; 50 to 75 percent have married in India and Bangladesh; less than 30 percent have married in North Africa and the Middle East and 20 to 40 percent have married in Latin America and the Caribbean.^{6,7}
- More than 40 percent of adolescent women in the developing world—the majority of them married⁸—will give birth before the age of 20.⁹
- The countries of sub-Saharan Africa have the highest levels of adolescent childbearing; contraceptive use by married women age 15–19 is below 10 percent.³ Levels of contraceptive use among married adolescents in every region are lower than rates among older married women (age 20–49).³
- Mali and Niger have especially high rates of over 200 births per 1,000 women age 15–19.⁸ In rural Mali, one in four girls is married by the time she is 15, and one in five has given birth by the age of 16.¹⁰

- As many as 40 percent of all young women age 15–19 in India are already married; no more than 7.1 percent of married women age 15–19 use contraception, compared with 21 percent among women age 20–24.⁴
- Approximately 90 percent of the female spouses in the 1.2 million marriages taking place annually in Bangladesh are below the age of 19.¹¹ More than 70 percent of married adolescents became pregnant before their first marriage anniversary.¹²

Although the average age at first marriage is increasing in most countries, it is still under the age of 19 in many.⁶ At the same time, the population pyramids of most countries show that the adolescent population is growing both in sheer number and sometimes as a proportion of the total population.³ Thus, the number of married adolescents will continue to increase, making the need to reach them with services all the more compelling.

What are the benefits of reaching newlywed and married adolescents?

Preventing pregnancies among married adolescents may have a long-term demographic impact. Globally, rates of population growth are more rapid in countries where women have their first child before the age of 20.⁸ Raising the average age at which females begin childbearing could yield substantial demographic dividends; across regions, a woman who has her first child before the age of 18 will have an average of seven children as compared with a woman who waits until her early 20s to begin childbearing, who will average five or six children.⁶ An older age at first birth also translates into longer intervals between generations.³ Delay of first birth has contributed significantly to fertility decline in some countries in sub-Saharan Africa.¹³

Delaying first birth can reduce maternal and infant health risks. If pregnancy occurs before adolescents are fully developed—especially in countries where anemia and malnutrition are common and where access to health care is poor⁸—girls can be exposed to particularly acute health risks, including damage to the reproductive health tract, delayed or obstructed labor, ruptures in the birth canal,

and elevated risks of maternal mortality.^{2,4,14,15,16} Babies born to adolescents may experience more birth injuries, low birth weight and stillbirth;¹⁵ infant mortality is highest in those countries with the largest proportions of adolescent births.³

Providing programs for married adolescents may fill an unmet need for family planning services. Births to married adolescents are often unplanned.⁶ A study in Ahmedabad, India, found that most married adolescents reported that their first pregnancy was unwanted.¹⁷ A national survey in India found that as many as 30 percent of women age 15–19 desired to delay their next birth but were not using contraception.⁴ Research found that 15 percent of married 15–19 year-old women in Egypt and 29 percent in Pakistan expressed not wanting to become pregnant but were not using contraceptives.⁹

Postponing childbearing beyond adolescence has benefits for young women. A woman who delays childbearing until after adolescence may gain advantages such as increased opportunities to acquire education and skills that may enable her to better care for her family and compete in the job market.⁶ Delayed childbearing may also be associated with greater aspirations of a young woman for her self and her family.

Reaching married adolescents can be cost efficient, may be introduced at scale, and is sometimes less controversial than introducing programs for unmarried youth. In countries that have a strong family planning infrastructure, reorienting the program to reach married adolescents may be achieved with minimal inputs, as was the case in Bangladesh.¹⁸ There, a Pathfinder-supported strategy was brought to scale by grafting services for newlyweds onto already existing family planning programs, achieving broad coverage of newlywed couples within a few years of program initiation.¹⁸

What are the barriers to reaching married adolescents?

