PPD Policy Brief on Adolescent Pregnancy

Partners in Population and Development (PPD)
An Inter-Governmental Organization
Promoting South-South Cooperation

Adolescent Pregnancy: Status, Socio-Economic Cost, Policy and Program Options for 25 Member Countries of PPD

July 2013

Background

'Adolescent pregnancy' is the theme for the World Population Day this year. Partners in Population and Development (PPD) is taking this opportunity to highlight the status of adolescent pregnancy in its member countries and discuss relevant policy and program options for them.

PPD is a southern-led, southern-run Inter-governmental organization of 25 developing countries across Africa, Asia, the Middle-east and Latin America, promoting South-South Cooperation in Reproductive Health, Population and Development (http://www.partners-popdev.org/).

The adolescents aged 10-19 years stood about 1.2 billion in 2011 constituting 18% of the total world population. About 90% of the adolescents live in developing countries and nearly 62% in 25 PPD member countries. In the member countries of PPD, the proportion of adolescents ranged from highest 25% in Ethiopia, Yemen and Zimbabwe to lowest 15% in China and Thailand in 2011 (Table 1).

Early Marriage and Adolescent Pregnancy

While adolescent marriage is a human rights abuse, it also presents a formidable threat to adolescent girls' lives, health and future prospects. According to WHO and UNFPA reports, 2012, over 30% of adolescent girls in developing countries were married before 18 years of age and about 14% before the age of 15 years. The prevalence of adolescent marriage before 18 years among women aged 20-24 years ranged widely among the member countries of PPD, with the highest 66% in Bangladesh and the lowest 6% in South Africa (Table 1).

Early marriage can lead adolescent girls to complications related to pregnancy and childbirth, and expose them to sexually transmitted infections including HIV. In developing countries, complications of pregnancy and childbirth are the leading causes of death among adolescent aged 15-19 years and accounts for about 50,000 deaths each year. Adolescents who give birth carry a much higher risk of dying from maternal causes compared to women who are in their twenties and thirties. The risk increases exponentially as maternal age decreases, adolescents under 15 years carry five times more risk of dying during childbirth compared to women in their twenties. The adverse effects of adolescent pregnancy also impact the health of their newborns. Still births and newborn deaths in the first week of birth are 50% higher among babies born to adolescent mothers than among babies born to mothers aged 20-29 years.

Adolescent Pregnancy in PPD Member Countries

Among the 25 member countries of PPD, pregnancy among adolescents aged 15-19 years was highest in Egypt (9.6%) and lowest in Tunisia (0.9%). Among the member countries of PPD in Asia-pacific region, the rate was highest in Bangladesh (6.1%) and lowest in Vietnam (1.6%). In Sub-Saharan Africa, Mali (5.4%), Uganda (5.7%) and Zimbabwe (5.5%) had similar high rates of adolescent pregnancy. The lowest rate of adolescent pregnancy was in South Africa (2.3%). In the MENA region, the highest prevalence of adolescent pregnancy was in Egypt (9.6%) and the lowest was in Tunisia (0.9%). The prevalence of adolescent pregnancy was 4.3% in Colombia and 3.9% in Mexico.

According to WHO, 2012, about 16 million adolescents aged 15-19 years and 2 million adolescents under the age of 15 years give birth every year. About 95% of these births occur in developing countries. The prevalence of women aged 20-24 years who gave birth before 18 years, ranged widely in PPD member countries, from the highest 46% in Mali to the lowest 3% in Vietnam (Table 1). A considerable proportion of adolescent pregnancies are either unplanned or unwanted and 30% to 60% of these pregnancies among adolescents end in abortion.

According to the Guttmacher Institute and UNFPA, 2009, around 44% of married adolescents aged 15–19 years in the developing countries wanted to avoid pregnancy of which only 33% used a modern contraceptive method. The prevalence of contraceptive use (modern methods) ranged widely in 25 member countries of PPD. The prevalence was highest in Thailand (67%) followed by Colombia (55%), South Africa (48%), Indonesia (45%), Bangladesh (37.6%), Morocco (36%) and Zimbabwe (36%). The lowest prevalence was in Nigeria (2.4%).

Among adolescents who wanted to avoid pregnancy in PPD member countries, the prevalence of unmet need of contraceptive was highest in Ghana (62%) followed by Mali (35%), Ethiopia (33%), Senegal (31%), India (27%), Benin and South Africa (26%), Bangladesh and Pakistan (20%), Nigeria (19%), Zimbabwe (17%), Uganda (11%), Kenya (9%), Colombia (8%) and Morocco (1%).

PPD has been actively advocating for repositioning family planning in the international development agenda and working with its member countries to realize the commitments made by the governments at the London FP Summit 2012 to address the unmet need.

Currently, PPD is working with a research consortium of 6 partners (Population Council, ICDDR,B, London School of Hygiene and Tropical Medicine, Marie Stops International, African Population and Health Research Centre and PPD) on the STEP UP (Strengthening Evidence for Programming on Unintended Pregnancy) project to generate policy-relevant research to promote an evidence based approach for improving access to family planning and safe abortion. The evidence will inform programs to address the unmet need and unintended pregnancies of adolescents. As one of the partners of this international consortium, PPD is involved in increasing the research evidence uptake, capacity building as well as creating partnership and networking in five focus countries (Bangladesh, India, Kenya, Ghana and Senegal).

