Policy Brief: Zambia

Beginning a Family and Adopting a Healthy Lifestyle: Situation Analysis for Zambia

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This policy brief examines two primary transitions facing adolescents—beginning a family and adopting a healthy lifestyle—and their long-term effect on adolescents and their communities as well as on Zambia’s potential to harness a demographic dividend.

Decisions Made in Adolescence Affect Health, Human Development and Economic Development

Decisions made during youth have long-term impacts on human development, which is key to poverty alleviation and economic development. During adolescence, two of the primary transitions are beginning a family and adopting a healthy lifestyle. Youth face many choices and challenges around these key decisions, such as when to initiate sex, when to marry, when to have children, whether to engage in risky behaviors, and what foods to consume—all of which affect their future health and future opportunities. Consequences of these early decisions can have long-lasting effects on adolescents and their communities, potentially increasing public health costs and slowing the accumulation of human capital.

Trends in Marriage, Fertility, Nutrition, and Health

Early marriage is common in Zambia: 17 percent of adolescent girls between the ages of 15 and 19 are married (DHS 2013–14).1 This figure has remained unchanged since 2007. The median age at first marriage was 18.4 years in 2013–14, only a slight improvement since 2007. Early marriage is more common in rural than in urban areas: the percentage of married adolescent girls is twice as high in rural as in urban areas (22 and 10 percent, respectively) (figure 1). Median age at first sexual intercourse is 17.3 years and has changed little since 2007 (when it was 17.2 years). In 2013–14, 49 percent of adolescent girls age 15–19 had been sexually active.

Fertility has declined only slowly, and adolescent fertility remains one of the highest in Eastern and Southern Africa (figure 2).

1 Data in this brief are from the Demographic and Health Surveys, unless otherwise noted.
Fertility has declined overall (albeit slowly): the average number of children a woman would have over her lifetime if she had children at the current rates of fertility is now 5.3 children compared to 6.1 children in 1996. However, nearly one-third (29 percent) of adolescent girls are pregnant or already a mother. The median age when a woman gives birth in Zambia is now 19.1 years, only a slight increase since 1996. Moreover, the proportion of adolescents that have given birth or are pregnant is higher in rural than in urban areas (36 and 20 percent, respectively). Significant variation also exists by province, ranging from 16 percent in Copperbelt province to 41 percent in Northwestern province. While adolescent fertility has declined in urban areas, it remained nearly constant in rural areas over the 1996–2014 DHS reporting period. The fertility rate for girls 15–19 years of age who live in rural areas is double that of those who live in urban areas. Given current fertility and age patterns, between 61,000 and 92,000 children will be born to teenage mothers each year between 2015 and 2050. Furthermore, fertility preferences of adolescents have seen little recent change. For example, among adolescent girls, the ideal number of children declined from 4.6 children in 1996 to 3.7 children in 2007, before rising to 3.8 in 2013–14.

Use of modern contraception remains lower among adolescent girls than among older women (figure 3). Between 1996 and 2013–14, modern contraceptive use increased from 14 to 45 percent among married women of all ages, compared with 9 and 36 percent, respectively, of married adolescent girls. Among unmarried adolescent girls, this figure is even lower, with only 18 percent using modern methods in 2013–14. Even when controlling for key demographic and socioeconomic factors, adolescents were approximately 20–30 percent less likely than other women to use modern contraception.2

Moreover, unmet need for contraception has increased among married adolescents (figure 4). Unmet need—the proportion of currently married women who want to stop or space childbearing but are not using contraception (or who are pregnant with

2 Results of a multivariate regression model using a pooled cross-sectional data set on whether current use of modern methods of family planning is associated with adolescence, current marital status, religion, region of residence, urban or rural residence, household wealth quintile, woman’s level of educational attainment, and survey year; the model was restricted to women who were not pregnant but who were sexually active. Full findings are available from the authors upon request.
a mistimed or unwanted pregnancy) has declined among married women in Zambia (from 25 percent in 1996 to 21 percent in 2013–14), but it has increased among married adolescents, from 22 percent in 1996 to 25 percent in 2013–14.

Maternal mortality has declined in Zambia (figure 5). Some of the factors associated with the decline could include declining fertility, increased skilled deliveries, improved education, better transport, and poverty reduction. The maternal mortality ratio (MMR) was estimated to be 280 maternal deaths per 100,000 live births in 2013, which represents a 56 percent decline since 1995 (when the ratio was 630) (WHO et al. 2014). While this is substantial, the decline is insufficient to meet the fifth Millennium Development Goal target.