Social and religious norms support demonstration of fertility soon after marriage.^{3,5,8,17,18,19} Motherhood may be one of the few ways in which a young married woman can affirm her value and identity to herself and her community.⁸ In some societies, if a female fails to give birth within a few years of marriage, she encounters difficulties with her husband and in-laws.⁹ In Yemen, for example, 11 percent of wives age 15–29 state that they refuse the use of contraception because of opposition expressed by their husbands.²⁰ If polygyny is common, as it is in parts of sub-Saharan Africa, a young woman may be inclined to quickly prove her fecundity so that her husband will avoid, or at least put off, taking a second wife.²¹

Married adolescent women who want to delay pregnancy may lack the autonomy to do so. When a married adolescent does not want children but faces clear familial expectations to become pregnant,

she may lack the power within her family to use contraceptives.⁹ Differences in age between husbands and their young wives may exacerbate problems surrounding women's autonomy, decreasing young women's ability to negotiate with their husbands about sex, contraception and childbearing.^{6,9} This problem is evidenced by a multicountry study that found contraceptive use was more likely when both partners—as opposed to only the wife—desired to prevent childbearing.²²

Other factors that disempower young wives can serve as barriers to the use of reproductive health services. In many developing countries, the mobility of adolescent girls' is highly constrained,⁹ making it difficult for them to seek services—especially in rural areas where health services are not readily available nor accessible. Moreover, in areas with high rates of adolescent marriage, girls' education levels are often very low;⁹ lack of education may further decrease a young woman's ability to use contraceptives properly, inhibit her decision-making power in areas related to contraceptive choice, or result in her having fewer alternatives to motherhood and therefore weaker motivation to delay marriage or first birth.

Family planners may be influenced by social norms and not target or serve young married couples.^{4,8,18} Studies in the Middle East have found that societal attitudes determine that newlyweds should not approach any form of family planning until they have had at least one child,²³ which may deter providers from serving them. Substantial cross-regional evidence exists that when young married females seek contraceptive services in Ghana, Egypt and India, they encounter substantial, often explicit, provider resistance.⁹ A UNFPA assessment found that some health professionals helped young couples avoid exposure to a premarital educational intervention on family planning that was mandated by the state.²⁴

Individuals may not want to use contraceptives until a desired level of fertility is achieved.¹⁸ Family planning programs sometimes have less success promoting contraceptives to women who have had fewer children than they desire, and these programs often target older women with more children as a result. For example, a study in India found that family planning methods are often first used after two sons are born.¹⁷

What successful strategies can be used to reach married adolescents?

Reorient reproductive health programs and field workers to reach married adolescents. In China and Bangladesh, family planning field workers bring congratulatory letters to newlyweds and motivate them to use contraception during home visits.^{18,25} In Pathfinder-sponsored program areas in Bangladesh, contraceptive use increased from 19 percent in 1993 to 42 percent in 1997 among all newlywed couples, prompting the government to reorient its family planning field workers and institutionalize programs for newlyweds.¹⁸ In Taiwan, operations research found that the most

effective home-visit strategy provided two dozen free condoms during a field worker's first visit, as opposed to merely informing couples where they could obtain contraceptives.²⁶

Reorient reproductive health programs to promote maternal and child health care for newlywed adolescent women. In Bangladesh, Pathfinder-supported field workers encouraged pregnant newlyweds to seek prenatal services and care from trained birth attendants, as well as provided education about nutrition and breastfeeding. An evaluation found that 78 percent of the births to newlyweds reached by the program were attended by trained traditional birth attendants or health professionals,¹⁸ compared with 41 percent of births to all 15–19 year-olds.²⁷ Of the newlyweds reached by the program, 89 percent breastfed colostrum to their newborn babies,¹⁸ as compared with only 50 percent of all mothers who did so.²⁸ A program in Jamaica found that providing education and support to adolescent mothers also encouraged delay of second births; 10 years after completing the program, 50.7 percent of the participants had only one child, and the average spacing between first and second births was 5.5 years.²⁹

