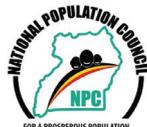




REPUBLIC OF UGANDA

THE COST OF INACTION

The Economic and Social Burden
of Teenage Pregnancy in Uganda







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of Teenage Pregnancy in Uganda

Preface

Uganda is able to drive and achieve her Vision 2040 by timely reaping the demographic bonus accruing from her youthful population. This will not be an automatic harvest, it requires investment. The country's main strategy for harnessing the Demographic Dividend (DD) is built around ensuring that the adolescents are healthy, properly educated and appropriately skilled to take up jobs that will be created in the economy as per the third National Development Plan (NDP III) programme lay out.

The bedrock of this strategy is rapid fertility decline, arising mainly from young people delaying marriage and childbirth as they complete their education and build careers, which will trigger the age structure transformation and in turn effect harnessing of the DD. Teenage pregnancy is a key bottleneck to harnessing the Demographic Dividend if no action is taken.

Teenage pregnancy (TP) is a significant health and social challenge in Uganda, it poses high morbidity and mortality for both the mother and the child, denies schoolgirls an opportunity to remain in school, in end affects their future careers and shatters their dreams and childhoods. Disturbingly, the majority of these early and unwanted pregnancies end up in unsafe abortions, which risks the lives of these girls to maternal mortality and morbidity. As a result, young people in Uganda are predisposed to various challenges affecting their wellbeing which in turn leads to poor developmental outcomes for the individual, household and country.

In Uganda, teenage pregnancy has stagnated for the last fifteen years at 25% even when the country's desired rate and target is 15% by 2020. Inevitably, Covid-19 has compounded the already existing magnitude of the problem arising from school closures, sexual abuse and exploitation of young people, limited access to integrated Sexual and Reproductive Health/HIV/Gender Based



Violence information and services, the increased decline in household incomes, and job losses during Covid-19 lockdown. According to the District Health Information system-2 (DHIS-2), in 2021, the country recorded 31,565 pregnancies every month which translates into 1,052 pregnancies recorded daily, including 250 children aged below 15 years who got pregnant monthly.

It is worth noting that the actual figures of teenage pregnancy could be much higher given that not all pregnant girls attend antenatal care which is used as a proxy measure of teenage pregnancy.

Teenage pregnancy comes with social and economic costs that are born by a range of institutions starting with individuals and households at the micro level to macro level and impacts on national development in varied ways. The choice of inaction is therefore not an alternative for Uganda on her journey to harnessing demographic dividend. The cost of inaction study is a crucial and timely piece of evidence that clearly spells out in economic and social terms what as a country we are set to lose or gain depending on our choice. This study is a rich and sound advocacy tool that will support the agenda of mobilizing efforts and resources to be channeled into the fight against teenage pregnancy and its effects.

Hon. Amos Lugoloobi,
Minister of State for Finance, Planning and Economic
Development (Planning)

Acknowledgement

This work has been a collaborative effort between National Population Council and National Planning Authority. Many individuals and organizations have made tremendous contributions towards the success of the work.

First and foremost, the Kingdom of the Netherlands is greatly appreciated for providing the main funding which enabled the study that produced this publication. In similar vein, the United Nations Population Fund (UNFPA) is thanked for the financial and technical assistance towards this study. In particular, Mses. Batula Abdi and Florence Mpabulungi are appreciated for their continued technical engagement in the course of the study.

We are also grateful to Uganda Bureau of Statistics (UBOS) who produced the bulk of the data on which this study is based. Thanks are particularly due to Messrs. Pamela Kakande, Margaret Nakirya and Mr. Johnstone Galande of UBOS, who participated in the conceptualization of the study and handled most of the required data processing. Similar gratitude is expressed towards Dr. Betty Kyaddondo of National Population Council and Ms. Judith Mutabazi of National Planning Authority for the supportive work towards the development of this study. Members of the two organizations are also appreciated for the valuable comments in the course of the preparation of this publication.

Last, but not least, the two organizations are grateful to the Lead Consultant, John B. Ssekamatte-Ssebuliba, Ph. D and the Associate Consultant Mr. Andrew Mukulu for their lead in the conceptualization, design and execution of the study and preparation of this publication. We also take this opportunity to thank all persons and organizations who in one way or another contributed to the successful execution of this study.



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Foreword

Teenage pregnancy is a major health, social and economic issue that has affected many young people, their families, communities and countries globally.

In Uganda, one in four women give birth by the age of nineteen and about a half of these, the pregnancies are unintended. The determinants of adolescent pregnancy are complex, multidirectional, multidimensional and vary significantly across regions, age and income groups, families and communities.

The consequences of early childbearing are severe, including death which occurs during pregnancy and delivery. For the individual teenagers, early childbearing has potential to disrupt their healthy development into adulthood, it impacts negatively on their education aspirations, livelihoods, health and future social economic productivity. The households and communities are compelled to shoulder an extra burden in supporting the young mother and her child but also may lose the dividends hadn't early motherhood intersected with childhood. Moreover, early childbearing has a direct financial cost to the government budgets, expenses and is a key constraint to harnessing the Demographic Dividend.

Preventing teenage pregnancy is therefore essential for Uganda's economic development. It leads to high economic returns and offers the best guarantee of a productive workforce in the future. Further, a reduction in early childbearing and unintended pregnancies would enable families to reap savings in maternal and child health care and boost young women's education and economic prospects. It saves the government millions of shillings that are spent on reproductive health care of teenage mothers notably, antenatal and postnatal care, fistula repair and post abortion care. This is a journey that UNFPA has collaboratively walked with several other actors and will continue to so adopting multisectoral approach that aim to develop girls' human capital, focus on their agency to make decisions about their reproductive health, and promote gender equality and respect for human rights. At UNFPA, we are dedicated to supporting young people fulfill their potential and transit to responsible adulthood.



UNFPA through its GOU/UNFPA 9th Country Programme (2021-2025) will continue to strengthen the capacity of implementing partners to implement evidence based high impact interventions to prevent teenage pregnancy. Through Joint efforts, UNFPA in partnership with government, development partners, Civil society organizations (CSOs) and sister UN agencies will work with the champions of government leaders to advance the campaign against teenage pregnancy through the national campaign to end teenage pregnancy and child marriage. UNFPA and partners will continue to advocate for and support sustainable conversion of the youthful population into productive and valuable human capital capable of making significant difference in economic growth of Uganda.

Accountability is essential on the part of each duty bearer irrespective of which level we are. I, and you and all of us have a duty to rally our efforts to protect the rights of women and girls. Based on global evidence we know what works to prevent teenage pregnancy; ensuring quality, accessible and affordable sexual and reproductive health services, keeping girls in school and preventing women and girls from gender-based violence. What is required is to implement these evidence-based high impact interventions at scale. Investing in adolescent health and wellbeing is smart choice both from a human rights perspective, but also as an investment choice given the return both at micro ad macro levels. This is the right thing to do, it is a rights issue, it not only makes economic sense, but in the spirit of Ubuntu, it is our moral duty. The cost on inaction study has not only heightened and amplified our antennas to reimagine teenage pregnancy as a human rights violation, but also has called for an investment case.

UNFPA representative
Dr Mary Otieno

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List of Acronyms

COVID-19	Novel coronavirus or SARS-CoV-2
DD	Demographic Dividend
DHIS	District Health Information Software
HMIS	Health Management Information System
GBV	Gender Based Violence
GDP	Gross Domestic Product
NDP	National Development Plan
SRHR	Sexual Reproductive Health Rights
TP	Teenage Pregnancy
UDHS	Uganda Demographic and Health Survey



Executive summary

The country's main strategy for harnessing the Demographic Dividend (DD) is built around ensuring that the adolescents are healthy, properly educated and appropriately skilled to take up jobs that will be created in the economy as per the third National Development Plan (NDP III) programme lay out.

The corner stone of this strategy is rapid fertility decline, arising mainly from young people delaying marriage and childbirth as they complete their education and build careers, which will trigger transformation of the age structure and in turn ensure Uganda realizes the Demographic Dividend. Fertility is already declining which is an indication of the demographic transition. Teenage pregnancy will undermine this strategy in so many ways if no action is taken.

Magnitude of teenage pregnancy

Teenage childbearing has existed in Uganda for several decades. The Uganda Demographic Health Surveys of 2016, 2011 and 2006 have shown that nearly three out of every five women (58.2%) aged 20 – 49 Years started childbearing while still teenagers. The percentage of women aged 15-19 who have given birth or are pregnant with their first child declined between 2001 and 2006 from 31% to 25% and has remained since stable at 24% in 2011 and 25% in 2016. The 2020 National Survey on Violence revealed that over the last 45 years, more than half of the girls have experienced childhood sexual abuse which may also explain the unchanging level of teenage pregnancy. However, incidence of violence affecting the current generation has slightly reduced from 64% to 50%.

Social cost of teenage pregnancy on the individual

Education attainment: Teenage mothers are more likely than non-teenage mothers to attain only primary level education and on the other hand, teenage mothers are six times less likely to complete secondary education compared to non-teenage mothers. Therefore, keeping girls in school reduces teenage pregnancies.

