

Adolescent Women in Sub-Saharan Africa

A CHARTBOOK ON
MARRIAGE AND
CHILDBEARING

The data for this chartbook are drawn from the Demographic and Health Surveys (DHS) Program. Between 1986 and 1991, DHS collected data from nationally representative samples of women of reproductive age (15 to 49) in the following sub-Saharan African countries: Botswana, Burundi, Ghana, Kenya, Liberia, Mali, Nigeria, Senegal, Togo, and Zimbabwe, and in Uganda where coverage was 80 percent. Trained local interviewers (in most cases female) conducted the surveys, usually in the native language of the interviewed women. The DHS data contain a wealth of information on women's reproductive histories, knowledge and use of contraception, sexual experience, and infant and child health. Because DHS uses standard questionnaires and survey procedures in all participating countries, a comparative assessment of these dimensions is possible. Additional information on DHS may be obtained by writing:

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INTRODUCTION

Young African women need to participate in and benefit from socioeconomic development. Today, one of the best ways is to pursue an education. Doing so enables them to elevate their social status, to make significant financial contributions to their families, and to participate in the development of their societies. Yet, childbearing among adolescent African women is a relatively common event. Marriage* and/or pregnancy at a young age is likely to curtail a young woman's schooling and thus lower her economic potential. Early childbearing also can carry significant health risks for both the mother and her infant.

Across most of Africa, the social organizations that traditionally provided support to young mothers are weakening. The declining role of kinship groups leaves young women with less guidance on how to manage the transition to adulthood — including initiation of sexual relationships, marriage, and childbearing — and less dependable economic support when they do start having children.

The adverse consequences of adolescent childbearing fall not only upon young mothers; society at large, in addition to bearing additional costs for maternal and child health care, may also lose the added potential of an educated person. Policies and programs to help teenagers make the decision to avoid pregnancy and stay in school can begin to alleviate some of the negative consequences.

Until recently, the data on which to base policy decisions have been sparse and inadequate, making it difficult to develop education, family planning, and maternal and child health programs that consider the special needs of adolescent women. This chartbook, based on data collected by the Demographic and Health Surveys (DHS) Program, is intended to help meet the need for better informa-

tion on adolescent sexual experience, contraceptive use, and childbearing.**

For the purposes of this chartbook, "adolescents" or "teenagers" will be defined as young women between ages 15 and 19.*** The data for that age group are from the 11 sub-Saharan African countries which participated in the DHS Program between 1986 and 1990. The 15- to 19-year-olds who were interviewed in each DHS country were selected to be representative of teens in their country. (See Table 1, page 2, for selected background characteristics.) Overall, these 11 countries constitute 40 percent of the 15 to 19 age group in sub-Saharan Africa.¹ Important differences, as well as similarities, emerge among the countries represented in the charts that follow. New program initiatives must be adapted to the unique circumstances of each country.

*Throughout this chartbook the term "married" refers to any consensual union, formal or informal.

**See the inside front cover for more details about DHS.

***Although the 15- to 19-year-old age group is the one typically used in studies of adolescent pregnancy and childbearing, no one definition of adolescence is universally accepted. Generally, societies have defined the period of adolescence as beginning with the biological onset of puberty. The end of this period is usually more culture-specific; the definition is based on a particular culture's delineation of the achievement of maturity or adulthood. When adulthood is defined by marriage, as is the case in many sub-Saharan African countries, the period of adolescence can be quite brief, for example, when young women marry soon after regular menstruation is established. However, increases in age of marriage in African countries concurrent with decreases in age of menarche are resulting in an increased gap between sexual and social maturity.²

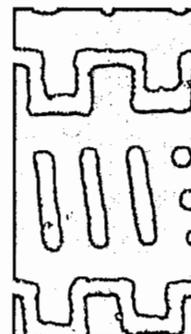


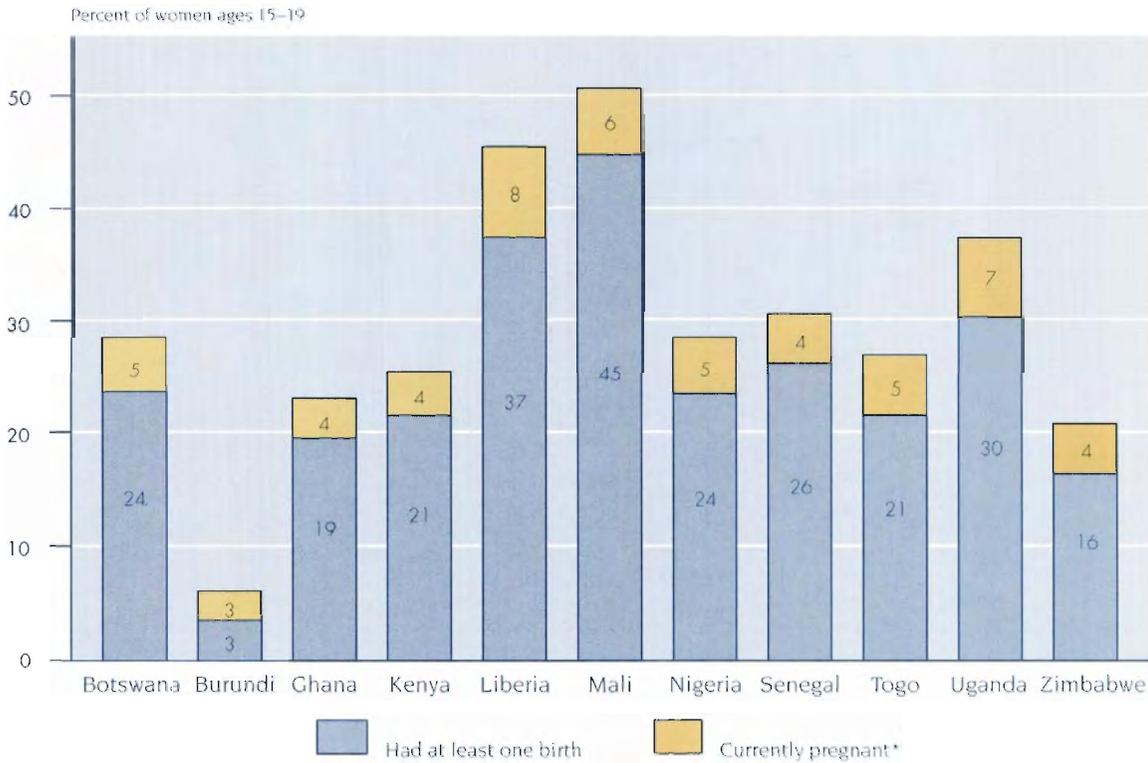
Table 1: Background Characteristics of Adolescent Women in Sub-Saharan Africa

Year of Survey	Country	No. of Females 15-19 ¹	Sample Size	Urban* (%)	No Education (%)	Primary Education (%)	Secondary Education (%)
1988	Botswana	70,000	946	31	6	57	38
1987	Burundi	271,000	740	4	73	25	1
1988	Ghana	781,000	849	39	19	21	60
1989	Kenya	1,287,000	1,481	18	5	74	21
1986	Liberia	129,000	1,169	49	37	41	22
1987	Mali	484,000	557	30	76	24	<1
1990	Nigeria	5,954,000	1,678	29	34	33	34
1986	Senegal	380,000	975	45	69	18	14
1988	Togo	175,000	724	41	38	47	16
1989	Uganda	958,000	1,199	13	21	67	12
1989	Zimbabwe	558,000	1,021	32	3	48	50

*Urban and education data are rounded percentages of the 15- to 19-year-old females in each sample.

EXTENT OF ADOLESCENT CHILDBEARING

Chart 1: Childbearing among Teenage Women



*Teenage women with no previous births

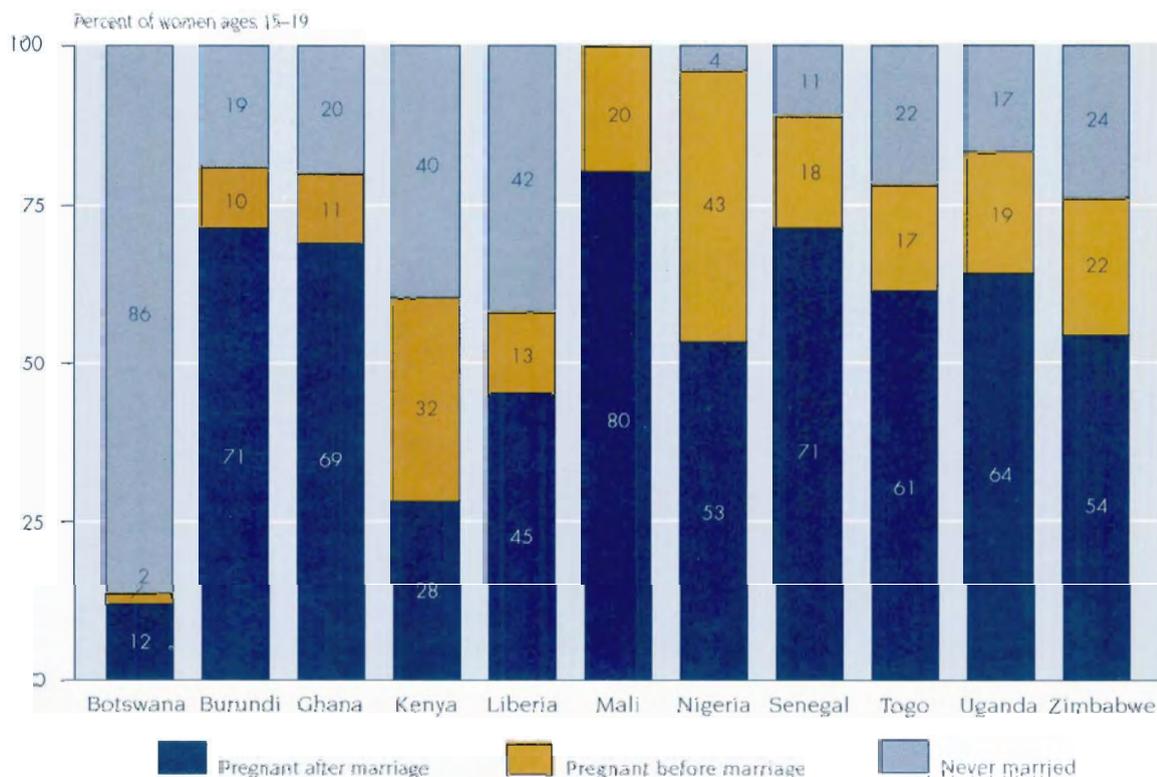
Chart 1 shows how common childbearing is among sub-Saharan African teenage women. In 10 of the 11 countries, at least 1 out of every 5 teenagers had one or more children or was currently pregnant at the time of the DHS interviews. Liberia, Mali, and Uganda are at the high end; in these three countries between one-third and one-half of the adolescent women had given birth or were pregnant. Burundi is the only country where teenage childbearing is relatively uncommon.

