In most of the world, family planning programs have had great success in slowing population growth and improving women’s reproductive health status by providing services to married couples. Yet in many countries, these programs tend to reach older women, often after they have had their desired number of children. Even as family planners encourage women to plan their family size and adequately space births, the youngest married couples, particularly those in which the wife is still an adolescent under the age of 19, are often overlooked. The majority of births to adolescent women in developing countries occur within wedlock, despite some evidence that premarital births are on the rise, making newlywed and married couples in which the wife is an adolescent an important group to receive reproductive health information and services.

How many adolescents are married and bearing children?

The following data highlights marriage and childbearing statistics for young women, since most young men postpone marriage and parenthood until the 20s or later.

Data from 46 Demographic and Health Surveys (DHS) showed that the proportion of young women age 18 who are married varies considerably from country to country, about half of adolescent girls have married or entered a union in most countries in sub-Saharan Africa; 50 to 75 percent have married in India and Bangladesh; less than 30 percent have married in North Africa and the Middle East and 20 to 40 percent have married in Latin America and the Caribbean.

More than 40 percent of adolescent women in the developing world—the large majority of them married—will give birth before the age of 20.

The countries of sub-Saharan Africa have the highest levels of adolescent childbearing; contraceptive use by married women age 15–19 is below 10 percent. Levels of contraceptive use among married adolescents in every region are lower than rates among older married women (ages 20–49).

Mali and Niger have especially high rates of over 200 births per 1,000 women age 15–19. In rural Mali, one in four girls are married by the time they are 15, and one in five have given birth by the age of 16.

As many as 40 percent of all young women age 15–19 in India are already married; 17 percent of all adolescent females age 13–19 are already mothers or are pregnant with their first child. Nationally, no more than 7.1 percent of married women age 15–19 use contraception, compared to 21 percent among women age
20–24. 

Approximately 90 percent of the female spouses in the 1.2 million marriages taking place annually in Bangladesh are below the age of 19. More than 70 percent of married adolescents became pregnant before their first marriage anniversary, and the mean age at first pregnancy was 15.0.

It is interesting to note that while the average age at first marriage is increasing in most of these countries, it is still under the age of 19 in many of them. At the same time, the population pyramids of these countries show that the adolescent population is growing both in sheer number, and sometimes as a proportion of the total population. Thus, the number of married adolescents will continue to increase, making the need to reach them with services all the more compelling.

What are the benefits of reaching newlywed and married adolescents?

Preventing pregnancies among married adolescents may have a long-term demographic impact. Globally, rates of population growth are more rapid in countries where women have their first child before the age of 20. Raising the average age at which females begin childbearing could yield substantial demographic dividends; across regions, a woman who has her first child before the age of 18 will have an average of seven children by the time she has completed childbearing as compared to a woman who waits until her early 20s to begin childbearing, who will average five or six children. An older age at first birth also translates into longer intervals between generations. Delay of first birth has contributed significantly to the fertility decline in some countries in sub-Saharan Africa.

Delaying first birth can reduce maternal and infant health risks. If pregnancy occurs before adolescents are fully developed—especially in countries where anemia and malnutrition are common and where access to health care is poor—they can be exposed to particularly acute health risks including damage to the reproductive health tract, delayed or obstructed labor, ruptures in the birth canal, and elevated risks of maternal mortality. Babies born to adolescents may experience more birth injuries, low birth weight and stillbirth; infant mortality is highest in those countries with the largest proportions of adolescent births.

Programs for married adolescents may fill an unmet need for family planning services. Births to married adolescents are often unplanned. A study in Ahmedabad, India found that most married adolescents reported that their first pregnancy was unwanted. A national survey in India found that as many as 30 percent of women age 15–19 desired to delay their next birth, but were not using contraception. Research found that 15 percent of married 15–19 year old women in Egypt and 29 percent in Pakistan expressed not wanting to become pregnant but not using contraceptives.

Postponing childbearing beyond adolescence has benefits for young women. A woman who delays childbearing until after adolescence may gain advantages such as increased opportunities to acquire education and skills that may enable her to better care for her family and compete in the job market. Delayed childbearing may also be associated with young women’s greater aspirations for her self and her family.