Occupation: Teenage mothers are three times less likely to have professional jobs and twice more likely to be self-employed in agriculture.

About half of the teenage mothers (47%) are peasants in subsistence agriculture. Only 5% of the teenage mothers are employed in professional occupations. Subsequently teenage mothers will have a lower income level that eventually affects their standard of living and contribution to productivity.

Social effect of teenage pregnancy at Macro level Contribution to the newborns and the Population

at large: Teenage pregnancy is responsible for nearly one-fifth (18%) of the annual births in Uganda. Teenage pregnancy contributes 7% of the population of the population growth. Nearly half (46%) of the births by the teenagers were unwanted pregnancies.

Contribution to Infant and maternal mortality:

Teenage pregnancy contributes 20% of the Infant deaths in Uganda and on the other hand contribute to 28% of the maternal deaths. If no action is taken to reduce teenage pregnancy, teenage mothers may continue to suffer the most from deaths arising from reproductive health challenges like abortions due to Gender Based Violence with teenagers constituting about half (48%) of the GBV of cases.

Economic cost of teenage pregnancy

Individual level health care costs: Per capita reproductive health expenditure i.e what each teenage mother spends is 280 USD on herself and baby's health care. Per capita expenditure for minor health care of a child per episode is estimated at 29,645 UGX (8 USD).

Macro level health care costs: Families of all teenage mothers in 2020 spent Ug.Shs. 1.28 trillion (290 million USD) on Sexual Reproductive Health and the estimated health facility expenditure on teenage mothers was Ug.Shs. 246.9 billion (70 million USD). Collectively this is equivalent to 43% of the Ministry of Health 2019/20 budget. The largest amount of expenditure is spent on normal delivery and care for newborns.

Macro level education costs: Families of all teenage mothers in 2020 will spend Ushs.689.9 billion (194 million USD) on children born in 2020 to complete secondary education.

Expected Health care and education savings at Macro level

If the current teenage pregnancy rate is reduced from 25% to 10% as targeted in the current Health Sector Development Plan. Then each year:

- About half of the health care expenditure for teenage mothers will be saved equivalent to Ushs. 592 billion (169 million USD) and, the per capita health care expenditure will reduce from 280 USD to 105 USD.
- The resultant education cost for children born by teenage mothers of over Ushs.53 billion will be saved.

CONCLUSION

If no action is taken to reduce teenage pregnancy in Uganda by instituting measures to reduce childhood sexual abuse and exploitation, then teenage pregnancy will continue with 50% of teenage girls at risk each year. Teenage mothers may continue to suffer the most from deaths arising from abortions due to Gender Based Violence (48% of these death are teens). About 64% of teenage mothers will not complete primary education level and about 47% of teenage mothers will end up in peasant agriculture work. Consequently, on an annual basis more than Ug. shs. 645 billion will be spent on health care for teenage mothers and education of their children.

There is need:

- To improve the capacity of health facilities to offer quality adolescent and youth responsive SRHR services.
- Establish / functionalize adolescent sensitivity at all levels of care as outlined in the health sector development plan should be strengthened.
- The adolescent and youth friendly health care services manuals for Basic Health Staff and GBV guidelines for case management mechanism need to be revised accordingly.

Teen pregnancy reduction efforts should also address disparities seen from the 2016 UDHS by concentrating efforts on high risk and special populations such as: teenagers without educational attainment, current teenage mothers, and youth residing in rural and island

Teenage Pregnancy refers to girls age 10-19 years who are either currently pregnant or have had a birth.

areas and those within the low-income households, including regional efforts especially in North Buganda, Bukedi, Teso, Bunyoro and Toro. Teenage pregnancy prevention should also be considered within the context of Sexually Transmitted Infection (STI) prevention targeting about 6% of teen girls who reported STI symptoms in the 2016 UDHS.

Male involvement in SRHR and GBV issues is essential in prevention of teenage pregnancy given the high prevalence of over half of the women in Uganda reporting sexual abuse before the age of 15.

Prevention of teenage pregnancy in Uganda can also be achieved through proven strategies such as access to age-appropriate sexuality education which empowers young people to make informed choices; and promotion of SRHR training for “Gate Keepers” (especially teachers and partners).

The National Youth Council Strategic plan (2020-2025) should develop a costed action plan in order to implement the policies and legislation that the government has put in place.

An inter-agency approach to prevention of teenage pregnancy should be used to work closely and strengthen existing mechanisms for SRHR of adolescents and youth such as the National Coordination Mechanism for Youth Programmes. Additionally, support implementation of the multi-sectoral communication for development strategy for adolescent girls.

Teenage pregnancy and prevention programs should be data driven and data informed. Evidence based programs often require implementation to conformity, meaning the program is implemented exactly as the model requires and alteration may not be a choice. Leveraging data like the Youth Risk Behavioral Surveillance Survey results can help government to better understand youth sexual behaviors, practices and choices. The last such survey was conducted in 2004. It is therefore important to conduct a Knowledge, Attitudes, Practices and Behavior survey among teenagers.



Background

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1.1 Problem and Literature review

Uganda Vision 2040 recognizes that today's young people will be the drivers to achieve the Vision. It is therefore imperative that the right interventions are made to ensure that the aspirations set out in Vision 2040 are met, with harnessing of the demographic dividend (DD) as one of the strategies for the ultimate attainment of those targets.

The country's main DD harnessing strategy is built around ensuring that the adolescents are healthy, properly educated and appropriately skilled to take up the jobs that will be created in the economy as per the third National Development Plans (NDP III) programme lay out. The corner stone of this strategy is rapid fertility decline, arising mainly from young people delaying marriage and childbirth as they complete their education and build their careers, which will trigger the age structure transformation and in turn ensure Uganda realizes the Demographic Dividend.

Uganda is at the early transition phase of its demographic change, with declining mortality and relatively high fertility. Uganda's population will continue to grow because of the large number of people who are either currently at an age when they are having children or who will soon enter that age group.

Consequently, the National Vision 2040 document pronounced the country's current demographic profile as one of the threats to realizing the planned Vision targets given that it has high fertility with high but declining mortality and a resultant child-heavy age structure. However, the Vision also stated that with the right kind of investments, the country's erstwhile population burden can be turned into an opportunity. It is in this context that the Vision proclaimed investing in the country's abundant human resources to create human capital and thereby harness the demographic dividend, as one of the strategies that will be adopted to increase the likelihood of realizing Vision 2040.

The three National Development Plans (NDPs) developed so far have all focused on addressing the population issue with a view of making it more amenable to development planning. NDP I (2010/1 – 2014/5) started off by laying the foundation of mainstreaming

population factors into the country's planning and budgeting frameworks. Introducing the concept of human capital in planning, NDP II (2015/6 – 2019/20) for the first time in Uganda's development paradigm, pronounced allocations to health, education and social development as investment expenditure. NDP III (2020/1 – 2024/5) now has a full-fledged programme on Human Capital Development and another on Community Mobilization and Mindset Change. These two programmes represent a culmination of the envisaged Vision strategy of investing in the country's abundant human resource to harness the demographic dividend.

In support of the strategic direction taken on population, the two modeling exercises undertaken as part of preparations for both NDP II and III in 2014 and 2018 respectively, demonstrated that the scenario that prioritizes investments in human capital would lead the country to a GDP per capita in excess of USD 9,500 (the Vision target) in 2040, while the scenario emphasizing economic investments alone would lead to only USD 6,000. Both NDPs flatly rejected the "Business as Usual" approach as this would not move the country forward in any meaningful way.

It is now being continuously observed that teenage pregnancy (TP) poses one of the biggest threats to this bold move to human resource investment. Studies have shown that Uganda's teenage pregnancy rate declined from about 44 per cent in 1995 to 31% in 2000-01 and further to 25% in 2006. However, it has now stagnated at 25 per cent over the last 15 years.

Uganda has adopted a life-cycle approach to human capital development. This means that female teenagers make up 50 per cent of the cohort that is in the skilling pipeline for the next generation of wealth creators. If a quarter of these teenagers are ejected from this cohort due to teenage pregnancy, it means the economy will face a long-term confounding problem. On the one hand, it will suffer a deficit in the planned wealth creators who will drop out of school due to teen pregnancies. On the other, the economy will have to take care of those drop-outs as unproductive or under-productive dependents that only contribute to population growth rather than development.

The phenomenon of teenage pregnancy has presented challenges at both macro and micro levels, and in different spheres of life. Teenage pregnancy and motherhood have remained major health and social concerns in Uganda because of their association with higher morbidity and mortality for both the mother and the child. Early pregnancy or childbirth can be dangerous to the mother and to her child. This is because young girls may not be physiologically mature enough to give birth. In some cases, physiological immaturity may be compounded by poor nutrition, especially among the poor, and these risks occur regardless of marital status. In addition, pregnancy, especially among the unmarried, may be unplanned and this may lead to the withdrawal of social support and further complicate a woman's situation. In such cases, young women may turn to unsafe abortions with their attendant problems.

In addition to the physiological risks, there is also a negative effect on the socioeconomic status of the teen mother, and hence the child. For a long time, the school policy has been to expel pregnant girls from schools, thus terminating their education. Although there seems to be a softening of this policy stance, particularly during the COVID 19 period, its implementation is still unclear and there is still a lingering social stigma against teenage pregnancy that will almost ensure that girls drop out of school.