The data shown in Chart 1 are minimum estimates of overall teenage pregnancy. These figures, as well as others in this chartbook, do not take into account pregnancies terminated by spontaneous or induced abortion. Nonetheless, the data clearly reflect the high level of childbearing among teenage women.



MARITAL STATUS

Chart 2: Marital Status of Teenagers Who Have Given Birth*



*Marital status at time of first pregnancy

Chart 2 shows the marital status of adolescent women who have had babies. In 8 of the 11 countries considered here, the majority of teenagers' first pregnancies occurred after they had married.

Even in these eight countries, however, between 20 and 47 percent of teenagers first became pregnant outside of marriage. In Mali, Nigeria, Senegal, and Uganda, the majority of these teenagers had subsequently married by the time their babies were born. In contrast, at least half of such women had remained single in Burundi, Ghana, Togo, and Zimbabwe.

In three countries — Botswana, Kenya, and Liberia — the majority of teenagers conceived their babies before marriage. A significant portion of Kenyan teenagers subsequently married, while in Liberia and particularly in Botswana, few had married.

The marital status of an adolescent at the time of pregnancy is important because the support of a spouse and community may allay some of the negative consequences of pregnancy. Either early marriage or early childbearing can bring an abrupt end to a young woman's formal education. However, a

single mother may have a more difficult time supporting a child than a married mother. Furthermore, in some societies an unwed adolescent mother and the child of an unwed adolescent may be less acceptable to the mother's family and community. All these factors add extra stress to the challenges of motherhood for an unwed mother.

BIRTH RATES

Chart 3: Birth Rate of Teenage Women

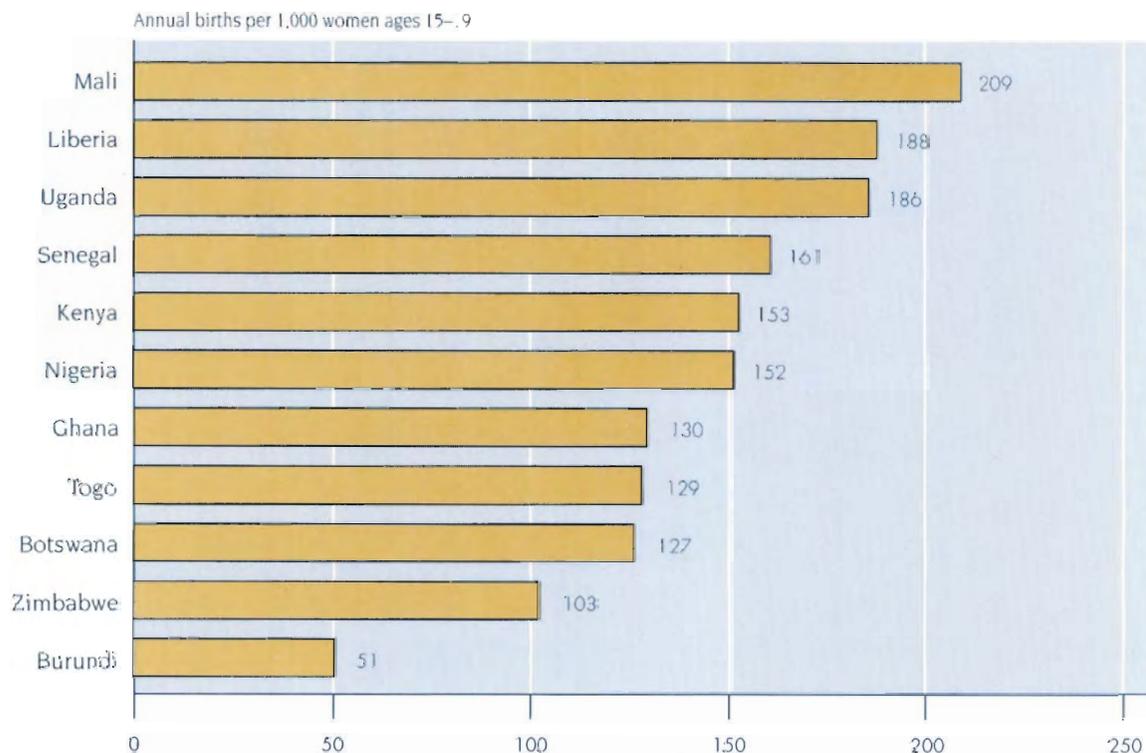


Chart 3 presents the birth rates* for teenage women, ranging from a high of 209 births per 1,000 women in Mali to a low of 51 in Burundi. (The rates for the same age group in developed countries range between 20 and 50.)

Annual birth rates as high as 200 mean that, on average, 1 in 5 adolescent women will have a birth in a given year. In practical terms, this means that a young woman is likely to have had at least one child by the time she reaches age 20. A rate of 100 means that, on average, half the teens will have had a child by age 20. Thus, based on the birth rates presented in Chart 3, it is likely that a majority of teenagers in 10 of the 11 sub-Saharan African countries shown will have had a birth by the time they reach their 20th birthdays.

In comparison to the other countries, Burundi stands apart. The fertility rate for 15- to 19-year-olds is far lower than in the other sub-Saharan African countries shown. A combination of delayed marriage and sanctions against premarital childbearing result in low teenage fertility rates. However, women in Burundi catch up with high fertility rates in their early 20s and the fertility rate for women ages 15 to 49 is as high or higher than that in other African countries.

* The birth rate is the annual number of births per 1,000 women ages 15 to 19. The rates in Chart 3 are weighted averages of the births during the three years before the survey in each country. These data are based on women who were 15 to 19 years of age when their babies were born, not necessarily when they were interviewed.



TEENAGE FERTILITY TRENDS

Chart 4A: No Evidence of Decline

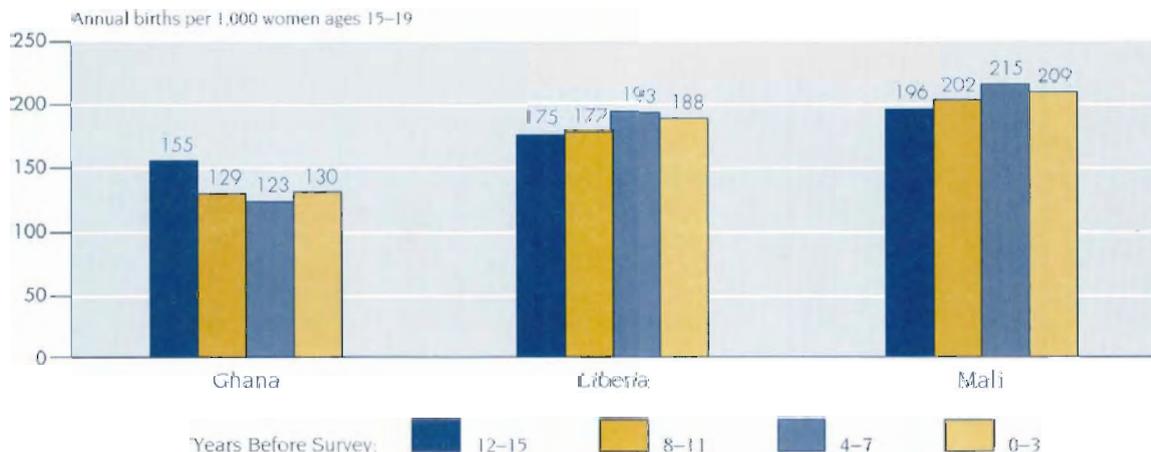
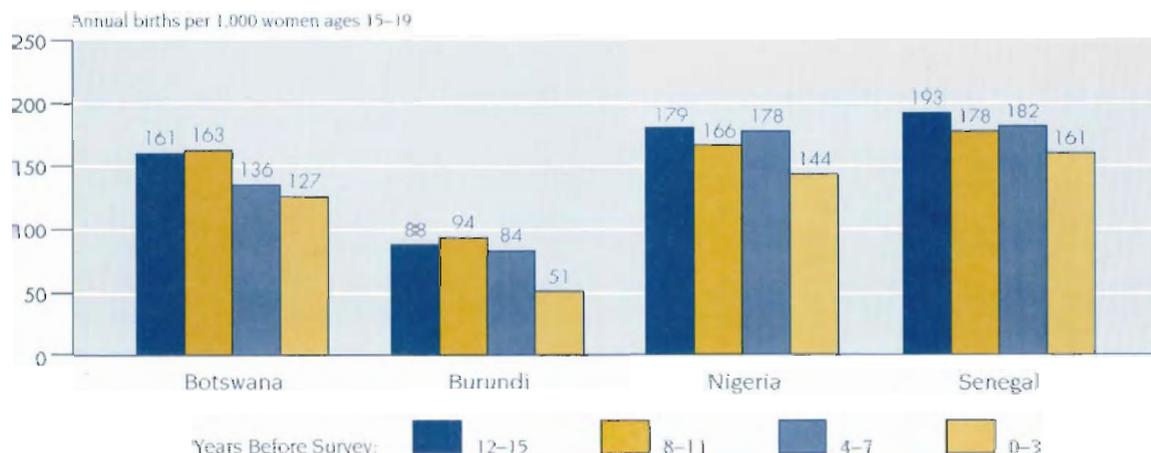


Chart 4B: Some Evidence of Decline



In general, fertility is high among teenage African women, yet in many countries it is beginning to decline. Charts 4A, 4B, and 4C highlight the different patterns of fertility decline among teenage women.* As Chart 4D shows, in some cases these fertility trends parallel and in some cases diverge from the patterns for women in other age groups.

Chart 4A shows that teenage fertility has remained about the same or increased slightly in Ghana, Liberia, and Mali. In these countries, the teenage and overall fertility declines (or lack thereof) follow similar patterns.

Chart 4B shows that in Botswana, Burundi, Nigeria, and Senegal, teenage fertility has declined in the recent past, in some cases significantly. The downward trend in teenage fertility in Botswana lags some-

what behind the sharp decline in fertility of older women. In contrast, the recent declines in teenage fertility in Burundi have occurred in the absence of a significant fertility decline in older women.