Reach adolescents through marriage registry systems. In Indonesia, Pathfinder trained marriage counselors from the Islamic marriage registry system as well as those from the National Family Planning Coordinating Board (BKKBN) to serve as family planning educators.^{30,31} Guidebooks provided a valuable and cost-effective way to reach a large number of counselors.³⁰ In Mexico, the National Population Council (CONAPO) helped three states establish a prerequisite to the civil marriage ceremony that requires couples to present a signed form from a doctor or social worker that certifies they have received a talk on family planning. Marriage registrars were also trained to provide written information and answer questions on family planning.²⁴ In the Philippines, a 1988 policy required that all marriage license applicants 25 years of age or less must participate in a premarital counseling course.²⁴

Reach adolescents who are preparing to marry. Family planning associations (FPAs) have been invited to provide education as part of the premarital counseling provided by the Catholic church in some parts of Latin America and in Indonesia,^{24,32} and in Jordan and Tunisia, FPAs provide educational materials for adolescent couples preparing to marry.³³

Raise the awareness and cultivate the active support of those who influence newlywed decision making. Because of the low decision-making autonomy of adolescent women, especially those who are living with their husbands' families, programs can try to raise the awareness of more powerful family decision makers such as in-laws and elders.^{4,18} In Bangladesh, Pathfinder encourages newlyweds and their husbands or in-laws to attend orientation meetings in which education is provided about family planning and reproductive health. The program increased the involvement of males married to adolescent wives; condom use in program areas

was 37 percent, significantly higher than the average rate of 15.7 percent among all married adolescents.¹⁸

Use married adolescents as agents of change in their communities. Married adolescents who use contraception can be encouraged to act as agents of community change.¹⁸ In addition to serving as examples for their peers, they can be trained as peer educators and advocate for contraceptive use, delayed childbearing and the use of health services such as prenatal care in places where health service utilization is low because of misconceptions or lack of knowledge.

Create mass media campaigns to raise awareness. In Bangladesh, Johns Hopkins University Population Communication Services (JHU/PCS) and John Snow, Inc. (JSI), produced a two-episode film about the life in a village of a young man and the woman he marries. The film touches on a number of social issues, including the importance of delaying first birth and seeking appropriate immunizations as well as the benefits of a small family.³⁴ In Taiwan, advertisements in newspapers encouraging newlywed couples to write for family planning samples were well received. A follow-up study found that 70 percent of married couples who wrote in and were sent kits were practicing contraception.³⁵

Work to increase young women's autonomy and opportunities after marriage. Research has shown that early marriage can have detrimental consequences for women.⁷ In Ghana, one program successfully supported women's autonomy by assembling a team of male supervisors to make household visits when discord about contraceptive use arose to call community attention to the husband's behavior and to persuade him to end the conflict.³⁶ Efforts to improve education, training and job opportunities for young women as childbearing becomes a lesser focus of adolescence are also crucial.⁸ In Bangladesh, Concerned Women for Family Planning encourages continued education through peer support groups that involve both married and unmarried young women and provides opportunities to study vocational skills such as sewing and embroidery.³⁷

Conduct advocacy efforts at the national level. In Bangladesh, a key to the growth of the newlywed strategy was efforts by Pathfinder to seek governmental support for the program.¹⁶ In Indonesia, Pathfinder launched an advocacy campaign that evaluators found encouraged influential leaders, such as government officials, health professionals, religious leaders and academics, to discuss the societal norms that lead to early marriage and childbearing. As a result, participants developed publications with regionally specific research—disseminated through a respected academic journal—that facilitated public discussion of the issues surrounding early childbearing. Participants also expressed a commitment to integrating education and research activities into their own regular programs as well as to conducting and financing projects on early fertility prevention in their communities.³⁰

What are the outstanding needs for improving services for married adolescents?