It is also important to note that although girls make up about 50 per cent of the population of teenagers, the adverse effects of teenage pregnancy are far greater than the 50 per cent mark, extending beyond the single girls affected. Teenage pregnancy will undermine the DD strategy in so many ways. It will not only fail the prospect of the fertility decline, but also raise the probability of mortality, both maternal and infant. The 2016 Uganda Demographic and Health Survey (UDHS) found that about a fifth (20%) of teenage girls aged 15 – 19 were already married or living with a man¹. The early exposure to the risk of childbearing is one of the greatest contributors to the observed high fertility in Uganda. The country's total fertility rate (TFR) currently stands at 5.4 children per woman, and the two youngest age groups, i.e. 15 -19 and 20 -24 account for more than 40 per cent of this total fertility rate.

Teenage pregnancy has also been found to worsen the mortality situation of Uganda's infants. The 2016 UDHS showed that the neonatal mortality rate among infants born to teenage mothers was 55 deaths per 1,000 live births, compared to the 25 per 1,000 among infants born to mothers aged 20 – 29 years. In addition, teenage mothers were found to be contributing a disproportionately larger share in the country's maternal mortality situation².

Teenage pregnancy will also lead to early school dropout in late primary and early secondary school years, hence dashing the plans of skills development and career formation for turning the country's abundant human resource into human capital. In short, it will make it much more difficult for the country to improve livelihoods and stay on course for harnessing the DD.

According to the World Bank's tenth Uganda Economic Update (2021), girls who are married or have children at a young age or drop out of school early are more likely to experience poor health, to have more children over their lifetime, and to hold mainly low productivity and low paying jobs during adulthood.

50%

Although girls make up about 50 per cent of the population of teenagers, the adverse effects of teenage pregnancy are far greater than the 50 per cent mark, extending beyond the single girls affected.



The 2016 Uganda Demographic and Health Survey (UDHS) found that about a fifth (20%) of teenage girls aged 15 – 19 were already married or living with a man.



Teenage mothers were found to be contributing a disproportionately larger share in the country's maternal mortality situation.

The Update also concludes that in addition to addressing the substantial risks and suffering faced by adolescent girls and their children, investments in ending these practices can produce huge economic gains, not just for the girls, or their households, but for the country at large.

Although no hard statistics are available now, scanty and anecdotal evidence suggests that this situation has been made much worse by the COVID-19 pandemic and the ensuing lockdowns. What it boils down to is that the expected investment in the human resource, in this case girls, did not materialize. Despite the fact that both NDPs rejected the “Business as Usual” scenario, there does not seem to have been much investment yet channeled into the fight against teenage pregnancy and its dire effects.

1.2 Objectives

The overall objective of this undertaking is to assess how much investment has been made to protect girls from getting pregnant; and in case of insufficient investment, estimate the cost of inaction. The specific objectives are:

- i. Establish the current state of teenage pregnancy and its effect on the individual teenagers, their households and the country at large; and
- ii. Through appropriate modelling, establish the “cost of doing nothing” to the situation brought out in (i) above to the country’s prospects of harnessing the demographic dividend.

1.3 Magnitude of Teenage Pregnancy in Uganda

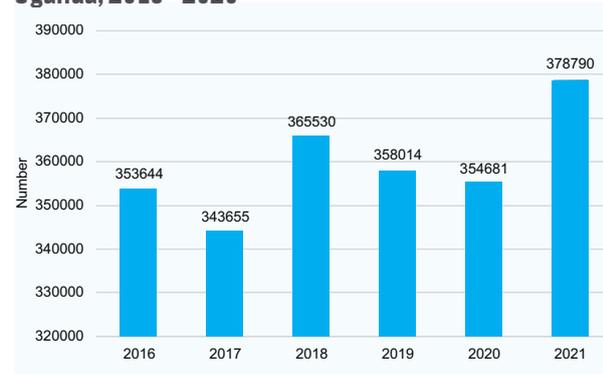
Teenage childbearing has existed in Uganda for several decades. The 2016 UDHS showed that nearly three out of every five women (57.9%) aged 20 – 49 years started childbearing while still teenagers. The equivalent percentages for the previous UDHSs are 62.9% in 2011 and 65.6% in 2006. The 2016 UDHS further showed that one quarter of the females aged 15 – 19 years in 2016 had already initiated childbearing. Therefore, teenage childbearing is responsible for 18% of the annual births in Uganda.

This is further buttressed by findings from the 2020 National Survey on Violence in Uganda that revealed that across all generations over half of the girls experienced childhood sexual abuse before the age of 15 years.

Annually, Uganda registers more Teenage Births than Tertiary School students.

Eight in every ten children (84%) are sexually abused in the afternoons and evenings, mainly on the roadside and in natural fields. This sexual abuse predisposes them to pregnancy, and this partly explains the unchanging level of teenage pregnancy in Uganda. According to the Health Management Information System (HMIS), teenage pregnancy contributed nearly two million births in Uganda between 2016 and 2020 (see Figure 1.1). This gives an average of 30,000 Teenage births per month.

Figure 1.1: Health Facility Teenage Pregnancy in Uganda, 2016 - 2020

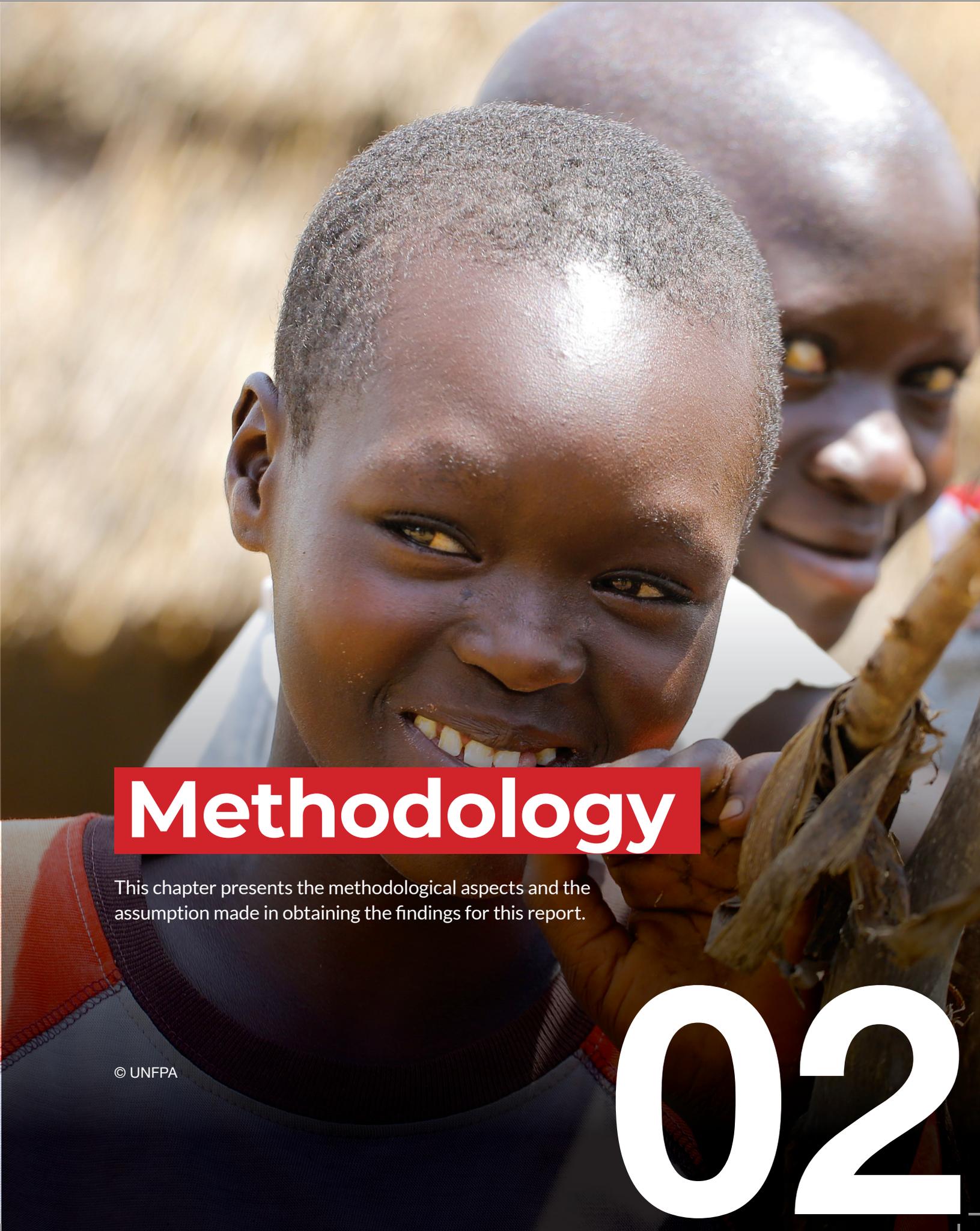


Source: DHIS2

1.4 Effect of COVID-19 Pandemic on teenage pregnancy

In March 2020, the World Health Organization declared COVID-19 a global pandemic. On its part, the Government of Uganda issued guidelines on management of the pandemic including, among others, the immediate closure of all educational institutions.