As Chart 4C shows, teenage fertility has declined steadily over the past 15 years in Kenya, Togo, Uganda, and Zimbabwe. In all four countries, these declines have been larger than the declines for women ages 20 to 34.

The divergence between trends in teenage fertility rates and fertility rates among older women suggests that different factors may be affecting the fertility of these two groups. Factors that might affect teenage fertility but not the fertility of older women include greater educational opportunities and changes in age at marriage.

Chart 4C: Clear Evidence of Decline

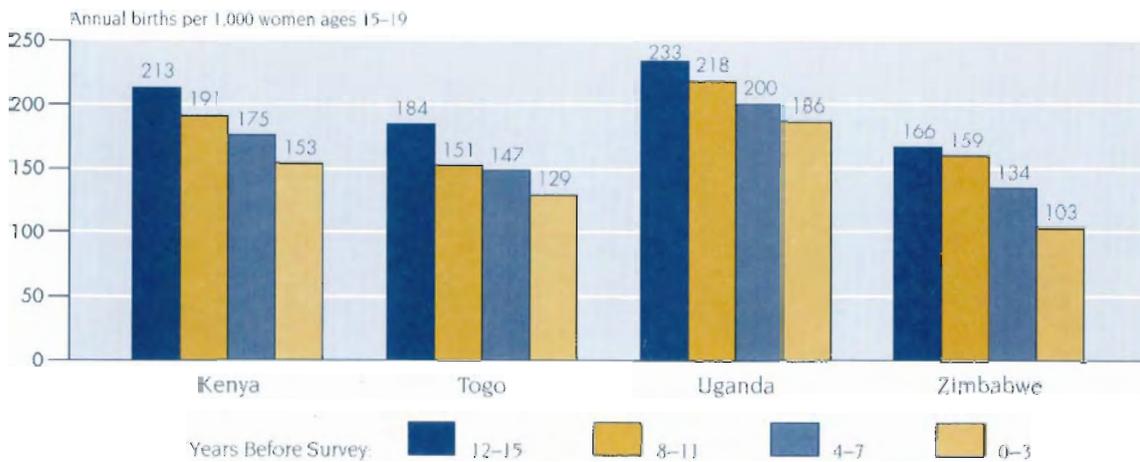
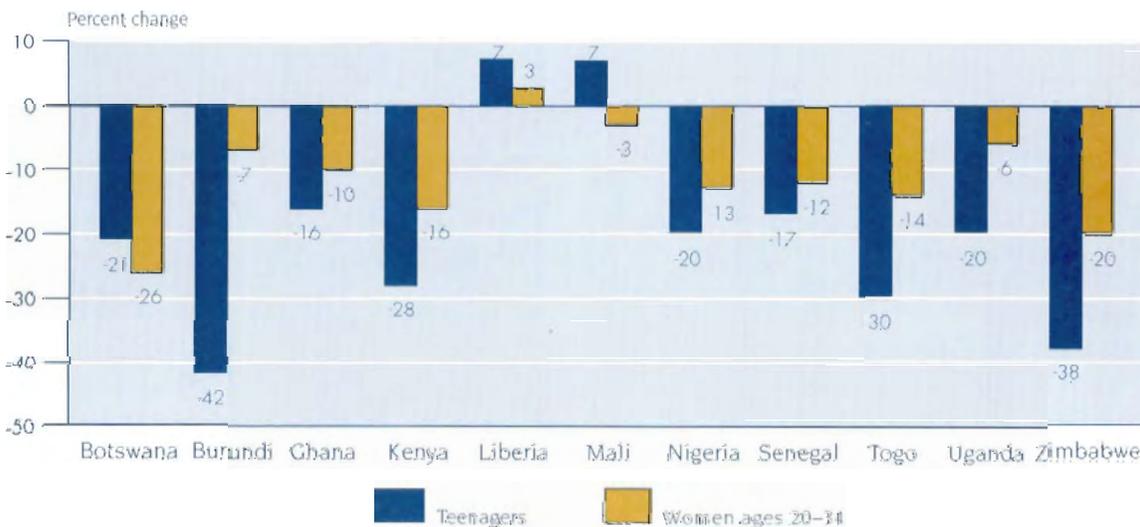


Chart 4D: Changes in Fertility in the Last 15 Years among Teenagers in Comparison with Women Ages 20-34



* Retrospective fertility data are gathered by asking a sample of women ages 15 to 49 how many children they have had and when those children were born. These birth histories are then used to calculate age-specific fertility rates for different time periods. For earlier time periods, the estimated fertility rates may be somewhat less precise because they rely on women's accurate recall of the dates of births that occurred in the past.



DEMOGRAPHIC CONTEXT

Chart 5A: Annual Number of Births to Teenagers

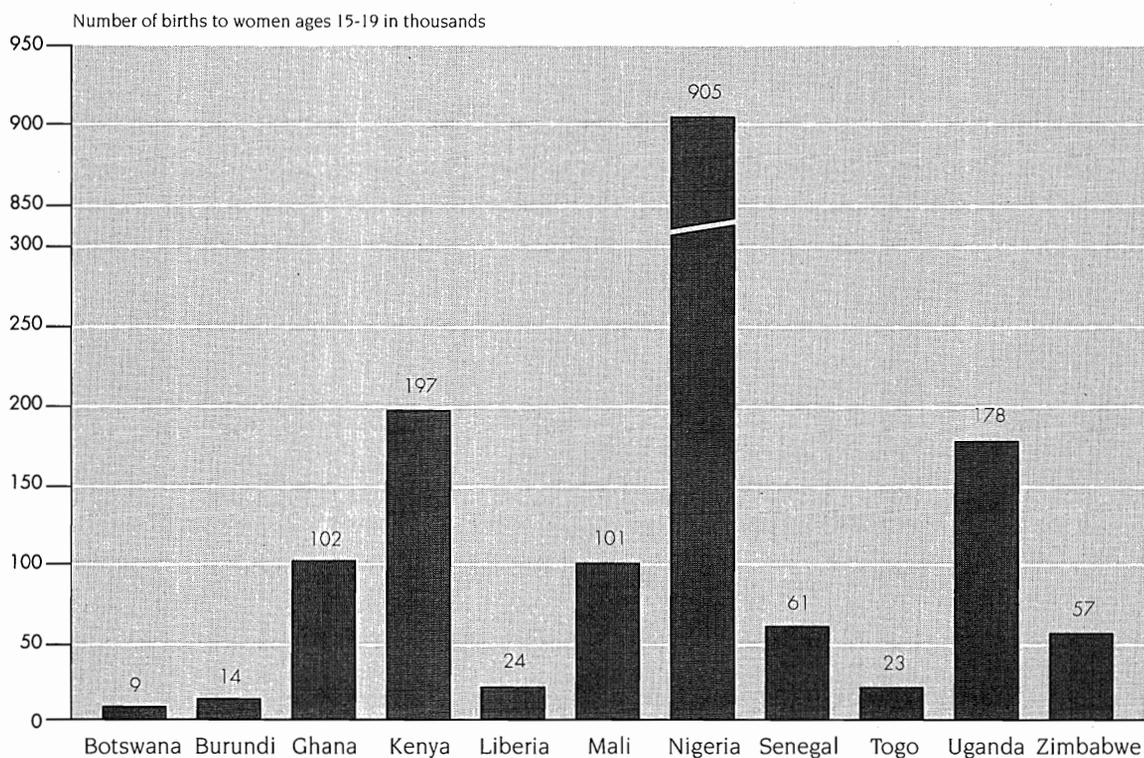


Chart 5A shows the annual numbers of births to teenage women in the 11 DHS sub-Saharan African countries, ranging from 8,900 births in Botswana to 905,000 in Nigeria. The magnitudes are, of course, not just related to the birth rates among adolescents; the overall population size of each country is a major determining factor. Thus, Nigeria, the largest African country, has a teenage birth rate in the middle of the range (see Chart 3), but has by far the largest number of teenage births.

The number of births has implications for each country's health-care system. Teenagers who give birth constitute a large population in need of antenatal, maternal, and child health services. Most of the births to teenagers are first births; women having their first child are at higher risk of serious medical complications during pregnancy and childbirth. In addition, their babies are more likely to die.

Chart 5B: Births to Teenagers as a Proportion of All Births

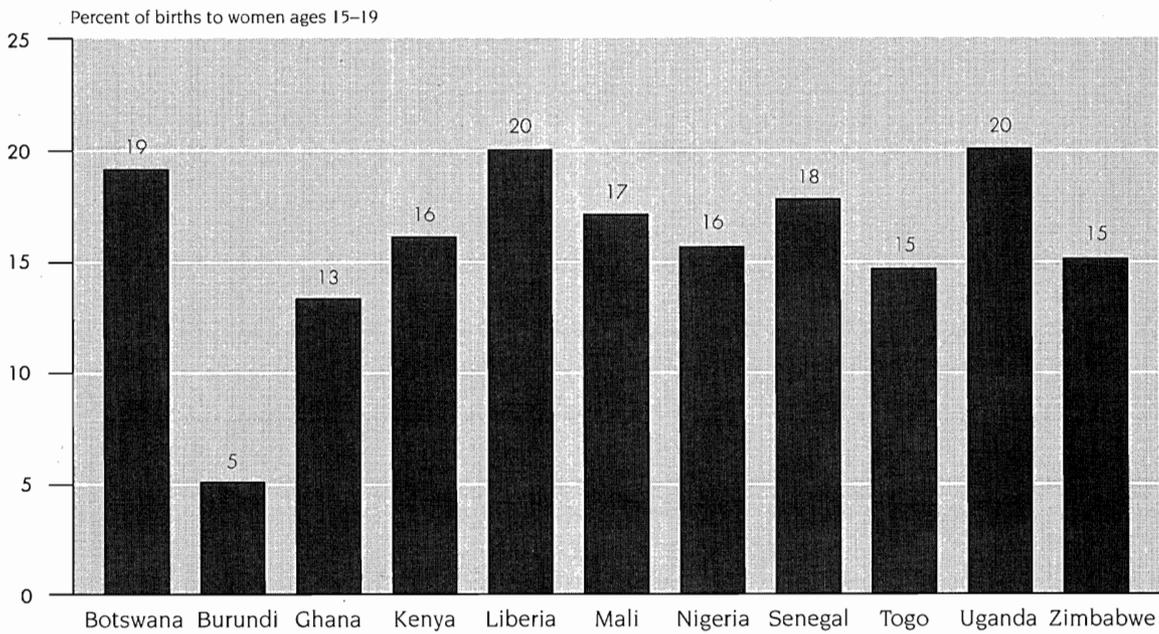
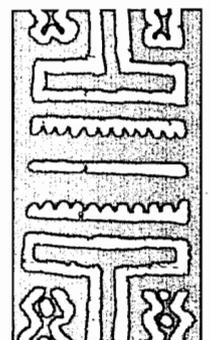
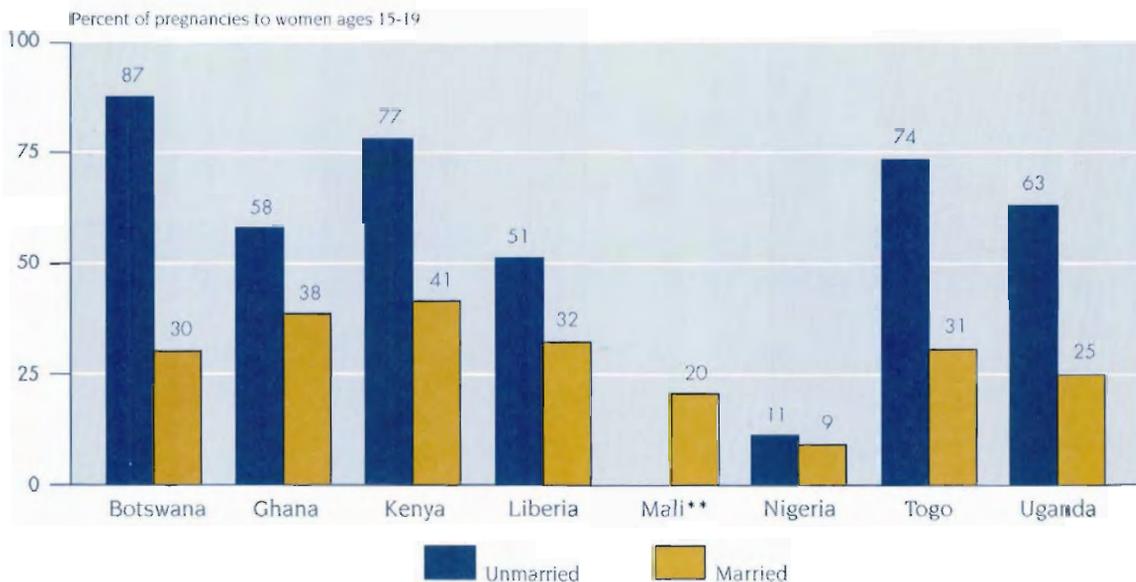


