

## **Meeting the Need: Youth and family planning in Sub-Saharan Africa**

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## **Background**

With nearly one in five people between the ages of 15 and 24 years, there are more youth in the world than ever before [1]. The majority of young people live in developing countries [2], and according to the 2010 World Population Data Sheet, 9 of 10 countries with the youngest populations are found in sub-Saharan Africa (SSA) [3]. In fact, 41 of SSA's 42 countries have a median age less than or equal to 25 years [4]. With growing recognition that the future success of the region is largely entwined with the prosperity of these youth, there is increasing attention to and investment in the well being of African youth.

Family planning is one area that is pivotal to ensuring the health and development of youth, reducing unnecessary health risks, and improving their opportunities for education and a productive livelihood. Trends indicate that increasingly more youth in SSA are delaying marriage, but the age of onset of sexual activity remains low [5, 25]. In SSA there are regional differences in the correlation between marriage and sexual initiation. In Ethiopia, pre-marital sex is uncommon [47], yet in Tanzania, the rise in female age at marriage is linked to longer time between sexual debut and marriage [48]. Overall, there is a growing gap between age at time of first intercourse and marriage [49]. Desire for later childbearing is also becoming more common even among married African youth [5]. Married adolescents want to delay, space, or limit their births more often than older married adult women, but are not using contraception [46]. Consequently, there is a growing and changing need for family planning among youth. Yet family planning programs in SSA have not been given the necessary emphasis in the last decade [5-7]. This neglect has tremendous consequences for individuals, societies, and the global community.

High unmet need for family planning is correlated with high fertility. Presently, 15 African countries are experiencing stalled fertility decline [8] and many countries in SSA are facing rapid population growth (annual growth of 2% or more, resulting in a doubling of population size every 36 years) [9-11]. This rapid population growth has made international experts from diverse disciplines question the ability of these countries to achieve any of the Millennium Development Goals (MDGs) by 2015 [10, 12]. Consequently, there is increasing momentum to reposition family planning as a priority on national and local agendas in SSA [13].

As efforts are made to revitalize family planning programs, it is imperative to address the expanding needs for contraceptives among African youth. Elevated fertility rates and high unmet need correspond with heightened risk of pregnancy-related morbidities and mortalities [10, 15], suggesting women 15 to 24 years account for a large portion of the staggering maternal mortality rates in the region [16]. Although current age-specific maternal mortality data is limited, it is well established in the literature that pregnancy-related complications are the leading cause of death among women ages 15 and 19 years in developing countries [17-20].

Too often these complications are related to pregnancies which were unwanted. Hubacher et al. (2008) calculated that from 2005 to 2010, 27.5% and 25.8% of total births among women 15-19 and 20-24 years of age, respectively, were unintended in the 42 mainland countries in SSA [34]. With this age pattern in unintended pregnancies, it is not surprising that abortion rates are highest among women in their 20s and that the 15-19 years subset of women account for the largest portion (57%) of the unsafe abortion in SSA [17, 21]. These patterns may also be reflective of age-related access to family planning services in SSA.

Early childbearing has also been linked to higher rates of child mortality and morbidity. Infants born to teenage mothers are 50% more likely to die in the first week of life than those

born to mothers 20 to 29 years old. At the same time, teenage mothers are also more likely to have preterm and low birth weight babies[17].

It is evident that investments made in youth to promote healthy transitions to adulthood are critical to both individual and overall health and development in SSA. By 2015, the deadline for meeting MDGs, the population of youth (15-24 years) is expected to reach 200 million in SSA [14]. Investing in their ability to make healthy and informed decisions about child-bearing and birth spacing now will yield high returns in the region well beyond 2015.

The objective of this paper is to illustrate the need for a concerted effort to address the gaps in family planning services for youth in SSA. To do so, we describe trends in youth fertility and child-bearing, unmet need for family planning options, and contraceptive prevalence among youth in SSA. We then provide estimates of exposure to the risk of pregnancy and need for contraception among youth, as well as estimates of new contraceptives users necessary to maintain and double contraceptive prevalence rates (CPR) among youth by 2015.

