

# Knowledge Brief

*Health, Nutrition and Population Global Practice*

## SOCIOECONOMIC DIFFERENCES IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: CHILDBEARING

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### KEY MESSAGES:

- Delaying childbearing and preventing unplanned pregnancies improves health outcomes and increases opportunities for schooling, future employment, and earnings.
- An analysis of data from 6 countries shows that adolescent childbearing is closely tied to marital status. Around half (ranging from 42 percent in Nepal to 55 percent in Nigeria) of ever-married adolescents women have given birth. In comparison, non-marital adolescent childbearing is rare in all countries studied.
- In Bangladesh and Burkina Faso, childbearing among ever-married adolescent women is positively associated with rural residence, less wealth, and less education.

### Introduction

Adolescent Sexual and Reproductive Health (ASRH) is one of five areas of focus of the World Bank's Reproductive Health Action Plan 2010–2015 (RHAP), which recognizes the importance of addressing ASRH as a development issue with important implications for poverty reduction. Delaying childbearing and preventing unplanned pregnancies during adolescence has been shown to improve health outcomes and increase opportunities for schooling, future employment, and earnings (Greene and Merrick, 2005).

Childbearing has been shown to have negative health effects for adolescent mothers, including higher maternal mortality ratios compared with women aged 20–24; higher morbidities, such as eclampsia, systemic infections, and fistula; less prenatal care; and increased risk to the health of their children, including low birth weight, preterm delivery, and severe neonatal diseases (Ganchimeg et al., 2014; Nove, Matthews, Neal, and Camacho, 2014). Research has shown that childbearing also carries negative socioeconomic consequences for adolescent

mothers and their children, including lower educational attainment, social exclusion, higher likelihood of single parenthood, intimate partner violence, and reduced earnings (Erulkar, 2013; Madhavan and Thomas, 2005; McQueston, Silverman, and Glassman, 2013).

At the regional level, Sub-Saharan Africa (SSA) has the highest adolescent fertility rate in the world at 108 births (per 1,000 15–19 year olds), followed by Latin America and the Caribbean (LAC) at 68 births (per 1,000 15–19 year olds). South Asia (SA) and East Asia and the Pacific (EAP) have adolescent fertility rates of 39 and 19 births (per 1,000 15–19 year olds) respectively. Between 2002 and 2012, the adolescent fertility rate decreased 13.5 percent in SSA, 16.3 percent in LAC, and 47.4 percent in SA. In EAP, however, the adolescent fertility rate increased 6.4 percent during that time period (World Bank, 2014).

This brief is part of a larger study in which the overall purpose is to: (i) gain a deeper understanding of the multisectoral determinants of ASRH outcomes; (ii) explore further the multi-sectorial supply and demand-side

determinants of access, utilization, and provision of services relevant to identified ASRH outcomes; and (iii) identify multisectoral programmatic and policy options to address critical constraints to improving ASRH outcomes. The goal is to incorporate the main findings and recommendations from these studies into existing and new World Bank lending operations while simultaneously informing ASRH policies, policy dialogue, and interventions for inclusion in country strategies.

Using data from the most recent Demographic and Health Surveys (DHS) on female respondents ages 15–19, this brief examines the current status of adolescent childbearing and socioeconomic disparities associated with adolescent childbearing in 6 countries: Bangladesh, Burkina Faso, Ethiopia, Nepal, Niger, and Nigeria.

Cross tabulations between socioeconomic characteristics and childbearing outcomes for never-married and ever-married adolescent women within each country were completed if at least 10 percent of the subpopulation (for example, never-married women in Nepal) reported an outcome. Pearson’s chi-squared tests were used to assess the statistical significance of differences in childbearing outcomes by rural/urban residence, education level, employment status, and household wealth quintile. Throughout the brief, only differences significant at the 0.05 level (two-tailed tests) are discussed. All data in this brief are weighted.

