Policy Brief: Zambia

November 2015

Education Global Practice

Health, Nutrition, and Population Global Practice

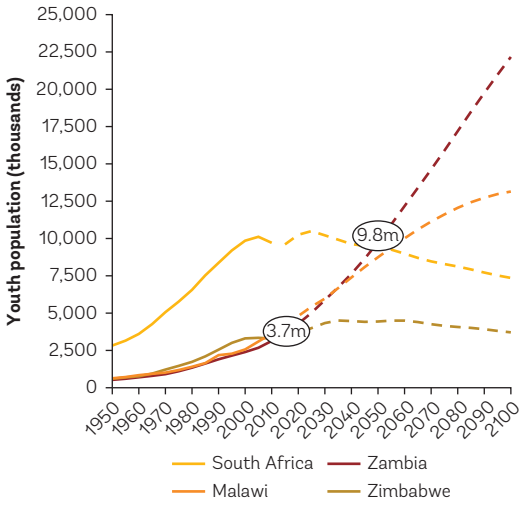
Adolescent Girls in Zambia: Executive Summary

Introduction and Overview

Adolescence is a Transformative Time. Adolescence (defined here as 10 to 19 years of age) is a time of transition that fosters both challenges and opportunities. Choices made during adolescence not only have immediate consequences but also greatly influence the economic opportunities, health outcomes, and skill sets attained later in life. Yet adolescence is also a period when social norms create pathways defined largely by gender. During adolescence, gendered roles and responsibilities often create opportunities for males, but curtail them for girls.

Adolescents—and Their Decisions—Have Important Implications for Harnessing the Demographic Dividend.[1] Zambia's persistently high fertility combined with decreasing mortality is not only causing high population growth but also creating a large share of youth dependents, giving way to higher dependency ratios which result in low investments in human capital and productivity. In Zambia, adolescents make up a substantial 24 percent of the population, and the already large number of adolescents is expected to more than double in the upcoming decades from 3.7 million to 9.8 million in 2050, adding challenges for society to provide health, education and job training services to prepare them for a productive future (Figure 1).

Figure 1. Actual and Projected Population (Ages 10–19) in Zambia and Select Countries in Sub-Saharan Africa, 1950–2100



Source: United Nations Department of Economic and Social Affairs 2011.

The cost of inaction is high for adolescent girls themselves, for the next generation, and for the nation as a whole. In Zambia, the high prevalence of child marriage and teenage pregnancy contributes to high fertility and population growth and is closely interrelated with a range of economic and sociocultural determinants (including attitudes around various forms of gender-based violence) that perpetuate a vicious cycle for the poorest and most vulnerable girls. Child marriage and teenage pregnancy also contribute to high child mortality and poor maternal health. A vicious cycle is perpetuated whereby girls drop out of school earlier

[1] A demographic dividend is the accelerated economic growth that may result from a rapid decline in a country's mortality and fertility rates and the subsequent shift in the age structure of the population. As a country's working-age population grows in relation to the number of young dependents, a small window of opportunity exists to achieve strong economic growth.

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than boys, marry too soon, become sexually active, do not use protection and become pregnant early on, are exposed to sexually transmitted infections, are unable to participate in productive activities, and eventually are unable to provide adequate care for their children or to break the intergenerational cycle of poverty. Delayed marriage and pregnancy can contribute to a lower fertility and a changing age structure with a smaller share of young dependents compared to working-age adults. In combination with policies to improve education, employment, and governance, this can bring transformative changes to Zambia and improve its prospects for human capital accumulation, productivity, and economic growth.

