Improving the Reproductive Health of Sub-Saharan Africa's Youth

A ROUTE TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS

POPULATION REFERENCE BUREAU

BY **KARIN RINGHEIM**
AND **JAMES GRIBBLE**

www.prb.org

TABLE OF CONTENTS

PRB INFORM EMPOWER ADVANCE

USAID FROM THE AMERICAN PEOPLE

BRIDGE

Front Cover photo © 2006 Jane Brown/CCP, Courtesy of Photoshare.
Young adolescent females at a community meeting in Choma district, Zambia.

Back Cover photo © 2005 Tamara Keller, Courtesy of Photoshare.
Schoolgirls in Kenya sing a song about HIV/AIDS.

© 2010 Population Reference Bureau. All rights reserved.

INTRODUCTION

As the fastest-growing region in the world, sub-Saharan Africa is confronting many of the greatest global health and development challenges. With a population of more than 840 million, and growing at the rate of 2.4 percent per year, sub-Saharan Africa will double in size in just 30 years. Half the population in these countries is younger than 18. It is widely accepted that the future of sub-Saharan Africa rests to a great extent on the investments made in the education, health, and employment opportunities of its youth and on how successfully its youth transition to a healthy and productive adulthood.[1]

Achieving the Millennium Development Goals

In 2000, 189 of the world's countries committed to reducing poverty and many of its associated factors through the achievement of eight Millennium Development Goals (MDGs). Each goal has specific targets and indicators to be achieved by 2015, many of which relate to youth. With just five years remaining in this 20-year plan, far greater attention to the educational and health needs of the world's giant generation of youth is needed, especially in sub-Saharan Africa, which is facing the highest hurdles in meeting the MDGs.

Although youth around the world share many similarities, the experience of being a young woman or man is as diverse as the cultures from which young people come. In the West African country of Mali, a young woman is very likely to have experienced female genital cutting by age 5. She may never have attended school. She is likely to be married and have a child by age 16, and to believe that her husband is justified in beating her for certain "transgressions." In southern Africa, a young Zambian woman is more likely to have gone to school, but has few job opportunities and has among the world's highest risks of becoming infected with HIV. By contrast, a young woman in the East African country of Rwanda is the most likely of the three girls to be educated and the least likely to be sexually active, married, or have a child. She may have a boyfriend, but she is less likely to have a pregnancy during adolescence than is a girl in the United States. She is only one-tenth as likely to be HIV positive as a girl in Zambia.

These three young women have very different experiences, but they share common dreams and ambitions about health, family, and work. With government investments in health, education, and job opportunities, and political commitments to the aspirations of the Millennium Development Goals, these young women—a part of the more than 1.2 billion young people around the world—have a chance to realize their personal goals and help their nations achieve higher levels of economic and social development.* These efforts will spur progress on the many MDG outcomes that directly or indirectly concern youth.[2]

© 2009 Arturo Sanabria, Courtesy of Photoshare

A young girl after an HIV talk in Zambia.

* This chartbook focuses on youth ages 15 to 19. The world's youth population of 1.2 billion as defined by the United Nations refers to ages 15 to 24.

Why Focus on the Youth of Sub-Saharan Africa?

Not only is sub-Saharan Africa the fastest-growing region in the world, but young women here face a dual threat of unplanned pregnancy and risk of HIV unequaled in the rest of the world.[3] Young men also face myriad challenges, including coping with the environmental degradation occurring in many of their countries. The realization of personal goals for these young women and men, and the economic and social development of their countries, depend to a great extent on the ability of youth to avoid unintended outcomes. This chartbook aims to provide policymakers, program managers, and the interested public in sub-Saharan Africa and around the world with a better understanding of the needs and experiences of youth in the region and how investments in youth can help achieve the MDGs.

FIGURE 1

15 Countries Highlighted in This Chartbook

The 15 countries profiled in this chartbook (Figure 1) are among the most populous countries on the continent; they are also reasonably representative of the diversity of the sub-Saharan region as a whole. The 15 include five countries in West Africa—Ghana, Liberia, Mali, Nigeria and Senegal; nine in East Africa—Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Tanzania, Uganda, and Zambia; and one in Central Africa—the Democratic Republic of Congo (DRC).

Ages 15 to 19 are a time of transition from childhood to adulthood, a time of increased responsibility and independence, as well as of increased health risks. During this period, youth of both sexes generally complete or leave school and become sexually active; many girls marry and begin childbearing. As youth make these transitions, national investments in reaching the MDGs can help ensure that youth are able to maximize their potential for healthy, productive lives that contribute to alleviating the high levels of poverty that impede development.

Youth and the MDGs

Achieving the MDGs depends to a great extent on improving the health, education, and economic and social well-being of young people.

MDG	YOUTH-RELATED ACTION REQUIRED TO ACHIEVE THE MDG
Goal 1: Eradicate extreme poverty and hunger.	Reduce the youth proportion of the population living on less than $1.25 per day.
Goal 2: Achieve universal primary education.	Increase literacy among 15-to-24-year-olds.
Goal 3: Promote gender equality and empower women.	Equalize the enrollment of girls and boys in primary, secondary, and tertiary education.
Goal 4: Reduce child mortality.	Increase age at first birth among adolescents.
Goal 5: Improve maternal health.	Reduce adolescent fertility and unmet need for contraception. Increase skilled attendance at birth.
Goal 6: Combat HIV/AIDS, malaria, and other diseases.	Reduce HIV prevalence among 15-to-24-year-olds. Increase consistent condom use.
Goal 7: Ensure environmental sustainability.	Improve the lives of youth who live in slums. Increase access to safe drinking water and sanitation.
Goal 8: Develop a global partnership for development.	Reduce unemployment among 14-to-24-year-olds.

Rapid Population Growth in Sub-Saharan Africa Poses Challenges to Achieving the MDGs

One of the challenges to achieving the MDGs is that many of the poorest countries have very youthful populations, with women beginning to have children at a young age and having many children over the course of their lives. As shown in Table 1, the countries in this chartbook include the largest in Africa and contain two-thirds of the population of sub-Saharan Africa. Youth ages 15 to 19 in these countries represent slightly more than two-thirds of all youth in the region. The median age (an average of 17.7 years) and population growth rates (an average of 2.5 percent per year) in these countries are also representative of sub-Saharan Africa as a whole. In all countries except Ghana, the median age of the population profiled here falls within the 15-to-19 age range used in this chartbook.

Rural and Urban Youth Face Challenges

In most sub-Saharan Africa countries, the majority of the population lives in rural areas, which increases the difficulty of extending education and services needed to achieve the MDGs. Although urbanization is increasing, youth in these 15 countries live predominantly in rural areas. In Ethiopia, Kenya, Malawi, Rwanda, and Uganda, less than 20 percent of the population lives in urban areas. In many of these countries, rapidly growing rural populations are faced with a shortage of farmland and deforestation. Living in rural areas also hampers access to media and information, and to employment opportunities. Youth who lack opportunity are more motivated than older adults to migrate from rural to urban areas. They often end up living in densely crowded shanty towns. Nearly half or more of the populations of Nigeria, Liberia, and Ghana now live in urban areas. With the exception of Ghana and Senegal, the majority of the urban population in countries profiled here lives in urban slums that lack clean water and sanitation facilities, and are characterized by higher rates of poverty and crime, and diseases including TB and HIV/AIDS.[4]

© 2008 Helen Hawkings, Courtesy of Photoshare

Refugees displaced by the fighting in North Kivu, DRC, line up for latrines and water containers.

TABLE 1

Selected Population Characteristics of Featured Countries

COUNTRY	POPULATION (MILLIONS)	POPULATION AGES 15-19 (%)	MEDIAN AGE OF POPULATION	POPULATION GROWTH RATE (% PER YEAR)
Nigeria	149.3	10.7	19.0	2.3
Ethiopia	85.3	10.4	16.9	2.6
DRC	68.7	11.2	16.4	2.7
Tanzania	41.0	11.5	18.0	2.9
Kenya	39.0	10.4	18.7	2.6
Liberia	34.4	9.6	18.0	4.4
Uganda	32.4	11.6	15.0	3.3
Ghana	26.7	11.2	20.8	2.0
Mozambique	21.7	11.7	17.4	2.2
Madagascar	20.7	10.9	18.0	2.6
Malawi	15.0	11.0	17.1	2.5
Senegal	13.7	10.8	18.6	2.6
Mali	13.4	10.4	16.2	2.4
Zambia	11.8	12.6	17.0	2.5
Rwanda	10.7	10.2	18.6	2.7

Source: U.S. Census Bureau, International Data Base (accessed November 2009); and World Bank, *World Development Indicators*, 2009.

Weak Economic Growth Also Impedes the Investment in Youth Necessary to Achieve the MDGs

As shown in Table 2, the majority of the population in each of these countries lives on less than $2 per day. The gross national income per person is, on average, much lower in East and Central Africa than in West Africa. Overall, the average rate of economic growth in these countries is only 1 percent per year, but there is considerable diversity. The economies of several countries, especially that of the DRC, have been shrinking (negative economic growth) in recent years, while a few countries, including Mali, Mozambique, and Uganda, have experienced economic growth rates above 2 percent per year.

About the Data

Improving the Reproductive Health of Sub-Saharan Africa's Youth draws primarily from the Demographic and Health Surveys (DHS), which have been conducted in more than 60 countries since the 1980s. These periodic surveys, with support from the U.S. Agency for International Development, host countries, and other donors, provide policymakers and program managers with accurate and timely information on an increasing body of demographic and health indicators. DHS routinely collect information from nationally representative samples of reproductive-age women (15 to 49) and from men in some countries. Data were accessed from the most recent surveys available. Because not all surveys include the same data, two surveys were used for four countries. A list of implementing agencies for the 19 surveys used in this chartbook is provided in the Appendix.

Periodically conducting a DHS within a country enables decisionmakers to monitor changes over time in the health status of the population. In recent years, the surveys have become an invaluable and primary source of information on country progress toward achieving the MDGs.

TABLE 2

Gross National Income, Economic Growth Rate, and Percent of Population Living on Less Than $2/Day

COUNTRY	GROSS NATIONAL INCOME (GNI/PPP) ($US)	ECONOMIC GROWTH RATE (% PER YEAR)	POPULATION LIVING ON LESS THAN $2/DAY (%)
Nigeria	1,770	0.8	92
Senegal	1,640	1.2	56
Kenya	1,540	-1.0	58
Ghana	1,330	2.0	79
Zambia	1,220	-0.3	87
Tanzania	1,200	1.7	90
Mali	1,040	2.2	72
Madagascar	920	0.7	85
Uganda	920	3.1	NA
Rwanda	860	0.1	88
Ethiopia	780	1.5	78
Malawi	750	1.0	63
Mozambique	690	4.3	74
DRC	290	-5.2	NA
Liberia	290	NA	NA

NA: Not available.
Note: Gross national income (GNI) takes into account both the gross domestic product (GDP) plus the net flows of income (remittances) from abroad, which have become substantial in many countries. Purchasing power parity (PPP) takes into account differences in the relative prices of goods and services and provides a better overall measure of economic output of one economy in comparison with another. PPP is intended to represent the same purchasing power (standard of living) across countries.
Source: World Bank, *World Development Indicators* (2009).

EDUCATION

The MDGs call on all countries to achieve universal primary education and for girls and boys to have equal school enrollment at all levels by 2015. Nothing is more critical for the youth of sub-Saharan Africa than an education that prepares them for a healthy life and the ability to support themselves and their families. The relationship between mother's education and the timing of her marriage and first birth is well established, as is the relationship between a mother's education and the health of her children. Keeping girls in school delays marriage and the start of childbearing, and reduces health risks associated with pregnancy at a young age for young mothers and their offspring. With growing evidence of these relationships has come greater attention to investing in girls as part of a comprehensive development strategy.[5]

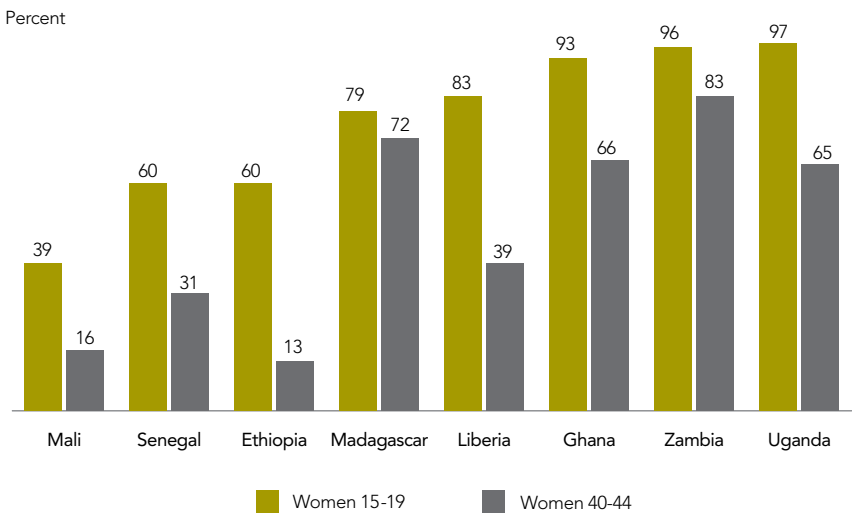
Young Women Have More Education Than Their Mothers

Access to education is increasing for young women, compared to the opportunities that older women had. Figure 2 compares the percentage of girls ages 15 to 19 who have had any formal education with women ages 40 to 44, the approximate ages of their mothers.

- In the eight countries profiled, more young women have attended school than their mothers did. The differences are especially striking in Ethiopia, Liberia, and Mali, where the percentage of girls with at least some formal education is more than twice as high as for their mothers.
- In Ghana, Uganda, and Zambia, 90 percent or more of young women now have some formal education. However, less than 40 percent of girls ages 15 to 19 in Mali have received any education, and only 60 percent of young women in Senegal have ever attended school.

FIGURE 2

Women Who Have Attained Any Formal Education



Source: Demographic and Health Surveys, 2003-2008/9.

Access to education is also increasing among young men. As shown in Figure 3, the opportunities for men are generally higher than for women, but in countries where older men had limited access to school, younger men have had greater opportunities.