Reaching married adolescents can be cost efficient, may be introduced at scale, and is sometimes less controversial than introducing programs for unmarried youth. In countries that have a strong family planning infrastructure, reorienting the program to reach married adolescents may be achieved with minimal inputs. In
Bangladesh, Pathfinder found that reorienting family planning workers to conduct outreach to serve married adolescents required minimal additional resources. The strategy was brought to scale quickly by grafting services for newlyweds onto already-existing family planning programs, achieving broad coverage of newlywed couples within a few years of program initiation.\textsuperscript{18}

**What are the barriers to reaching married adolescents?**

Social and religious norms support demonstration of fertility soon after marriage.\textsuperscript{3,5,8,17,18} Motherhood may be one of the few ways in which a young married woman can affirm her value and identity to herself and her community.\textsuperscript{8} In some societies, if a female fails to give birth within a few years of marriage, she encounters difficulties with her husband and in-laws and may even be rejected or physically harmed.\textsuperscript{9} In Yemen, for example, 11 percent of wives age 15–29 state that they refuse the use of contraception due to opposition expressed by their husbands. If polygyny is common, as it is in parts of sub-Saharan Africa, a young woman may be inclined to quickly prove her fecundity so that her husband will avoid, or at least put off, taking a second wife.

Married adolescent women who want to delay pregnancy may lack the autonomy to do so. When a married adolescent does not want children but faces clear familial expectations to become pregnant, it may not be that the family planning infrastructure fails to meet her needs; rather, she may lack the power within her family to use contraceptives.\textsuperscript{9} Differences in age between husbands and their young wives may exacerbate problems surrounding women’s autonomy, decreasing young women’s ability to negotiate with their husbands about sex, contraception and childbearing.\textsuperscript{6,9} This is evidenced by a multi-country study that found contraceptive use was more likely when both partners—as opposed to only the wife—desired to prevent childbearing.

Other factors that disempower young wives can serve as barriers to use of reproductive health services. In many developing countries, adolescent girls’ mobility is highly constrained,\textsuperscript{9} making it difficult for them to seek services—especially in rural areas where health services are not readily available nor accessible. Moreover, in areas with high rates of adolescent marriage, girls’ education levels are often very low;\textsuperscript{9} lack of education may further decrease a young woman’s ability to use contraceptives properly, inhibit her decision-making power in areas related to contraceptive choice, or result in her having fewer alternatives to motherhood and therefore weaker motivation to delay marriage or first birth.

Family planners may be influenced by social norms, and not target or serve young married couples.\textsuperscript{4,8,18} Studies in the Middle East have found that societal attitudes determine that newlyweds should not approach any form of family planning until they had at least one child, which may deter providers from serving them. There is substantial cross-regional evidence that when young married females seek contraceptive services in Ghana, Egypt and India, they encounter substantial, often explicit, provider resistance.\textsuperscript{9} A UNFPA assessment found that some health professionals helped young couples avoid exposure to a premarital educational intervention on family planning that was mandated by the state. Moreover, family planning programs usually are often not experienced in reaching and influencing men, who may control fertility decisions, especially in couples where the wife is an adolescent.

Individuals may not want to use contraceptives until a desired level of fertility is achieved.\textsuperscript{18} Family planning programs sometimes have less success promoting contraceptives to women who have had fewer children than they desire, and often target older women with more children as a result. For example, a study in India found
that family planning methods are often first used after two sons are born.17

**What successful strategies can be used to reach married adolescents?**

Reorient reproductive health programs and field workers to identify and motivate married adolescents. In China and Bangladesh, family planning field workers bring congratulatory letters to newlyweds and motivate them to use contraception during home visits.18 The Government of Bangladesh has reoriented its family planning field workers and institutionalized programs for newlyweds,18 and although Bangladesh has the lowest average age at first birth (17.5 years) in Asia/Near East and East/North Africa, it has among the lowest total fertility rates.13 In Taiwan, operations research found that the most effective home-visit strategy provided two dozen free condoms during a field worker’s first visit, as opposed to merely informing couples where they could obtain contraceptives.

Reorient reproductive health programs to promote maternal and child health care for newlywed adolescent women. In Bangladesh, Pathfinder-supported field workers encouraged pregnant newlyweds to seek prenatal services and care from trained birth attendants, as well as provided education about nutrition and breastfeeding. An evaluation found that 78 percent of the births to newlyweds reached by the program were attended by trained traditional birth attendants or health professionals,18 compared to 41 percent of births to all 15–19 year olds. Of newlyweds reached by the program, 89 percent fed colostrum to their newborn babies,18 as compared to only 50 percent of all mothers who breastfed their infants within the first day after birth. A program in Jamaica found that providing education and support to adolescent mothers also encouraged delay of second births; 10 years after completing the program, 50.7 percent of participants had only one child, and the average spacing between first and second births was 5.5 years.

