SUBMISSION TO THE PARLIAMENTARY SESSIONAL COMMITTEE FOR YOUTH AND SPORT FOR THE THIRD SESSION OF THE 11th NATIONAL ASSEMBLY OF ZAMBIA 27TH JANUARY-16TH FEBRUARY 2014

Subject: ‘Teenage Pregnancy in Zambia’ Based on the Desk Research that was conducted by Restless Development

Executive Summary:

This position paper is a summary of secondary research on teenage pregnancy in Zambia conducted by Restless Development across 2011 and 2012. The findings highlight key statistics on teenage pregnancy rates in Zambia and their leading causes. Proposed solutions are suggested in section three that need to be urgently considered by Parliament to effectively reduce the rates of teenage pregnancies in Zambia. Renewed policies and increased budgetary allocations must aim to support formal reproductive health and life skills education to grade 6 to 9 pupils. The aim to provide more information to adolescents on how to access referral support services where sexual abuse, early marriages, economic strife or pregnancy may have taken root and follow on legal, economic and health support must be provided. Public health services must ensure that non-discriminatory adolescent sexual and reproductive health services are accessible by adolescents in need. As national resources are limited, the implementation of such policies must be prioritised in rural areas where the burden is greatest.

1. Overview

Zambia has a high rate of fertility, at an average rate of 6.2 in 2007. The number of pregnancies among teenagers has been rising in Zambia over the past decade. In 2002 there were 3,663 teenage pregnancies among school going teenagers; in 2004, the number rose to 6,528; in 2007 the figure had risen further to 11,391 and to 13,634 in 2009. By 2010, the Ministry of Education reported that there were over 15,000 teenage pregnancies among school going teenagers in Zambia. The trend for 2011 remains high at 12,285 which is still a high rate. Despite the trend revealed by these statistics, discussion of subjects such as sexual health, sexuality and HIV are still regarded as inappropriate in many areas of the country, especially in rural communities. Therefore, young people in Zambia do not get appropriate guidance on how to avoid pregnancy.

Government strategies and services for primary Sexual and Reproductive Health (SRH) are also better defined and delivered in urban areas, while inadequate access and clinical referral to youth-friendly health services is still characteristic of rural areas. The problem is further compounded by the fact that the capacity to provide these services on a sustainable basis is low, especially in rural areas that make up 60.5% of Zambia’s population. This leads to an increased risk of young people in rural communities not accessing relevant information regarding their sexual and reproductive health. See figure 1 and 2 below to support this observation.

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1 Central Statistical Office, Zambia Demographic Health Survey 2007, p.56.
4 MOESTVEE, Annual School Census for 2011
Figure 1: Cases of Both in and out of School Teenagers Who Had Began Child Bearing per Province (2007)

Source: Zambia Demographic Health Survey (2007)

Figure 2: Grade 1-12 Teenage Pregnancies per Province (2010)

Source: MESTVEE Zambia Annual School Census (2010)
Evidence suggests that youths are becoming sexually active at a young age, which is a risk factor for sexually transmitted infections (STIs) including HIV, reproductive health complications and a lack of girl child retention in education. The Sexual Behaviour Survey (SBS) of 2003 reported that some young people initiate sexual activity before the age of 15 (14% of female respondents and 16% male respondents aged 15-24 reporting that they had sex before age 15). The consequences of a lapse in clear policies supporting effective sexual education have been obvious. According to Save the Children’s Situation Analysis of Children’s Rights in Zambia, 10,441 girls dropped out of school as a result of pregnancies in 2004. The figure rose to 11,994 in 2006 and further increased to 13,000 in 2008. The dropout rates have not been matched by re-admissions, especially in basic schools, where there were higher numbers of teenage pregnancy dropouts than in high schools. Over the period 2002-2009, the re-admission rate remained at an average of 38%. This means that 62% of the girls who dropped out of school as a result of pregnancy were not re-admitted into the schools during this period.

The 2007 Zambia Demographic Health Survey (ZDHS), a nationally representative survey of 7,146 women aged 15 – 49, revealed that about 28% (2,000) of women aged 15 – 19 had begun childbearing; 22% (1,572) had already given birth to a child while 6% (429) were pregnant with their first child.

The Education Sector reported an increase in the number of schoolgirls who became pregnant in basic schools from 3,663 in 2002 to 12,370 in 2008; at high school level, the number of pregnancies increased from 765 in 2002 to 1,566 in 2008. The overall incidence of teenage pregnancy had increased to a record high of 15,300 in 2009, with figures for 2010 currently at just fewer than 15,000. Although these figures must be qualified in light of the nationwide population increase over 2000 to 2010, rising primary school enrolment rates over the same period and improvements in data collection, the incidence of teenage pregnancy remains untenantably high directly affecting educational survival rates of school girls and gender parity indices.

2. Key Findings

The review draws information from research providing information on teenage pregnancies in Zambia, undertaken by both national institutions and international organisations. From the outset studies have identified clear evidence on the correlation that higher levels of education see a drop in fertility rates and lower incidence of childbearing among teenagers. Adolescent girls in Zambia with no education accounted for 54% of those who had begun childbearing, while teenagers with primary education accounted for 33% and those with secondary school education only 21%. International data further demonstrates that keeping girls in school has multiple benefits: each year remaining in school raises a girl’s later income by 10-20%, decreases chances of domestic violence and increases chances of civic participation (political decision making) in later life.