Chart 5B highlights another important aspect of adolescent childbearing in sub-Saharan Africa: the substantial proportion of all births that occur to teens — between 15 and 20 percent in most countries. When a large proportion of births in a country is to teenagers, the length of time between generations is short, contributing to a rapid population growth rate. Thus, policies that encourage postponed childbearing could have longer term demographic and social impacts.



UNINTENDED FIRST PREGNANCIES

Chart 6: Unintended First Pregnancies*, by Marital Status at the Time of Pregnancy



*Only pregnancies that led to live birth

**Bars not shown for fewer than 25 cases (Mali and Burundi) and data not available for Senegal and Zimbabwe

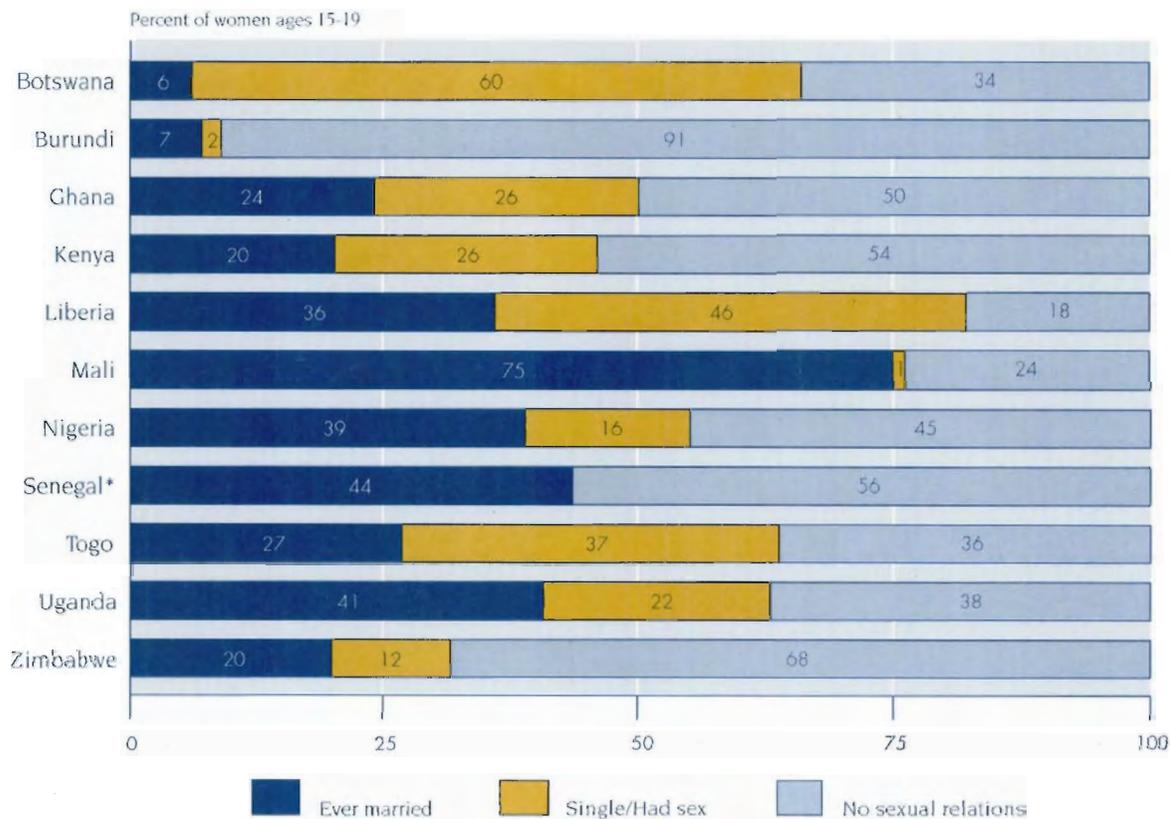
Chart 6 shows the percentage of teenagers' births that were unintended — mainly mistimed — according to the mother's marital status at the time she became pregnant.* As one might expect, a greater proportion of the premarital pregnancies was unintended; in 6 of the 7 countries for which data are available, the majority of teens who were pregnant outside of marriage reported that it was unintended. However, married teens also reported a significant number of unintended pregnancies. In 6 of the 8 countries shown, at least a quarter of the marital pregnancies were reported to be unintended.

These data clearly suggest that teenagers need better access to family planning counseling and services. Enabling teenagers to exercise their right to choose when they want to bear their children will help these young women have greater control over their futures. In addition, increasing contraceptive use would reduce the need to provide costly maternal and child health services for these higher-risk mothers and babies. Finally, family planning can reduce the number of abortions and post-abortion complications. Available evidence indicates that certain sub-groups in the teenage population — urban, unmarried, more highly educated — are resorting to induced abortion in increasing numbers.⁴

* Unintended pregnancies are likely to be under-reported for at least two reasons. First, once a baby is born, a woman may not want to admit that the pregnancy was unintended. Second, some unintended pregnancies may be ended by abortion and thus not reported here. The DHS questionnaire only asks about past pregnancies that resulted in a live birth.

SEXUAL EXPERIENCE

Chart 7: Marriage or Sexual Experience



*Never married women not asked about sexual experience in Senegal

Chart 7 provides information about the sexual experience* of adolescent women: in 7 of the 11 countries shown, more than half of the teenage women have had sexual intercourse at least one time. Moreover, sexual experience in most countries is not limited to married women. For example, in Botswana, Ghana, Kenya, Liberia, and Togo, more than half of the teens with sexual experience are not married. By contrast, in Burundi and Mali, sexual activity takes place almost exclusively within marriage.

Although these data show that many teens initiate sexual activity prior to marriage, other analyses suggest that their sexual activity may not be frequent.⁵ Nonetheless, even infrequent sexual activity puts these teens at risk of unintended pregnancy if no preventive measures are taken.

* "Sexual experience" is defined as ever having had sexual intercourse.



PATTERNS BY AGE

A woman's age at the time she begins bearing children is related to the ultimate size of her completed family, as well as to the proportion of her life she devotes to childbearing and childrearing. The countries included in this study vary considerably in the intervals between the initiation of sexual experience, marriage, and childbearing. Charts 8A, 8B, 8C, and 8D demonstrate how the patterns of these three events interact and change with age. Four countries are presented here, each representing a typical pattern.

The first pattern, Chart 8A, is illustrated with data from Mali. In Mali, marriage occurs at a young age: about one-third of 15 year olds and two-thirds of 16 year olds are married. Virtually all sexual experience and childbearing occur within the context of marriage. The majority of married 15 and 16 year olds have not yet given birth, in part because they are too recently married to have had time to give birth and in part because some of these very young women may still be sub-fecund. After age 17, an increasingly greater percentage have had babies. Senegal also follows this pattern.

Ghana, shown on Chart 8B, represents a pattern in which marriage and childbearing occur at a somewhat later age than in Mali. Childbearing occurs primarily but not exclusively within the context of marriage. Sexual activity outside of marriage is not uncommon; through age 18, at least half of the sexually active teens are single. Although at risk for pregnancy, a rather small proportion of sexually experienced women reports having had babies. Similar patterns can be seen in Nigeria, Togo, and Uganda.

Chart 8C highlights the third pattern, using data from Kenya. Here, the proportions of teens with premarital sexual experience and childbearing are relatively high. Other countries that follow this pattern are Botswana and Liberia. In all three countries, a significant proportion of sexually experienced, unmarried teenagers has had at least one birth, and unmarried women account for a large proportion of all teenage mothers.

Zimbabwe represents a fourth pattern, shown on Chart 8D. Compared to the other countries, a smaller proportion of adolescent women in all age groups is sexually active, and a smaller proportion has had babies. Most childbearing occurs within marriage, although by age 19 the proportion of women who are unmarried and giving birth has increased. Burundi also falls into the pattern of later marriage and childbearing, but even by age 19, there is little reported sexual activity and childbearing outside of marriage.