It is generally believed that the closure of schools coupled with a restriction of movement predisposed the school-age children to sexual exploitation and abuse leading to a surge in teenage pregnancy levels. By the end of 2021, the DHIS recorded a total of 378,790 teenage births, this is seven percent (7%) higher than the annual average registered in the previous five years.



Methodology

This chapter presents the methodological aspects and the assumption made in obtaining the findings for this report.

2.1 Sources of data

The study utilized existing secondary data compiled from various sources such as:

1. **Uganda Bureau of Statistics:** Population projections and estimates; 2016 Uganda Demographic and Health survey (UDHS), The 2020 National survey on violence in Uganda; and the Annual National production accounts based on Producer Prices
2. **Ministry of Health:** District health Information System (DHIS); the 2020/2021 Annual Health sector Performance Report; report on comprehensive costing of SRH services for different levels of care and ownership in Uganda (provider's perspective) in September 2018.
3. **Other published reports:** 2020/2021 Annual Health sector Performance Report; the study report on "Cost and Pricing: An assessment of Private health facilities in Uganda produced by the coalition for health promotion and social development (HEPS Uganda); and samasha medical foundation for USAID/ Uganda private health support program in May 2014.

The study also used appropriate demographic and econometric modeling, the established associations were plotted into costing and predictive frameworks to establish the likely consequences of different courses of action. (See description of the cost approach in appendix 1). The likely results were arranged in two different scenarios according to different predictive assumptions. The scenarios were then placed in a costing model to establish the various costs associated with the different courses of action, to reflect the "cost of doing nothing". The detailed explanation of the approaches is given in the next subsection.

2.2 Social costs & consequences of teenage pregnancy

To establish the social cost of teenage pregnancy, the 2016 UDHS dataset formed the basis of obtaining the number of teenage mothers aged 15-19 years in order to obtain the human costs of teen childbearing and the implications for the child and the mother. The associated health risks were explored in the HMIS for health outcome. This was obtained through cross tabulations and a logistic regression model of teenage mothers against selected background characteristics such as: age at first sex by age 15, marital status, lifetime sexual partners, family planning use among others.

To estimate the effect of school dropout due to teenage pregnancy on selected labour force indicators and loss to Gross Domestic Product (GDP), the 2016 UDHS dataset was used to generate a logistic regression model to ascertain the relationship between teenage pregnancy and current occupation, seasonal working, payment mode among others.

The average monthly wage/salary by occupation was estimated for the teenage mothers and gross estimates as contribution to 2019/20 GDP and compared with that for non-teenage mothers.

1. To assess the extent of the contribution of teenage pregnancy to maternal mortality, the District Health Information Software 2 (DHIS-2) data was extracted by cause of death for the year 2020. The 2020 National survey on violence in Uganda dataset was used to demonstrate retrospectively the extent of childhood sexual abuse and its link to teenage pregnancy.
2. To demonstrate the effect of the national lockdown due to COVID-19 on teenage pregnancy, the DHIS-2 data on teenage mothers who report for the first antenatal care in the first trimester was extracted by month for the years 2016 to 2020 for trend analysis. This was extrapolated using 2016 UDHS rates to get the national incidence of teenage pregnancy by month that includes all those who go for antenatal care and those who do not go. The other UDHS variable used was percentage of girls aged 15-19 who attend antenatal care during the first trimester. (Only 29.1% as seen in 2016 UDHS).

2.3 Financial costs and consequences of teenage pregnancy

Teenage pregnancy has costs at various levels (i.e. to the individual, family and the country). The analysis for this report first focused on costs that relate to the country as a whole as well as at the individual level. To estimate the economic cost of teenage pregnancy, the Teenage Pregnancy Economic Impact model was used.

The model was constructed by SRI International (1979) for the Population Resource Center -USA. It was derived from a review of 12 studies that estimated the cost to the public of teenage childbearing conducted in USA. This methodology uses all teenagers experiencing a first birth as its population base.

This is used to estimate both 'single-cohort' and the 'single-year' spending related to teenage pregnancy. Single-cohort estimates 'look forward' (18 years after the birth) to measure the costs of teenage births in a given year and single-year estimates 'look backward' to measure the costs of expenditures in a given year attributable to teenage births.

For this report, single-year estimate is the total out of pocket spending related to children born to teen moms in 2020 until they reach age 18. It is calculated as the sum of projected individual spending (by multiplying average annual spending per person by total number of eligible children and by the number of years the children will be eligible for the programs) for the financial year 2019/20. The cohort was set from 2019/20 to 2037/38. The total health care spending related to teenage childbearing is the estimated total out of pocket spending made by teenage mothers and their children plus health facility costs for related conditions.

2.3.1 Financial costs

The financial costs were calculated based on the costs of healthcare and education. Health care costs related to out of pocket costs for sexual and reproductive health by teenage mothers aged 10 – 19 years was broken down by:

- Ambulatory services/outpatient services;
- Inpatient services/admissions; and
- In-patient services with surgical operation.

Health care costs related to health facility running for sexual and reproductive health were broken down by:

- Facility cost per birth;
- Facility medical expenses;
- Facility cost per outpatient visit;
- Facility cost per in-patient bed day based on the average length of stay (patient days per admission);
- Facility cost for each Anti-Retroviral Therapy (ART) visit excluding Anti-Retroviral drugs (ARVs);
- Projected annual facility cost of treating a new ART patient, inclusive of ARVs.

Out of pocket health care expenditure for babies by teenage mothers only focused on costs for:

- Immunization;
- De-worming;
- Consultation fees; and
- Treatment of colds/cough, plus fever.

For prices not readily available in financial year 2019/20, the inflation adjustment factor was used in the calculations. The choice of cost items was based on availability of data on prices.

Estimated base numbers

To estimate the number of teenage mothers in Uganda for the last 18 years, the teenage pregnancy rate from UDHSs: 2000/1, 2006, 2011 and 2016 were applied to the projected number of girls' aged 10-19 years. Similarly, the same procedure was used to get the number of C-section mothers, urine test in ANC, took drugs intestinal parasite during pregnancy, blood test in ANC, health facility deliveries, and the estimated number of living children born to teenage mothers.

Computations

After obtaining the total number of births to teenage mothers for the last 18 years the following were estimated:

1. **Single-year cost estimate for teenage mothers:** total out of pocket spending in financial year 2019/20 related to teenage births in 2019/20. This is a single-year estimate calculated as the sum of estimated spending.

- 2. Single-cohort cost estimate for teenage mothers:** total out-of-pockets pending related to the children born to teenage mothers in 2003 through a period of 18 years – the duration when a child is expected to become an adult (single-cohort estimates), obtained by multiplying average cost per enrollee by the total number of eligible children for all children born to teenage mothers from 2003 to 2020.
- 3. Single-year cost estimate for children born to teenage mothers:** total out of pocket spending in 2019/20 related to all children that will be born by teenage mothers. Annual spending was estimated by multiplying average cost per enrollee by total number of eligible children born to teenage mothers in 2019/20.
- 4. Single-cohort cost estimate for children born to teenage mothers:** this was estimated by multiplying average cost per enrollee by total number of eligible children aged 18 years or younger and born to teenage mothers. It was calculated as the sum of estimated spending.

2.3.2 Savings related to reduced teen birth

To estimate the potential savings accrued from reduced prevalence of teenage pregnancy, two scenarios were created based on the single-year estimations as follows:

- a. Scenario 1:** the teenage parenthood rate is reduced from 25% to 10% as stipulated in the health sector development plan.
- b. Scenario 2:** the current teenage parenthood rate of 25% is reduced by 10%.

The potential cost savings were computed directly as the average cost per enrollee multiplied by the number of reduced teenage births/mothers.