Together with other policies that address high fertility, reducing child marriage and teenage pregnancy can contribute significantly to the fertility declines needed to accelerate the demographic transition and ultimately create better life outcomes for adolescent girls, better opportunities for the next generation, and the potential to harness a demographic dividend. The conceptual framework (Figure 2) for this series of policy briefs acknowledges the complex, bidirectional nature of the relationships that exist among child marriage and teenage pregnancies; the opportunities for adolescent girls to access quality education, jobs or livelihoods, and health and nutrition services; the social and cultural norms that prevail; and the legal and policy framework in place. It also posits that positive changes in opportunities and norms can lead to delayed marriage and pregnancy among adolescent girls and foster better opportunities for the next generation. This series of policy briefs focuses on four key areas for action (or pillars):

(1) Keeping girls in school;
(2) Equipping out-of-school girls with skills;
(3) Beginning a family and adopting a healthy lifestyle; and
(4) Addressing the early childhood development needs of children born to teenage mothers.

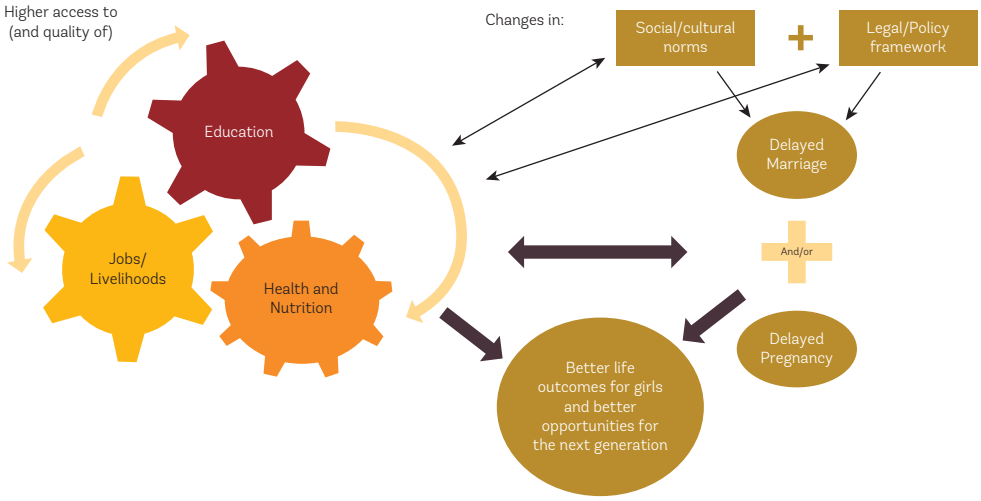
Under each of the four pillars, the series includes two policy briefs: one that documents the current situation and trends in Zambia and one that summarizes the global evidence on what has worked to promote positive impacts in this particular area.

Pillar 1: Keeping Girls in School

Staying in school and completing a quality education remains a substantial challenge for adolescent girls in Zambia. Girls are dropping out of school at double the rate of boys in Grade 7 and triple the rate of boys by Grade 11. Socioeconomic status and geography matter, with adolescent girls from extremely poor backgrounds and certain provinces most at-risk of leaving school. Early marriage disproportionally affects adolescent girls in Zambia and the number of girls dropping out due to pregnancy increases throughout upper primary and secondary school.

While several ongoing initiatives are helping to keep Zambian girls in school, the challenge remains to both focus on girls before they reach puberty and to ensure that they get the support they need to complete primary school and transition successfully

Figure 2. Conceptual Framework



to secondary school. The most at-risk adolescent girls, including those who have dropped out due to pregnancy, will need to be targeted with comprehensive programs including mentorship, financial assistance, childcare support, and sexual and reproductive health services to better ensure that they re-enter the education system and complete their schooling.

Global evidence indicates that parents are more likely to maintain adolescent girls in school when economic opportunities exist for women and when information is available to girls and families about the returns to education. Additional supply and demand-side interventions are necessary in contexts where large numbers of adolescent girls dropout of school. On the supply side, interventions are needed to provide greater access to "girl-friendly" schools that can provide high-quality, safe, and relevant education to female students. On the demand side, interventions to reduce the opportunity-cost of schooling require adequate targeting and a mix of incentives should be used to serve different ages and demographic groups in optimal ways. This may include conditional cash transfers for younger girls to encourage school enrollment and transition to unconditional cash transfers after puberty in order to delay early marriage and pregnancy.