Chart 8A: Childbearing Experience According to Marital Status, by Age—Mali

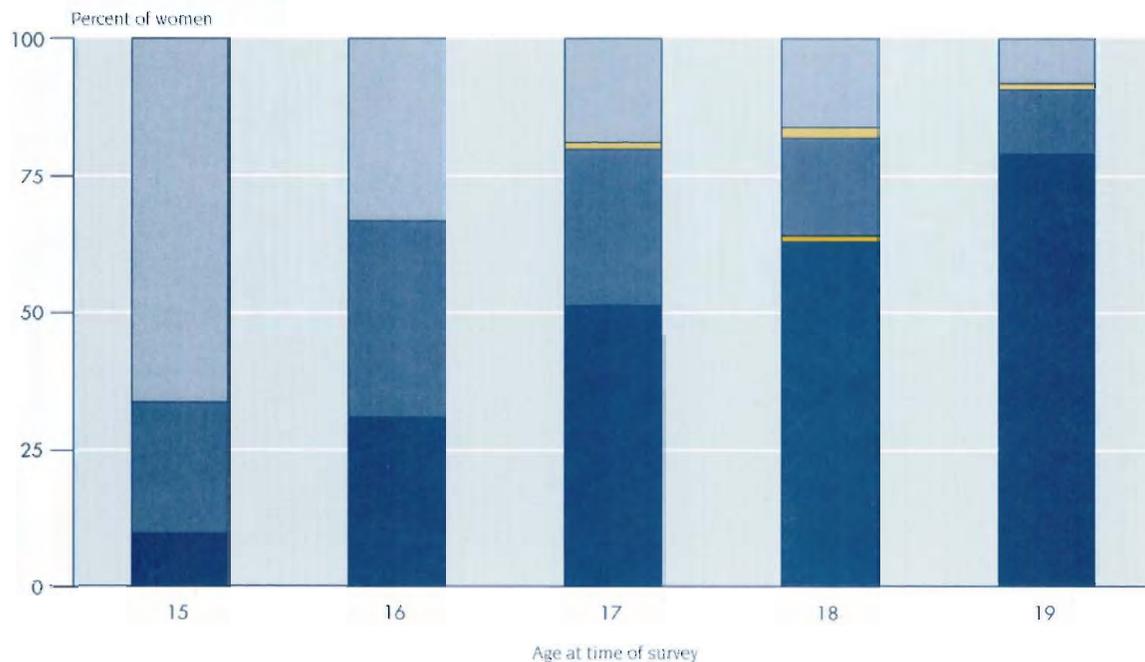
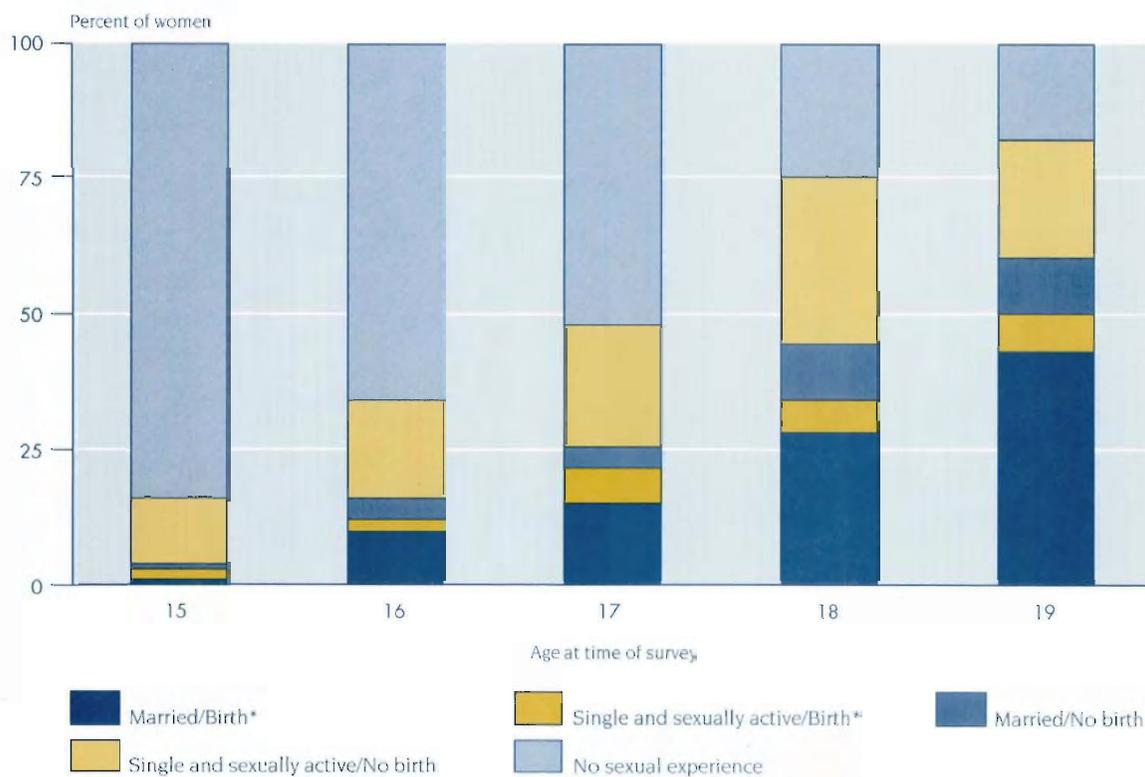


Chart 8B: Childbearing Experience According to Marital Status, by Age—Ghana



*"Birth" includes currently pregnant women

Chart 8C: Childbearing Experience According to Marital Status, by Age—Kenya

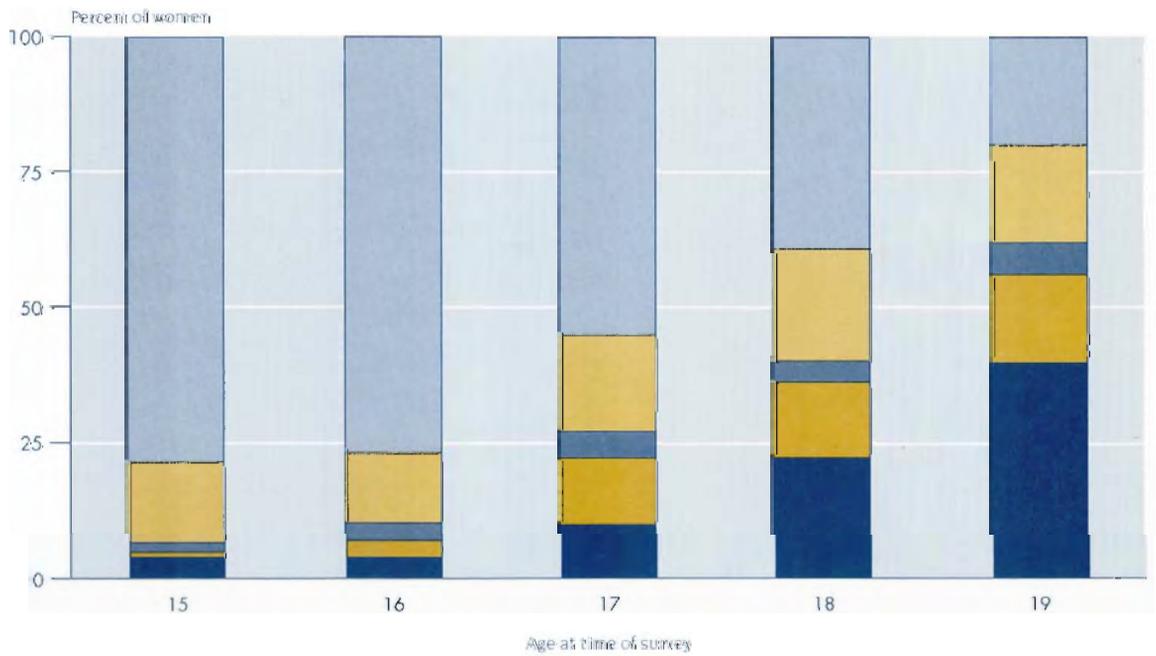
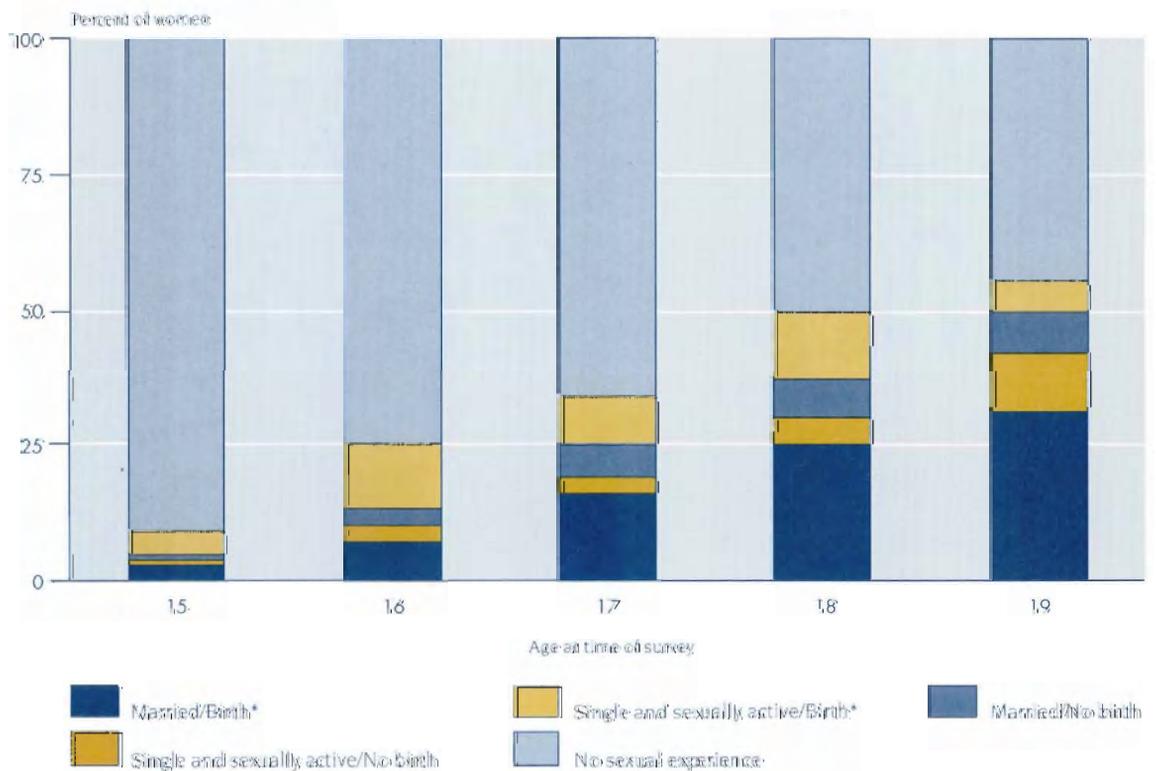