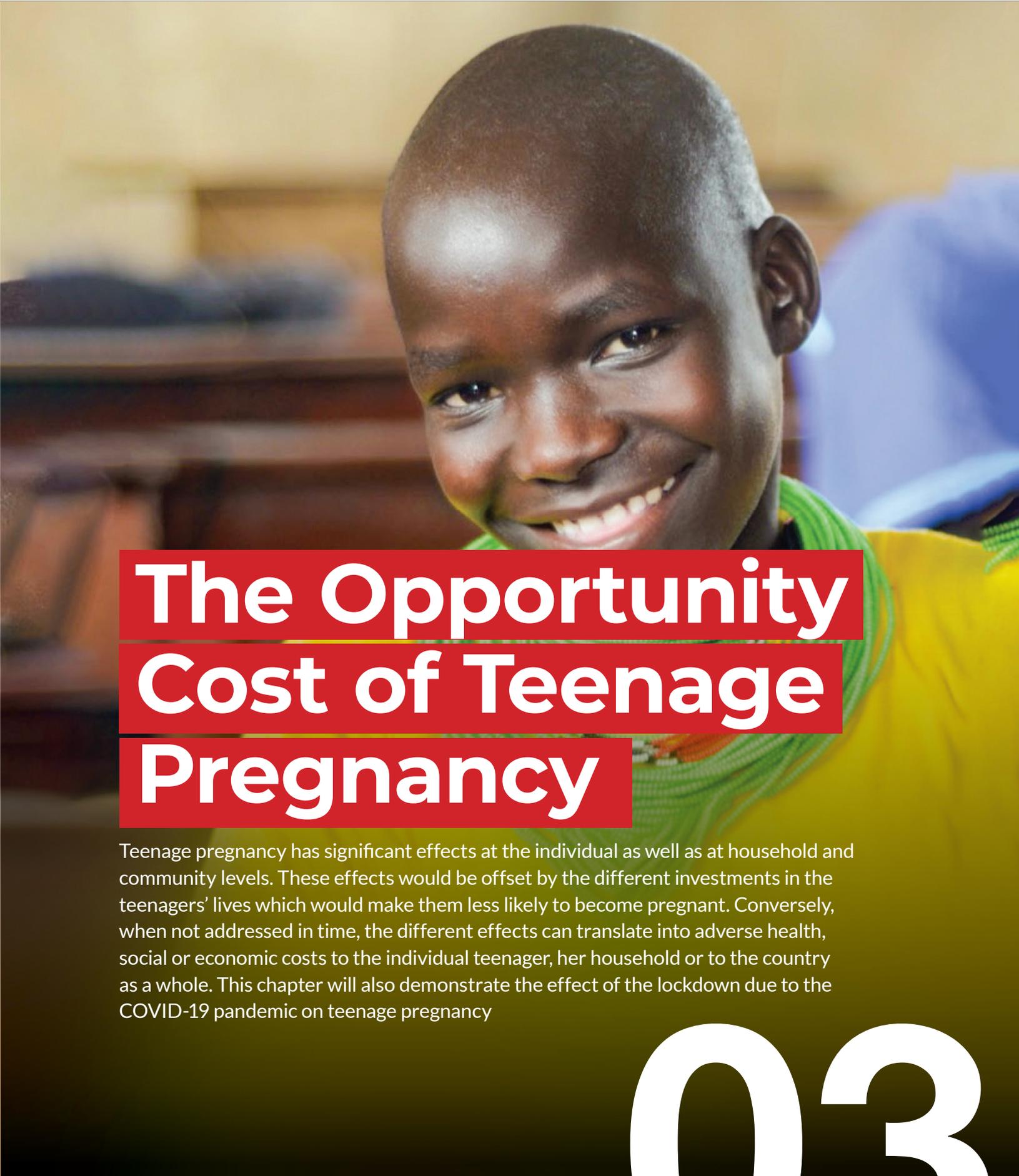
The average annual spending and cost savings were further used to estimate their contribution to Gross Domestic Product (GDP) for the year 2019/20 and also their proportion of the Ministry of health budget of the same year in order to illustrate the economic impact.

At the individual level, health care costs were computed as: (i) per capita reproductive health care expenditure i.e. what each teenage mother spends on her own health care; (ii) per capita expenditure for minor health care of a child per episode.

2.3.3 Assumption

The following assumptions were made during the analysis:

- a. The prevalence rates of selected indicators from the 2016 UDHS are still applicable to the current situation given that behavioral indicators do not change over a short period of time. More so, rates for teenagers 15-19 years were applicable for children aged 12 – 14 years. Therefore, teenage mothers were considered to be age 12 – 19 years although data from the DHIS refers to 10-19 year olds.
- b. All first visits for antenatal care within the first trimester were considered as a new pregnancy.
- c. For education costs, all living children of teenage mothers between the ages of three and six years were all enrolled in nursery school.



The Opportunity Cost of Teenage Pregnancy

Teenage pregnancy has significant effects at the individual as well as at household and community levels. These effects would be offset by the different investments in the teenagers' lives which would make them less likely to become pregnant. Conversely, when not addressed in time, the different effects can translate into adverse health, social or economic costs to the individual teenager, her household or to the country as a whole. This chapter will also demonstrate the effect of the lockdown due to the COVID-19 pandemic on teenage pregnancy

03

3.1 Macro level costs

3.1.1 Teenage pregnancy and the Demographic Dividend

One of the macro factors is the contribution of teenage births to the population size and growth. Teenagers contribute 18 per cent (about one sixth) of the annual births recorded in Uganda. This is a dire situation and is likely to have disastrous effects on the country's prospects of harnessing the demographic dividend. Unless the teenage contribution in terms of these births is curbed, the much anticipated accelerated fertility decline is not likely to be realized and thereby also putting off the dramatic age structure transformation that it is expected to trigger.

The results from the 2016 Uganda Demographic and Health Survey also showed that more than 46 per cent of the teenage births were from unwanted pregnancies. This is a serious situation and an indictment on the system which failed these teenagers in protecting them against unwanted pregnancies. It is certainly much cheaper to invest in pregnancy-preventing interventions among teenagers than dealing with the host of challenges arising out of teenage pregnancies.

However, this is a double-edged sword. If 46 per cent of the teenage births were unwanted, then more than half of those births were actually wanted by those teens or at best, did not mind having them. The girls may consider the birth wanted because of family or peer pressure, alcohol influence and more so the circumstantial marriage affair, that is pushed by lack of education, poverty among others. Given that these are the girls that are expected to be the vanguard of not only the fertility decline but also the intensive skilling efforts to produce the anticipated future human capital, it must be very concerning that this crop of teenagers actually wanted to be pregnant. It means that the country has not invested enough in this area and still has an insurmountable task of educating the teenagers about the real dangers of teenage pregnancy and childbearing.

3.1.2 Teenage pregnancy and Mortality

Teenage pregnancy and childbearing have also been shown to contribute to Infant and maternal mortality. UDHS data have demonstrated that babies born to mothers aged below 20 years are at a heightened risk of mortality compared to their counterparts born to older women. It is estimated that teenage pregnancy is responsible for about one-fifth (19.8%) of the Infant deaths. This is certainly a public health crisis and not doing anything about it will mean it will only get worse. It is noteworthy that Uganda notes in her demographic dividend harnessing road map that the DD will not be automatic. One of the prerequisites to its harnessing is the accelerated mortality decline, especially infant and child mortality.

In an extension of the public health crisis, teenage pregnancy and childbearing is also a serious maternal mortality risk to the teenagers themselves. The Ministry of Health data show that teenagers as a group are the biggest contributors to maternal mortality. Based on the 2016 UDHS, it is estimated that teenager mothers contribute only about 12 per cent of the annual number of births, and yet contribute nearly 30 per cent of maternal deaths. The country cannot afford to continue not doing anything about this looming crisis.

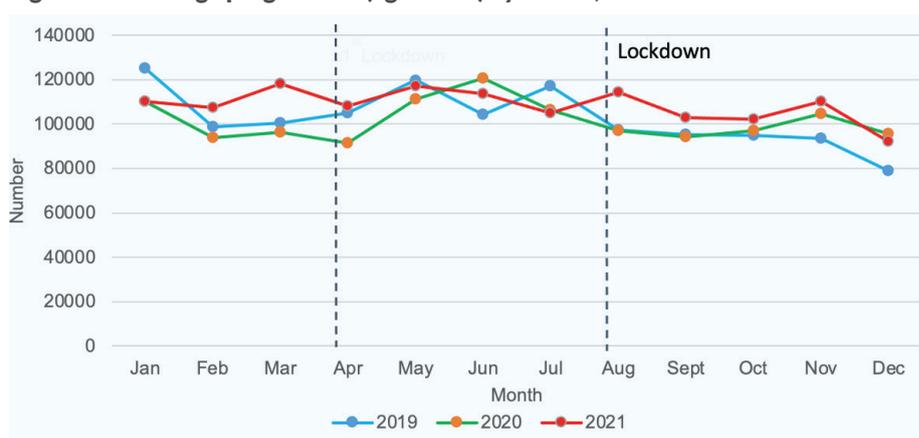
The DHIS figures for 2020 also showed that teenagers contribute to 48% of the health facility maternal death due to abortions from Gender Based Violence. Therefore, if no action is taken to reduce teenage pregnancy, teenage mothers may continue to suffer the most from deaths arising from abortions due to Gender Based Violence.

3.1.3 Teenage pregnancy and lockdown due to COVID-19

Teenage pregnancies are generally believed to have increased in Uganda during the lockdowns due to the COVID-19 pandemic. To demonstrate the effect of the two lockdowns that happened in March and June 2021, a review of the DHIS2 data was done by month based on first time attendees for antenatal care during the first trimester.

Figure 3.1 shows that new teenage pregnancies are generally higher in January compared to the months over the three years of 2019, 2020 and 2021. The year 2021 recorded an increase in March (during the first lockdown). The number of pregnancies was generally higher between February to May compared to 2020 and started to decline until July and increased in August during the ongoing lockdown and was much higher than the previous two years. This is an indication that the year 2021 characterized by lockdowns recorded more teenage pregnancies as earlier indicated in section 1.4 of this report. Hence young girls are better and safer at schools.

Figure 3.1: Teenage pregnancies (age 10-19) by month, 2019-2021



Source: Authors computation based on data from DHIS2

3.2 Individual level costs

Teenage pregnancy and childbearing are also associated with various individual level effects which are no less disastrous if no urgent and decisive responses are put in place.