Pillar 2: Providing Out-of-School Girls with Skills

A strong case can be made for examining in more depth the trends in female adolescent employment and the links between employment and child marriage and early pregnancies. Adolescent girls in Zambia are more economically active, more likely to be engaged in part-time employment, to be unemployed, and to earn less than their male counterparts. Educational attainment and the incidence of skills training is low for both adolescent boys and girls –58 percent of employed adolescent girls have between one to seven years of schooling, and only 1.4 percent of girls aged 15-19 have received skills training. However, very little is known about how these trends affect the choices made by adolescent girls and their households. What the data do tell us is that more than a fourth of women cite family responsibilities and pregnancy as reasons for being economically inactive. Further analysis of these trends could facilitate the development of policy options designed to create potential for a demographic dividend in Zambia.

The majority of skills training programs are run by skills training providers and, to a limited extent, by the formal schooling system and industry. Most training institutions are run by the public sector, private sector, and churches. Skills training is also offered as part of secondary school curricula to students selected for a technical stream at grades 8 and 10, albeit on a small scale. Of note are several skills training programs targeting women and girls run by the public sector and NGOs, such as that run by the Ministry of Community Development, Mother, and Child Health which trains vulnerable women, mostly between 15 and 35 years of age and with no previous schooling, in selected trades. In addition, the Adolescent Girls Empowerment Program imparts health and financial education and life skills to girls 10–19 years of age from low-income backgrounds.

Skills development offers a range of benefits to out-of-school adolescent girls and alleviates a key obstacle to youth employment in developing countries. But do increased skills lead to delays in early marriage and pregnancy? Not always, according to the empirical evidence. Although the global evidence on skills training is growing and despite a theoretical basis for the relationship between skills, employment, and fertility, the documented impacts of skills interventions on sexual or reproductive health outcomes are still too limited to draw strong conclusions. The substantial heterogeneity of what constitutes a skills intervention contributes to the uncertainty, and overall the evidence-base under Pillar 2 is less conclusive than across the other three pillars. The strongest evidence is in support of holistic community-based programs that combine information on sexual and reproductive health with skills training and other financial and social assets in girl-only or girl-friendly settings. This community-based approach has the potential to be involve key stakeholders from the start (e.g. parents, husbands, etc.), be cheaper, more effective, and sustainable. However, more research is needed to isolate the impacts of various program components and disentangle the causal pathways leading to delays in marriage and pregnancy.

Pillar 3: Beginning a Family and Adopting a Healthy Lifestyle

While there have been some improvements for adolescents' health behaviors and outcomes, substantial gaps remain to

be addressed. Zambia has one of the highest adolescent fertility rates in Eastern and Southern Africa. Married adolescent Zambian girls use modern contraception less than older married women, and over the past decades, have increasingly reported unmet needs for modern contraception. Adolescent girls in Zambia engage in risky sexual behaviors more than older women, putting them at higher risk for illness and death. Additionally, the higher rates of undernutrition for adolescent girls can have adverse effects on their own health and that of their children. It is necessary to address the sexual and reproductive health, nutrition, and behaviors of adolescents, to harness the demographic dividend in Zambia.

A number of policies in Zambia address the health of women and adolescent girls – including a multisectoral National Population Policy and a multisectoral National Youth Policy, as well as a number of health sector specific policies such as the National Health Policy, Adolescent Health Strategic Framework, National Child Health Policy, National Reproductive Health Policy, and National Food and Nutrition Policy. A multitude of partners were involved in the development and implementation of these policies, and although respondents perceived broad buy-in to the policies, they expressed concerns about the depth of commitment from the government (primarily attributed to low resource mobilization). New institutions have been created within several ministries to support these activities, but stakeholders reported that several are not fully operational. The policies are largely accompanied by detailed implementation plans and accountability mechanisms, and the process has reportedly been evidence-driven although normative change, necessary to achieve progress on health indicators, remains slow.