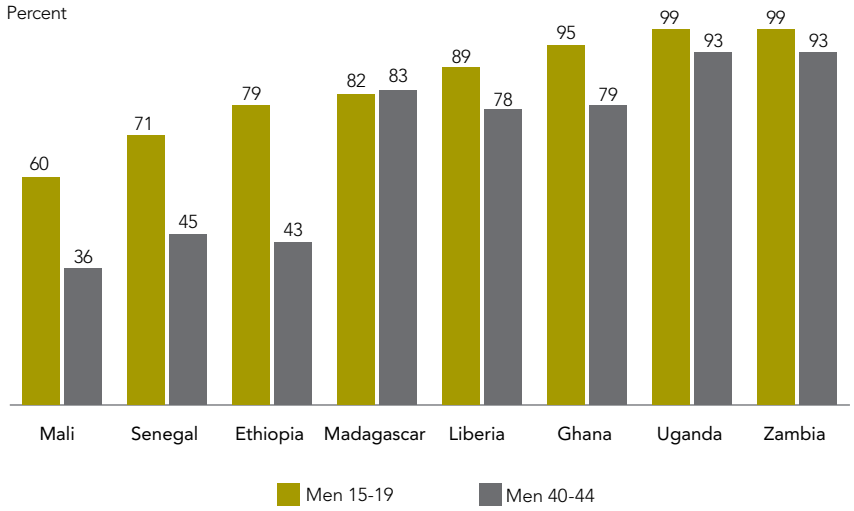
- In five of the eight countries profiled, 75 percent or more of men who are now ages 40 to 44 had some formal education in their youth, whereas 80 percent or more of young men have had some formal education.
- In three countries—Ghana, Uganda, and Zambia—95 percent or more of young men have attended school.
- Educational levels among men are lowest in Mali, as they were for young women: Only 60 percent of young men have had any formal education.

© 2005 Allen Eghrari, Courtesy of Photoshare

Girls sell eggs, nuts, and other goods at a roadside stop in Nigeria.

FIGURE 3

Men Who Have Attained Any Formal Education



Source: Demographic and Health Surveys, 2003-2008.

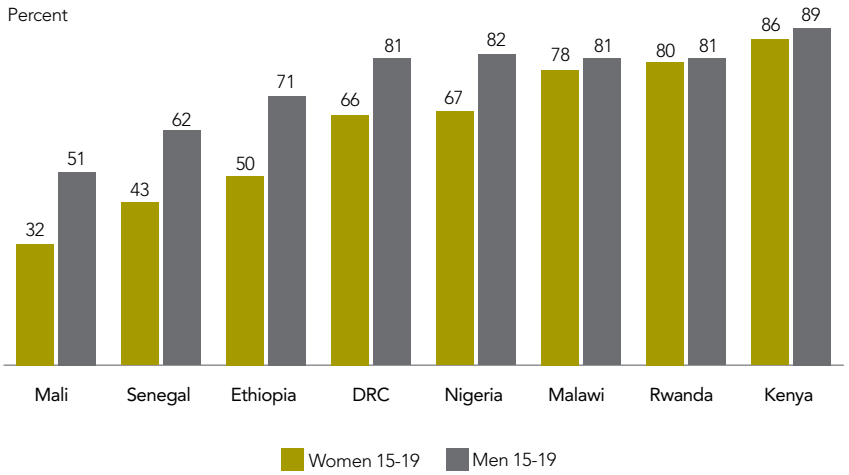
The Ability to Read and Write Is Fundamental to Skilled Employment

Individuals who have had any formal education are not necessarily literate. Figure 4 (page 7) shows the percentage of women and men ages 15 to 19 who are literate, according to their ability to read at least part of a sentence.

- In all eight countries profiled, young women are less likely to be able to read and write than young men. However, in no country does the literacy level among young men reach 90 percent.
- In Mali, Senegal, Ethiopia, DRC, and Nigeria, literacy among young women is much lower than in the other countries, and literacy is approximately 20 percentage points higher among young men than among young women.
- Literacy in Malawi, Rwanda, and Kenya is close to 80 percent or higher, and the difference in literacy between young women and men is no more than 3 percentage points.

FIGURE 4

Youth Literacy Ratio



Source: Demographic and Health Surveys, 2003-2008.

© 2006 Greg S. Allgood, Courtesy of Photoshare

Female students in Kenya participate in a water purification demonstration.

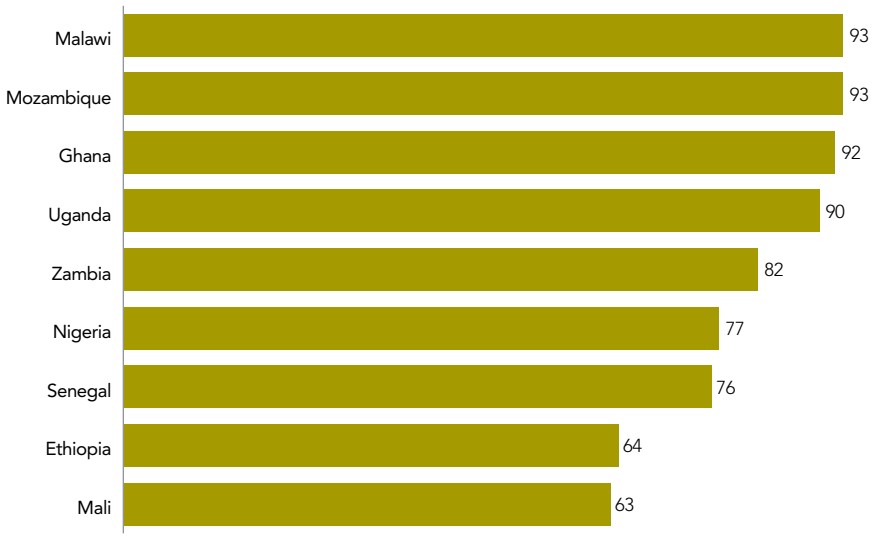
Secondary Education for Girls Is Key to Development

Enabling girls to complete schooling yields substantial economic and social benefits. The economic gains for girls' secondary schooling are especially large.[6] Yet in all countries considered here, fewer young women are enrolled in secondary school than young men (see Figure 5). This "gender parity ratio"—the number of girls in secondary school for each 100 boys—indicates a large and important gap that must be reduced if national development is to progress.

- The ratio of girls enrolled to the number of boys is as low as 63 girls for every 100 boys in Mali. Ethiopia and Senegal show better gender parity ratios, but levels indicate that young women lag behind young men in reaching secondary school.
- In Malawi, however, girls and boys are about equally likely to be enrolled in secondary school.
- Girls are more likely than boys to drop out of school at each progressive grade level. The general pattern shows that the higher the grade level, the lower the percentage of students who are girls.

FIGURE 5

Gender Equality in Secondary School Enrollment



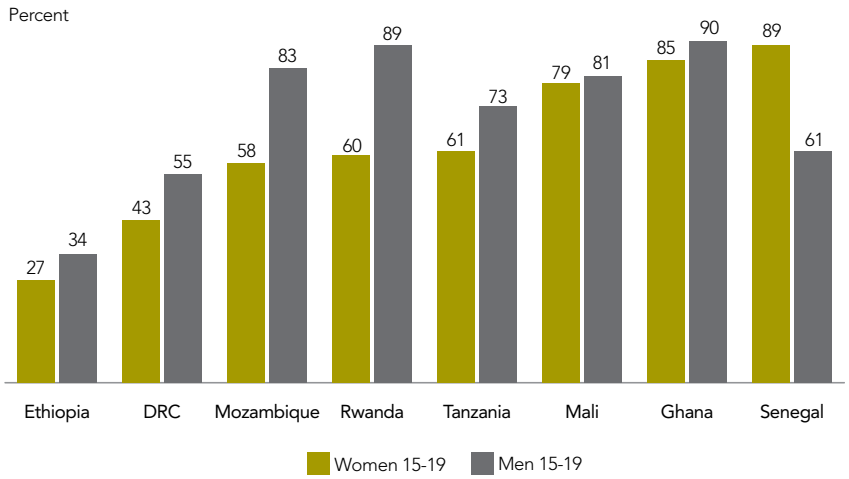
Source: UNESCO, Beyond 20/20 Web Data Server, 2009

To achieve the MDGs requires not only education, but access to information and the ability to understand and apply it. Yet in general, young women have less access to information than young men (see Figure 6). Without regular access to newspapers, radio, or television, women are likely to remain uninformed about how to improve their health and the health of their families.

- In seven of the eight countries profiled, young women are less able than young men to access information through print media such as newspapers, books, and health brochures. Only in Senegal do young women have greater access to the media (television, radio, and newspapers) than do men of the same age.
- In Ethiopia, less than 30 percent of girls and 35 percent of boys had seen a television program, listened to the radio, or read a newspaper in the week preceding the survey. This limited access is hampered by the largely rural, dispersed population.
- In Rwanda, where most young men and women have attended school, young women have substantially less regular exposure to mass media—60 percent of young women have regular access compared with almost 90 percent of young men.
- Ghana is the only country profiled where as many as 90 percent of young men and 85 percent of young women have any regular (weekly) access to the media.

FIGURE 6

Youth With Access to Media



Source: Demographic and Health Surveys, 2003-2008.

© 2006 Jane Brown/CCP, Courtesy of Photoshare

Adolescent girls celebrate their victory in a soccer match during the launch of a girls' empowerment program in Malawi.

Improving access to education and information is necessary for these countries to achieve the MDGs. Educated girls have smaller families, make greater investments in each child's health and education, and are more likely to contribute financially to their families.[7] Although young women are better educated than their mothers, they still lag behind young men, especially in secondary schooling. Young women are also less literate, which limits their opportunities to find skilled work. And with limited access to the media, young women have less access to information about reproductive health and family planning, and HIV prevention. These findings suggest the need for innovative channels to reach adolescents, particularly in remote and rural areas and where girls and women have limited ability to freely move about on their own.

SEXUAL EXPERIENCE AND MARRIAGE

The sexual experience and timing of marriage of youth in sub-Saharan Africa have a bearing on MDG 3, which calls for gender equity and targets the equal education of girls and boys. Achieving MDG 3 is also critical for achieving MDG 5 (to improve maternal health) and MDG 6 (to reduce the spread of HIV). Each goal is much more likely to be achieved if youth delay their sexual debut and wait until they are fully mature to marry and begin having children.

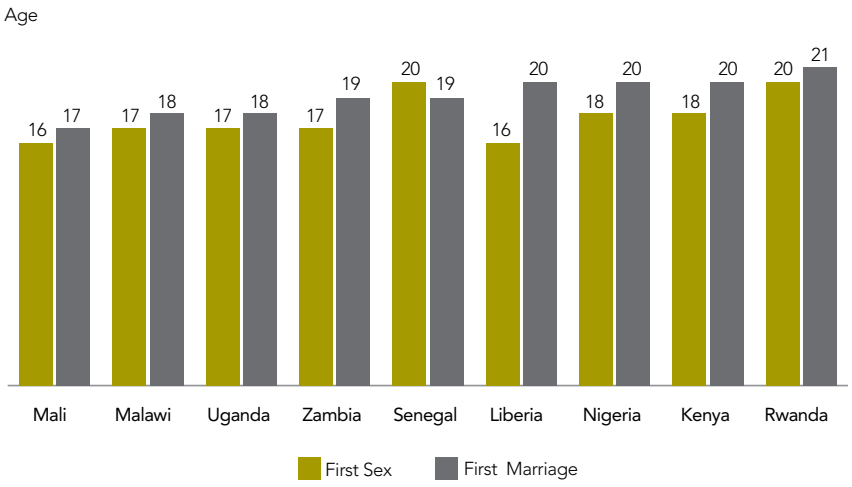
Early Marriage Is Common, Often Involuntary, and Violates International Agreements

Young women tend to become sexually active at a young age in these countries, often within or shortly before marriage. The international standard for the legal age of marriage for girls is 18, but in many of these countries, the legal age is 16 and girls are often married at much younger ages. Figure 7 shows data on the median age at first sex and first marriage for women who were ages 20 to 24 at the time of the survey.

- In most countries profiled, the median age of first sexual experience among women is between ages 16 and 18, and the median age of first marriage is between 18 and 20.
- Men tend to have a longer interval between first sex and marriage; on average they initiate sex between ages 15 and 20, and marry between ages 22 and 26 (data not shown).
- The time between sexual debut and marriage has implications for the health of young people. As the interval between first sex and marriage becomes longer, youth have a greater need for family planning and reproductive health information and services.

FIGURE 7

Median Age at First Sex and First Marriage, Women Ages 20-24



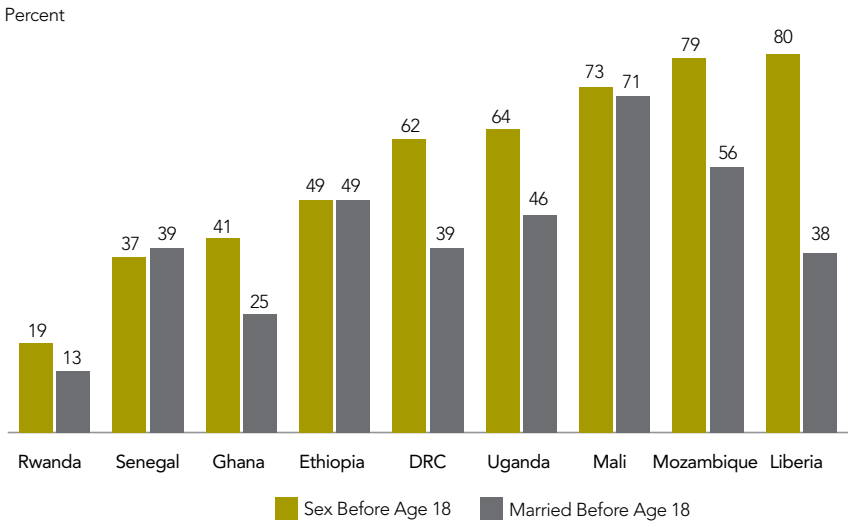
Source: Demographic and Health Surveys, 2003-2008.

Child marriage is most common in rural areas and among the poor and the poorly educated. The more education a girl has, the less likely she is to be married as a child.[8] Figure 8 shows the percentage of women who were ages 20 to 24 at the time of the survey and who had sex or were married before age 18.

