ADOLESCENT PREGNANCY AND POLICY RESPONSES IN UGANDA

BY ASHLEY WALLACE

SUMMARY

- Uganda has a high adolescent pregnancy rate, which increases the risk of maternal death for teenagers and limits future employment opportunities for pregnant teenagers.

- On paper, Uganda has good policies to address the health challenges associated with adolescent pregnancy. However, these policies are poorly implemented because of funding shortfalls.

- Improved funding and access to education programs are key to reducing adolescent pregnancy rates in Uganda.

With 25 percent of adolescent girls becoming pregnant before the age of 19, Uganda has one of the highest rates of adolescent pregnancy in Sub-Saharan Africa. The country’s high adolescent pregnancy rate has two distinct implications.

First, the risk of maternal death is higher in adolescents than in older women. A Uganda government survey on demography and health indicates that there is a higher morbidity and mortality rate among pregnant teenagers and their babies (Republic of Uganda, 2006: 62). Furthermore, pregnant adolescent girls are more susceptible to pregnancy- and childbirth-related complications because they have not yet developed the physical maturity required for a healthy pregnancy. Other common medical problems associated with adolescent pregnancy include obstructed labour, eclampsia, fistula, low birth weight, stillbirths, and neonatal death.

Second, the socio-economic impacts of adolescent motherhood are devastating. Adolescent girls who become pregnant are often unable to complete a secondary education, a fact that diminishes their potential to find employment.
In Uganda, education and economic status are factors that influence adolescent pregnancy. Adolescents who have completed secondary school tend to have low pregnancy rates (15 percent) compared to adolescents who have no secondary education (50 percent). From an economic perspective, adolescents from poor households are more likely to become pregnant compared to adolescents from wealthier families. For the former, the pregnancy rate is 41 percent and for the latter the rate is 16 percent (Republic of Uganda, 2006: 62).

Uganda’s National Adolescent Health Policy defines adolescents as people between the ages of 10 and 19 years. Twenty-five percent of Uganda’s population is comprised of adolescents. A 25-percent pregnancy rate among adolescents in a population of 30 million people is therefore a worrying issue for the government of Uganda (Republic of Uganda, 2006: 62). Concern is further heightened by the fact that 33 percent of the population consists of young people, defined as between the ages of 10 and 24 (Republic of Uganda, 2004b: 11).

The Uganda government has enacted policies to address adolescent pregnancy. These policies set definite targets and are aimed at protecting young girls from unplanned pregnancies. This paper outlines these policies and examines their efficacy.

**SOCIAL AND CULTURAL CONTEXT**

Traditionally, social, economic and cultural norms in Uganda encourage marriage and childbearing at an early age. As such, female adolescents in Uganda face cultural and social pressure from their families to marry young and begin child-bearing early (Sekiwunga and Whyte, 2009: 120). However, adolescent pregnancy outside wedlock is frowned upon in Uganda. The social stigma associated with pregnancy outside wedlock is further compounded when adolescents are forced to terminate their studies and families feel compelled to send their pregnant daughters away (Atuyambe et al., 2005: 306). The social stigma and the resultant stress often compromise the health and well-being of pregnant adolescent girls and their unborn babies.

Stigma, coupled with lack of support from families and society at large, compels some unmarried pregnant adolescents to seek abortions.
Statistics show that about 15 to 23 percent of female youths aged between 15 and 24 have had an abortion (Ssengooba et al., 2004: 17). This is an issue of concern because abortion, which is illegal in Uganda, is performed by untrained midwives in unsafe conditions, greatly increasing the risk of disability and death for pregnant adolescents. Figures indicate that 13 percent of maternal deaths and 27.8 percent of deaths among adolescents in Uganda are primarily due to unsafe abortions (Ssengooba et al., 2004: 5, 18).

**POLICY ENVIRONMENT**

Uganda is committed to meeting the targets of the Millennium Development Goals (MDGs), which among other things stipulate the reduction of national maternal mortality rates. Thus far, Uganda has committed to reducing maternal mortality by three-quarters by 2015. This translates into reducing deaths from 505 out of every 100,000 live births to 131 (Republic of Uganda, 2010b: 22). Plans for achieving MDG targets span a 15-year timeline and are outlined in the country’s Poverty Eradication Action Plan (PEAP) (Republic of Uganda, 2004a: 221-2).

All national health policies, including those that deal with adolescent and maternal healthcare, operate under the framework of the PEAP to eradicate poverty. For instance, the Health Sector Strategic Plans I and II contain provisions for free basic healthcare services, including adolescent and maternal healthcare (Republic of Uganda, 2000: 3).