Although work with newlyweds is becoming better established, little is known about the factors that influence the decision making of an adolescent married couple in most contexts.^{8,9} Moreover, the approaches to date have focused mostly on increasing contraceptive use; more needs to be done to address the gender inequities that result in lack of autonomy by young women, as well as to broaden the spectrum of programs that provide adolescent reproductive health services. In particular, the following strategies could be used to improve services for married adolescents:

- conduct applied research documenting the social, contextual and interpersonal factors that influence the decision making of married adolescents;
- improve documentation and evaluation of existing programs for married adolescents;
- increase the priority that governments place on meeting adolescent needs in general, with specific planning and programming for married youth; and
- increase the proportion of overall resources allocated to programs for newlywed and married adolescents.

The In FOCUS series summarizes for professionals working in developing countries some of the program experience and limited research available on young adult reproductive health concerns. This issue was developed by Dr. M. Alauddin, Country Representative, Pathfinder Bangladesh and Laurel MacLaren, Communications Advisor, FOCUS on Young Adults. The In FOCUS series and other publications can be downloaded from the FOCUS Web site <www.pathfind.org/focus.htm>.

- Alauddin, M. and M. Van Landingham. 1989. "Young, Low-Parity Women: Critical Target Group for Family Planning in Bangladesh." *Asia-Pacific Population Journal* Vol 4(1). Economic and Social Commission for Asian and the Pacific.
- Alauddin, M. 1993. "The Significance of Newly Married Couples in Bangladesh Family Planning Program." In Ministry of Health and Family Welfare. *Population Award to the NGOs by the Prime Minister*. Dhaka: Government of Bangladesh and Pathfinder International.
- McDevitt, T.M. 1996. *Trends in Adolescent Fertility and Contraceptive Use in the Developing World*. Washington, DC: U.S. Department of Commerce.
- Jejeebhoy, S.J. 1996. *Adolescent Sexual and Reproductive Behavior: A Review of the Evidence from India*. ICRW Working Paper No. 3. Washington, DC: International Center for Research on Women (ICRW).
- Bledsoe, C.H. and B. Cohen, eds. 1993. *Social Dynamics of Adolescent Fertility in sub-Saharan Africa*. Washington, DC: National Academy Press.
- The Alan Guttmacher Institute. 1998. *Into a New World: Young Women's Sexual and Reproductive Lives*. New York: Alan Guttmacher Institute.
- Singh, S. and R. Samara. 1996. Early marriage among women in developing countries. *International Family Planning Perspectives* 22 (4): 148-157.
- Singh, S. 1998. Adolescent childbearing in developing countries: A global review. *Studies in Family Planning* 29 (2): 117-136.
- Mensch, B.S., J. Bruce and M.E. Greene. 1998. *The Uncharted Passage: Girls' Adolescence in the Developing World*. New York: The Population Council.