3.2.1 Teenage pregnancy and level of Education attainment

The most common individual level effect of teenage pregnancy is dropping out of school. Either the teenage girls decide to discontinue school once they discover that they are pregnant, the parents or guardians kick the pregnant teenager out of the home, or the school authorities formally expel the teenager for being pregnant. Whichever way it plays out, the teenage girls find themselves out of school on account of their pregnancy.

Once the teenager is kicked out of school then she starts a chain of all inadvertently orchestrated developments to set her on the road to perpetual poverty as a result of low education level. Overnight, she becomes a second class human being with virtually no rights. She becomes very vulnerable and, if not already, she and her child are condemned to a life of poverty and uncertainty.

Many studies have shown that teenage pregnancy is the leading cause of school dropout among girls and thereby the main contributor to inter-generational poverty. The data presented in figure 3.2 show that non-teenage mothers are six times more likely to complete senior four than teenage mothers.



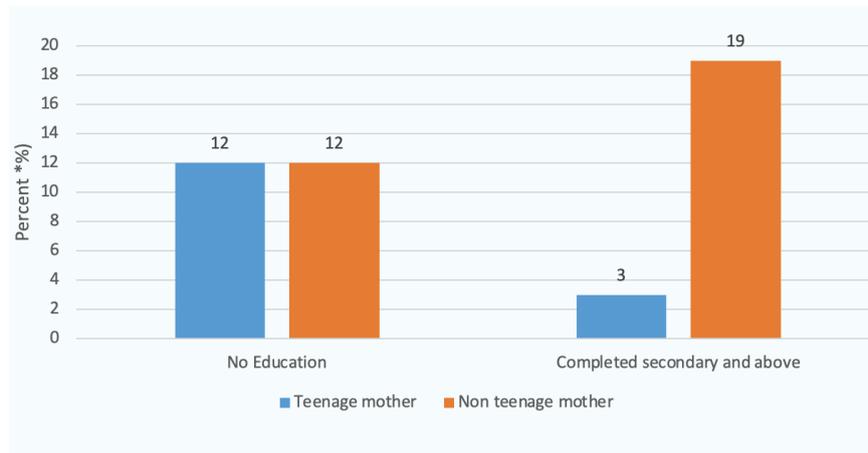
The most common individual level effect of teenage pregnancy is dropping out of school.



Once the teenager is kicked out of school then she starts a chain of all inadvertently orchestrated developments to set her on the road to perpetual poverty as a result of low education level.

This has negative implications on opportunities not only for higher education but also for vocationalisation, possession of life skills and hence presents higher risks of poverty, infant and child mortality as well as of the mother herself.

Figure 3.2: Teenage pregnancy by level of education attainment

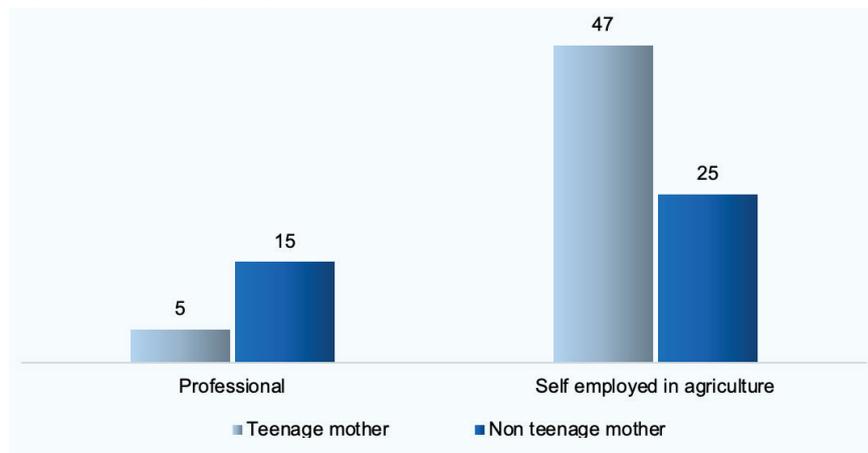


Source: 2016 UDHS

3.2.2 Teenage pregnancy and occupation

Teenage mothers are three times less likely to have professional jobs and twice more likely to be self-employed in agriculture. About half of the teenage mothers (47%) are peasants in subsistence agriculture. Only 5% of the teenage mothers are employed in professional occupations. (Figure 3.3) Subsequently teenage mothers will have a lower income level that eventually affects their standard of living and contribution to productivity.

Figure 3.3: Teenage pregnancy by current occupation



Source: 2016 UDHS

6x

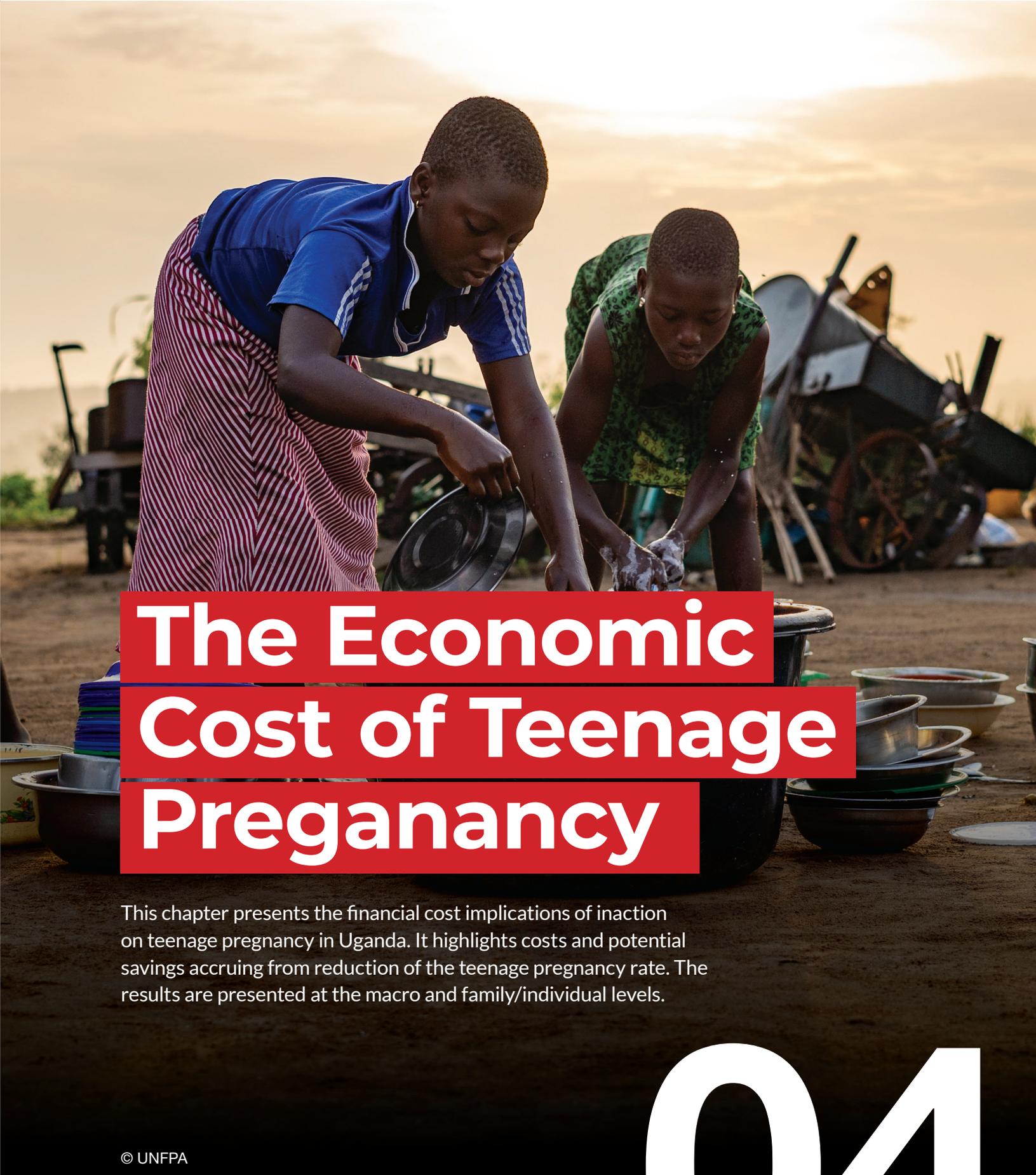
The data presented in figure 3.2 show that non-teenage mothers are six times more likely to complete senior four than teenage mothers.



Teenage mothers are three times less likely to have professional jobs and twice more likely to be self-employed in agriculture. About half of the teenage mothers (47%) are peasants in subsistence agriculture.

05%

Only 5% of the teenage mothers are employed in professional occupations.

A photograph of two young girls in a rural setting, likely in Uganda, washing dishes outdoors. The girl on the left is wearing a blue shirt and a red and white striped wrap, while the girl on the right is wearing a green patterned dress. They are surrounded by various metal pots and bowls on the ground. In the background, there are wooden wheelbarrows and a simple structure, suggesting a rural or semi-rural environment. The sky is bright, possibly during sunrise or sunset.