## **Methods**

For the purposes of this paper, the term “youth” will refer to individuals 15-24 years of age, in accordance with the World Health Organization definition, whereas the term “adolescents and young people” will refer to 10-19 and 10-24 years of age, respectively. The data sources used for this illustrative analyses were extracted from the Demographic and Health Surveys (DHSs) using STATCompiler. We tracked trends in six countries in SSA that met the following criteria: 1) Four rounds of DHSs available; 2) Most recent DHS conducted in 2006 or later; 3) High unmet need for family planning (>20% for youth); 4) DHS data for tracking age-specific fertility, sexual activity, and contraceptive prevalence available; and 5) Is currently experiencing a stall in fertility decline according to Bongaarts’ recent study of fertility transitions in

developing countries [8]. The countries and survey years of the DHSs selected for this paper are: 1) Ghana: 1993, 1998, 2003, 2008; 2) Kenya: 1993, 1998, 2003, 2008-9; 3) Mali: 1987, 1995-6, 2001, 2006; 4) Nigeria: 1990, 1999, 2000-1, 2006; 5) Uganda: 1988-9, 1995, 2000-1, 2006; and 6) Zambia: 1992, 1996, 2001-2, 2007. The availability of these surveys enables us to examine trends during four successive periods. The four rounds of DHS data are referred to as DHS 1-4, with DHS 4 being the most recent.

Analyses in this paper, except for those related to teenage pregnancy and fertility planning status, compare observations of youth, 15-24 years. Because DHS data is reported separately for youth aged 15-19 and those aged 20-24, we used weighted averages to combine the data for these age cohorts for the same country and year. To analyze trends in teenage pregnancy, we combined data from respondents 15-19 years into one weighted average. For trends in fertility planning status, we combined data from <20 years and 20-24 years age cohorts into one weighted average. These averages were plotted by country and DHS round to illustrate trends over the years.

To supplement DHS data, we conducted calculations to determine the number of female youth at risk for pregnancy and the number of young adolescents, 10-14 years, who may require family planning as they enter the age of sexual activity. For these calculations, we obtained population estimates from US Census Bureau International Database and used the most recent DHS data estimates for the proportion of sexually active female youth and proportion of modern contraceptive users among female youth. We also calculated the number of new young users of modern contraception needed to maintain current CPR and to double CPR by 2015 for the six African countries. We did so using midyear estimates for 2011 and 2015 from the US Census

Bureau International Database and the most recent DHS data on contraceptive prevalence among youth in the respective countries.

We used GoogleScholar, PubMed, and Web of Science as search engines for relevant literature on youth fertility and associated risks, experiences among youth in accessing family planning services, and strategies that have had an impact on improving access to family planning services among youth.

## **Results**

### ***Fertility and childbearing***

As indicated in Table 1, the size of the youth population in six African countries is expected to range from approximately 3 million youth in Mali to over 35 million youth in Nigeria by 2015. On average, youth will comprise an estimated 20% of the total population of the respective countries through 2015 (Table 1). With high fertility rates still common in many African countries, it is likely that the population of youth as a percentage of the total population has yet to peak in the region [22].

As the youth population continues to grow in SSA, meeting their family planning needs will also be a rising challenge. Although the percentage of sexually active African youth has gradually decreased over time, the declines between surveys have been modest. At the time of DHS 4, 20-43% of youth from these six countries were sexually active (data not shown). Meanwhile, Zambia, Uganda and Mali have average birthrates of 146, 152, and 188 births per 1,000 women ages 15-19 years, respectively, with Nigeria and Kenya not far behind at 121 and 103, respectively (Table 1).