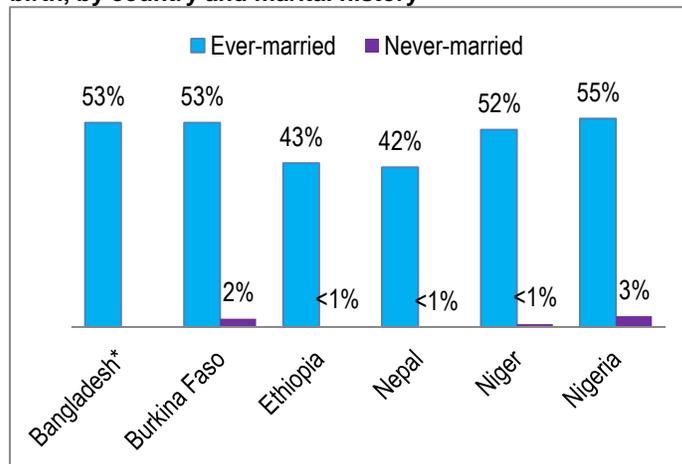
## Study Findings

### ANY CHILD BORN

Figure 1 presents the percentage of adolescent women ages 15–19 that have ever given birth among the 6 countries studied. As expected, there is an exceptionally strong association between marriage and adolescent childbearing. More than half of ever-married adolescent women have given birth in Bangladesh (53 percent), Burkina Faso (53 percent), Niger (52 percent), and Nigeria (55 percent). The incidence of adolescent childbearing is slightly lower in Ethiopia (43 percent) and Nepal (42 percent). Non-marital adolescent childbearing is rare in all countries studied. Among never-married adolescent women, almost none (less than 1 percent) have given birth in Ethiopia, Nepal, and Niger. The incidence of childbearing among this group is 2 percent in Burkina Faso and 3 percent in Nigeria.

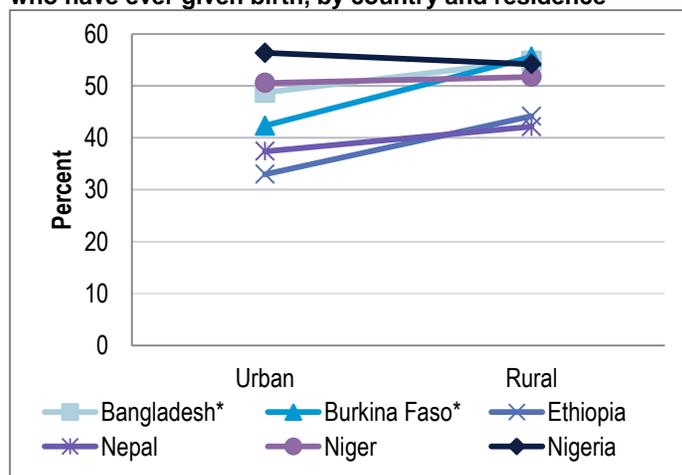
We found significant socioeconomic differences in childbearing among ever-married adolescent women in the 6 countries studied. In Bangladesh and Burkina Faso, the percentage of ever-married adolescent women who have given birth is statistically higher in rural areas than urban areas (Figure 2).

**Figure 1. Percentage of women aged 15–19 who have given birth, by country and marital history**



\*Only ever-married women were surveyed in Bangladesh  
**Source:** Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

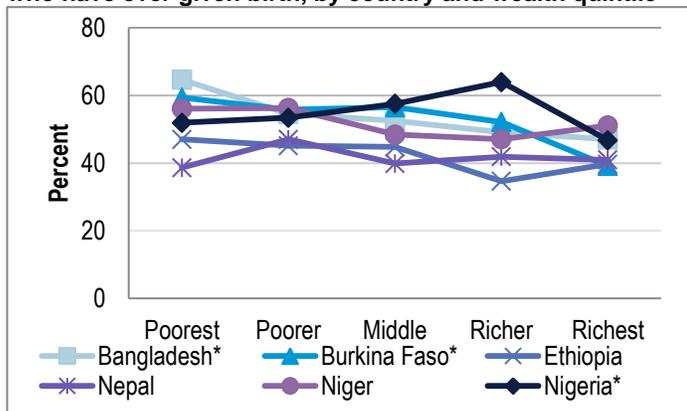
**Figure 2. Percentage of ever-married women aged 15–19 who have ever given birth, by country and residence**