- Seligman, B., L. Weiss and S. Pacque-Margolis. 1999. *Mali Youth Profile (Draft)*. Washington, DC: FOCUS on Young Adults.
- Islam, M.M. and M. Mahmud. 1996. Marriage patterns and some issues related to adolescent marriage in Bangladesh. *Asia Pacific Population Journal* 11 (3): 27-42.
- Islam, M.N., M. M. Islam and H. Yusuf. 1995. *Fertility and Reproductive Health Status of Married Adolescents in Rural Bangladesh*. Dhaka: Population, Development and Evaluation Unit.
- Mboup, G. and T. Saha. 1998. *Fertility Levels, Trends and Differentials: Demographic and Health Surveys Comparative Studies No. 28*. Calverton, MD: Macro International.
- United Nations. 1989. *Adolescent Reproductive Behavior: Evidence from Developing Countries*. ST/ESA/SER.R/76. New York: United Nations.
- World Health Organization (WHO). 1989. *The Health of Youth*. Background Technical Document, Technical Discussions 1989. A42/Technical Discussions/2. Geneva: WHO.
- Senderowitz, J. 1995. Adolescent health: Reassessing the passage to adulthood. *World Bank Discussion Paper* No. 272. Washington, DC: World Bank.
- International Center for Research on Women. 1997. *Adolescent Sexuality and Fertility in India: Preliminary Findings*. ICRW Information Bulletin. Washington, DC: ICRW.
- Alauddin, M. In press. *Newly Married Couples in Bangladesh: Pathfinder Experience in Adolescent Reproductive Health Interventions*. Dhaka: Pathfinder International, Bangladesh.
- Samera, R. 1997. "Adolescent Motherhood in Guatemala: A comparative perspective." In Bixby, L.R., A. Pebley and A. Bermudez-Mendez. *De los Mayas a la Planificación Familiar: Demografía, del Istmo*. San Jose, Costa Rica: Editorial de la Universidad de Costa Rica, Programa Centroamericana de Población.
- Central Statistical Organization. 1998. *Demographic and Maternal and Child Health Survey 1997: Yemen*. Calverton, MD: Macro International, Inc.
- Onduso, P. 1999. Pathfinder Kenya. Personal Communication. June 18.
- Bankole, A. and S. Singh. Couples' fertility and contraceptive decision-making in developing countries: Hearing the man's voice. *International Family Planning Perspectives* 24 (1): 15-24.
- Sukkary, S. and Y. Mossavar-Rahmani. 1982. "Fertility in cultural perspective: Egypt, Jordan, Morocco, Tunisia and Yemen." (Unpublished paper).
- Technical and Evaluation Division, UNFPA. November 1990. "Review and Analysis of Premarital/Newlywed Education Activities in Mexico, Indonesia and the Philippines." (Unpublished document prepared for UNFPA, New York).
- Hengdong County Family Planning Commission. 1986. A new aspect for family planning opened up by "eight visits." *Population Research* 3 (1): 46-49.
- Chen, C., C.D. Chiang and C.Z. Chen. 1984. The effectiveness of small incentive on acceptance of condoms among newlyweds. *Journal of Population Studies* 7: 141-156.
- National Institute of Population Research and Training (NIPORT). 1995. *Demographic and Health Survey 1995: Bangladesh*. Calverton, MD: Macro International, Inc.
- National Institute of Population Research and Training (NIPORT). 1994. *Demographic and Health Survey 1993-1994: Bangladesh*. Calverton, MD: Macro International, Inc.
- McNeil, Pamela. 1999. *Women's Centre, Jamaica: Preventing Second Adolescent Pregnancies by Supporting Young Mothers*. Project Highlights Series. Washington, DC: FOCUS on Young Adults.
- Dornsife, N. and A. Mahmood. 1985. "An Evaluation of Pathfinder's Early Marriage Education Programs in Indonesia." (Unpublished paper prepared for Pathfinder International, Indonesia).
- Sampoemo, D. 1984. "Marriage law education and training projects: Indonesia." In Edmunds, M. and J. Paxman. *Early Pregnancy and Childbearing in Guatemala, Brazil, Nigeria and Indonesia: Addressing the Consequences*. Chestnut Hill, MA: Pathfinder International.
- Stewart, L. FOCUS on Young Adults. 1999. Personal communication, June 10.
- Gaata, R. International Planned Parenthood Federation. 1999. Personal communication, June 25.
- Bangladesh Ministry of Health and Family Welfare. 1992. "Final Report: The "Swapper Shuru: Family Planning Film Series, Bangladesh Project AS-BAN-05." (Unpublished report prepared for USAID).
- Taiwan Provincial Department of Health Committee on Family Planning. 1973. Offering contraceptive kits to newlyweds. *Taiwan Population Summaries* November 1973.
- Bawah, A.A., P. Akweongo, R. Simmons and J.F. Phillips. 1999. Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana. *Studies in Family Planning* 30 (1): 54-66.
- Bond, K. and L. MacLaren. 1998. "Trip Report on Consultancy to the Operations Research Project of the ICDDR, B in Dhaka, Bangladesh." (Unpublished report submitted by the FOCUS on Young Adults program to USAID Bangladesh).

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