Data in Table 2 indicates that teenage pregnancy rates have decreased between DHS 2 and DHS 4 in every country except Nigeria, which witnessed a slight increase. Uganda saw the

largest decline between DHS 2 (42.8%) and DHS 4 (25.0%). However, teenage pregnancy is still common. Over 20% of young women 15 to 19 years in Mali, Nigeria, Uganda, and Zambia were mothers or pregnant with their first child at the time of DHS 4 (Table 2). With widespread teenage pregnancy, the percentage of births to mothers 24 years and younger that are unintended (wanted later or not at all) is also considerable (Table 2). At the time of DHS 4, four countries had over 38% of female youth report a pregnancy as wanted later or not at all in the 5 years preceding that survey. The data from DHS 4 in Ghana (45.8%), Kenya (41.9%), and Zambia (38.4%) only differ slightly from the percentage of unintended pregnancies found in DHS 3—45.9%, 41.7%, and 36.9%, respectively. Interestingly, in Uganda, where there was the greatest decline in teenage pregnancy between DHS 2 and DHS 4, there was also the greatest increase in the percentage of unintended pregnancies between DHS 2 (26.4%) and DHS 4 (39.6%).

### ***Unmet need for family planning***

Although youth appear to be using contraception increasingly in all six countries, the gains are not universal or sufficient. Among sexually active youth, wide regional variation exists, with 19.4% of sexually active youth using a modern contraceptive in Zambia, while only 7.0% of married and sexually active single females (15-24 years) were using a modern contraceptive method in Mali at the time of DHS 4 (Table 2). The trends in percentage of current use of modern contraceptives in Table 2 demonstrate low use and stagnating or even declining performance, as is the case in Uganda. Thus, it is not surprising that in these six countries, 21-46% of married females, 15-24 years, have an unmet need for family planning (Table 2). Over four successive surveys, unmet need remained greatest in Ghana and least in Nigeria (20.6%), which closely mirrors the percentages of unwanted pregnancy in that Ghana had the highest rate

of unwanted pregnancy for three out of four surveys and Nigeria had the lowest rate of unwanted pregnancy for all four surveys.

### ***Meeting the need for family planning***

Using the most recent DHS data on sexual activity and use of modern methods of contraception among sexually active female youth, the calculations in Table 3 estimate that between 479,079 (Ghana) and 5,538,170 (Nigeria) women aged 15-24 years are exposed to risk of pregnancy and have a potential need for contraception in six African countries (Table 3). At the same time, between 885,750 (Zambia) and 2,316,521 (Nigeria) adolescent girls age 10-14 years will become sexually active in those same countries (data not shown). Given the population growth, current CPR and expected new users of modern contraceptives in six countries in SSA, Table 4 estimates the number of youth who will require family planning services to maintain current level of modern CPR and double modern CPR among youth by 2015. Zambia, which has the highest CPR, would need to increase family planning service provision to 52,500 and 595,000 new users to maintain and double CPR by 2015. Ghana and Mali, which currently have low CPR, would need to provide contraceptives to 9,600 and 20,600 new users to maintain current CPR and 518,400 and 182,000 to double CPR, respectively, by 2015. However, Nigeria, which also has a low CPR, would need to provide contraceptives to 240,800 new users to maintain current CPR and 3,164,800 to double CPR by 2015. This is due to its extraordinary population size and high fertility.

### **Discussion**

The results emphasize the importance of targeting youth in efforts to revitalize family planning. Approximately 20% of the total population in SSA is comprised of youth. Whereas the rest of the world, including other less developed regions, has witnessed a steady decline in



the population of youth as a percentage of the total population, this proportion in SSA has remained relatively constant over the last 15 years [2]. Increasing youth populations are reflective of the overall population growth in SSA. Since the second part of the 1990s and early 2000s, African countries that were previously at the forefront of the fertility decline have seen a stall in their progress [8].

The fertility of youth is necessarily important with 20-43% of youth from the six African countries in this analysis reported being sexually active at the time of the last DHS. Although the trends did show decline in the percentage of sexually active youth over the course of the four DHSs, other researchers found rates of sexual activity are not declining, but are instead remaining the same or even increasing [41]. There is reason to believe that youth underreport sexual activity because there are many settings in SSA where premarital sex is taboo [40]. Alternatively, misreporting could be a result of campaigns promoting abstinence for youth at the time of the surveys, such as was the case in Uganda [39].