\*Statistically significant difference (p<.05)  
**Source:** Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

In Bangladesh and Burkina Faso, there is a negative association between household wealth and childbearing among ever-married adolescent women (Figure 3). In both countries, the incidence of childbearing is highest among ever-married adolescent women from the poorest households (65 and 59 percent, respectively) and lowest among those from the richest households (47 and 39 percent, respectively). In Nigeria, there is a positive association between household wealth and adolescent childbearing, however ever-married adolescent women from the richest families have the lowest childbearing rates (47 percent).

**Figure 3. Percentage of ever-married women aged 15–19 who have ever given birth, by country and wealth quintile**

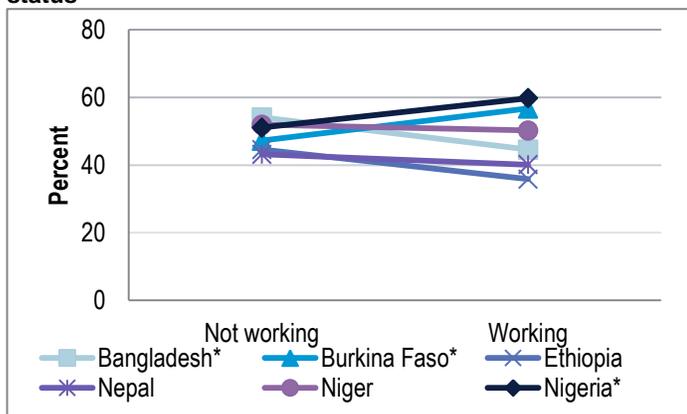


\*Statistically significant difference (p<.05)

Source: Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

In Burkina Faso and Nigeria, the incidence of childbearing among ever-married adolescent women is higher among those who are working (57 percent and 60 percent, respectively) than those who are not working (47 percent and 51 percent, respectively) (Figure 4). The opposite is true in Bangladesh: childbearing is more common among adolescent ever-married women who are not working (54 percent) than those who are working (45 percent).

**Figure 4. Percentage of ever-married women aged 15–19 who have ever given birth, by country and employment status**



\*Statistically significant difference (p<.05)

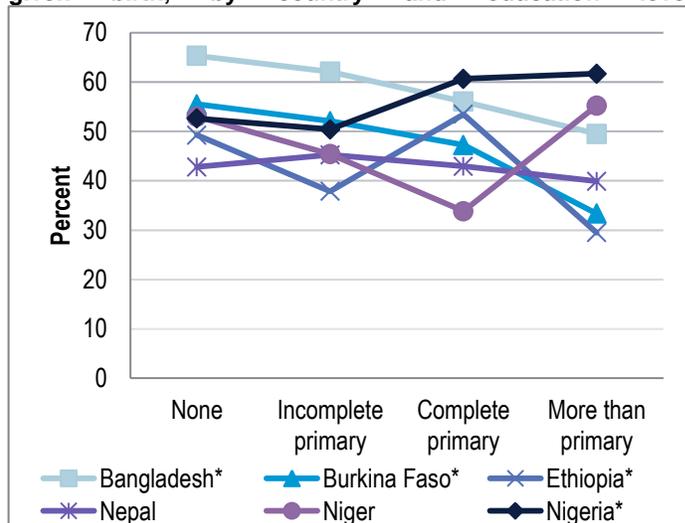
Source: Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

In Bangladesh and Burkina Faso, the percentage of ever-married adolescent women who have given birth declines as the education level increases (Figure 5).

In Nigeria, the incidence of adolescent childbearing is similar across all education groups, although it is lower among those with incomplete primary education than among the other groups. In Ethiopia, childbearing rates are around 50 percent for ever-married adolescent

women with no education or a primary education, but they are lower for those with incomplete primary (38 percent) or more than primary (30 percent).