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8 Ibid., p.220.
10 Demographic and Health Survey, p.64.
14 Charting the Future, p.2
Leading Causes or Factors of Teenage Pregnancies In Zambia

Teenage pregnancy is caused by interrelated educational, health, economic and social cultural factors, which highlight an unsupportive and unsafe environment for girls. The vulnerability of adolescent girls to early pregnancy is particularly acute, especially in rural communities. Key among these are:

- Lack of or limited access to SRH education, SRH services and knowledge and access to psychosocial and health support services when defilement and rape occurs.
- Temporary accommodation of girls in a community near their school without regular boarding facilities, or ‘weekly boarding’ due to poverty and long distances to schools.
- Transactional and intergenerational sex.
- Alcohol use leading to multiple partners and decreased condom use.
- Social-cultural practices such as early marriage polygamy; sexual cleansing; premarital sex; treatment of infertility.

Reviewed studies have shown that teenage pregnancy is caused by a number of interrelated educational, health, economic and cultural factors, poverty/wealth inequalities and a lack of a practised and comprehensive life skills and sexual reproductive health education nationally are key contributing factors:

- Girls who fall pregnant in basic (primary) schools are more likely to drop out than girls in high (secondary) schools. More specifically, 2010 School Census data shows that school girl pregnancy in Grades 5 to 9 accounts for 88% of recorded pregnancies with highest figures among Grade 9 pupils (3,909), followed by grade 7 (3,799), grade 8 (2871), grade 6 (1,761), and grade 5 (753). See Figure 3 below.

![Figure 3: Teenage Pregnancies from Grade 1-12 (2010)](zambia_annual_school_census_2010)

- These trends in teenage pregnancy have remained consistently high in 2011 as seen from the School census conducted in 2011 again among Grades 5 and 9. See Figure 4 below.

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15 Zambia Annual School Census-2010
3. Proposed Solutions and Recommendations for Government - Education and Health Sectors (Including Community Development, Mother and Child)

- **Increased Budgetary Allocations to Reproductive Health (including family planning)**
  - There should be an increased budgetary allocation to family planning services within the health sector. Currently there is a minimal contribution financially and in human resources for family planning programmes in Zambia.  

- **Build an effective response team to address teenage pregnancy:**
  - Create an inventory of organisations (by Province) working with in and out of schools with content of what they provide and to link this up with nationwide mapping of organisations by Ministry of Community Development, Mother and Child. This directory must be widely disseminated to ensure resources are prioritized and efforts are not duplicated.
  - Strengthen coordination structures between Education, Health, House of Chiefs, Youth and Community Development to coordinate activities more effectively at sub-District level and to

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16 MOESTVE, *Annual School Census 2011*.  
maximise respective annual budget resources. Taking advantage of current attempts to systematically strengthen SRHR-HIV linkages by National AIDS Council and Reproductive Health Unit of Ministry of Health now falling under Community Development Mother and Child.

- Establish adequate surveillance systems with the Ministry of Health for teenage pregnancy in communities, schools and health centres to ensure a comprehensive understanding of the nature and trends of teenage pregnancy, which in turn will allow relevant interventions to be implemented. This should also include a system to track school completion rates for girls being readmitted after delivery.
- Commission further research to refine the existing stated causes on the legal, socio cultural, economic and educational causes behind teenage pregnancy.

- **Share existing policies effectively and finalise on the draft policies**
  - Article 18 of the 2011 Education Act which outlaws early marriage should be immediately circulated (via Provincial Offices) and publicly advertised in all schools.
  - Finalise the development of the MoESTVVE reduction strategy for Teenage Pregnancy and Alcohol abuse whose terms of references were developed in September 2013 by MoESTVVE and national partners.
  - The MoESTVVE Child Protection Policy needs to be formally and widely disseminated
  - Disseminate user-friendly version of Ministry of Health Adolescent Friendly Health Services Policy and Standards.

- **Change reproductive health policy and guidelines**
  - Set minimum criteria for effective and consistent reproductive health education and life skills.
  - Ensure that the code of conduct for both health practitioners and teachers is enforced for those who discriminate against adolescents needing reproductive health information or services.

- **Ensure access to SRH education in the education sector are optimised**
  - Ensure children who live far off have access to safe single-sex boarding environments.
  - Establish a SMS/Toll free line for reporting and monitoring cases of child abuse, early marriage, sexual violence in schools as recommended by Education Sector Gender Audit 2009. Disseminate Child Line nationwide.
  - Strengthen guidance & counselling within the school system and increase its annual budgetary allocation within the MOEVSTEE ‘equity’ budget line.
  - Domestication of the recently signed Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA) at ICASA 2013 by Ministers of Health and Education. (See attached commitment signed.)
  - Establish and integrate School-Clinic Referrals (based on MoH Adolescent Health Services Standards) including looking at option of establishing rural health clinics in school infrastructure to tackle long distances to accessing health services by rural communities.
  - Retrain and reorient health workers on adolescent reproductive health services utilising forthcoming Adolescent Friendly Health Services Standards of Ministry of Health.