Socio- Economic Cost of Adolescent Pregnancy

While adolescent pregnancy and child birth presents serious threats to adolescent girls' health and lives, it also results in substantial social and economic costs. While there is information gap in developing countries, reviews in developed countries reported substantial social and economic costs linked to adolescent pregnancy and child birth. According to the Centre for Disease Control (CDC), 2008, in the United States, adolescent pregnancy and child birth accounted for nearly USD 11 billion each year. An economic evaluation of a comprehensive adolescent pregnancy prevention program in the United Kingdom, 2011, reported that the cost savings from averted births were nearly USD 1,599 per adolescent per year. Adolescent pregnancy and childbearing also have significant long term social consequences for the adolescents, their children, families and communities. Reviews showed that adolescent pregnancies led them to less educational attainment, poor health and poverty. Children born to adolescent mothers also experience poor health outcomes, low level of cognitive development, have behavioral problems and less educational attainment.

Policy and Program Options

PPD is urging the governments of its member countries to take immediate steps to end early marriage and adolescent pregnancy. It can be achieved through formulating policies and programs for empowering girls, changing social and cultural norms, undertaking legal reform and reinforcement, designing and implementing programs ensuring universal access to reproductive health.

Proven strategies include keeping adolescent girls in schools using economic incentives and livelihood programs, protect them from coerced sex, offering life skills, informing families and communities on adverse effects of adolescent pregnancy, and mobilize them to support girls to grow and develop into women before becoming mothers.

The programs need to include Sexual and Reproductive Health and Rights (SRHR) information, skills building and services for adolescents e.g. a) informing adolescents about their rights to have access to health care services b) providing accurate knowledge on sexual and reproductive health c) increasing the use of contraception by adolescents at risk of unintended pregnancy d) addressing unmet need for Family Planning e) increasing access to adolescent friendly services f) reducing unsafe abortion among adolescents and to ensure post abortion care g) increasing the use of skilled antenatal, childbirth and postnatal care h) increasing community awareness and participation i) addressing gender equity and equality j) promoting youth-adult partnerships, and k) ensuring male participation in all SRHR programs for adolescents.

PPD is also urging its member countries to share their lessons learned with each other from existing SRHR programs for adolescents to prevent early marriage, adolescent pregnancy, and improve over-all adolescent health. PPD is willing to facilitate the exchanges as a part of promoting South-South Cooperation among its member countries in Reproductive Health, Population and Development.

Table 1. Status of Adolescent Girls in 25 PPD Member Countries

Member Countries	Adolescents (10-19 yrs) as proportion of total population 2011 %	Women aged 20-24 yrs who were married by age 18 2000-2011 %	Adolescent (15-19 yrs) Pregnancy 2002-2008 %	Women aged 20-24 yrs who gave birth before age 18 2007-2011 %	Contraceptive (modern methods) use by adolescents (15-19 yrs) 2001-2010 %	Unmet Need for FP of Adolescents (15-19 yrs) 2004-2011 %
Asia-Pacific						
Bangladesh	21	66	6.1	40	37.6	20
China	15	-	-	-	-	-
India	20	47	3.9	22	7	-
Indonesia	18	22	1.9	10	45	27
Pakistan	23	24	2.6	10	4	20
Thailand	15	20	2.7*	8	67	-
Vietnam	17	10	1.6	3	14	-
Sub-Saharan Arica						
Benin	23	34	4.6	23	4.7	26
Ethiopia	25	41	3.1	22	9	33
Gambia	24	36	-	23	-	-
Ghana	22	25	3.4	16	8	62
Kenya	22	26	4.5	26	20	9
Mali	24	55	5.4	46	6	35
Nigeria	22	39	4.3	28	2.4	19
Senegal	24	33	3.6	22	5	31
South Africa	20	6	2.3	15	48	26*
Uganda	24	46	5.7	33	8	11
Zimbabwe	25	30	5.5	21	36	17
MENA						
Egypt	19	17	9.6	7	19.8	-
Jordan	23	10	1	4	15	-
Morocco	19	16	2.2	8	36	1
Tunisia	16	-	0.9*	-	9*	-
Yemen	25	32	3.4*	-	6	-
Latin America						
Colombia	19	23	4.3	20	55	8
Mexico	19	23	3.9*	39	5*	-

**data reported before year 2000*

- data not available

Sources:

http://www.unfpa.org/public/world-population-day/
http://www.unicef.org/sowc2013/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf
http://www.who.int/maternal_child_adolescent/documents/countries/en/index.html
http://www.devinfo.info/mdg5b/
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2960203-7/fulltext
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2960407-3/fulltext
http://www.bmj.com/content/339/bmj.b4254
http://www.indianpediatrics.net/feb2004/feb-137-145.htm
http://www.cdc.gov/teenpregnancy/aboutteenpreg.htm
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3020976/
http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Full.pdf
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf
http://whqlibdoc.who.int/hq/2012/WHO_FWC_MCA_12_02.pdf
http://www.who.int/maternal_child_adolescent/documents/mpsnnotes_2_lr.pdf
http://www.unicef.org/media/files/PFC2012_A_report_card_on_adolescents.pdf
http://www.guttmacher.org/pubs/AddingItUp2009.pdf
http://www.icpdtaskforce.org/beyond-2014/policy-recommendations.html