Chart 8D: Childbearing Experience According to Marital Status, by Age—Zimbabwe



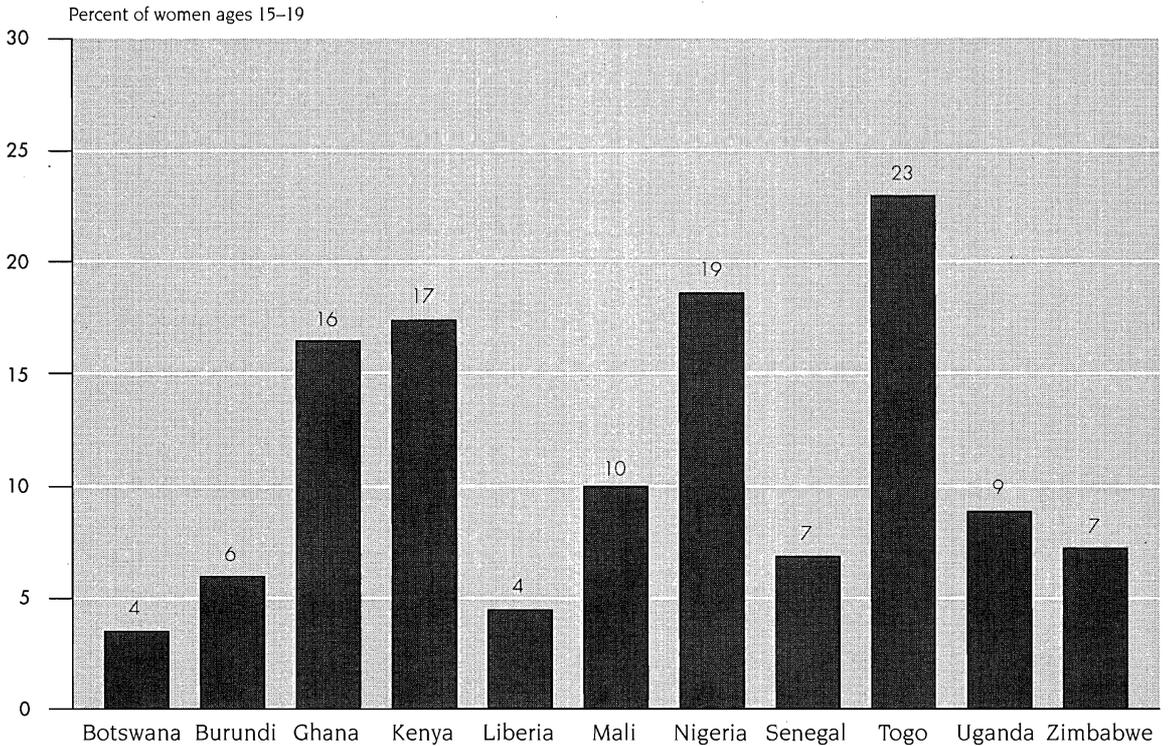
*"Birth" includes currently pregnant women

Table 2: Percentage of Teenagers with Sexual Experience, in Union, and With Birth or Pregnancy

		Age at time of Survey				
		15 (%)	16 (%)	17 (%)	18 (%)	19 (%)
Botswana	Married/Birth	0	0	5	4	12
	Single/Birth	6	11	28	37	35
	Married/No Birth	0	0	0	4	4
	Single/No Birth	20	36	38	43	37
Burundi	Married/Birth	0	0	1	9	12
	Single/Birth	0	1	1	1	1
	Married/No Birth	0	0	0	2	7
	Single/No Birth	0	1	1	1	0
Ghana	Married/Birth	1	10	14	29	43
	Single/Birth	2	2	6	6	7
	Married/No Birth	1	4	4	10	10
	Single/No Birth	12	18	23	31	22
Kenya	Married/Birth	4	4	10	22	40
	Single/Birth	1	4	12	14	16
	Married/No Birth	1	3	5	4	6
	Single/No Birth	14	13	19	21	18
Liberia	Married/Birth	7	13	26	38	44
	Single/Birth	11	11	20	25	26
	Married/No Birth	5	10	11	12	9
	Single/No Birth	34	39	30	18	17
Mali	Married/Birth	10	31	51	63	79
	Single/Birth	0	0	0	0	0
	Married/No Birth	24	36	29	18	12
	Single/No Birth	0	0	1	2	1
Nigeria	Married/Birth	13	20	28	39	40
	Single/Birth	0	1	2	0	3
	Married/No Birth	21	10	11	7	6
	Single/No Birth	5	12	14	22	23
Senegal	Married/Birth	8	15	27	40	45
	Single/Birth	1	2	2	5	4
	Married/No Birth	19	18	17	13	13
	Single/No Birth	NA	NA	NA	NA	NA
Togo	Married/Birth	7	10	19	29	42
	Single/Birth	1	5	3	7	10
	Married/No Birth	2	6	7	8	6
	Single/No Birth	25	25	38	38	34
Uganda	Married/Birth	6	17	34	53	50
	Single/Birth	2	4	11	5	9
	Married/No Birth	7	9	10	10	12
	Single/No Birth	18	17	18	13	12
Zimbabwe	Married/Birth	3	7	16	24	31
	Single/Birth	1	3	3	6	11
	Married/No Birth	1	3	3	7	5
	Single/No Birth	4	8	12	9	8

KNOWLEDGE OF THE FERTILE PERIOD

Chart 9: Knowledge of Fertile Period During Menstrual Cycle*



*Knows fertile period occurs in middle of menstrual cycle

As shown on Chart 9, few teenage women can correctly identify when during the menstrual cycle they are most likely to become pregnant.* Being able to identify this fertile period — the middle of the cycle — is key to being able to successfully practice natural family planning (also known as the “rhythm” method). The highest level of knowledge is in Togo, where slightly more than 20 percent of teenage women had the correct information. In more than half the countries, fewer than 10 percent of teens could identify the fertile period correctly.

Lack of understanding of the fertile period reflects a general deficit in basic knowledge about human reproduction. This knowledge is particularly relevant for sexually active teenagers who may not have access to contraceptives and for whom using the “rhythm” method may be one of their few alternatives. If women who are sexually active neither

abstain from sex during the fertile period nor use contraceptives, they face a high risk of unintended pregnancies.

* Because of the difficulties entailed in coding this question, the data on Chart 9 are a conservative estimate and may not fully reflect knowledge of the fertile period.

KNOWLEDGE AND EVER USE OF FAMILY PLANNING

Chart 10: Knowledge and Ever Use of a Modern Method of Family Planning

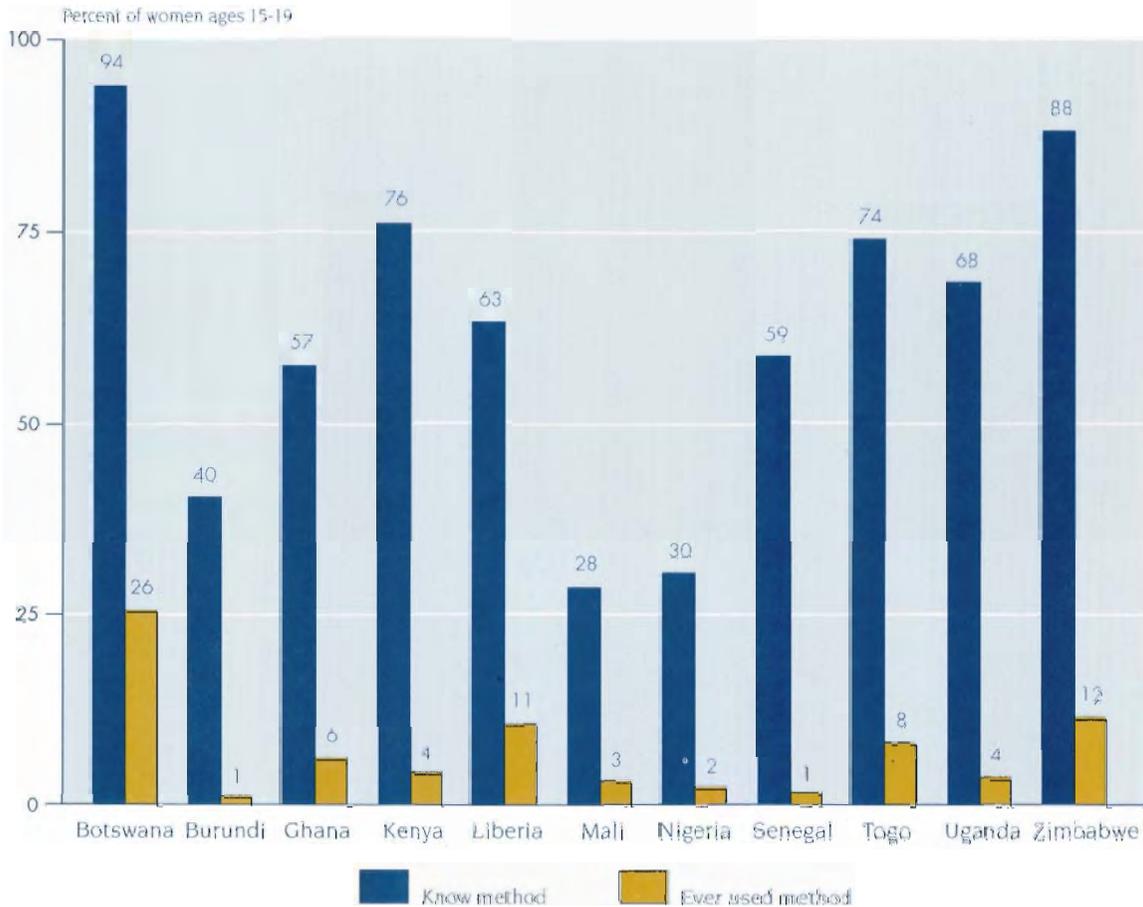


Chart 10 shows the percentage of teenagers who know about or have ever used modern methods of contraception. Knowledge varies widely — from about 30 percent to nearly 95 percent. In 8 of the 11 countries, more than half the adolescent women know about at least one modern method of contraception.