- In five of the nine countries profiled, at least 60 percent of all women had their first sexual experience before age 18; and in Mali, Senegal, and Ethiopia, sex was nearly entirely initiated within marriage.
- Child marriage is especially common in Mali, where more than 70 percent of women married before 18. In contrast, only 13 percent of Rwandan women were married before 18.
- In some countries such as Liberia, the gap between first sex and marriage is wide, indicating that women are initiating sex well before marriage and are at risk of an unintended pregnancy outside of marriage for some time.

FIGURE 8

Women Ages 20-24 Who Had Sex or Married Before Age 18



Source: Demographic and Health Surveys, 2003-2008.

© 2008 Paul Jeffrey, Courtesy of Photoshare

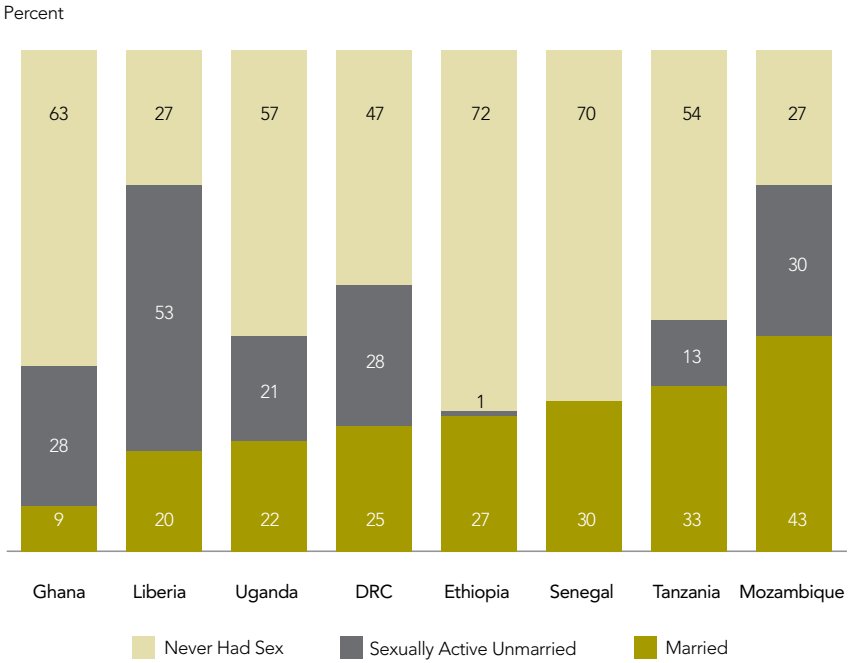
A young woman plants rice as part of a community agriculture project in the DRC.

Across the region, the sexual experience of young women varies by their marital status, as shown in Figure 9.

- Sexual activity within marriage ranges between 9 percent and 43 percent, shown in the bottom section of each column. For many of these young women, early marriage led to early sexual activity.
- Sexual activity outside of marriage (shown as the middle section of each column) ranges from nearly zero in Senegal to 53 percent in Liberia.
- Ethiopia and Senegal have the largest percentage of young women who are not sexually active, as shown in the upper part of each column.

FIGURE 9

Sexual Experience Among Women Ages 15-19



Source: Demographic and Health Surveys, 2003-2008.

Adolescents Have a Diversity of Experience and Needs

The diversity of experience among adolescents requires reaching them with a range of sexual and reproductive health information and services — before they initate sex, as sexually active unmarried youth, or as married individuals and couples.

© 2009 Arturo Sanabria, Courtesy of Photoshare

A young Zambian woman and her children after a family planning consultation in Lusaka.

The adverse effects of early sexual activity, whether occurring within or outside of an early marriage, have a direct bearing on several of the MDGs. Early marriage and childbearing almost ensure that young women will not advance in their education. This slows progress on the MDG 3 target to achieve gender equity in all levels of schooling and places girls and their offspring at a great disadvantage in life. In addition, early sexual debut increases the risk of unplanned pregnancy, unsafe abortion, HIV/AIDS, and sexually transmitted infection.

Enforcing international marriage standards is a first step to ending early marriage and its negative consequences; at the same time, investment in programs to change gender-biased social norms and raise the status of women is also critical to achieving the MDGs related to health and gender equity.

© 2009 Alexandria Smith, Courtesy of Photoshare

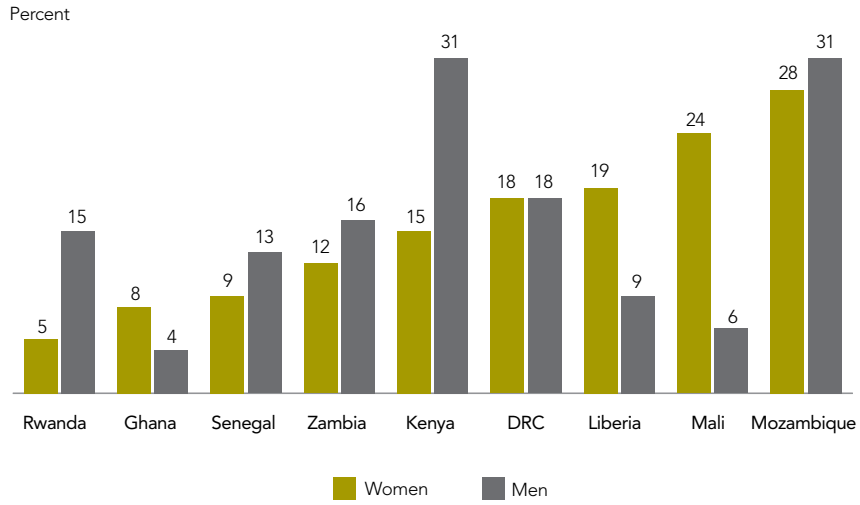
A young Ugandan woman and her mother walk down the mountain with their harvest.

As shown in Figure 10, median age of first sexual experience can disguise what is, in some countries, a substantial percentage of youth who initiate sexual activity before age 15. Adolescents rarely use protection when having sex for the first time and younger adolescents face greater risk than older adolescents of acquiring sexually transmitted infections, including HIV.

- In Mali, 24 percent of women had their first sexual experience before age 15, most in the context of child marriage.
- In the DRC and Liberia, nearly a fifth of young women have initiated sex before age 15; in these countries, sex is more likely to have taken place prior to marriage.
- The highest rates among both men and women are found in Mozambique, where 28 percent of women and 31 percent of men have initiated sex before age 15.

FIGURE 10

Youth Who Have Had Sex Before Age 15



Source: Demographic and Health Surveys, 2003-2008/9.

HIV/AIDS

Halting and reversing the spread of HIV/AIDS is the primary aim of MDG 6. In sub-Saharan Africa, where two-thirds of the 33 million people living with HIV reside, the AIDS epidemic has altered virtually every aspect of life: Nearly three-quarters of all deaths due to HIV in 2008 occurred in sub-Saharan Africa.[9] Throughout the region, 60 percent of all those infected are women, and new HIV infections are occurring most frequently among youth, especially young women.

Youth in Sub-Saharan Africa, Especially Women, Face the Greatest Risk of HIV

Cross-generational sex between an unmarried adolescent girl and a man 10 or more years older is not unusual in the region. DHS surveys showed that as many as 20 percent of 15-to-19-year-old girls in Uganda and 25 percent in Nigeria had such an older partner in the last year. These relationships are often driven by economic need, and they expose young women to grave health risks, including HIV.[10]

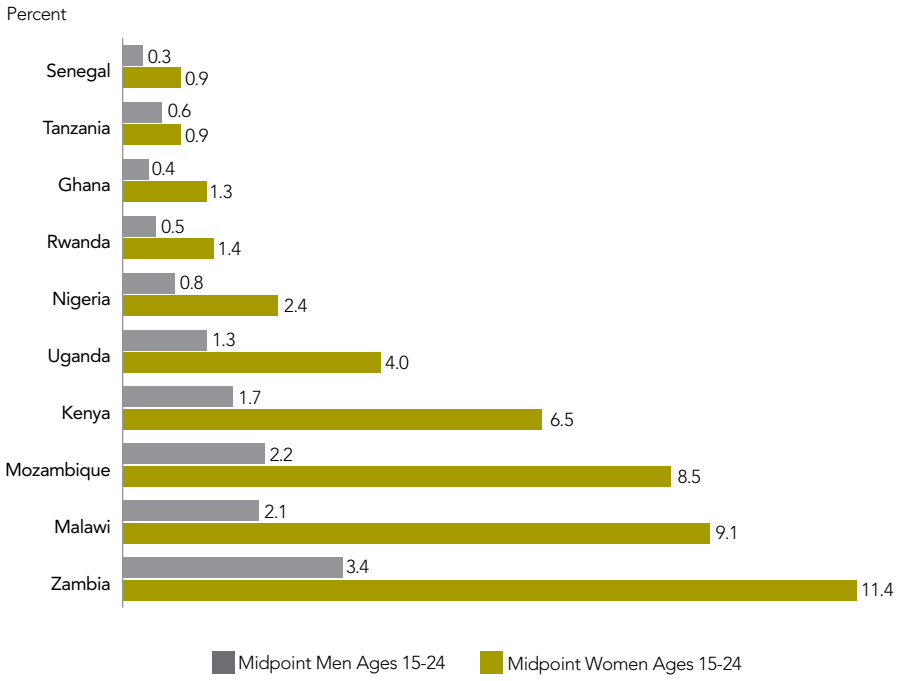
The countries profiled in this chartbook include some of those most deeply affected by HIV, such as Malawi, Mozambique, and Zambia, as well as countries where HIV prevalence among the population ages 15 to 49 remains below 1 percent, including Madagascar and Senegal.

HIV prevalence among the population ages 15 to 24 is an indicator used to track progress on MDG 6. Figure 11 shows the midpoint of the estimated prevalence among young women and young men across the region.

- Regionwide, young women are generally three times as likely as men of the same age to be infected with HIV (3.2 percent vs. 1.1 percent).[11] This ratio is fairly consistent regardless of the HIV prevalence within the country.
- In the five countries profiled with the highest prevalence (Uganda, Kenya, Mozambique, Malawi, and Zambia), more than 2 percent of all youth are HIV positive. These five countries are located in East Africa—one of the two regions, along with southern Africa, that has been hardest hit by the epidemic.
- UNAIDS reported in 2009 that the epidemic is stabilizing in most countries in the region, although at a high level of infection. Zambia and Tanzania are among the few countries where a drop in incidence has been reported in the last several years.

FIGURE 11

HIV Prevalence Among Women and Men Ages 15-24



Source: Calculations based on UNAIDS, 2009.

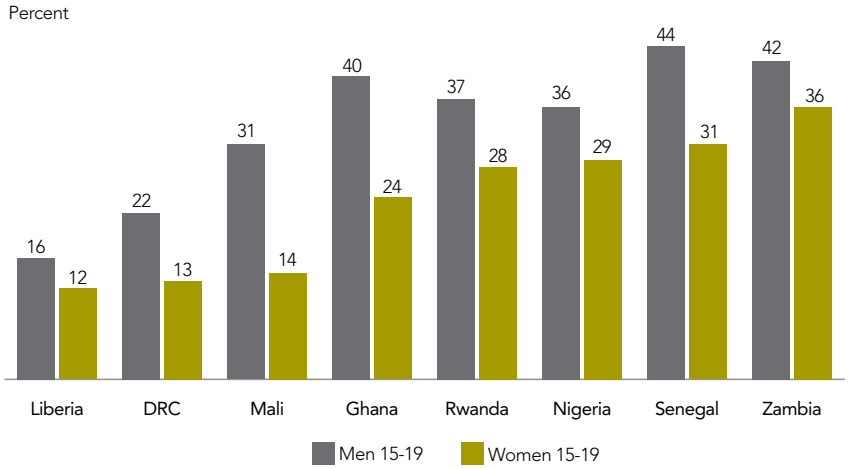
Using Condoms Is Critical to Stopping the HIV Epidemic Among Youth

Condom use at last high-risk sex is another of the indicators used to measure progress on MDG 6. Sexually active individuals who are not in an exclusively monogamous relationship with an uninfected partner are urged to use condoms with any nonregular partner. Any such relationship would be considered "high risk." Making advances on this indicator will require changes in gender roles so that young women have a greater ability to negotiate condom use. Figure 12 presents data from eight countries on condom use at last high-risk sex among young women and men.

- Among these countries, young women in Zambia reported the highest use of condoms at last high-risk sex. While condom use is still low, increasing use may be contributing to the declining prevalence observed in Zambia.
- Even with its relatively low HIV prevalence, the infrequent use of condoms during high-risk sex in Liberia suggests that the epidemic could expand rapidly.
- In all eight countries profiled, fewer young women used condoms than young men. This may reflect the inability of young women to negotiate condom use, especially when exchanging sex for money or food, or in the context of coerced and forced sex.
- In all eight countries, fewer than half of young men reported that they used condoms at their last high-risk sex, suggesting that they underestimate their risk of HIV infection.

FIGURE 12

Condom Use at Last High-Risk Sex



Source: Demographic and Health Surveys, 2003-2008.

© 2006 David Colwell, Courtesy of Photoshare

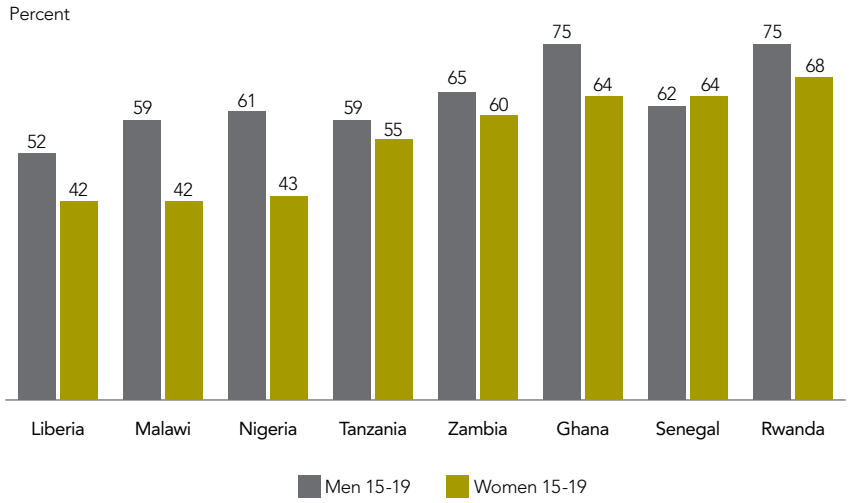
High school girls in Zambia act out a skit about transactional sex in which a girl meets an older boy with a car.