The Economic Cost of Teenage Pregnancy

This chapter presents the financial cost implications of inaction on teenage pregnancy in Uganda. It highlights costs and potential savings accruing from reduction of the teenage pregnancy rate. The results are presented at the macro and family/individual levels.

4.1 Single year cost estimate of teenage pregnancy

The single-year estimate refers to the total out of pocket spending including health facility spending related to children born to teenage mothers in 2020 until they reach age 18.

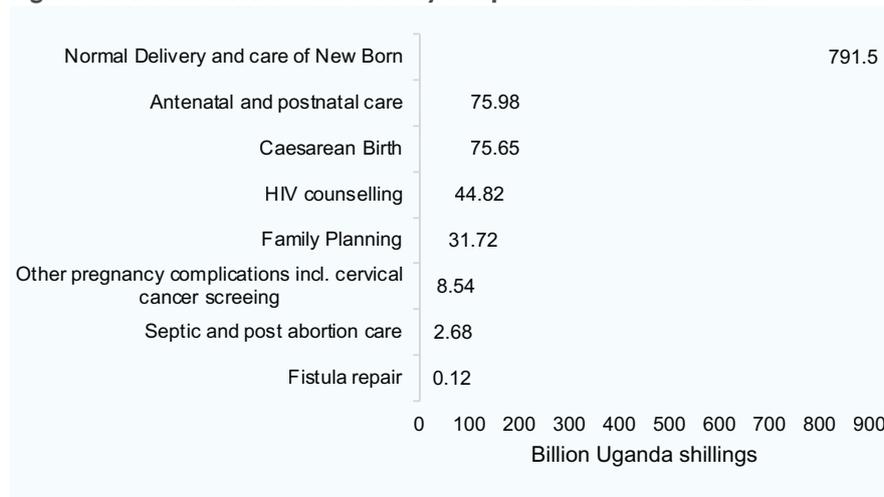
4.1.1. Macro level health care costs

According to the model, the summation of all annual cost estimates based on number of teenage girls accessing particular sexual and reproductive health care services (such as family planning, maternal health care-delivery, antenatal care etc), Ug.shs. 1.28 trillion (362.5 million USD) was spent on Reproductive Health care of teenage mothers in 2020. Of this, the health facility expenditure (including both public and private) was Ug.Shs.246.9 billion (70 million USD). Families of all teenage mothers spent Ug.Shs.1.03 trillion (290.6 million USD) on the Sexual Reproductive Health (SRH) care of the mother, while, Ug.Shs.8.1 billion (2.2 million USD) was spent by families on minor health care for the child.

Collectively, what would be spent on caring for teen mothers is equivalent to 43% of the Ministry of Health 2019/20 budget and would contribute 0.89% of the Gross Domestic Product (GDP) in 2019/20

Figure 4.1 shows that Ug.shs. 791.5 billion was spent on normal deliveries and care of newborns by teenage mothers in the year 2019/20. This is based on 78.6% (2016 UDHS) teenage mothers that gave birth in a health facility.

Figure 4.1: Distribution of SRH costs by component of service in 2020



Source: Model results

Given the above, inpatient services /Admissions take up 78% of the total cost, ambulatory services/outpatient services contribute 15% while inpatient services with surgical operation contribute 7% of the total SRH costs. The most utilized SRH component is delivery and therefore constitutes the largest amount of 77% to SRH expenditure and this is followed by antenatal and postnatal care (8%).



UGX 1.28 trillion (362.5 million USD) was spent on Reproductive Health care of teenage mothers in 2020.

43%

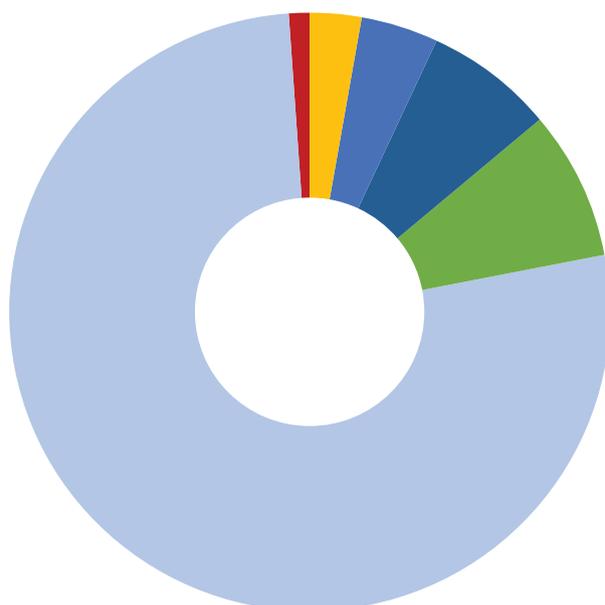
Collectively, what would be spent on caring for teen mothers is equivalent to 43% of the Ministry of Health 2019/20 budget and would contribute 0.89% of the Gross Domestic Product (GDP) in 2019/20

77%

The most utilized SRH component is delivery and therefore constitutes the largest amount of 77% to SRH expenditure and this is followed by antenatal and postnatal care (8%).

Fistula repair and abortion care constitute less than one percent as seen in figure 4.2.

Figure 4.2: Utilization of SRH components in 2020



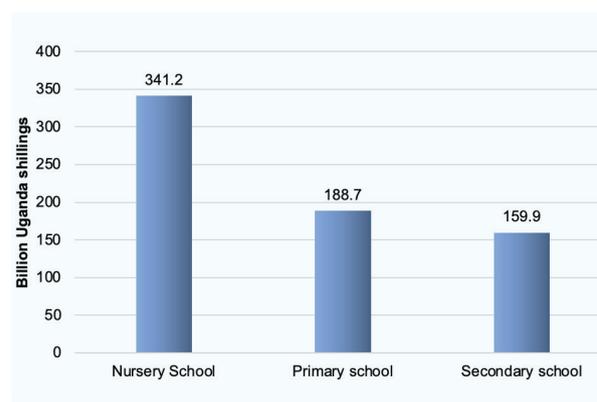
	Septic and post abortion care	0%
	Family Planning	3%
	HIV counselling	4%
	Caesarean Birth	7%
	Antenatal and postnatal care	8%
	Normal Delivery and care of New Born	77%
	Other pregnancy complications incl. cervical cancer screening	1%

Source: Model results

4.1.2 Macro level education costs

Families of all teenage mothers in 2020 will spend Ug.shs.689.9 billion (194 million USD) on children born in 2020 to complete secondary education. This is a cost that would have been averted if there were teenage pregnancies in 2020. Figure 4.3 shows that the bulk of the expenditure is in nursery school and reduces as the classes increase. This is based on the net primary school attendance ratio and the average transition rate to senior one.

Figure 4.3: Distribution of education costs by level of schooling for children born in 2020 by teenage mothers



Source: Model results

4.1.3 Individual level health care costs

To demonstrate the cost implication at the individual level, the per capita reproductive health expenditure was computed i.e., what each teenage mother and her child's health care spends. This was estimated at Ug.shs.992,426 (280 USD). Per capita expenditure for minor health care of a child per episode was estimated at Ug.shs.29,645 (8 USD).

Since most of the teenage mothers are not in very well paying jobs, these costs are most often incurred by their next of kin creating a financial burden on the household.

4.2 Single cohort cost estimate of teenage pregnancy

Single-cohort cost estimate for teenage mothers refers to the total out of pocket spending related to the children born to teenage mothers in 2003 through a period of 18 years- the duration when a child is expected to become an adult.

Families of all teenage mothers in 2003 (18 years ago) spent approximately Ug.shs.9.6 Trillion (2.7 million USD) on formal school education for their children.

4.3 Potential Health care and Education savings

SCENARIO 1:

The potential savings accrued from having the teenage pregnancy rate reduced from 25% to 10% as expected in the Human Capital Development Programme. That is a reduction from 1.3 million teenage mothers in 2020 to about 0.5 million.

The analysis showed that the overall health care expenditure for teenage mothers and their children will reduce by 46% from Ug.shs. 1.28 trillion (362.5 million USD) to Ug.shs. 694 billion (196 million USD). While the amount of savings on health facility expenditure for teenage mothers will reduce by only 15% from Ug.shs. 246.9 billion (70 million USD) to Ug.shs. 210 billion (59 million USD).

More than half (53%) of the Sexual Reproductive health care expenditure for teenage mothers will be saved, equivalent to Ug. shs. 592 billion (169 million USD). Therefore, the per capita health care expenditure will reduce from Ug.shs. 992,500 (280 USD) to Ug.shs. 371,300 (105 USD).

The resultant education cost for children born by teenage mothers of over Ug.shs.53 billion (15 million USD) will be saved each year.