Our finding of high birthrates among youth also suggests that sexual activity may be underreported. At more than double the global average birthrate among young women, the average of 143 births per 1,000 women ages 15 to 19 years in SSA is startling [23]. These heightened birthrates among youth contribute to the rapid population growth in the region, which will continue unless the growing population of young people of reproductive age is given increased access to family planning. With birthrates of 66 and 176 births per 1,000 women age 15 to 19 years and 20 to 24 years, respectively, Ghana's birthrates were far less than the other countries. However, unsafe abortion also kills more women than AIDS does in Ghana [42, 43].

The case of Ghana is not unique. Birth rates among young women are entangled with rates of abortion [5]. More often, sexually unmarried adolescents are not seeking to become

pregnant, and married adolescents do not want to become pregnant at a young age or, if they have already had a child, wish to delay a second pregnancy [30,32]. In fact, childbearing and marriage are increasingly unrelated [5]. This may be linked to the high levels of unintended pregnancy we found, which were greater than 38% in four countries. Our results were consistent with those of Hubacher et al. (2008), who found that young women, 15 to 24 years, accounted for 43.9% of all unintended pregnancies among women of reproductive age from 2005-2010 [34].

These levels of unintended pregnancy are illustrative of the trends in contraceptive prevalence and unmet need for family planning in the analysis. These indicators are often proxies of a country's success in the implementation of and sustained efforts in family planning programs. The level of investment in family planning programs is reflected in both our findings and those in the literature. Less than 20% of all sexually active youth, married and unmarried, use any form of modern contraception in SSA [31]. Cleland et al. (2006) found that 37% of unmarried, sexually active sub-Saharan women aged 15-24 years use contraception, and of that total, only 8% use a non-barrier method [32]. Biddlecom et al. (2007) reported that a substantial proportion of sexually-active youth do not know of any source to obtain contraceptive methods [33]. Given these low levels of reported contraceptive use, coupled with a desire to delay childbearing, our unmet need results of 24-46% at the time of the last DHS were expected. Data of unmet spacing needs indicate that the needs of youth are 2.3 times higher than those of the adult population [22]. In fact, the actual levels of unmet need among youth most often exceed those observed [44]. By including only married sexually active women instead of all sexually active women in indicators for unmet need in population surveys, there is underestimation of the extent of need for services [45]. By using data on contraceptive use among all sexually active

young women, we estimate that over 9 million young women, 15-24 years, are exposed to risk of pregnancy and have potential need for contraception in six African countries (Table 3). While the calculations do not distinguish between the young women who would like to become pregnant and those who do not, they do underscore the considerable effort, depicted in Table 4, that is needed to ensure that sexually active youth have access to the tools they need to decide when or whether to have a child.

## **Conclusion**

The African youth of today have hopes of delaying marriage and childbearing in the pursuit of education and better livelihoods. It is clear that African youth are at heightened risk for pregnancy-related morbidity and mortality; many of these pregnancies can be prevented with the expansion of youth-accessible family planning services. With young women bearing the greatest global burden for pregnancy-related morbidity and mortality [18, 19] and growing evidence to suggest the clear role of family planning in achieving the Millennium Development Goals [10, 11], the need for improving access to modern contraceptive methods among African youth is necessary now more than ever. There is not a one-size-fits-all solution: It is imperative for governments, NGOs, and international donors alike to understand the circumstances that shape the lives of youth, as well as the factors that affect their access to and uptake of family planning services.

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**Table 1:** Size of youth population, total fertility rate, and birthrates among females aged 15-24 for six countries in SSA.

	Youth Population (Thousands)*	Percentage of Total Population*	Current Fertility		
			Total Fertility Rate	Birthrate per 1000 women 15-19 years	Birthrate per 1000 women 20-24 years
Ghana	5335	19.8	4.0	66	176
Kenya	9058	20.7	4.6	103	238
Mali	3061	20.9	6.6	188	283
Nigeria	35256	20.0	5.7	121	225
Uganda	8155	20.5	6.7	152	309
Zambia	3090	20.6	6.2	146	274

\*2015 estimates

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2008 Revision.