A much smaller percentage of adolescent women reports having ever used a modern contraceptive. In fact, use is quite low in all countries except Botswana, where it exceeds 25 percent. (Botswana is also the country with the highest knowledge.) Low levels of contraceptive use, despite widespread knowledge, in part reflect both a lack of need among the many young women who are not sexually active and a lack of interest among those teenagers who want to start bearing children. However, low levels of contraceptive use may also be a consequence of socio-cultural barriers that attach a stigma to use of

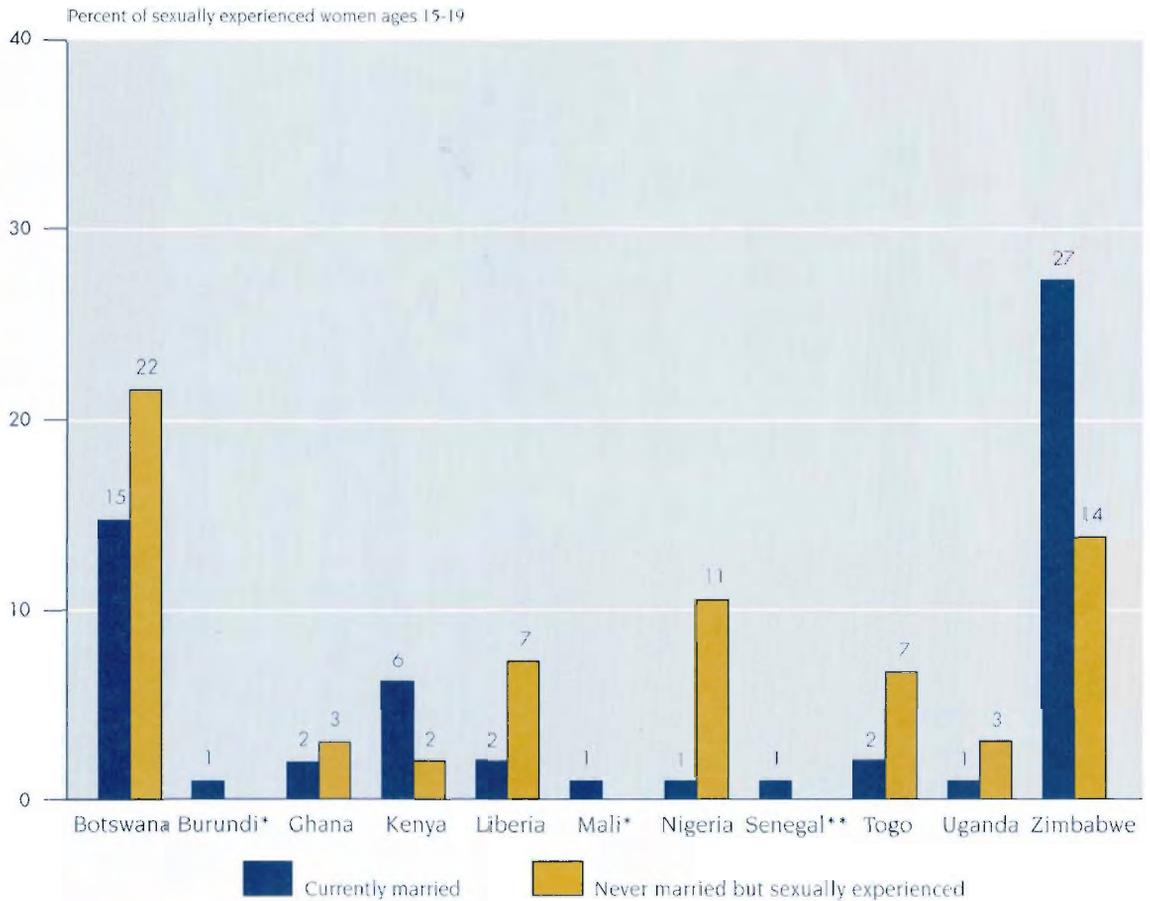
contraception by teenagers and prevent teens from having access to contraceptive methods.

* Modern methods include pills, injectables, IUDs, condoms, vaginal methods, and male and female sterilization.



CURRENT USE OF FAMILY PLANNING

Chart 11A: Use of Modern Methods of Family Planning, by Marital Status



*Bars not shown for fewer than 25 cases

**Questions on sexual experience not asked of never married women in Senegal

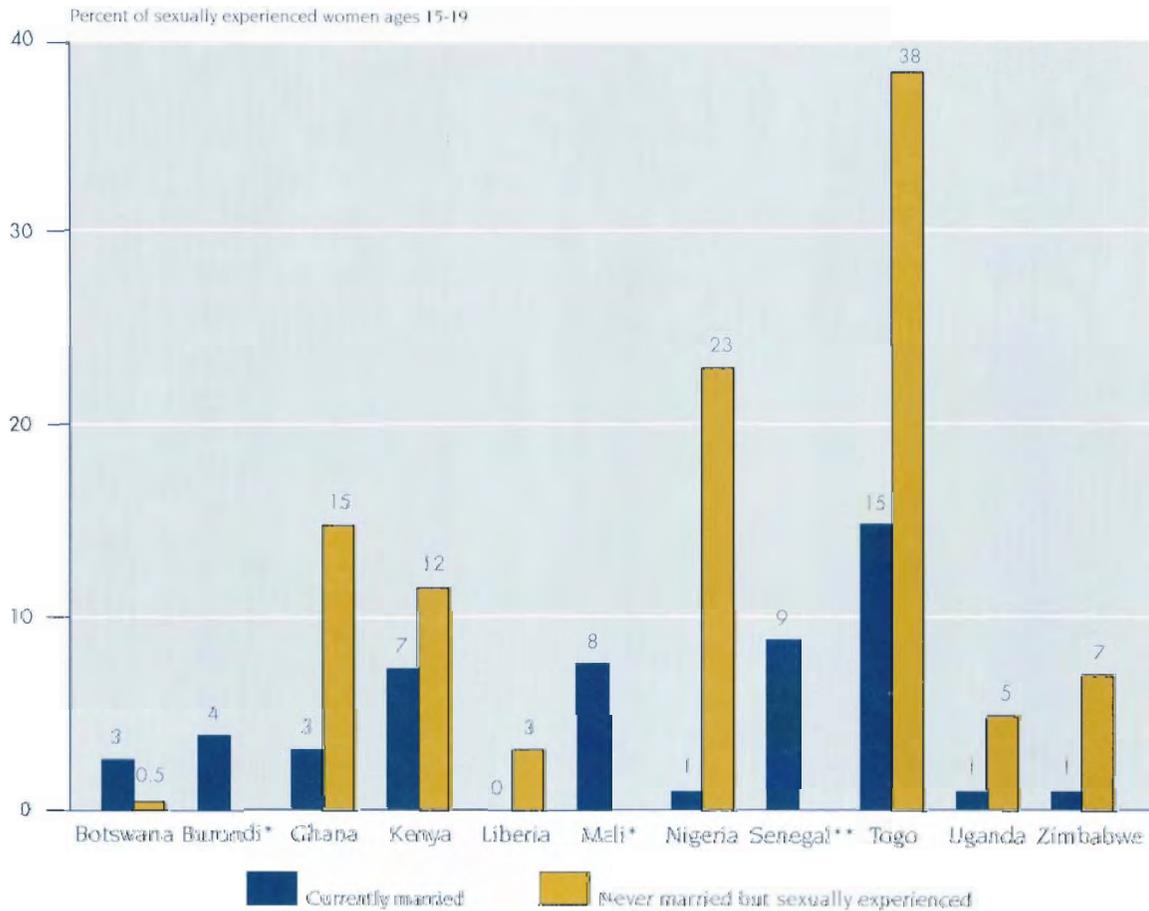
Charts 11A and 11B show that few teenagers, even among those exposed to the risk of pregnancy (i.e., married and unmarried but sexually experienced teenagers), were using a method of family planning at the time of the DHS interviews. The highest proportion of users of modern methods is found among unmarried, sexually experienced teenagers in Botswana, Nigeria, and Zimbabwe and married teenagers in Botswana and Zimbabwe. In the remaining countries, modern methods of contraception are used by fewer than 10 percent of teens, regardless of marital status.

In several countries, use of traditional methods* is more common than use of modern methods. Among unmarried, sexually experienced teenage women in Ghana, Kenya, Nigeria, and Togo,

between 12 and 38 percent reported using traditional methods to avoid pregnancy. Clearly, many sexually active teenagers who are not married are motivated to prevent pregnancy. The greater use of traditional than modern methods in these countries may be explained in part by lack of access to modern contraception for teenagers.

* Traditional methods include abstinence, natural family planning (the "rhythm" method), and withdrawal.

Chart 11B: Use of Traditional Methods of Family Planning, by Marital Status



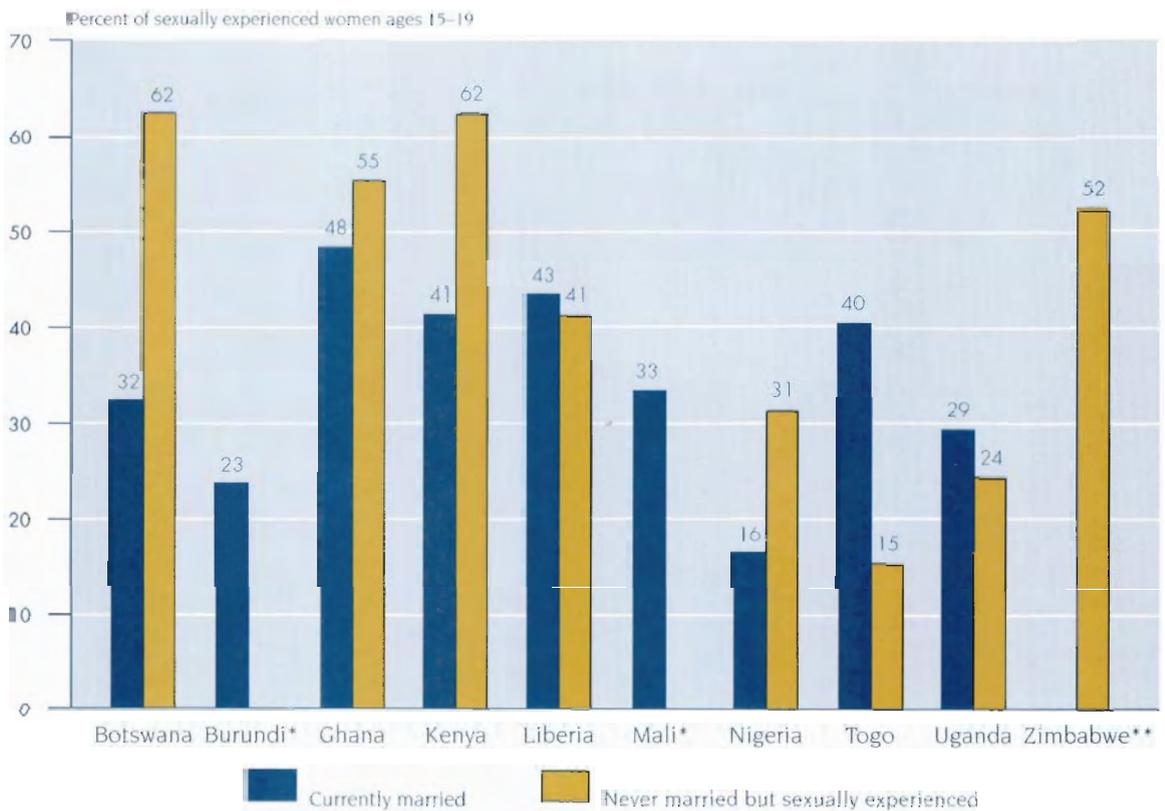
*Bars not shown for fewer than 25 cases

**Questions on sexual experience not asked of never married women in Senegal



UNMET NEED FOR FAMILY PLANNING

Chart 12: Unmet Need for Family Planning, by Marital Status



*Bars not shown for fewer than 25 cases

**Not available for Senegal and currently married women in Zimbabwe

Chart 12 shows the proportion of currently married and never-married, sexually experienced adolescents that has an unmet need for family planning. A woman is defined as having an unmet need if she is not pregnant and not using contraception but does not want to get pregnant soon.⁶

As the chart shows, more than 30 percent of currently married teenagers have an unmet need for family planning, except in Burundi, Nigeria, and Uganda. Most of these young women would like to either postpone the birth of their first child or wait longer for the birth of their next child.