SCENARIO 2:

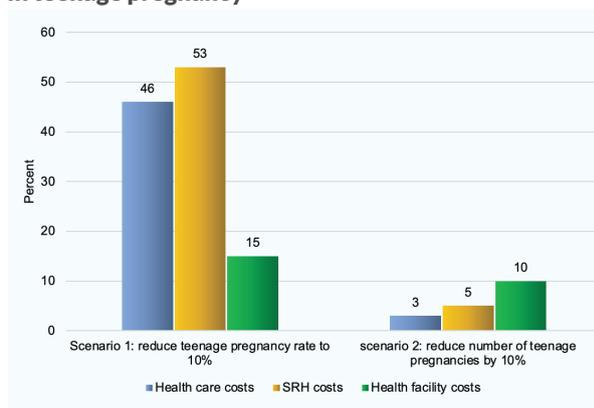
If the current number of teenage pregnancy is reduced by 10%. That is reduce from 1.3 million teenage mothers in 2020 to about 1.2 million, then the potential savings would include a 5% reduction of the overall health care expenditure for teenage mothers and their children from Ug.Shs.1.28 trillion (362.5 million USD) to Ug.Shs.1.23 billion (345 million USD).

While the amount of savings on health facility expenditure for teenage mothers will reduce by only 10% from Ug.shs. 246.9 billion (70 million USD) to Ug.shs. 222 billion (63 million USD).

Only 3% of the Sexual Reproductive health care expenditure for teenage mothers that will be saved is equivalent to Ushs. 35.3 billion (9.9 million USD). Therefore, the per capita health care expenditure will reduce from Ug.shs. 992,500 (280 USD) to Ug.shs. 768,500 (217 USD).

Figure 4.4 shows that a slight reduction in number of teenage pregnancies reaps a small saving as seen for scenario two but this is better than no action at all. However, if the Ministry of health target of 10% is achieved then greater savings will be achieved as seen in scenario one.

Figure 4.4: Percentage reduction in costs by reduction in teenage pregnancy



Source: Model results



Conclusions and recommendations

In conclusion, if no action is taken to reduce teenage pregnancy in Uganda by instituting measures to reduce childhood sexual abuse, then teenage pregnancy will continue with 50% of teenage girls at risk each year. Teenage mothers may continue to suffer the most from deaths arising from abortions due to Gender Based Violence (48% of these deaths are teens).

About 64% of teenage mothers will not complete primary education level and about 60% of teenage mothers will end up in peasant agriculture work. Consequently, on an annual basis more than Ug. shs. 645 billion will be spent on health care for teenage mothers and education of their children.

A number of interventions have been put in place to end teenage pregnancy but may have not been effective. Therefore, an assessment of these actions is important to provide a basis for refocusing, understanding the gap between current level of teenage pregnancy and the kinds of investment that have been put in place to enhance teenage girl welfare and protect them from early pregnancy the probable explanatory factors.

The National Development Plan III recognizes that there is low access to adolescent health friendly services and limited disease surveillance resulting into high teenage pregnancies. The Adolescent Health Policy Guidelines and Service Standards require that reproductive health services should encompass promotive, preventive, curative and rehabilitative care for adolescents.

Recommendations

The ultimate goal is to keep girls healthy, safe and prevent teenage pregnancy in a multisectoral approach that aims to develop girls' human capital, focus on their agency to make decisions about their reproductive health and sexuality, and promote gender equality and respect for human rights. The following are therefore the key recommendations;



1. **Improve access to quality adolescent and youth responsive sexual and reproductive health services** taking into account that young people could access services through several points within the health system and therefore, a system approach to their needs is critical.



2. **Improve access to sexuality education for in and out of school adolescents and youth.** This provides young people with age appropriate, culturally relevant and scientifically accurate information. It also provides young people with structured opportunities to explore attitudes and values and to practice skills they will need to be able to make informed decisions.



3. **Invest strategically in adolescent girls' education-** Education of all children is a right in itself and increases the chances to be socially and economically empowered. Keeping girls in school is a high impact intervention that reduces child marriage and teenage pregnancy. There is therefore need to deliberately invest in girl child education including implementation of re-entry guidelines for teenage mother.



4. **Strengthen the policy and legal framework by promoting policy coherence;** effective enforcement of existing laws prohibiting defilement and child marriage as key contributors to teenage pregnancy and overall capacity for service delivery to fight against sexual exploitation and child marriage and accelerate the approval of relevant pending policies and guidelines.



5. **Develop evidence-informed social behavior change communication package** to address the drivers of teenage pregnancy.

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A photograph of a woman in profile, facing right. She is wearing a bright yellow tank top and has a baby strapped to her back. The baby is wearing a patterned cloth. She is holding a large umbrella with a floral pattern of pink roses on a blue background. In the background, there is a chain-link fence and a tree. The word "Appendices" is overlaid in a red box with white text.

Appendices

1: Model for estimating the economic cost of inaction on teenage pregnancy

To estimate the economic cost of teenage pregnancy, a number of methods were used to demonstrate the costs and savings associated with teenage pregnancy. Below are two models that were applied: the social costs were derived from desk reviews to beef up the analysis because a lot of work around this area already exists.

Teenage pregnancy economic impact model: The model was constructed by SRI International (1979) for the Population Resource Center -USA. It was derived from a review of 12 studies that estimated the cost to the public of teenage childbearing conducted in USA. This methodology uses as its population base all teenagers experiencing a first birth. Burt et al reviewed 12 available studies that estimate public costs attributable to teenage childbearing. The studies use very different methodologies, and a primary purpose was to extract some basic principles for making such estimates. These principles serve as the basis for the national estimates presented, and they double as recommendations to local planners interested in making similar estimates for their own populations. Some studies calculate the public cost over a 20-year period of the family begun by a single teen birth, and the total cost for the same 20-year period of the cohort of families begun by a teen birth in a single year. They ask, for example, what will the family of a woman who has her first baby as a teenager cost the public by the time her first baby reaches adulthood?

Expected output is: total state spending in one year related to teen births, total state spending related to the children born to teen moms in 2021 until they are age 18 (single-cohort estimates), Total state spending in 1st year related to all children aged 18 years or younger and born to teen mothers, potential cost savings related to a reduction of 1000 teen births, 500 teen births, and 10% of teen births in 1st year based on the single-cohort estimation method.

Burt, Martha R. "Estimating the Public Costs of Teenage Childbearing." Family Planning Perspectives, vol. 18, no. 5, [Wiley, Guttmacher Institute], 1986, pp. 221-26, <https://doi.org/10.2307/2134980>.

2: Logistic regression results for teenage mothers by selected characteristics

Teenage girls who have begun childbearing	Model 2006 UDHS		Model 2011 UDHS		Model 2016 UDHS	
	OR	CI	OR	CI	OR	CI
Occupation	1.046	[0.9,1.2]	1.075	[0.9,1.2]	1.076	[1.0,1.2]
Never had sex	1.000	[1.0,1.0]	1.000	[1.0,1.0]	1.000	[1.0,1.0]
First sex by age 15	0.550**	[0.4,0.8]	0.673	[0.4,1.0]	1.124	[0.9,1.5]
Marital status	10.07***	[7.0,14.6]	12.05***	[8.4,17.4]	8.980***	[7.2,11.2]
Current Family Planning use	0.763	[0.5,1.3]	1.179	[0.7,1.9]	1.246	[1.0,1.6]
Life time Sexual partners	2.184***	[1.6,3.0]	1.700**	[1.2,2.4]	1.421***	[1.2,1.7]
Wealth index	0.878	[0.7,1.1]	0.828*	[0.7,1.0]	0.860**	[0.8,1.0]
Education new	0.606*	[0.4,0.9]	1.163	[0.8,1.7]	0.645***	[0.5,0.8]
Number of Observations	776		810		1957	

Exponentiated coefficients; 95% confidence intervals in brackets

* p < 0.05, ** p < 0.01, *** p < 0.001

3: Socio-economic Characteristics of Women 20 – 49 Years, Uganda, 2016

Socio-economic Characteristics of Woman	Had 1st Birth before 15 Years	Had 1st Birth before 20 Years	Had 1st Birth after 20 Years	Total
Number of Women	1,015	8,051	4,626	13,692
Educational Attainment				
None	23	12	11	12
Some Primary	57	52	32	46
Completed Primary	10	15	12	13
Some Secondary	9	18	26	20
Completed Secondary	0	0	3	1
Post-Secondary	1	2	16	7
% completed Secondary Education	1.0	2.8	19.1	8.2
Employment Status				
Currently employed	81.6	84.7	85.4	85
Not currently employed	0.0	0.0	0.0	0
Not employed in the 12 months preceding the survey	18.4	15.3	14.6	15
% Economically Active	81.6	84.7	85.4	84.7
Occupation				
Professional/technical/managerial	4.5	5.2	14.5	8
Clerical	0.0	0.2	1.4	1
Sales	8.9	9.5	11.3	10
Agricultural - self employed	47.7	47.1	35.3	43
Household and domestic	2.0	1.9	1.8	2
Services	3.9	4.9	5.9	5
Skills level				
Skilled manual laborers	11.7	12.5	11.3	12
Unskilled manual laborers	2.8	3.6	3.9	4
Mean Monthly Earnings	195.7	199.1	233.8	210.7
Not receiving any earning	57.4		46.5	51.1
Earnings Parity index				1.1
Number of Children Ever Born				
Less than 3	13.5	*	43.5	34.6
Less than 4	26.5	45.9	59.1	49
4 or more	73.5	54.1	40.9	51
% with > 4 Live births	73.5	54.1	40.9	51.1

Source: UDHS 2016







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