Awareness of HIV and AIDS is now nearly universal among youth. However, comprehensive knowledge of how HIV is transmitted is still rare among young people. Respondents who indicated in the DHS that HIV transmission can be prevented through using condoms, limiting sex to one uninfected partner, and abstaining from sex are considered to have a "comprehensive knowledge" of HIV prevention. Figure 13 presents the percentage of youth who reported three ways to prevent HIV transmission.

- In seven of the eight countries presented, young men had a better understanding of how to prevent HIV transmission than young women. The difference in their knowledge was greatest (17 percentage points or more) in Nigeria and Malawi. In Senegal, more young women reported knowing how to prevent HIV transmission than young men, although the difference was very small.
- In Malawi, a high-prevalence country, knowledge of how to prevent HIV was among the lowest of the countries presented. Improving knowledge of prevention among youth is essential if MDG 6 is to be achieved in Malawi.

FIGURE 13

Youth Who Know 3 Ways to Prevent HIV



Source: Demographic and Health Surveys, 2003-2008; and Statcompiler.

© 2008 Bob Msangi, Courtesy of Photoshare

A young storekeeper in Tanzania listens to an HIV/AIDS radio program.

Knowledge of HIV Status May Help Youth Change Their Behavior

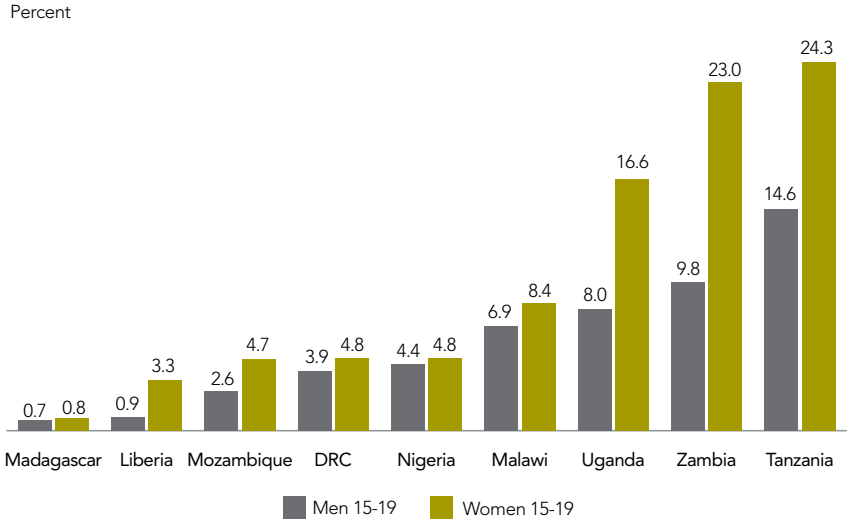
The risk of HIV in high-prevalence countries has fostered awareness-raising campaigns to encourage all sexually active people, including young people, to get tested for HIV.

Youth often express concerns about their privacy and about having confidential information exposed to their parents. Figure 14 illustrates data on the percentage of young women and men who have been tested for HIV.

- In most countries, less than 5 percent of youth have been tested, including in high-prevalence countries such as Mozambique, where more HIV testing is urgently needed.
- Only in Tanzania and Zambia, two countries that have recently registered some decline in HIV prevalence, have more than 20 percent of young women been tested. It is vital that young people who engage in risky sexual behavior be tested regularly.
- As might be expected according to their greater vulnerability to HIV, young women in profiled countries are more likely to seek HIV testing than are young men.

FIGURE 14

HIV Testing Behavior Among Youth



Source: Demographic and Health Surveys, 2003-2008.

It is essential that young women and men who are tested also return to testing sites to obtain their results. In Madagascar, virtually all interviewed young men, but only 25 percent of young women, returned to obtain their test results. In contrast, more than 80 percent of both young women and men in Uganda obtained test results.

Reaching youth with information and services is critical to achieving MDG 6. Regardless of the national prevalence, youth need to have full understanding of how HIV is transmitted so that they can avoid infection. Young women need confidence and competence in negotiating condom use, and young men must recognize the importance of consistent condom use for their own health and that of their partners. Integrating HIV testing with reproductive health services will encourage more youth to be tested in a less stigmatized environment than in a stand-alone HIV testing site.[12] Changing harmful gender norms that condone cross-generational sex and leave young women more vulnerable to exchanging sex for money or food are essential to reversing the HIV/AIDS epidemic in the region.

© 2006 Ashley Pinsent, Courtesy of Photoshare

HIV peer educators perform in Dar es Salaam, Tanzania.

MATERNAL HEALTH AND CHILDBEARING

MDG 5 aims to reduce maternal mortality, and achieve universal access to reproductive health, by 2015. Target indicators include the contraceptive prevalence rate, the adolescent birth rate, and the unmet need for family planning. Because adolescent childbearing is risky for mothers and their infants, achieving MDG 5 is critically dependent on meeting the contraceptive needs of adolescents, delaying the first birth, ensuring antenatal care and skilled attendance at birth, and preventing unsafe abortion.

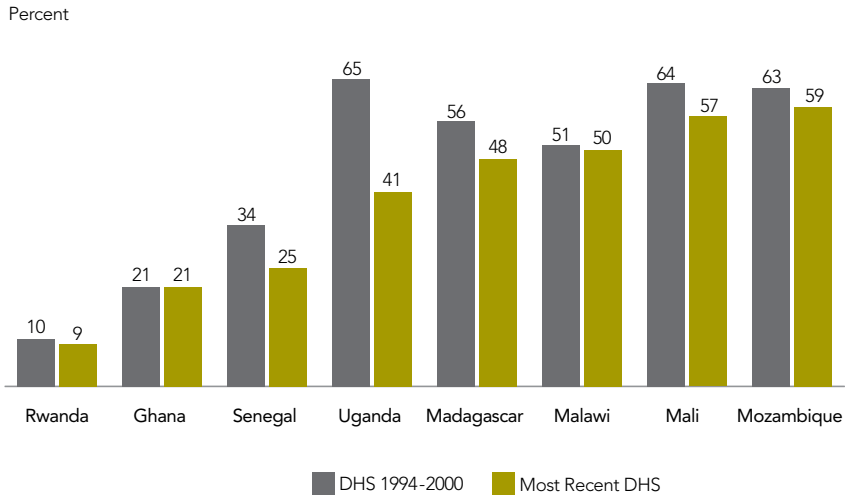
Adolescent Birth Rates Have Declined Over Time Only in Some Countries

Childbearing during adolescence is common in sub-Saharan Africa, and primarily occurs within marriage. If young married women do not use contraception, early marriage is soon followed by early pregnancy. Figure 15 presents the percentage of young women who are mothers by the time they reach 18.

- While early childbearing is generally lower in the most recent DHS than in the 1990s, at least 40 percent of 18-year-olds in five countries have already become mothers or are pregnant with their first child.
- In Mozambique and Mali, almost 60 percent of 18-year-olds have become or are about to become mothers.
- By contrast, less than 10 percent of 18-year-olds in Rwanda have either been pregnant or have already become mothers. As was shown in Figure 8 (page 10), only 19 percent of young women under age 18 have been sexually active.

FIGURE 15

Women Age 18 Who Are Mothers or Pregnant With First Child



Source: Demographic and Health Surveys, 2008/9.

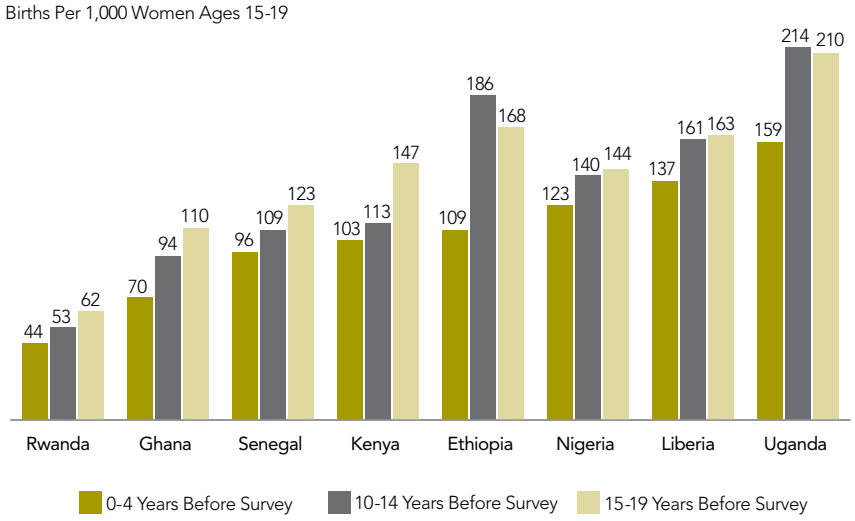
Early Childbearing Is Clearly Decreasing in Only About Half of These Countries

Because adolescent birth rates are an indicator for MDG 5, it is helpful to look at whether and where changes are occurring over time. Figure 16 provides a comparison of age-specific birth rates among 15-to-19-year-olds in countries where there is clear evidence of decline, and Figure 17 presents countries where there has been little or no decline over the last 20 years. Birth rates are reported for three time periods: the most recent (0 to 4 years before the survey), 10 to 14 years, and 15 to 19 years before the current survey.*

- A birth rate of more than 100 births per 1,000 girls ages 15 to 19 suggests that over a five-year period, a majority of adolescents in all but three of these countries will have given birth by the time they reach their 20th birthday.
- Two of these exceptions—Ghana and Rwanda—now have birth rates among adolescents that approach the lower levels seen in developed countries.
- In contrast, as shown in Figure 17, birth rates in Madagascar have increased dramatically in the past 10 years; in Mozambique, there has been a notable increase; and in Tanzania, birth rates among adolescents today are nearly the same as they were 20 years ago.
- Births among 15-to-19-year-olds are highest in Mali and Mozambique, and are about four times as high as among adolescents in Rwanda.

FIGURE 16

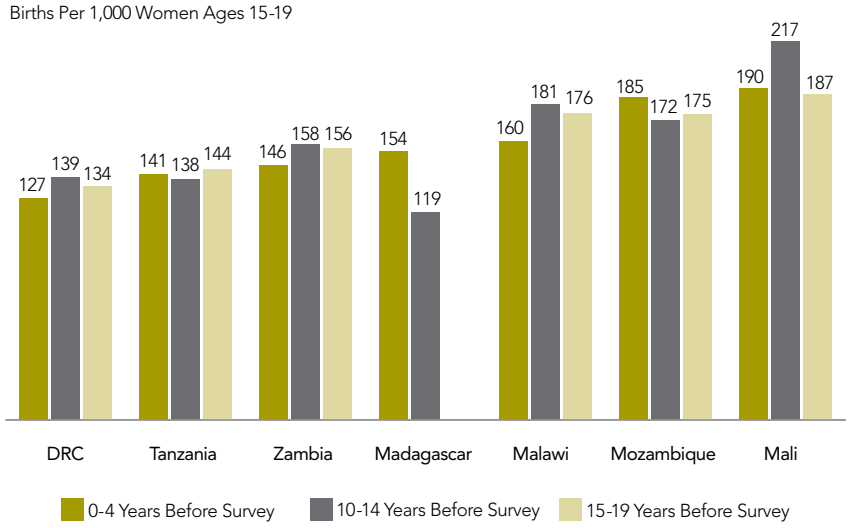
Countries With at Least a 15 Percent Decline in Adolescent Birth Rates Over the Last 20 Years



Source: Demographic and Health Surveys, 2003-2008/9.

FIGURE 17

Countries With Little or No Decline in Adolescent Birth Rates Over the Last 20 Years



Note: Data on 15-19 years before survey are not available for Madagascar.
Source: Demographic and Health Surveys, 2003-2008.

*There are slight differences between current adolescent fertility, which is based on births during the three years prior to the survey, and the trend fertility reported in Figures 16 and 17 (reported in five-year increments). Current adolescent fertility in Rwanda is 40 births per 1,000 girls ages 15 to 19, as compared with 44 births for the most recent five years.

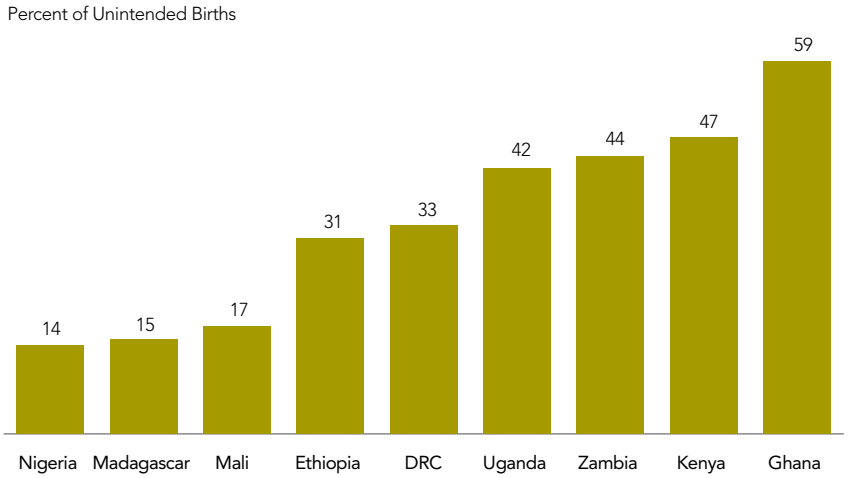
Unintended and Mistimed Pregnancies Are Common

Many births to adolescents are unintended or wanted later. Globally, unintended pregnancies are highest in Africa, especially in East Africa. This variation in the rate of unintended pregnancies can be explained by differences in use and availability of modern contraceptives in East and West Africa.[13] Figure 18 shows the percentage of births that were unintended (either unwanted or mistimed) among women ages 15 to 19 and provides evidence that adolescents are becoming mothers sooner or more frequently than they intended.