Unmet need is also significant for unmarried, sexually experienced teenagers. In 4 of the 8 countries with data — Botswana, Ghana, Kenya, and Zimbabwe — more than half of this group can be defined as having an unmet need for family planning.

The extent of unmet need among teenage women demonstrates that there are many potential users of family planning if teenage women had access to appropriate services. Making family planning acces-

sible, however, means more than just providing services at convenient locations. Accessibility for teenage women may also mean having access to reproductive and family planning information, knowing where to obtain services, feeling comfortable using existing services, and being encouraged or allowed to seek family planning methods.

INFANT MORTALITY

Chart 13: Infant Mortality Rate*, by Age of Mother

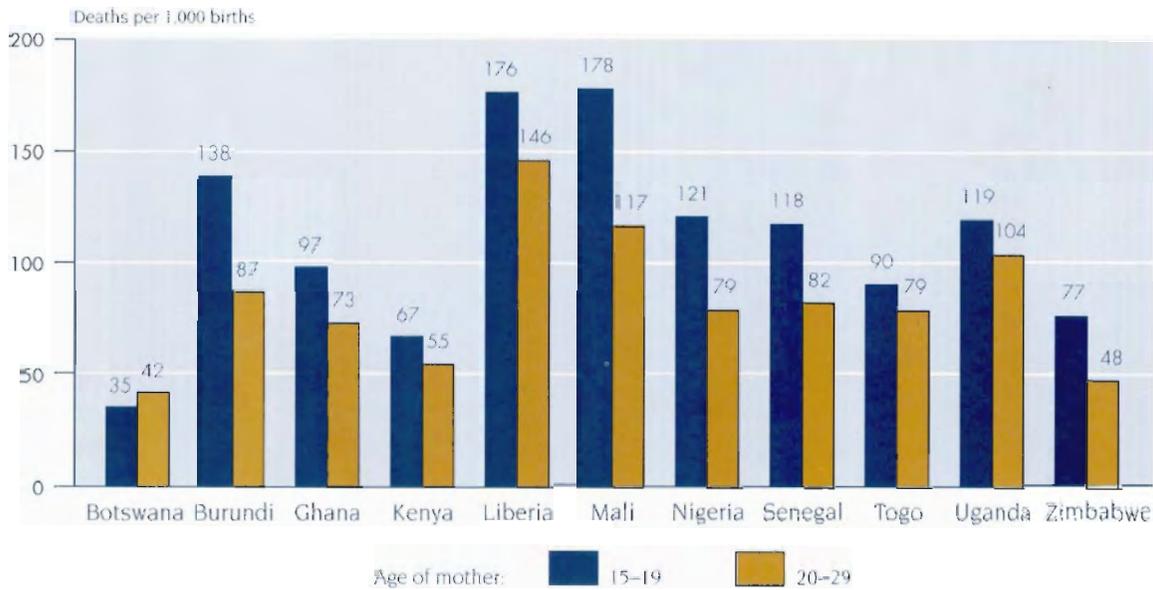


Chart 13 presents a comparison of the infant mortality rate of children born to mothers under age 20 with that of children born to women ages 20 to 29.* The chart shows that infants born to mothers under 20 years of age are at greater risk of dying than infants of women in the middle of their reproductive years. The elevated risk of dying for children of teenagers is particularly pronounced in Burundi, Mali, Nigeria, Senegal, and Zimbabwe. Botswana, where the infant mortality rate is the lowest, is an exception and shows a lower risk of dying for children born to teenagers than for children born to mothers between the ages of 20 and 29.

There is no simple biological explanation for the relationship between infant mortality and age. Births to teenage mothers are often first births: first-born infants face a higher risk of death than second- or third-born babies, regardless of the age of the mother. Moreover, poor living conditions and inadequate access to health and other social services are often the underlying causes of both infant mortality and early childbearing. Young women who lack the knowledge or the means to avoid unwanted pregnancies may also be unable to afford or know how to get the appropriate health care they and their children need.

* The infant mortality rate is the number of deaths to infants under one year of age per 1,000 live births. The rates here have been calculated using data for a ten-year period before each of the IHS surveys.



CONCLUSIONS

The graphics presented in this chartbook clearly show that many adolescent women in sub-Saharan Africa are sexually active and that many of them are also mothers. In almost all of the 11 sub-Saharan African countries shown here, it is likely that a majority of teenage women will have had a baby by the time they reach the age of 20. While most of these babies will be born to married teenage mothers, a significant proportion will not. Early marriage and/or childbearing can curtail a young woman's education and limit her future economic potential. In addition to its socio-economic consequences, early childbearing can have negative health consequences. DHS data show that infants whose mothers are under 20 years of age are at greater risk of dying than infants of women in the middle of their reproductive years.

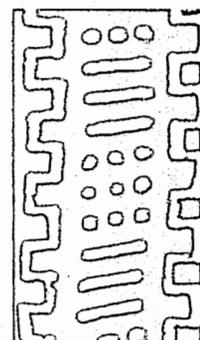
The charts also show that many of the births to adolescent women were unintended. As one might expect, a greater proportion of the pre-marital pregnancies was unintended. However, married teens also reported unplanned pregnancies. That many births are unintended is not surprising because so few adolescent women report use of contraceptives, either modern or traditional. Yet many of these same women (and sexually experienced women with no children) would like to avoid or postpone future pregnancies. More than 30 percent of currently married teenagers in 8 of the 11 countries surveyed can be defined as having an unmet need for family planning.

POLICY IMPLICATIONS

Effective policies rely on the correct identification of the problem: recognizing the extent of adolescent sexual activity and childbearing is a crucial first step. Policymakers in sub-Saharan Africa can use DHS findings as a basis to raise awareness about

the causes and consequences of adolescent childbearing. The data also point to the need to consider several types of policies and programs that could help adolescent women achieve their full potential, including:⁷

- Policies that discourage early marriage and childbearing by providing viable educational and employment alternatives.
- Programs to help young women stay in school, even if they have children.
- Programs to establish or expand family-life education, for teenagers in and out of school.
- Information, education, and communication programs aimed at the partners, parents, and other relatives of adolescent women.
- Policies that increase access to high-quality, appropriate family planning services and counseling for sexually active adolescents.
- Maternal and child health programs that seek out teenagers who may not know what health care they and their babies need or where to obtain services.



SOURCES

1. *Global Estimates and Projections of Population by Age and Sex*, 1988 Revision (New York, NY: United Nations, 1989).

2. Benjamin Gyepi-Garbrah, *Adolescent Fertility in Sub-Saharan Africa: An Overview* (Boston, MA: The Pathfinder Fund, 1985).

3. *Adolescent Reproductive Behaviour, Volume 1, Evidence from Developed Countries* (New York, NY: United Nations, 1988).

4. Francine M. Coeytaux, "Induced Abortion in Sub-Saharan Africa: What We Do and Do Not Know," *Studies in Family Planning* Vol. 19, No. 3 (May/June, 1988); and Odile Frank, "Demand for Fertility Control in Sub-Saharan Africa," *Studies in Family Planning* Vol. 18, No. 4 (July/August, 1987).

5. Ann K. Blanc and Naomi Rutenberg, "Coitus and Contraception: The Utility of Data on Sexual Intercourse for Family Planning Programs," *Studies in Family Planning* Vol. 22, No. 3 (May/June, 1991).

6. These estimates have been developed for all unmarried women (but not published) by Charles F. Westoff, Princeton University.

Estimates for married women (except Nigeria) are from Charles F. Westoff and Luis H. Ochoa, "Unmet Need and the Demand for Family Planning," *DHS Comparative Studies* No. 5 (Columbia, MD: IRD, 1991).

7. For examples of the kinds of pregnancy-prevention programs that are currently being targeted toward adolescents see International Center of Adolescent Fertility, *Serving the Future: An Update on Adolescent Pregnancy Prevention Programs in Developing Countries*. Available from:

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DHS surveys were collected in collaboration with the following organizations:*

BOTSWANA (1988)

Central Statistics Office, Ministry of Finance and Development Planning and Family Health Division, Ministry of Health

BURUNDI (1987)

Ministère de l'Intérieur, Département de la Population

GHANA (1988)

Ghana Statistical Office

KENYA (1989)

National Council for Population and Development, Ministry of Home Affairs and National Heritage

LIBERIA (1986)

Bureau of Statistics, Ministry of Planning and Economic Affairs

MALI (1987)

Centre d'Etudes et de Recherches sur la Population pour le Développement, Institut du Sahel

NIGERIA (1990)

Federal Office of Statistics

SENEGAL (1986)

Division des Enquêtes et de la Démographie, Direction de la Statistique, Ministère de l'Economie et des Finances

TOGO (1988)

Unité de Recherche Démographique and Direction de la Statistique and Direction Générale de la Santé

UGANDA (1988-89)

Ministry of Health

ZIMBABWE (1988-89)

Central Statistical Office, Ministry of Finance, Economic Planning, and Development

* The data are tabulated from the standard recode tapes for each country and are available from the organizations listed above or from DHS (see address on the inside front cover).

