Howard E. Kulin

Adolescent pregnancy in Africa

In this article the social and medical problems associated with teenage pregnancy in Africa are outlined and possible ways of tackling them are discussed.

In the developing world, views on adolescent pregnancy have lagged behind those in North America and Europe. However, the special needs of adolescents have been recognized in several centres outside these areas, most notably in Latin America (1). Collaborative arrangements for the study of adolescents have been pioneered by the East-West Center's Population Institute in Honolulu, and in China the special requirements of youth are beginning to be taken into account (2).

Data on the reproductive health of adolescents are inadequate throughout the developing world, and, indeed, no instant solutions are available anywhere for the multitude of problems in this field. There is a need for a sound understanding of adolescence as a special stage by community-based professionals with multidisciplinary backgrounds.

The African scene

Over 100 million people between the ages of 15 and 24 live in Africa. They have a very high age-specific fertility rate and also make a significant contribution to total fertility (3).

Obstetricians and gynaecologists, confronted by illicit abortion, maternal mortality, and sexually transmitted disease, are particularly aware of young people's needs but are not always equipped to deal with their emotional requirements.

The extent to which adolescent childbearing influences infant and child mortality remains uncharted. As traditional restraints on sexual activity have diminished, media messages from developed countries have begun to impinge on the lives of Africans. The sexual behaviour of urban adolescents in Nigeria and Liberia is now very similar to that of people in the same age category in the USA and Europe (4).

That pregnancy is perceived as a negative event by some young people is suggested by the rising rates of illicit abortion among teenagers. Additionally, there are data indicating that some groups of adolescents use contraceptives more frequently than their elders (5). One almost invariable consequence of teenage pregnancy is that the girl involved leaves school, something that greatly reduces her prospects in life.

As in the USA, it is widely believed in Africa that sex education, whether at home or in school, should lead to enlightened

Professor Kulin is Chief of the Division of Pediatric Endocrinology, The Milton S. Hershey Medical Center, Pennsylvania State University College of Medicine, Hershey, PA 17033, USA.
behaviour and reduce the incidence of adolescent pregnancy. International organizations have joined with African governments in stressing the benefits of family life education. Unfortunately, little attention is given to the need to make contraceptives accessible at the same time as educational programmes are mounted. The African public and some policy-makers are more concerned with what they see as troublesome premarital behaviour, and church organizations stress the moral aspects of sexual activity in unmarried girls.

With few exceptions, abortion is illegal in Africa. Illicit abortion causes great suffering, especially among unmarried teenagers. All social levels are involved and mortality is high. There is a tremendous drain on already overstretched hospital resources. As many as 20–25% of girls who undergo an induced abortion subsequently have a second, similar procedure.

Of the health issues that impinge on adolescent fertility, sexually transmitted diseases are of particular importance. In Kenya, for example, over 50% of the urban teenage population is infected with such diseases. The number of adolescents carrying the AIDS virus is not known.

Efforts aimed at tackling the problem of adolescent pregnancy are beginning to be made in the family planning sector but there is no institutional base that would allow a continuing focus on the broad needs of young people. No committed organizational framework exists for youth, and there is no body to oversee the training of personnel, supervise research, or develop appropriate interventions.

Which way now?

Health workers should assume a major role in dealing with adolescent pregnancy in Africa. Physicians, being highly respected by both public and policy-makers, could make inroads into sensitive and controversial areas. Paediatricians in particular should be in the forefront of a movement for adolescent health care.

The establishment of departments of adolescent health care in medical schools should be considered (6). The prime purposes would be to provide future physicians with an insight into the health needs of adolescents and to give continuing training to all interested professionals. There could also be a service component with outreach programmes involving school systems.

An academic component for programmes on adolescent pregnancy is suggested because local experts in adolescent behaviour are likely to belong to university communities. However, decisive steps should be taken as soon as possible to encourage the best workers from all sectors to collaborate in this enormous task. Skilled individuals from the fields of family planning, religion and education should be urged to join health and university professionals in mounting programmes for young people.

Multiservice care facilities for adolescents might also be established independently of universities. They could help to unite the efforts of professional workers while promoting service to populations under study. Health care given by paediatricians,
obstetricians and gynaecologists could be bolstered by contributions from behavioural scientists, sociologists and educators. Such facilities could also provide recreational possibilities and counselling on jobs and career choices. Successful urban centres could be used to encourage the establishment of similar units elsewhere, bearing in mind that most Africans live in rural settings.

There is no need to satisfy a specific research agenda before larger institutionalized programmes begin. Since adolescent problems are similar in many parts of the world, attention should now be concentrated on capacity-building. In Africa the teenager merits increased consideration by population planners, health providers, educators and psychologists, all working towards a common goal.

The establishment of departments of adolescent health care in medical schools should be considered.

Acknowledgement

The author wishes to thank the Population Council, New York, for assistance during his sabbatical period as Visiting Senior Associate with that body. Visits to Kenya and Zimbabwe were made at this time to gather information.

References


The Editor would welcome readers’ comments and suggestions relating to the proposals made by Professor Kulin for tackling the problem of adolescent pregnancy in Africa.