- In Ghana, one of the few countries where contraceptive use among adolescents has remained static in recent years, nearly 60 percent of adolescents report that their recent birth was unintended.
- More than 40 percent of births to adolescents in Kenya, Uganda, and Zambia, and more than 30 percent in the DRC and Ethiopia, were reported as unintended. Most unintended births are mistimed rather than unwanted, suggesting that these young women have an unmet need for contraception to space or postpone their next pregnancy.
- Most pregnancies in Nigeria, Madagascar, and Mali were reported as intended, reflecting early marriages and social norms that support early childbearing.

FIGURE 18

Percent of Unintended Births Among Women Ages 15-19



Source: Demographic and Health Surveys, 2003-2008.

© 2005 Felix Masi/Voiceless Children, Courtesy of Photoshare

A young father is one of the few youths in his village in Kenya who has taken on the responsibility of parenthood at an early age.

Young Women Want Fewer Children Than Their Mothers Wanted

With the exception of Ghana and Kenya, women in the countries profiled in this chartbook have on average five to six births over the course of their lifetimes. Figure 19 compares the mean ideal number of children wanted by women ages 15 to 19 with those of women ages 45 to 49, and Figure 20 shows countries that also include data from men on ideal family size. Desired number of children is generally higher among rural residents.

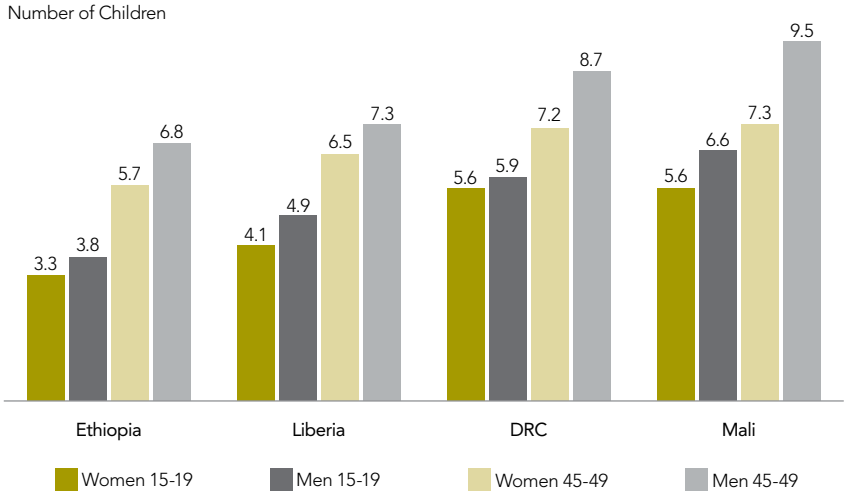
FIGURE 19

Ideal Family Size Among Adolescent and Older Women

Source: Demographic and Health Surveys, 2003-2008.

FIGURE 20

Ideal Family Size Among Youth and Adults, Male and Female



Source: Demographic and Health Surveys, 2003-2008.

- In nearly all countries, ideal family size has declined among younger women, especially in Malawi and Zambia where women ages 45 to 49 wanted five to six children and women ages 15 to 19 want three to four children each.
- Desires for children are consistently higher for men than for women but ideal family size is substantially smaller among younger than older men.
- In Mali, for example, young men ages 15 to 19 said they wanted one child more than women of the same age did, but three fewer children than older men wanted.
- As ideal family size gets smaller among young generations, ensuring access to family planning will help young women and men avoid mistimed pregnancies and unintended births so that they do not give birth to more children than they intend to have.

Adolescents Are Twice as Likely as Women in Their Twenties to Die of Maternal Causes

Young women who give birth before age 20 are at greater risk for complications of pregnancy and delivery than are older women. These risks are heightened if women give birth without the assistance of a trained health worker. Figure 21 presents data on the percentage of births to young women that were attended by skilled health personnel.

- In Ethiopia, where most people reside in rural areas, less than 10 percent of adolescent births are attended by skilled health personnel. In addition, younger women in Ethiopia are less likely than older women to receive good antenatal care: to be informed of the signs of pregnancy complications, to be weighed, or to have their blood pressure measured.[14]
- The DRC is the only one among these countries where the level of skilled attendance at birth reaches almost 80 percent for women ages 15 to 19.

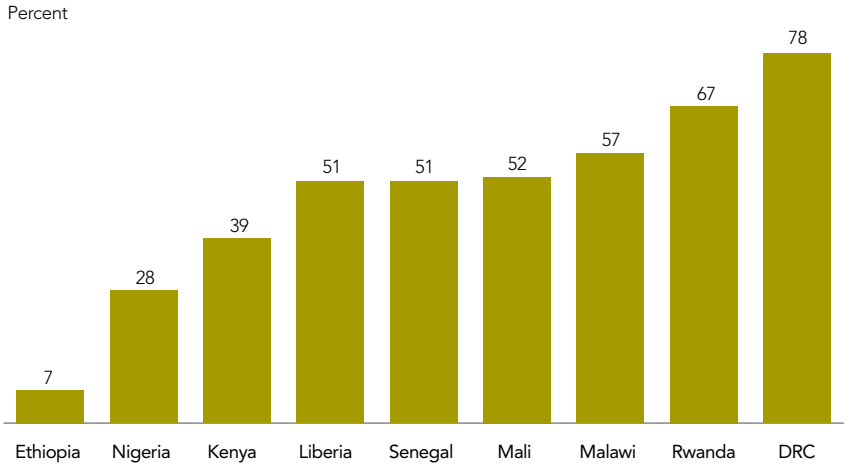
The high adolescent birth rates in these countries contribute to among the highest rates of maternal mortality in the world. Among women ages 15 to 49, maternal mortality is above 600 deaths per 100,000 live births in Ethiopia, Liberia, Malawi, and Rwanda, and above 400 in most of the remaining countries. Although maternal mortality ratios are not available for women ages 15 to 19, complications of pregnancy and delivery are the main causes of death for girls of this age. Women in sub-Saharan Africa have a one in 22 lifetime risk of dying of causes related to pregnancy and childbirth, and maternal deaths for women ages 15 to 19 are twice as high as for women in their 20s.[15]

Infants Born to Adolescent Mothers Are Also at Greater Risk

The relationship between a mother's age at birth and the survival of her infant is well illustrated in Figure 22.

FIGURE 21

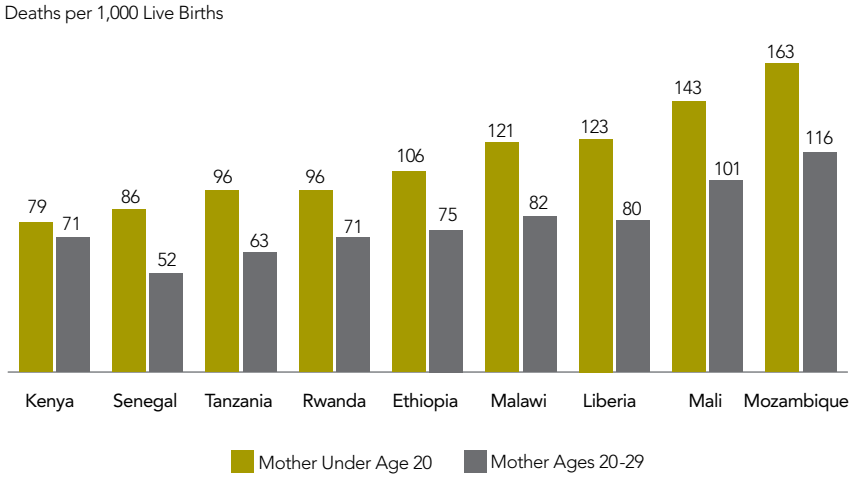
Skilled Attendance at Birth, Women Ages 15-19



Source: Demographic and Health Surveys, 2003-2008/9.

FIGURE 22

Infant Mortality Rates by Age of Mother at Birth



Source: Demographic and Health Surveys, 2003-2008/9.

Infants born to women under age 20 are more likely to die in the first year of life than are infants born to women ages 20 to 29. In most of these countries, at least one in 10 infants born to mothers younger than 20 dies in the first year of life.

- In Mozambique, one in six infants born to women younger than 20 dies.
- Even in Rwanda, where infant mortality has declined by 35 percent between 2005 and 2008, deaths to infants are still 25 percentage points higher among women under 20 than among older mothers.[16]
- New research based on DHS data shows that the firstborn children of young mothers are also more likely to have stunted growth, to be underweight, and to suffer from anemia. Children born to women ages 15 to 18 are one-and-a-half times as likely to die before age 5 as are children born to women ages 24 to 27.[17]

Encouraging and enabling young women to delay their first pregnancy until they have physically and socially matured is an important strategy to reach MDG 4: to reduce child mortality and cut infant mortality by two-thirds of its 1990 level by 2015. Keeping girls in school, increasing access to modern contraception, and changing gender and social norms that promote early childbearing can jointly spur progress to achieve MDG 4.

© 2007 Emmanuel 'Dipo Ololorin, Courtesy of Photoshare

A teenage mother in Nigeria holds her underweight infant in the Kangaroo Mother Care position to keep the baby warm until it can maintain its own body temperature.

Risk of Unsafe Abortion Is High for Young Women

In sub-Saharan Africa, where maternal mortality reaches its highest levels, complications from abortions that are performed unsafely have led to the highest rate of abortion-related death in the world. Globally, 13 percent of maternal deaths are due to unsafe abortion, but one in five maternal deaths in East Africa and up to a third of maternal deaths in some African countries are due to complications of unsafe abortion.[1] Treating such complications overwhelms already inadequate health systems, and diverts very limited health care resources from other critical areas.[2]

- Sixty percent of all unsafe abortions occur among women age 25 or younger.
- Seventy percent of women hospitalized with complications from an unsafe abortion are under the age of 20.[3]
- Ninety-nine percent of all abortions in Africa are performed under unsafe conditions, leading to hospitalization rates for complications of unsafe abortion that are twice as high in Africa as in Asia.
- Unmarried adolescents who fear discovery of an out-of-wedlock pregnancy by their parents may be especially unlikely to seek medical care. Even if girls are aware of the dangers they face—severe bleeding, infections, infertility, or death—they may endure the risks of unsafe abortion out of desperation.

Abortion is not permitted for any reason in 14 African countries, including the DRC, Madagascar, and Senegal. Abortion is legal only to save the life of the mother in Kenya, Malawi, Mali, Nigeria, Tanzania, and Uganda. In Ghana, Liberia, and Zambia, abortion is permitted to preserve the mother's mental health. Ethiopia liberalized its abortion law in 2005 to allow abortion in the case of rape, incest, or fetal impairment, as well as for adolescents who lack the capability to bring up a child.[4]

References

1 Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress* (New York: Guttmacher Institute, 2009).

2 David Grimes et al., "Unsafe Abortion: The Preventable Pandemic," *Lancet* 368, no 9550 (2006):1908-19.

3 Iqbal Shah, "Age-Patterns of Unsafe Abortion in Developing Country Regions," *Reproductive Health Matters* 12, no. 24 (2004) .

4 Guttmacher Institute, *Facts on Abortion and Unintended Pregnancy in Africa*, and *Facts on Abortion in Kenya*, *In Brief* (New York: Guttmacher Institute, 2009).

CONTRACEPTION

MDG 5 aims to reduce maternal mortality and ensure universal access to reproductive health services for all women by 2015. The targets for this goal include increasing contraceptive prevalence and lowering unmet need for contraception. In much of sub-Saharan Africa, young women's sexual activity too often results in unplanned pregnancies and complications and deaths due to unsafe abortion. Fulfilling unmet need for contraception and generating informed demand for family planning services are critical strategies for enabling young, sexually active women, whether married or unmarried, to reach their full potential. If they can avoid unplanned pregnancies and choose the timing and spacing of their births, they and their societies will reap the benefits of delayed childbearing and reduced fertility.

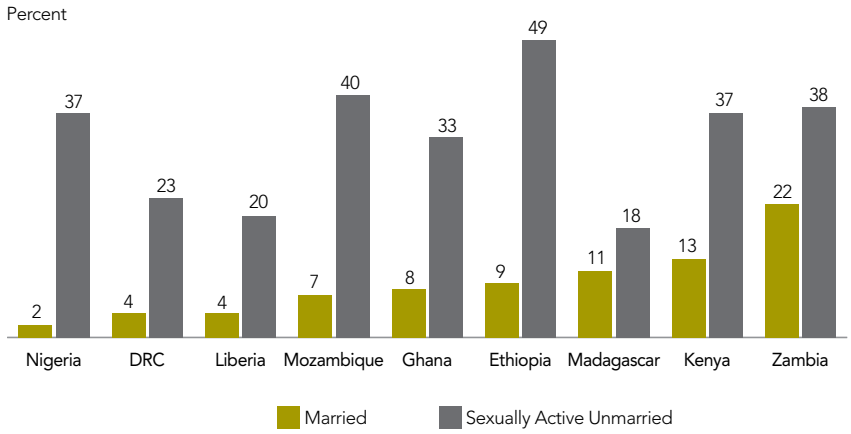
Young Married Women Rarely Use Contraceptives, Although Many Want to Avoid Becoming Pregnant

In recent decades, most young women have become aware of at least one modern method of contraception (the oral pill, injectables and implants, IUDs, male and female sterilization, condoms, and modern vaginal methods such as diaphragms and spermicides).[18] However, as shown in Figure 23, young women in sub-Saharan Africa, especially those who are married, are not likely to use modern methods.

- In six of the nine countries profiled, less than 10 percent of married adolescents are using any modern method. Factors associated with low contraceptive use among married adolescents include inadequate knowledge about contraception, limited ability to make independent decisions about using contraceptives or about when to have children, and lack of experience in obtaining family planning services.[19]
- Use of modern contraception among sexually active unmarried women is several times higher than among married women, including in countries with a sizeable percentage of unmarried women who are sexually active, such as Kenya, Mozambique, Nigeria, and Zambia.
- In countries where nearly all adolescents who are sexually active are married, such as Ethiopia, higher contraceptive rates among unmarried women apply to a relatively small percentage of women.

FIGURE 23

Current Use of Modern Contraception by Married and Unmarried Women Ages 15-19



Source: Demographic and Health Surveys, 2003-2008.