**Figure 5. Percentage of women aged 15–19 who have ever given birth, by country and education level**



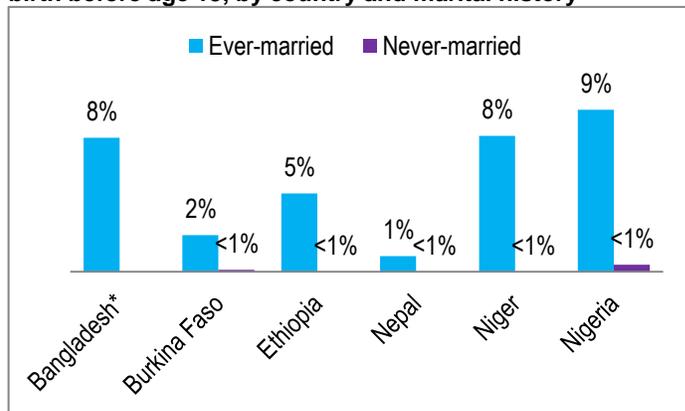
\*Statistically significant difference (p<.05)

Source: Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

### FIRST BIRTH UNDER AGE 15

Among ever-married adolescent women, the incidence of childbearing before age 15 is low in all 6 countries studied; it is highest in Nigeria (9 percent), Niger (8 percent), Bangladesh (8 percent), and Ethiopia (5 percent). Childbearing before age 15 is less common among ever-married adolescent women in Burkina Faso (2 percent) and Nepal (1 percent) (Figure 6). Among never-married adolescent women, childbearing before age 15 occurs rarely (less than 1 percent) in all the countries studied.

**Figure 6. Percentage of women aged 15–19 who have given birth before age 15, by country and marital history**



\*Only ever-married women were surveyed in Bangladesh

Source: Bangladesh DHS 2011; Burkina Faso DHS 2010; Ethiopia DHS 2011; Nepal DHS 2011; Niger DHS 2012; and Nigeria DHS 2008.

## Policy Challenges

Adolescent childbearing puts adolescents and their children at risk for poor health and development, resulting in high costs for communities, perpetuating the intergenerational transmission of poverty. It leads to greater poverty for the mother, which is then transmitted to her child through malnutrition, poor health status, and low educational attainment (Ganchimeg et al., 2014; McQueston, Silverman, and Glassman, 2013; Nove, Matthews, Neal, and Camacho, 2014). The WBG's RHAP is supporting better access to, and provision of, affordable ASRH services and strengthening monitoring and evaluation. Post-2015, the WBG is working to ensure Universal Health Coverage (UHC) of SRH by helping countries build healthier, more equitable societies.

To do this requires the following, adapted to each country's unique needs:

- (i) Scaling up the most effective ways to incentivize demand for ASRH, including family planning at the country level;
- (ii) Delivering on the continued need to strengthen country capacity;
- (iii) Leveraging the WBG's multisectoral advantage to improve ASRH outcomes, including SRH as a tool for women's empowerment; and
- (iv) Reaching the poorest, marginalized, and vulnerable populations to facilitate access to health services and promote UHC and equity.

## Conclusion

This study highlights the socioeconomic factors associated with adolescent childbearing. The results indicate the importance of investing in the prevention of early pregnancy, particularly among young adolescents. In Burkina Faso and Bangladesh, programs should target women who are at higher risk of childbearing, specifically married adolescents who live in rural areas and have less education and wealth. Programs should also include efforts to increase awareness at the individual, family, and community level of the health, emotional, and socioeconomic benefits of delaying childbearing.

These findings can inform efforts by countries, the World Bank, other agencies, and donors to continue to improve the availability of family planning as a means of delaying

early childbearing within the broader context of improving adolescent health. While reducing early marriage would be a critical factor in achieving a reduction in adolescent childbearing, even among those that do get married, more investments can be made in helping young couples to delay childbearing until later in the adolescent years, enabling each to continue to pursue opportunities to realize their educational goals. If educational services are not readily available in rural communities, it will be harder to delay childbearing even within the context of a married relationship.

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