Reach adolescents through marriage registry systems. In Indonesia, Pathfinder trained marriage counselors from the Islamic marriage registry system as well as those from the National Family Planning Coordinating Board (BKKBN) to serve as family planning educators.30 Guidebooks provided a valuable and cost-effective way to reach a large number of counselors, and have been adapted by several religious organizations to address the specific concerns of their members about adolescent contraceptive use.30 In Mexico, the National Population Council (CONAPO) helped three states establish a prerequisite to the civil marriage ceremony that requires couples to present a signed form from a doctor or social worker which certifies that they have received a talk on family planning. Marriage registrars were also trained to provide written information and answer questions on family planning.24 In the Philippines, a 1976 Presidential Decree required all marriage license applicants to receive information on family planning and responsible parenthood, and a 1988 article further mandated that couples 25 years of age or less must participate in a premarital counseling course.24

Reach adolescents who are preparing to marry. Family planning associations (FPAs) have been invited to provide education as part of the premarital counseling provided by the Catholic church in some parts of Latin America, and in Jordan and Tunisia, FPAs provide educational materials for adolescent couples preparing to marry. In Indonesia, the Catholic church participates in a four-hour "preparation for marriage" course that includes information on fertility control.24

Raise the awareness and cultivate the active support of those who influence newlywed decision making. Due to the low decision-making autonomy of adolescent women, especially those who are living in their husbands’ families, programs can try to raise the awareness of more powerful family decision makers such as
in-laws and elders. In Bangladesh, Pathfinder encourages newlyweds and their husbands or in-laws to attend orientation meetings where local officials and health workers provide education about family planning and reproductive health. The program increased the involvement of males married to adolescent wives; condom use in program areas was 37 percent, significantly higher than the average rate of 15.7 percent among all married adolescents.

Utilize married adolescents as agents of change in their communities. Married adolescents who use contraception can be encouraged to act as agents of community change. In addition to serving as examples for their peers, they can be trained as peer educators and advocate for contraceptive use, delayed childbearing and the use of health services such as prenatal care in places where health service utilization is low because of misconceptions or lack of knowledge.

Create mass media campaigns to raise awareness. In Bangladesh, Johns Hopkins University Population Communication Services (JHU/PCS) and John Snow, Inc. (JSI) produced a two-episode film about the life in a village of a young man and the woman he marries. The film touches on a number of social issues, including the importance of delaying first birth, the benefits of a small family, and seeking appropriate immunizations. In Taiwan, advertisements in newspapers encouraging newlywed couples to write for family planning samples were well received. A follow-up study found that 70 percent of married couples who wrote in and were sent kits were practicing contraception. Korea has also used mass-marketed slogans to emphasize sex education for newly-married youth, although no evaluation of the program was conducted.

Work to increase young women’s autonomy and opportunities after marriage. Research has shown that early marriage can have detrimental consequences for women. In Ghana, one program successfully supported women’s autonomy by assembling a team of male supervisors to make household visits when discord about contraceptive use arose in order to call community attention to the husband’s behavior and persuade him to end the conflict. Efforts to improve education, training and job opportunities for young women as childbearing becomes a lesser focus of adolescence are also crucial. In Bangladesh, Concerned Women for Family Planning encourages continued education through peer support groups that involve both married and unmarried young women, and provides opportunities to study vocational skills such as sewing and embroidery.

Conduct advocacy efforts at the national level. In Bangladesh, a key to the growth of the newlywed strategy was efforts by Pathfinder to seek governmental support for the program. In Indonesia, Pathfinder launched an advocacy campaign that evaluators found encouraged influential leaders, such as government officials, health professionals, religious leaders and academics, to discuss the societal norms that lead to early marriage and childbearing. As a result, participants developed publications with regionally-specific research—disseminated through a respected academic journal—which provided objective information that facilitated public discussion of the issues surrounding early childbearing. Participants also expressed a commitment to integrating education and research activities into their own regular programs as well as to conducting and financing projects on early fertility prevention in their communities.

What are the outstanding needs for improving services for married adolescents?

While work with newlyweds is becoming better established, little is known about the factors that influence adolescent married couple’s decision making in most contexts. Moreover, the approaches to date have focused mostly on increasing contraceptive use; more needs to be done to address the gender inequities that
result in young women’s lack of autonomy, as well as to broaden the spectrum of adolescent reproductive health services programs provide. In particular, the following strategies could be used to improve services for married adolescents:

Conduct applied research documenting the social, contextual and interpersonal factors that influence married adolescent decision making;

Improve documentation and evaluation of existing programs for married adolescents;

Increase the priority that governments place on meeting adolescent needs in general, with specific planning and programming for married youth; and

Increase the proportion of overall resources allocated to programs for newlywed and married adolescents.

The In FOCUS series summarizes for professionals working in developing countries some of the program experience and limited research available on young adult reproductive health concerns. This issue was developed by Dr. M. Alauddin, Country Representative, Pathfinder Bangladesh and Laurel MacLaren, Communications Advisor, FOCUS on Young Adults. The In FOCUS series and other publications can be downloaded from the FOCUS Website www.pathfind.org/focus.htm.

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