Contraceptive Use and Method Mix Vary Across Regions

Figure 24 provides a closer look at contraceptive use among unmarried, sexually active women ages 15 to 19. Although in most of the region, having children outside of marriage is not socially accepted, most sexually active, unmarried young women are not using any form of family planning to prevent an unintended pregnancy.

- In six of the profiled countries, condoms are used more than any other form of contraception by unmarried adolescents. These women may find condoms easier to locate or purchase than clinic-based methods. Young women may also recognize the importance of condoms in preventing HIV and other sexually transmitted infections. However, in only three countries (Mozambique, Nigeria, and Zambia) do approximately 30 percent of sexually active unmarried women use condoms.
- In the DRC, Nigeria, Madagascar, and Ghana, many women rely on traditional methods instead of modern methods including condoms. In the DRC, traditional methods represent about half of the family planning method mix.

Contraceptive Knowledge Among Young Women in Ethiopia

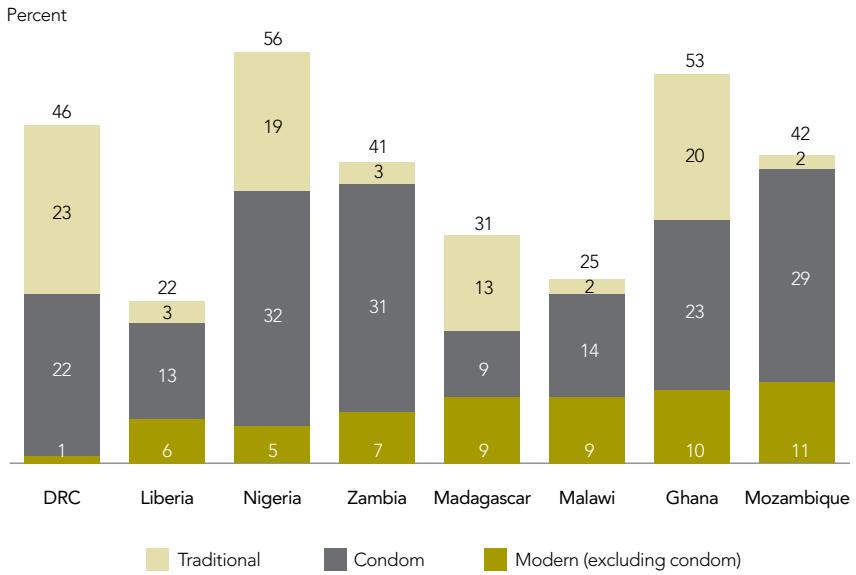
Among young women ages 15 to 19 in Ethiopia, contraceptive knowledge increased markedly between 2000 and 2005, and use of contraception doubled between the two surveys. Nevertheless, more than three of four sexually experienced women ages 15 to 24 (mostly married) have never used a contraceptive method.[1] These young women need much better family planning information and access if they are to achieve the much smaller family sizes they desire.

Reference

1 Zhushi Moore et al., *Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005* (Calverton, MD: ICF Macro, 2008).

FIGURE 24

Contraceptive Method Mix Among Unmarried Women Ages 15-19



Source: Demographic and Health Surveys, 2003-2008.

© 2008 Samaila Yusuf, Courtesy of Photoshare

Trained volunteers address the common misconceptions about family planning and the importance of healthy timing and spacing of pregnancy for adolescent and older mothers in Kano State, Nigeria.

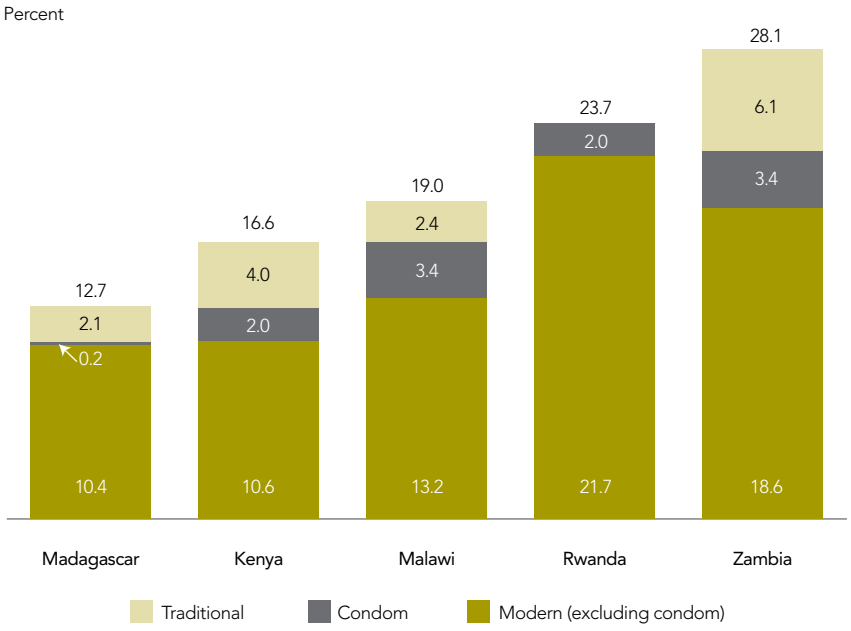
Contraceptive Methods Are Less Used by Young Married Women in West Africa

Method mix among married adolescents is shown in Figures 25 and 26 by region. There is considerable variation in both contraceptive prevalence and the types of methods preferred across regions.

- In general, married adolescents in East Africa have much higher rates of modern contraceptive use than do married adolescents in Central and West Africa.
- Use of modern methods excluding condoms in selected East African countries range from 10 percent in Madagascar to 22 percent in Rwanda. In contrast, modern contraception excluding condoms among married adolescents in Central and West African countries ranges from less than 1 percent in DRC to 6 percent in Ghana.
- Condom use among married women remains well below 5 percent in all countries. The low use of condoms may reflect young women's inability to negotiate condom use, especially within marriage.

FIGURE 25

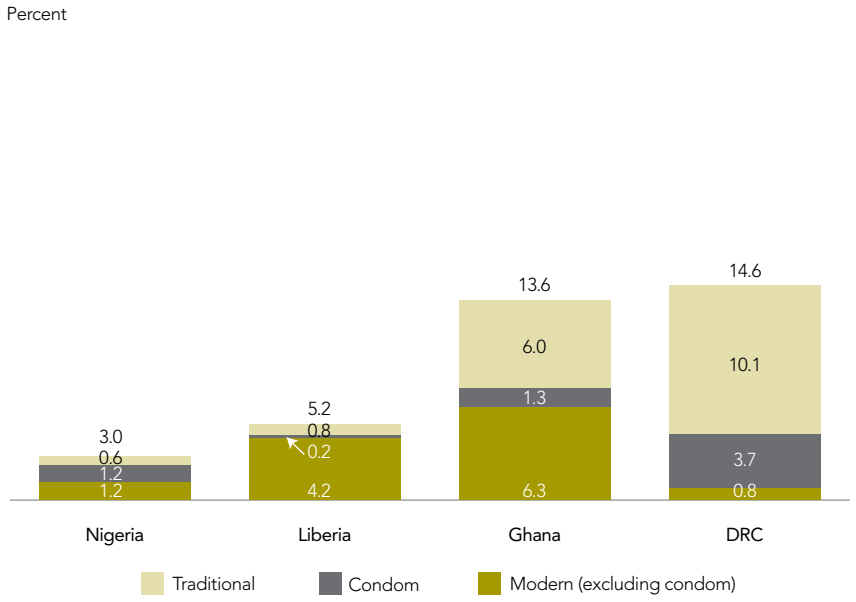
Contraceptive Method Mix Among Married Women Ages 15-19, East Africa



Source: Demographic and Health Surveys, 2003-2008.

FIGURE 26

Contraceptive Method Mix Among Married Women Ages 15-19, Central and West Africa



Source: Demographic and Health Surveys, 2003-2008.

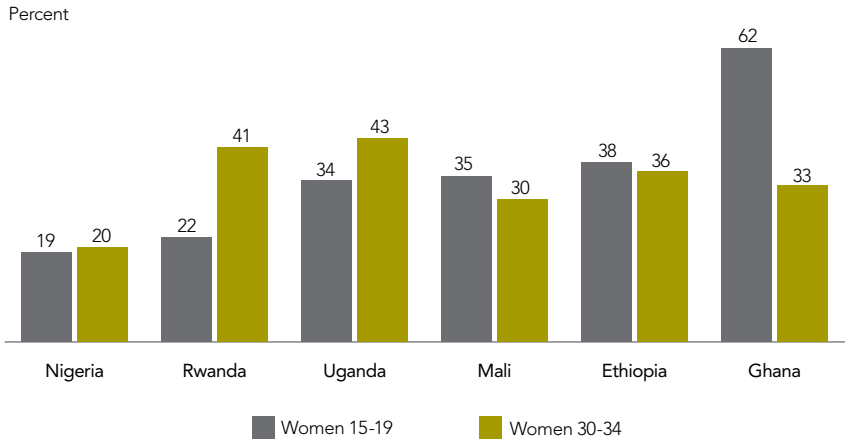
Reducing Unmet Need Among Youth Is Critical to Achieving MDGs 4, 5, and 6

Unmet need for family planning is defined as the percentage of women who do not want any more children, or want to postpone their next birth by at least two years, but are not using a method of contraception to make this possible. An estimated 215 million women worldwide have an unmet need for an effective method of contraception.[20] As shown in Figure 27, unmet need is high among married women ages 15 to 19 and 30 to 34.

- Among married women ages 15 to 19, unmet need ranges from 19 percent in Nigeria to 62 percent in Ghana.
- Unmet need is higher among younger married women in Ethiopia and Mali, and especially in Ghana, than it is among older married women ages 30 to 34.

FIGURE 27

Unmet Need for Contraception Among Currently Married Women Ages 15-19 and 30-34



Source: Demographic and Health Surveys, 2003-2008.

- The low level of unmet need in Nigeria, coupled with low contraceptive use among married adolescents, suggests that many young married women want to become pregnant or are responding to cultural norms to have children early in marriage.

Although use of modern contraception is low among married young women, many of them indicate that they do not want to become pregnant. Unmet need among adolescents is fueled by lack of information and fear of social disapproval, by opposition from their husbands, and from concern about contraceptive side effects or effects on health. To achieve the MDG 5 targets to reduce unmet need and improve maternal health, reproductive health programs need to ensure that a variety of modern methods are available to meet the diverse needs of clients—especially adolescents.[21]

© 2009 Shandy Fox, Courtesy of Photoshare

A young mother and her new baby in Mozambique stand in the doorway of the local hospital's Casa de Espera, or "House of Waiting."

Young Women Are Very Likely to Experience Gender-Based Violence

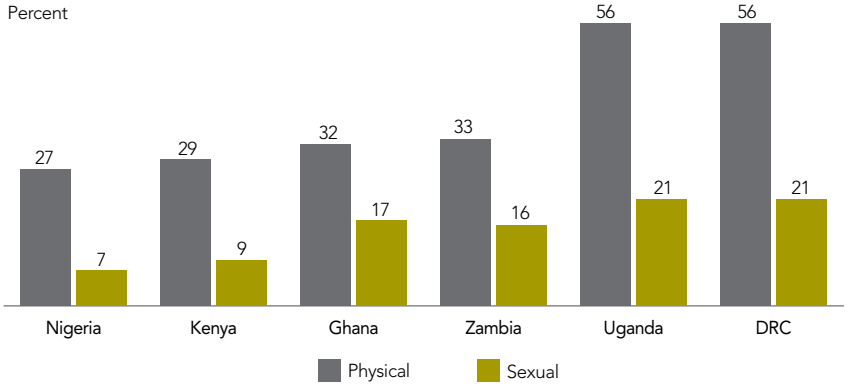
Achieving MDG 3 to promote gender equity and empower women requires changing harmful gender norms and behaviors that stand in the way of women's full participation in society. A profound measure of gender inequity is the frequency of violence and harmful practices directed against women. The extent of such violence is increasingly recognized as a major global health problem. In research conducted in 10 countries by the World Health Organization, the majority of women had experienced physical or sexual violence (or both) from an intimate partner at some time in their lives.[22] Young women ages 15 to 19 were at higher risk in all but two of these countries.

Figure 28 shows that both physical and sexual violence are commonly experienced by young women in all six countries profiled.

- More than half of young women had experienced physical violence in Uganda and DRC, and more than one in five young women had experienced sexual violence.
- Violence during pregnancy is associated with low birth weight and other risk factors for poor birth and health outcomes. Women are especially at risk of violence during an unintended pregnancy.

FIGURE 28

Percentage of Women Ages 15-19 Who Have Experienced Physical or Sexual Violence



Source: Demographic and Health Surveys, 2003-2008.

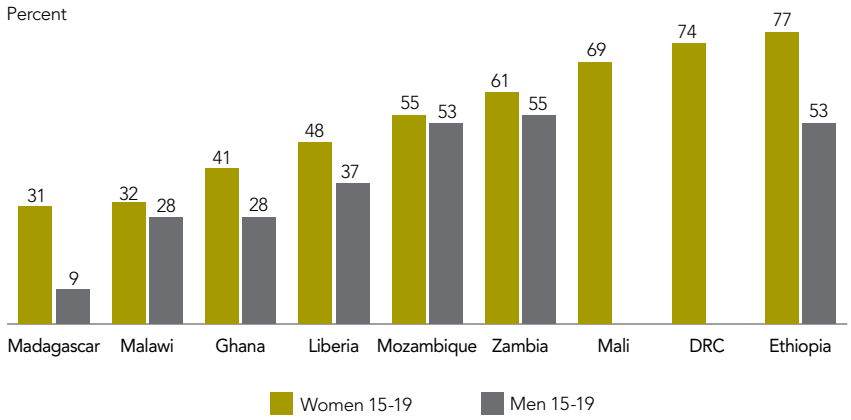
Violence Against Women Is Culturally Accepted by Both Women and Men

Figure 29 shows that violent behavior toward women is often an ingrained cultural norm subscribed to by women and men.

- In these countries, women ages 15 to 19 are more likely than men of the same age to agree that a husband is justified in hitting or beating his wife for one or more specific reasons, such as burning the food, arguing with him, going out without telling him, neglecting the children, or refusing to have sex with him.
- Nearly 80 percent of young women in Ethiopia agree with one or more justifications for a husband to beat his wife.
- In Madagascar, more than three times as many young women as young men believe that wife beating is justified for one or more reasons.