**NATIONAL POLICIES FOR ADOLESCENT REPRODUCTIVE HEALTH: ACCOMPLISHMENTS**

There are various policies designed to delay and protect young women from becoming pregnant during adolescence. These policies include the National Health Policy, the National Adolescent Health Policy, the National Policy on Young People and HIV/AIDS, the Sexual Reproductive Health Minimum Package, the Minimum Age of Sexual Consent Policy (set at 18 years of age), the defilement law and a universal primary education policy (Darabi et al., 2008; 21). These policies also serve the purpose of fostering a supportive environment to encourage adolescent reproductive health.

Notable among these policies is the National Adolescent Health Policy,
introduced in 2004 to address the specific needs of adolescents, including pregnant girls. The policy’s objective is to streamline adolescent health needs to national health and development policies. It draws on the roles of parents, teachers and policy makers in various ministries, sets guidelines for promoting information regarding reproductive health and works as a reference for adolescent health concerns. For instance, it aims to increase deliveries in health facilities from 48 percent to 80 percent (Republic of Uganda, 2004b: 15). Other objectives of the policy include plans to increase contraceptive use, encourage safe sex practices and abstinence, build life skills, and improve access to adolescent-friendly services at health centres. The policy also encourages adolescent girls to continue education after delivery.

Additionally, Uganda released the National Policy Guidelines and Service Standards for Reproductive Health Services in order to provide direction for reproductive health service provision and set national rules and regulations (Republic of Uganda, 2001). The guideline calls for increased access to contraception, adolescent-friendly services and post-abortion services, as well as support for unwanted pregnancies and services for single adolescent mothers.

The Uganda government has also enacted laws to protect adolescent girls from pregnancy and sexual coercion. The minimum age of sexual consent was raised from 14 to 18 in the 1990s to help curb the spread of HIV/AIDS (MacKian, 2008: 110). Further, a law governing defilement makes it a criminal offence to impregnate a girl under the age of 18 (Atuyambe et al., 2005: 308).

**NATIONAL POLICIES FOR ADOLESCENT REPRODUCTIVE HEALTH: SHORTCOMINGS**

One of the major shortcomings of Uganda’s health policies is the lack of full and proper implementation. This is mainly because of funding shortfalls that stymie support for dissemination and implementation of these policies across the country (Neema et al., 2004: 11; Republic of Uganda, 2010c: 44). For example, although maternal and child health is identified as a priority by the government, huge funding gaps prevent the health sector from achieving the goals outlined in the National Health Policy (Republic of Uganda, 2010c: 23-4). Health care centres in the country are underfunded,
understaffed and overcrowded, which means adolescent-friendly services are few and far between.

Additionally, various stakeholders lack knowledge about the country’s health policies and awareness of individuals’ roles and responsibilities in implementing them (Neema et al., 2004: 11). For instance, the National Adolescent Health Policy states that pregnant adolescent girls should be readmitted to school after they have delivered, but Uganda’s Education Policy is silent on this issue (Republic of Uganda, 2004b: 15; Darabi et al., 2008; 21). As a result, researchers have noted that “school systems tend not to offer social support to pregnant girls, but rather send them away” (Atumyambe et al., 2005: 308). Terminating studies for adolescent mothers places them in a precarious socio-economic situation. Girls without secondary school education will have greater difficulty finding employment over the long term.

Furthermore, Uganda’s health policies fail to recognize the influence of parents and the community on the health of adolescent mothers. Women in Uganda do not make choices for health care independently. Instead, networks that include husbands and other family members, alternative health care providers and traditional notions of health within the community, influence women’s health choices and the decision to seek care (MacKian, 2008: 112). In essence, this means the people who have financial resources greatly influence health care decisions for pregnant adolescents (Atuyambe et al., 2009: 792). These may be parents, relatives or boyfriends.

From a legal perspective, although there is a defilement law to protect adolescent girls, males often deny responsibility for pregnancy because they fear the implications of the law (Kaye, 2008: 5). As a result, adolescent mothers face limited safety and security, and emotional and financial support (Atuyambe et al., 2009). Pregnant adolescent girls face rejection from their families and partners, and are at increased risk of physical and physiological violence (Atuyambe et al., 2005).

**THE NEED FOR PREVENTIVE MEASURES**

Uganda’s national health and adolescent health policies recognize the special health needs of adolescent mothers and the need to scale up adolescent-friendly health services and access to contraceptives. The
adolescent health policies make a concerted effort to increase the use of maternal health services and provide preventative services for adolescents to reduce the number of unwanted pregnancies among that age group. Increased funding, improved dissemination of policies and social support programs for adolescent mothers are imperative aspects of adolescent reproductive health that policies must take into consideration to improve the standard of living of pregnant adolescents in Uganda.

REFERENCES


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