The global evidence indicates that to improve the key health behaviors and outcomes discussed above, the most promising interventions in the health sector combine social and behavior change communication with increasing access to health services. Examples include targeting communication change to adolescent girls themselves, as well as to their social networks, families and community members; providing comprehensive sexuality education (both in-school as well as for out-of-school adolescents); offering youth-friendly sexual health services at health facilities and training providers on providing care to this unique population; using community-based mechanisms to distribute information and supplies for family planning; programs that work to delay marriage via community-level engagement; addressing undernutrition via supplementation during risky periods (e.g., pregnancy) as well as food fortification programs; and improving maternal health by strengthening the provision of skilled birth attendance.

Pillar 4: Early Childhood Development

Early childhood is a critical period of human development, but children born to adolescent mothers face many challenges. They are at higher risk of adverse health outcomes in terms of mortality, morbidity and nutrition, as well as lower overall development and school readiness by age 6. For Zambia to reap its full demographic dividend, it will be necessary to ensure improved health and early childhood development outcomes—particularly given the large number of children born to adolescent mothers currently and in the coming decades.

Zambia has various policies to address ECD and health, including the National Population Policy, National Health Policy, National Child Health Policy, National Child Policy, National Education Policy, and National Early Childhood Education Policy. However, existing ECD programs are limited in scope, especially those focusing on early stimulation and learning for young children, and too few children are benefiting from programs that address their overall development needs (including in the physical, cognitive, linguistic, and socioemotional areas).

While the poorest children are at greatest risk of lagging behind early in life, several types of ECD interventions have been proven effective to improve their development and life-long prospects. Programs to improve infant and child health are most effective when they combine maternal health and nutrition interventions, community-based distribution of health supplies, integrated service delivery, and postpartum counseling on infant feeding practices. Before and during pregnancy, programs that address women's reproductive health and nutrition are essential for healthy gestation and a strong foundation. For children 0–2 years of age, programs that combine early stimulation and nutrition are most likely to yield long-term effects. Center-based care can also promote child development while freeing up caregivers' time, but quality is paramount to ensure positive outcomes. For children

3–6 years old, preschools can be a highly cost-effective way to enhance school readiness and success later in life, as long as a sufficient level of quality can also be ensured. Cash transfers can alleviate financial and time constraints at the family level but are more likely to have an impact on child development outcomes when combined with access to health services, parenting education, and/or preschools. Finally, children are likely to benefit most when fathers and other family members in addition to the mother also receive ECD information and services, especially if the mother is not the primary caregiver or the main decision maker on child-rearing practices.

Conclusions

Looking ahead, a sharper and stronger focus on the needs and strengths of adolescent girls will be needed to meaningfully shift the current paradigm from high costs of inaction to evidence-based positive impacts. Reducing the prevalence of child marriage and teenage pregnancy in Zambia will not only improve the life trajectories of adolescent girls and their children, but will greatly benefit the nation as a whole through advancing human capital accumulation, economic growth, and productivity. However, the current and projected population trends for Zambia indicate the urgency with which action is required in order to benefit from a potential demographic dividend.

Zambia's policies and programs show promise for improving opportunities for adolescent girls and their families, but substantial improvements in their implementation are needed to achieve results. Current policies covering education, youth, children, and reproductive health all aim to protect and support the needs of adolescents in Zambia. Ongoing initiatives such as secondary school bursaries, skills training, and ECD programs skills are helping to address these needs. However, programs may need to consider expanding their scope and scale in order to reach a wider network of vulnerable youth and their families, and new policies will need adequate financial and human resources in order to be fully operational. The global evidence for each pillar encourages comprehensive multisectoral approaches that are anchored at the community level, specifically targeted to the needs of adolescent girls (and their children) depending on their ages and demographic groups. Ultimately, successful implementation will require sufficient resources to be allocated in the context of long-term policy implementation, robust M&E systems, the encouragement of agents of change (for example, Traditional Chiefs, high-level champions, and also boys and men at the community level) to be an active part of the solution, and strong coordination and partnerships between Government and non-state actors to reach the maximum number of girls with relevant, evidence-based interventions.

SKU K8898