FIGURE 29

Youth Who Agree That a Husband Is Justified in Hitting or Beating His Wife for at Least 1 Specific Reason



Note: Data on men are not available for Mali and DRC.
Source: Demographic and Health Surveys, 2003-2008.

Female Genital Mutilation Is Widely Practiced in Some Countries

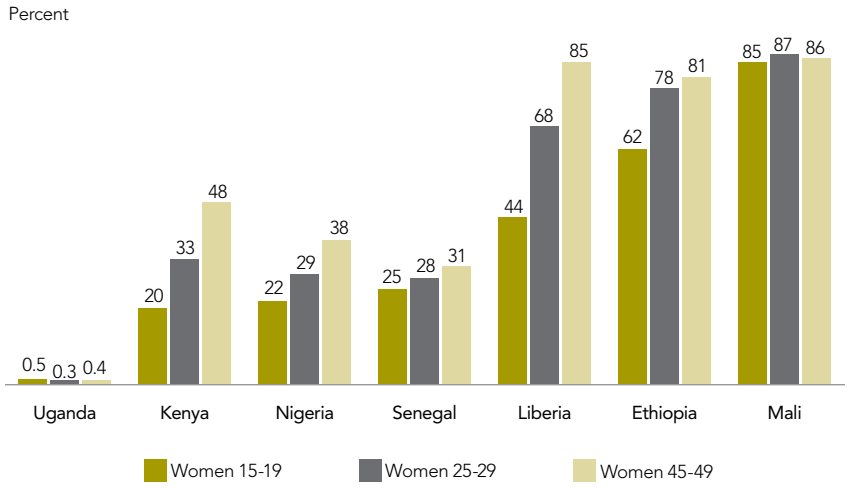
Female genital mutilation/cutting (FGM/C) is globally recognized as a harmful cultural practice that violates a girl's human rights, and is linked to adverse health outcomes for women, particularly during pregnancy and childbirth. Each year, more than 3 million girls, the majority of them living in sub-Saharan Africa, face risk of cutting.

Figure 30 shows the prevalence of FGM/C among women of different age groups in seven countries. Because FGM/C has usually taken place by the time a girl reaches early adolescence, the percentage of women who reach age 19 without having undergone FGM/C is an indication of whether the practice is diminishing in comparison with older women.

- FGM/C has almost disappeared in Uganda, where less than 1 percent of young women report being cut. By contrast, 85 percent of young women have been cut in Mali, despite FGM eradication efforts that have been underway for more than a decade.

FIGURE 30

Prevalence of Female Genital Mutilation/Cutting



Source: Demographic and Health Surveys, 2003-2008.

- In Kenya, Nigeria, Liberia, and Ethiopia, fewer young women ages 15 to 19 have undergone FGM/C, compared with older women. In Senegal, where FGM/C primarily occurs in early childhood, as it does in Mali, prevalence is declining more slowly than in the other four countries.

The realization of MDG 3 depends on the abandonment of deeply rooted gender inequities. To end these harmful practices and advance more equitable social norms, programs and schools must begin early in life to alter cultural expectations for girls, and to reinforce more equitable relationships between boys and girls. Women and men must be made aware that freedom from violence is a basic human right. Similarly, well-meaning parents who view FGM/C as a way to prepare daughters for marriage must come to recognize the practice as a violation of the rights of girls and women.

© 2005 Netsanet Assaye. Courtesy of Photoshare

Ethiopian girls smile because they are the first generation in their village who do not have to undergo female genital cutting. Their mothers were not willing to let them be cut because they have realized the consequences of that practice during their own lifetimes.

AGE STRUCTURE, POPULATION GROWTH, AND THE MDGS

The Youthful Age Structure of Sub-Saharan African Countries Presents an Obstacle and an Opportunity to Achieving the MDGs

Achieving the MDGs will require focused attention on meeting the needs of youth. This chartbook highlights some of the many health and development challenges facing adolescents in sub-Saharan Africa. For the region as a whole, achieving the MDGs is directly linked to addressing the continued high fertility and rapid population growth in the region, and the challenges of meeting the health and education needs of entire populations—and especially youth.

These countries are characterized by extremely youthful age structures, rapid growth in the working-age population, and rapid urbanization.[23] As their populations grow, there are more children and youth who need health services and housing, education, and employment. Most women in these countries begin childbearing at a young age and give birth to five or more children; some women lose as many as one in five children in the first five years of life.

Youth in Africa are primarily engaged in agriculture, where they make up 65 percent of total employment in that sector.[24] Rapid population growth places increased pressure on scarce land resources and can also outpace the ability of countries to create sufficient nonfarming job opportunities for young people. High youth unemployment represents a lost opportunity to capitalize on the potential for a demographic "bonus"—a one-time boost to economic advancement that is only possible when there is a favorable ratio of workers to those in the dependent ages.

© 2007 Zahur Ramji, Courtesy of USAID Photo Gallery

Two young women participate in a science camp for girls in Zanzibar, Tanzania, aimed to boost student performance in math, science, and English.

As displayed in population pyramids, age structure tells a story. Figure 31 shows the population pyramid for Mali, which in many ways typifies the age structure of the region.

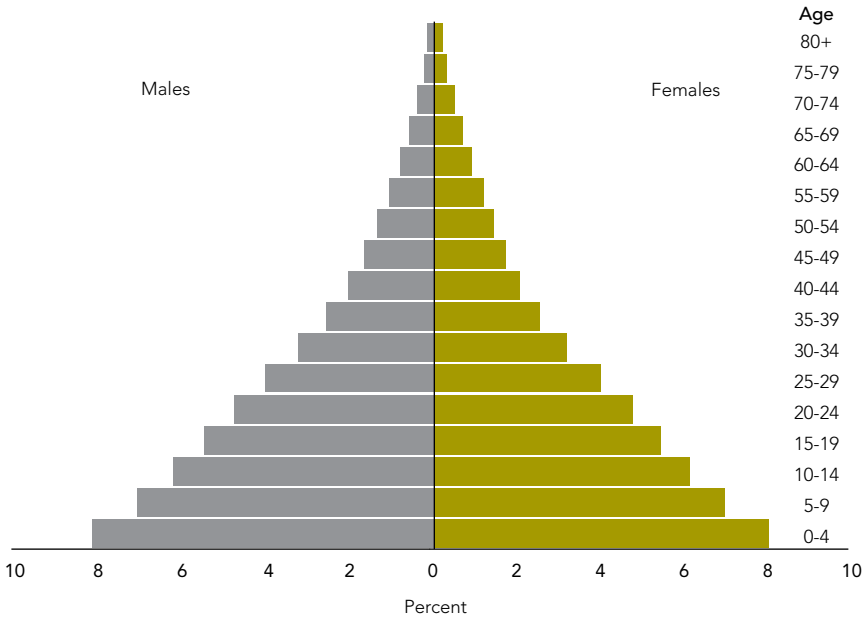
- Mali's annual growth rate is 2.4 percent: Its population will double in size in less than 30 years.
- The pyramidal shape, with its enormous base population of children ages 0 to 5, shows that even if fertility were to decline rapidly, the number of children already born who will become parents within a few years will ensure rapid population growth for many years to come.

Ever-larger numbers of people require ever-increasing investments just to maintain a given level of health, education, and jobs. Progress in these areas will require commitment to eliminating child marriage and early childbearing, improving youth access to information and media, and changing attitudes and norms about gender roles.

Mali's pyramid is in contrast to Western Europe. Figure 32 displays the age structure of a region where population growth has virtually ceased. While Western Europe faces problems related to the rapid aging of its population, its age structure enables investment in improving the quality of life for a stable number of citizens.

FIGURE 31

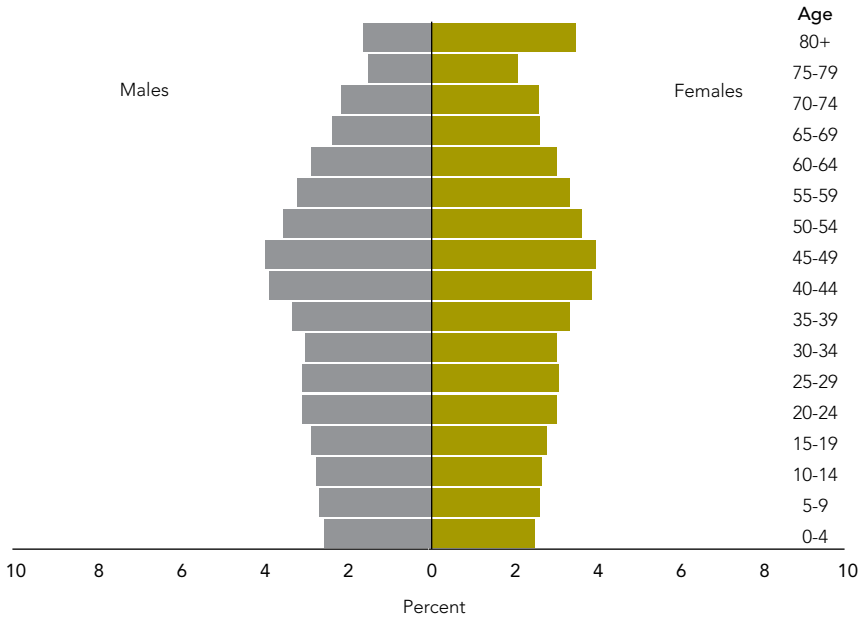
Population Pyramid, Mali, 2010



Source: United Nations Population Division, *World Population Prospects: The 2008 Revision* (2009), medium variant.

FIGURE 32

Population Pyramid, Western Europe, 2010



Source: United Nations Population Division, *World Population Prospects: The 2008 Revision* (2009), medium variant.

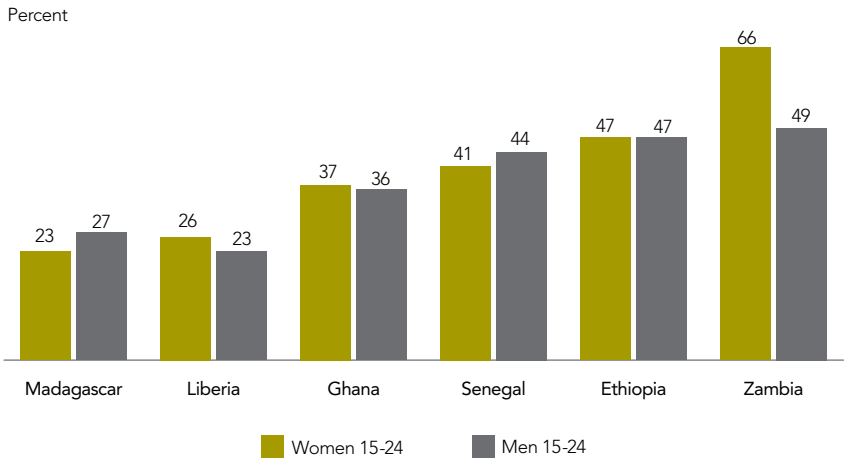
MDG 1 Calls for Full Productive Employment for All, Including Women and Youth

The employment prospects for youth, especially those with low levels of education and job skills, are hindered by the stiff competition for jobs that face this largest-ever cohort of youth. In sub-Saharan Africa, as many as three in five of the total unemployed are youth. Youth unemployment and underemployment can fuel social and political instability, as was recently demonstrated in Uganda, where violent and destructive street demonstrations, largely led by youth, occurred in 2008.[25]

Many youth manage to find partial employment, but underemployment is far more common among youth than among adults.[26] The share of total unemployment due to youth unemployment in shown in Figure 33.

FIGURE 33

The Share of Unemployed Women and Men Who Are Youth Ages 15-24



Source: Demographic and Health Surveys, 2003-2008.

- In Ethiopia and Zambia, almost half of unemployment among men occurs among young men ages 15 to 24.
- In five of the six countries profiled, young women and men represent similar portions of the unemployed. In Zambia, unemployment among young women represents two-thirds of all unemployment among women.
- The lower shares of youth unemployment in Madagascar and Liberia suggest that unemployment is greater in these countries among older adults.

© 2007 Gilbert Awekofua/Straight Talk Foundation, Courtesy of Photoshare

A teenage girl cracks stones at a quarry in northern Uganda. Like hundreds of others, she abandoned her village for fear of being abducted by Lords Resistance Army (LRA) rebels, who over the last 20 years have forced more than 20,000 children to become armed rebels and sex slaves.

To achieve MDG 1 and eradicate extreme poverty, youth need greater opportunities to earn a living. Because women are especially concentrated in agriculture and the low-paying and unregulated informal labor force, MDG 3 (to promote gender equity and empower women) calls for increasing the share of women in wage employment in the nonagricultural sector. Investment in job creation is critical to ending poverty. National investments in health and education will lead to a higher-skilled labor force; when coupled with investment policies that stimulate job creation, youth will be well positioned to help advance national economic and social development.

© 2004 Julia Lebetkin, Courtesy of Photoshare

The Kumasi Street Children Project in Ghana sponsors street child laborers and other at-risk youth to attend school or learn skilled trades. Adolescents laugh when a volunteer asks whether any of them has a boyfriend or girlfriend.

Demographic Dividend

In many countries profiled in this chartbook, there is, or soon will be, a favorable ratio of those in the working ages (generally 15 to 59) to those who are dependent on them for financial support (generally children and the elderly). Under the right conditions, this can create a short-term but substantial economic opportunity for a "demographic dividend." The relatively larger work force provides a window of opportunity to speed up economic development, save money on health care and other social services, improve the quality of education, and invest more in technology and skills to strengthen the economy. The window eventually closes as the work force ages and relatively fewer workers are available to support an increasing number of older people.

While up to a third of the rapid economic growth among the fastest-growing economies in East Asia can be attributed to this dividend and the accompanying increase in savings and wealth accumulation, countries in sub-Saharan Africa could experience a demographic bonus only if youth are educated, have job skills, are productively employed, and save and invest their incomes wisely.[1] The demographic bonus also depends on strong public health systems to improve health and child survival, widespread availability and use of family planning, decline in birth rates, increased schooling and quality of education, and a stable economy that promotes growth and job creation. An uneducated and unskilled youth population will not trigger a demographic dividend and can undermine national stability and economic security.