The percentage of recent births that were attended by a skilled provider (doctor, nurse, or midwife) increased for all women from 47 percent in 1996 to 64 percent in 2013–14; for adolescents, it is 70 percent. The increase in skilled deliveries has greatly contributed to the decline in MMR. However, there is evidence of inequity—higher proportions of educated women use skilled delivery than women with no or less education (figure 6). Similar inequity in coverage exists by residence—89 percent of women in urban areas gave birth in a health facility in 2013–14, compared with only 52 percent of women in rural areas.

Use of antenatal care (ANC), however, has been declining, and now only half of all women receive four or more ANC visits prior to delivery. This decline in ANC visits suggests that interventions delivered during ANC visits such as tetanus toxoid vaccination, screening for and treatment of infections, identification of warning signs during pregnancy, and nutrition counseling are not reaching those who need them. For example, only 19 percent of women received a tetanus toxoid vaccination during pregnancy according to the 2013–14 DHS.

Undernutrition among adolescents is a concern, as a sizable proportion of adolescents are classified as thin, though being overweight or obese is an increasing threat. Currently, 75 percent of adolescent girls are classified as having a normal body mass index (BMI), 16.4 percent have a below-normal BMI, while 8.6 percent are classified as overweight or obese. Undernourishment among adolescents can cause physical and emotional health problems. For example, adolescent girls with a low BMI who become pregnant may be at increased risk for pregnancy complications and poor fetal outcomes, including obstructed labor, prematurity and low birthweight. Among women in older age groups, being overweight or obese is increasingly common, and more than one-third (36.3 percent) of women older than 40 are overweight or obese, important risk factors for noncommunicable diseases.
Adolescent girls are more likely to engage in risky sexual behaviors than older women, with 5 percent of girls age 15–19 being HIV positive (HIV prevalence among all women is 15 percent). Adolescent girls are less willing to negotiate safer sex: 82 percent of adolescent girls think that a woman is justified in refusing sex with her husband if she knows he has sex with other women or in asking the husband to use a condom if he has a sexually transmitted infection (which is a lower percentage than older women or men of all ages). Adolescent women who are sexually active also less commonly report being tested and receiving results for HIV (71 percent of adolescent girls versus 88 percent of all women in 2013–14, an increase from 35 and 41 percent, respectively, in 2007) (figure 7). Furthermore, HIV prevalence is more than twice as high among urban youth than among rural youth.

Policy Framework in Zambia

Zambia has policies that aim to address the health of women and adolescent girls, both around fertility and healthy behaviors. The multisectoral National Population Policy aims to reduce fertility, especially among adolescents, as well as maternal, infant, and child mortality; additionally, a multisectoral National Youth Policy is under review that aims to improve economic and educational opportunities and health services for youth. The health sector has adopted policies, including the National Health Policy, which is accompanied by strategic plans, including the National Health Strategic Plan (2011–15) and the Adolescent Health Strategic Framework (2011–15). Additional policies are under review: the National Child Health Policy, the National HIV/AIDS, Sexually Transmitted Infection, and Tuberculosis Policy, the National Reproductive Health Policy, the National Food and Nutrition Policy, and the National Mental Health Policy. A National Social Protection Policy was launched in December 2014 to improve conditions for most vulnerable groups by addressing extreme poverty, food security, social security, and universal health coverage. The National Strategy on Ending Child Marriage includes Marriage Act legislation defining the minimum legal age of marriage as 18 years.

Key Findings and Conclusions

Substantial gaps remain to be addressed regarding key decisions made by adolescents about starting families and adopting healthy lifestyles:

- Early marriage remains common with 17 percent of adolescent girls married.
- Zambia has one of the highest adolescent fertility rates in Eastern and Southern Africa, and 29 percent of girls are already mothers or pregnant.
- Married adolescent girls use modern contraception less than other married women and have rising unmet need for modern contraception.
- Adolescent girls are often undernourished, adversely affecting their own health and that of their children.
- Adolescent girls engage in risky sexual behaviors more than older women, putting them at higher risk for illness and death.

While there have been some improvements for adolescents with regard to starting a family and adopting a healthy lifestyle, further implementation progress is necessary to help them to make better decisions and prepare them to be healthy, productive, and contributing members of society. Only by addressing sexual and reproductive health, nutrition, and risky sexual behaviors will the negative long-term effects of decisions made during adolescence be averted and the demographic dividend be harnessed in Zambia.

References