Most recent Demographic and Health Survey data for each country.

**Table 2:** Trends in pregnancy, unintended pregnancy, use of modern contraceptives, and unmet need for family planning among women age 15-24 years in six countries in SSA with four consecutive DHSs.

		GHANA	KENYA	MALI	NIGERIA	UGANDA	ZAMBIA
		Percentage of women, 15-19 years, who are mothers or pregnant with their first child	DHS 1	21.5	20.5	50.5	28.3
	DHS 2	14.1	20.9	41.5	21.9	42.8	30.7
	DHS 3	13.8	23.0	40.4	25.2	31.4	31.6
	DHS 4	13.3	17.7	35.5	22.8	25.0	27.9
Percentage of women, 15-24 years, with an unintended pregnancy in the 5 years preceding the survey	DHS 1	47.3	47.0	---	9.2	---	30.5
	DHS 2	38.9	45.9	21.3	18.3	26.4	34.6
	DHS 3	45.9	41.7	18.0	15.0	34.2	36.9
	DHS 4	45.8	41.9	15.0	11.0	39.6	38.4
Percentage of current users of modern contraceptives among sexually active women, 15-24 years	DHS 1	10.1	16.4	1.5	3.7	1.6	6.3
	DHS 2	13.7	22.2	4.6	6.6	5.7	13.5
	DHS 3	18.3	21.9	5.8	10.5	17.9	22.2
	DHS 4	19.4	29.7	7	11.7	22.2	32.8
Percentage of unmet need for family planning among married women, 15-24 years	DHS 1	42.6	40.6	---	20.0	---	28.7
	DHS 2	43.1	28.1	28.3	20.0	27.4	26.8
	DHS 3	44.3	31.2	30.2	15.7	32.5	26.4
	DHS 4	45.5	30.0	30.7	20.6	34.9	24.3

Source: Demographic and Health Surveys. Weighted averages for age groups 15-19 and 20-24.

DHS 1 data not available for Mali and Uganda for unintended pregnancy and unmet need for women 15-24 years.

**Table 3:** Number of females aged 15-24 with exposure to risk of pregnancy in 6 countries in SSA.

	Age group (in years)	Female Population	% sexually active	% using modern contraception	Female Youth at Risk (n)
Ghana	15 to 24	2,573,121	23.1%	19.4%	479,079
Kenya	15 to 24	4,015,953	29.4%	29.7%	830,025
Mali	15 to 24	1,370,858	49.9%	7.0%	636,174
Nigeria	15 to 24	15,223,284	41.2%	11.7%	5,538,170
Uganda	15 to 24	3,601,145	38.0%	22.2%	1,064,643
Zambia	15 to 24	1,396,133	55.3%	32.8%	518,825

Sources: Most recent Demographic and Health Survey data for each country

US Census Bureau, Population Division: International Database, 2011 Midyear estimates

Sources: US Census Bureau, Population Division: International Database, 2011 Midyear estimate; Most recent Demographic and Health Survey data for each country

**Table 4:** Projections of the number of new youth users necessary to maintain and double contraceptive prevalence by 2015 in 6 countries in SSA.

Country	CPR Among Sexually Active Female Youth	Youth Population mid-2011 (millions)	Youth currently using modern methods (millions)	Projected Youth Population mid-2015 (millions)	# of new youth users to <i>maintain</i> CP in 2015	CPR Doubled	Estimated number of new youth users of FP to double CPR by 2015
Ghana	9.6%	5.2	0.5	5.3	9,600	19.2%	518,400
Kenya	14.1%	8.1	1.1	8.4	42,300	28.2%	1,226,700
Mali	5.2%	2.7	0.1	3.1	20,800	10.4%	182,000
Nigeria	8.6%	31.2	2.7	34.0	240,800	17.2%	3,164,800
Uganda	10.8%	7.2	0.8	8.3	118,800	21.6%	1,015,200
Zambia	17.5%	2.8	0.5	3.1	52,500	35.0%	595,000

Source: US Census Bureau, International Data Base and most recent DHS data for each country