Policymakers need a greater understanding of the relationship between age structure of the population and economic development and that investments in reproductive health programs pay off: In communities with improved access to family planning and reproductive health services, families are wealthier and children are healthier and better educated.

Source

Luc Christiaensen et al., *Capturing the Demographic Bonus in Ethiopia: Gender, Development and Demographic Actions* (Washington, DC: World Bank, 2007).

INVESTING IN YOUTH AND THE MILLENNIUM DEVELOPMENT GOALS: RECOMMENDATIONS

With the global focus on 2015 and the MDGs, this chartbook highlights the life circumstances of youth in sub-Saharan Africa, showing how investments in youth can help achieve the MDGs. The very young age structure of sub-Saharan Africa has special significance for youth, who are entering their reproductive years and their years of productive employment. With so much competition for jobs, agricultural land, and environmental resources, policymakers must consider how the needs of youth can best be served and how meeting those needs will contribute to MDG targets.

Educate All Youth, Especially Girls. Expanding access to female education is vital to achieving all of the MDGs and should be the overriding priority of international development policies.[27] Ending the high dropout rate among adolescent girls requires educating parents about the importance of a girl's education to all aspects of her future; ensuring that schools and governments protect her physical safety to, from, and within schools; providing access to private hygiene and sanitation facilities; and ending gender-based harassment on the part of teachers and male students. The relationship between the increased education of girls and better health of women and children is clear. Investments to improve enrollment and the quality of education, especially at the secondary level, can be expected to reduce future fertility, slow population growth, and offer a wealth of benefits for present and future generations.

Provide Comprehensive Sexuality Education. All children and youth have a need for the information and skills that comprehensive, age-appropriate, culturally relevant and scientifically accurate teaching about sex and relationships for youth provides. Effective sexuality education programs have been shown to reduce misinformation and increase correct knowledge, strengthen skills for delaying sexual debut and negotiating safe sex, and promote positive values and attitudes. Well-designed sexuality education programs can foster increased communication between youth and their parents; lead to positive changes in behavior; and make an important contribution to MDG 3 to empower women, to MDG 5 to reduce maternal mortality and achieve universal access to reproductive health, and to MDG 6 to combat HIV/AIDS.[28]

Ensure Youth-Friendly Reproductive Health Services. Investing in reproductive health services that meet the needs of young women and men is central to reaching MDGs 3, 4, 5, and 6. Many youth hesitate to use health services because they fear a lack of confidentiality and judgmental providers. If reproductive health and family planning services are made more attractive for youth, their large unmet need for contraception could be satisfied, thus preventing unplanned births and abortions and enabling many young women to further their education and obtain meaningful employment.

Given the high level of unmet need for contraception as well as the unparalleled risk of HIV, the need for comprehensive integrated reproductive health and HIV/AIDS services, especially for youth, is nowhere more apparent than in sub-Saharan Africa. Linking these services is a cost-effective strategy that will better serve the needs of youth and further national development. Youth-friendly, integrated services are needed throughout the region, providing convenience, privacy, and low-cost or free reproductive health services including HIV testing and counseling for youth.

End Discrimination and Harmful Practices. Underpinning many of the MDGs is the need to promote gender equity, end violence, and eliminate practices including FGM/C that harm girls and women and limit their ability to achieve their potential. The large percentage of young women who believe that men can be justified in beating them indicates that gender-based violence is engrained in many cultures. Educational and community-based behavior change communication programs are needed to challenge these deeply rooted beliefs and behaviors among both men and women.

Child marriage is a violation of international human rights agreements. Child marriage seriously impairs the future prospects for young girls and impedes national development. Governments should establish and enforce laws and policies consistent with the international standard minimum age of marriage of 18 years, and educate parents about the risks of early marriage and childbearing.

Expand Economic Opportunities for Youth. MDG 1 draws attention to the pervasiveness of extreme poverty and the need to eliminate it. In most of the profiled countries, young women and men are poor, living on less than $2 per day, and represent a sizable portion of the unemployed and underemployed. Most employed young people engage in agriculture and face declining arable land and farm sizes. International investment is needed to build the skills and capacity of both young women and young men for productive employment in other sectors within their own countries. Such investment will contribute to the health of individuals, families, communities, and national economies, as well as to the stability and security of the region and the globe.

© 2009 Erberto Zani, Courtesy of Photoshare

Male and female youth help build a water system on the highest mountain in the Mafi Seva region of Ghana.

To succeed in today's competitive global economy, as well as to thrive within their own countries, the youth of sub-Saharan Africa require and deserve the attention and investments of their own governments and that of international donors. Creating a brighter future for the youth of sub-Saharan Africa will ultimately benefit us all.

REFERENCES

1 World Bank, *Development and the Next Generation: World Development Report, 2007* (Washington, DC: The International Bank for Reconstruction and Development/World Bank, 2006); and Caroline Zwiker and Karin Ringheim, *Commitments: Youth Reproductive Health, the World Bank and the Millennium Development Goals* (Washington, DC: Global Health Council, 2004).

2 World Bank, *Development and the Next Generation: World Development Report, 2007*.

3 Susheela Singh et al., *Adding it Up* (New York: UNFPA and Guttmacher Institute, 2009).

4 Population Reference Bureau and African Population and Health Research Center, *2008 Africa Population Data Sheet* (Washington, DC: Population Reference Bureau, 2008).

5 Ruth Levine et al., *Girls Count: A Global Investment and Action Agenda* (Washington DC: Center for Global Development, 2009).

6 George Psacharopoulos and Harry Patrinos, "Returns to Investment in Education: A Further Update," *Education Economics* 12, no. 2 (2004): 111-34.

7 World Bank, *Development and the Next Generation: World Development Report, 2007*.

8 UNICEF, *Early Marriage: A Harmful Traditional Practice, a Statistical Exploration* (New York: UNICEF, 2005).

9 UNAIDS, *Sub-Saharan Africa Fact Sheet* (Geneva: UNAIDS, 2009).

10 Demographic and Health Surveys: Nigeria, 2003 and Uganda, 2004-5, as reported in *Addressing Cross-Generational Sex: A Desk Review of Research and Programs*, by Ruth Hope (Washington DC: Population Reference Bureau, 2007).

11 UNAIDS, *2008 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2008).

12 Karin Ringheim et al., *Supporting the Integration of Family Planning and HIV Services* (Washington, DC: Population Reference Bureau, 2009).

13 Singh et al., *Adding it Up*.

14 Zhuzhi Moore et al., *Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005* (Calverton, MD: ICF Macro, 2008).

15 ICF Macro, *Demographic and Health Surveys, 1997-2004*; and UNICEF, *Progress of Nations, 2000* (New York: UNICEF, 2000).

16 Singh et al., *Adding it Up*.

17 David Canning, Jocelyn Finlay, and Emre Ozaltin, "Adolescent Girls Health Agenda: Study on Intergenerational Health Impacts, Harvard School of Public Health, Annex I," in *Start With a Girl*, ed. Miriam Temin and Ruth Levine (Washington, DC: Center for Global Development, 2009).

18 Singh et al., *Adding it Up*.

19 Singh et al., *Adding it Up*.

20 Singh et al., *Adding it Up*.

21 John Cleland et al., "Family Planning: The Unfinished Agenda," *Lancet* 368, no. 9549 (2006): 1810-27; and USAID, "Family Planning for Married Adolescent Girls," *Global Health Technical Briefs*, accessed at www.maqweb.org/techbriefs/tb25.maradol.pdf, on March 31, 2010.

22 World Health Organization (WHO), *Multi-Country Study on Women's Health and Domestic Violence Against Women* (Geneva: WHO, 2005).

23 PAI, *Family Planning in Sub-Saharan Africa: Reducing Risks in the Era of AIDS* (Washington, DC: PAI, 2006).

24 International Labour Organization (ILO), *Africa Employement Trends* (Geneva: ILO, 2007).

25 Mona Herbert, "Population Growth and Youth in Rural Areas: The Case of Uganda," presentation to the Brussels Rural Development Briefings, ACP-EU Development, December 2009.

26 World Bank, *Africa Development Indicators 2008/9: Youth and Employment in Africa* (Washington, DC: World Bank, 2008).

27 Wolfgang Lutz, "Toward a Better Consensus on Population: Adding the Quality Dimension," presentation to the Brussels Rural Development Briefings, ACP-EU Development, December 2009; and Stan Bernstein and Charlotte Juul Hansen, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (New York: UN Millennium Project, 2006).

28 UNESCO, UNAIDS, UNFPA, UNICEF, and WHO, *International Technical Guidance on Sexuality Education, Vol 1: The Rationale for Sexuality Education, 2009* (Geneva: UNESCO, 2009). The Interagency Youth Working Group website offers resources on this topic at http://info.k4health.org/youthwg/prog_areas/sex-education.shtml.

ACKNOWLEDGMENTS

Karin Ringheim is a senior policy adviser in International Programs at the Population Reference Bureau. James Gribble is vice president of International Programs at PRB. We would like to thank USAID Office of Population and Reproductive Health staff Gloria Coe, Carmen Coles, and Jenny Troung for their commitment to youth and their many contributions to this chartbook. Our appreciation to Carolina Hall, program assistant in International Programs at PRB, for gathering the data for the graphics in this chartbook; to Anne Cross of ICF Macro for help in securing new data; to Kata Fustos, communications intern at PRB, for help in checking the data; and to Ellen Carnevale, vice president for communications and marketing at PRB.

This publication was prepared with support from the BRIDGE Project (No. GPO-A-00-03-00004-00), funded by the United States Agency for International Development (USAID).

APPENDIX

DEMOGRAPHIC AND HEALTH SURVEYS AND IMPLEMENTING AGENCIES

DEMOCRATIC REPUBLIC OF CONGO (DRC)
Ministère du Plan and ICF Macro, *Enquête Démographique de Santé, République Démocratique du Congo 2007* (Calverton, MD: Ministère du Plan and ICF Macro, 2008).

ETHIOPIA
Central Statistical Agency and ICF Macro, *Ethiopia Demographic and Health Survey 2005* (Addis Ababa, Ethiopia, and Calverton, MD: Central Statistical Agency and ICF Macro, 2006).

GHANA
Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro, *Ghana Demographic and Health Survey 2008* (Accra, Ghana: GSS, GHS, and ICF Macro, 2009).

KENYA
Central Bureau of Statistics, Ministry of Health, and ICF Macro, *Kenya Demographic and Health Survey 2003* (Calverton, MD: ICF Macro, 2004).

Kenya National Bureau of Statistics, National AIDS Control Council, National AIDS/STD Control Programme, National Public Health Laboratories Services, Kenya Medical Research Institute, National Coordinating Agency for Population and Development, and MEASURE DHS, *Kenya Demographic and Health Survey 2008-2009, Preliminary Report* (Calverton, MD: ICF Macro, 2009).

LIBERIA
Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health and Social Welfare, National AIDS Control Program, and ICF Macro, *Liberia Demographic and Health Survey 2007* (Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services and ICF Macro, 2008).

MADAGASCAR
Institut National de la Statistique (INSTAT) and ICF Macro, *Enquête Démographique et de Santé de Madagascar 2003-2004* (Calverton, MD: INSTAT and ICF Macro, 2005).

MALAWI
National Statistical Office (NSO) Malawi and ICF Macro, *Malawi Demographic and Health Survey 2004* (Calverton, MD: NSO and ICF Macro, 2005).

MALI
Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de la Statistique et de l'Informatique du Ministère de l'Économie, de l'Industrie et du Commerce (DNSI/MEIC), and ICF Macro, *Enquête Démographique de Santé du Mali 2006* (Calverton, MD: CPS/DNSI and ICF Macro, 2007).

MOZAMBIQUE
Instituto Nacional de Estatística, Ministério da Saúde et MEASURE DHS+/ORC Macro, *Mocambique Inquérito Demográfico e de Saúde 2003* (Maputo, Mozambique: INE and Ministério da Saúde, 2005).

NIGERIA
National Population Commission (NPC) and ICF Macro, *Nigeria Demographic and Health Survey 2008* (Abuja, Nigeria: NPC and ICF Macro, 2009).

RWANDA
Institut National de la Statistique du Rwanda (INSR) and ICF Macro, *Rwanda Demographic and Health Survey 2005* (Calverton, MD: INSR and ICF Macro, 2006).

Ministère de la Santé (MINISANTÉ), Institut National de la Statistique du Rwanda (INSR), and ICF Macro, *Enquête Intermédiaire sur les indicateurs Démographiques et de Santé, Rwanda 2007-2008 (*Calverton, MD: MINISANTÉ, INSR, and ICF Macro, 2009).

SENEGAL
Salif Ndiaye et Mohamed Ayad, *Enquête Démographique et de Santé au Sénégal 2005* (Calverton, MD: Centre de Recherche pour le Développement Humain (Sénégal) and ICF Macro, 2006).

Salif Ndiaye et Mohamed Ayad, *Enquête Nationale sur le Paludisme au Sénégal 2008-2009* (Calverton, MD: Centre de Recherche pour le Développement Humain (Sénégal) and ICF Macro, 2000).

TANZANIA
National Bureau of Statistics (NBS) and ICF Macro, *Tanzania Demographic and Health Survey 2004-05* (Dar es Salaam, Tanzania: National Bureau of Statistics and ICF Macro, 2005).

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF Macro, *Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08* (Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF Macro, 2008).

UGANDA
Uganda Bureau of Statistics (UBOS) and ICF Macro, *Uganda Demographic and Health Survey 2006 (*Calverton, MD: UBOS and ICF Macro, 2007).

ZAMBIA
Central Statistical Office (CSO), Ministry of Health, Tropical Diseases Research Centre, University of Zambia, and ICF Macro, *Zambia Demographic and Health Survey 2007* (Calverton, MD: CSO and ICF Macro, 2009).

Improving the Reproductive Health of Sub-Saharan Africa's Youth

A ROUTE TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS

www.prb.org

POPULATION REFERENCE BUREAU

1875 Connecticut Ave., NW
Suite 520
Washington, DC 20009

202 483 1100 PHONE
202 328 3937 FAX
popref@prb.org EMAIL