Dissagregation of adolescent fertility data for improved programme planning and monitoring.

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The importance of the adolescent fertility rate (AFR) as a measure of a nation’s reproductive health is highlighted by its choice as an indicator within the Maternal Health MDG. However, the use of a single national figure fails to capture the complex patterns and inequalities that occur within countries, as well as the differing contexts in which these pregnancies occur. This paper explains why there is a need for greater disaggregation of adolescent pregnancy data in order to track progress and plan programme interventions.

Each year, an estimated 16 million girls and young women become pregnant between the ages of 15 and 19 (around 11% of all births), most of whom live in low or middle income countries (WHO 2008). Reliable estimates are available for national adolescent fertility rates (e.g. UN Population Division statistics) but while these national aggregate data are valuable in tracking progress at the global level, they fail to provide adequate data to plan services or fully evaluate progress within countries. The rate of adolescent fertility is underpinned by complex socio-economic, educational, cultural and service availability factors, which means that contexts, patterns and trends may differ markedly for different populations within countries. Further disaggregated data that examine patterns and trends for different groups are needed to enable programmes to be focused on those most at risk and ensure approaches can be targeted for different populations depending on the specific determinants or contexts of early pregnancy within specific communities. The proliferation of large-scale, nationally representative surveys such as the Demographic and Household Surveys (DHS) and Multi-Country Indicator surveys (MICS) provide opportunities for many countries to develop much more comprehensive data on adolescent fertility that incorporate some of the contextual, socio-economic and geographic factors described below. This will enable a much more nuanced and detailed picture of adolescent fertility patterns.

An important contextual factor in understanding adolescent fertility and motherhood is whether the majority of births occur within or outside marriage. The majority of adolescent births in developing countries occur within marriage, and up to an estimated 75% are intended (WHO 2008). However in many countries (particularly Latin America and the Caribbean and some parts of Sub-Saharan Africa) early pregnancies outside marriage may be prevalent, which are much less likely to be intended. Analysing and presenting national data by marital status is vital for developing effective interventions: married and non-married adolescents will have
diverse information needs and face different barriers in accessing family planning. In contexts where pregnancy is most commonly within the context of marriage efforts to improve access to contraception need to be introduced in tandem with multisectoral initiatives to reduce early marriage and the factors that underpin this practice. In some countries the context is changing rapidly: it is therefore important that changes in patterns of married and non-married adolescent pregnancy are identified over time.

WHO defines adolescent as the period between 10 and 19 years, which means the term spans a significant period of time during which young people undergo immense physiological and psychological transitions. In some countries girls may begin their reproductive careers as early as 12, and will obviously face very different experiences and risks to older adolescents. A number of studies highlight that the negative health consequences of adolescent motherhood are more severe for women in this younger age group (Conde-Agudelo 2005, Chen 1974), yet current statistics for adolescent childbirth are not disaggregated by age. The majority of adolescent fertility estimates refer only to ages 15-19, based on an assumption that the number of births who give birth younger than this is negligible. While in some countries this may well be true, in others, particularly in Sub-Saharan Africa this is certainly not the case. In Chad, Guinea, Mali, Mozambique, Niger and Sierra Leone more than 10% of young women aged 16-19 become mothers before they were 16 (see Figure 1, Neal et. al. 2012). The same study estimated that around a million girls worldwide gave birth each year before the age of 15. The lack of data makes early adolescent childbearing a largely hidden problem which is rarely specifically recognised or addressed through policy or programmes. While no study has looked at trends in time for pregnancies in under 15s, one study which examined trend data for adolescent fertility from 51 surveys from the 1990s and early 2000s disaggregated for 16/17 and 18/19 year olds found that while the older age-group had higher rates of fertility, the rate was declining faster than for the younger age-group (Rafalimanana 2006). These rather concerning findings highlight the importance of looking separately at trends in different adolescent age groupings.

In both developed and developing countries adolescent pregnancy is associated with poverty and deprivation as well as low economic attainment and rural residence (e.g. Rani and Lule, 2004), and greater disaggregation is vital monitoring whether progress is being made across populations and amongst the poorest and most vulnerable. There is limited evidence that in some countries progress is greater among the more wealthy and urban (Countdown 2015, 2010) which highlights the need for further ongoing analysis. Many countries show marked sub-national geographic differences and again it is important these are documented and where possible further disaggregated by age and marital status. While some sources (e.g. DHS reports)
provide some data on adolescent fertility by state, region or district, trend data is rarely presented disaggregated geographically, which again offers opportunities to identify marginalised groups and highlight successes. As adolescent fertility is so rooted in cultural factors, ethnicity and religion may also underpin inequalities, and again disaggregated data can provide insights about groups where rates are particularly high or where progress has stalled.

Under-reporting and data quality are global issues in monitoring and evaluation, and countries will need to look at ways of improving data on specific subgroups such as adolescents which may mean strengthening health information systems as well as carrying out specific studies. Further, more detailed quantitative and qualitative research may also be needed to look at particular contexts of adolescent fertility (e.g. abortion, non-live births or forced and coerced sex) or to understand the drivers of change and examine barriers to family planning services and abortion care. Countries should be encouraged to develop partnerships between policy makers, practitioners and academics to develop and carry out nationally relevant research agendas around adolescent fertility.

Figure 1: Examples or percentage of girls giving birth at aged 15 or under in Sub-Saharan Africa

From Neal et. al. 2012. Based on girls aged 16-19 at time of survey.

References


(accessed May 2013)