

THE TIME TO SOW

COMMENTARY: EARLY CHILDHOOD CARE



The time to sow

By Carol Bellamy

Poverty continues to enslave huge populations, denying 1.2 billion people – 600 million of them children aged one to five years – good health and productive lives. To change this painful situation, the world needs to begin with children, assuring every one of the 130 million born each year the best possible start in life.

We are finally understanding how enormous our children's promise is from the moment of birth, how well-prepared infants are to survive, thrive and learn.

They depend on us adults; they beguile, charm and demand that we give them the time, nurturing and attention they seem to know that they need. When they receive the essentials, they reward us all along the way, from their very first smile into the next generation.

The building blocks are fairly modest: Children need health care, sound nutrition (with an emphasis on breastfeeding), a safe and hygienic environment and playful and loving interaction. This is the minimum; it is neither extravagant nor exorbitant. Yet from this simple foundation, they go on to astound us with their achievements, mastering language, arts, sciences and the complexities of life.

Only recently have we learned, however, how wasteful of their talents we can be.

An exciting and expanding body of knowledge shows how the early years of life are absolutely vital, laying the ground for the child's survival, growth, health and later accomplishments. During this time, the neural network in the brain develops, depending largely on the stimulation and care the child receives. Before a healthy child reaches the age of two and a half, millions of neural links have been forged, connections upon which physical, mental and cognitive development largely depend.

Heart of development

We squander our children's innate capacities and stint their care in those critical early years at grave expense. In violating children's rights by denying them the essentials they need and deserve, we harm them and ourselves, permitting and encouraging the seeds of poverty,

alienation, hatred and despair to take root.

Effective early care for children lies at the very heart of human development. For those most persuaded by economic arguments, investments in services and support for children in the early years have an estimated return as high as 7 to 1. With 130 million infants born each year, this presents an enormous opportunity for social development that few leaders would want to ignore and an investment that few can afford to miss. Especially since it holds out the best promise we have for relieving poverty, which is now coiled so much more tightly around so many, and for changing the long-entrenched patterns of gender discrimination that violate girls' and women's rights and choke social progress.

Both poverty and gender discrimination replicate themselves from generation to generation. By ensuring children good early care, based on gender equity, we take vital and giant steps in breaking these cycles of discrimination and deprivation and unleashing new creative powers.

What does effective early childhood care entail for the vast majority of the world's estimated 1 billion children between the ages of zero and eight years? It recognizes the interaction among health, nutrition and the emotional well-being of children and their primary caregivers. To care for a child

by necessity means being concerned about the conditions a woman faces at home and in society at large. For in countries and cultures where women's voices are muffled and poverty and discrimination limit their access to resources and services, where they have rare respite from wearying rounds of work, minimal legal protection and low status, optimal child development is impossible. Where men have little or no role in bringing up small children, yet lack respect for the women who are the caregivers, the stage is set for underachievement by all but a handful of children.

Effective early care means homes and an environment where children are protected against disease, where there is access to clean drinking water and adequate nourishment; where women can start exclusively breastfeeding their children. It also means that there is time and space for infants to grow and learn through play and exploration and to develop language through interaction with others.

For all these reasons, effective early care has to reach beyond the home into the environment and culture surrounding the immediate family.

As members of an extended family with a vital stake in human development, community and religious leaders, health and nutrition workers, teachers, employers and entire nations have an interest in and a responsibility for the

care that the children in their communities and nations receive.

When children's rights are realized, both the immediate and longer-term rewards in human development are great. Supported from the moment of birth and before, children are likely to survive and to be healthier and happier, to be better able to learn throughout life and to become productive citizens.

The results are also visible on spreadsheets, in lower costs for remedial education and curative health expenditures. And in a delayed reaction well worth waiting for, effective care leads to better grounded, better nourished, healthier and more stable and productive societies.

All over the world, millions upon millions of families do provide excellent care for their children. Many millions of others, however, are unable to do so, usually because they are among the 1.2 billion people in developing countries who live below the poverty line of \$1 per day.

They wage a vast but largely unnoticed struggle against disease, unsafe water, poor sanitation, ignorance, malnutrition, gender discrimination and often war and violence. How can we continue to be surprised that 11 million children below age five die each year in this unequal contest and that millions more lose physical and intellectual potential?

It is difficult to grasp the physical and cognitive effects of malnutrition alone: Half the children of South Asia and one third of those in sub-Saharan Africa are malnourished, their motivation, attention, curiosity and cognitive abilities dulled. Malnutrition and the repeated infections that accompany it produce a lethal lethargy that can prevent a young child from enjoying the care he or she deserves. Implicated in nearly half of all child deaths and countless failures to thrive, malnutrition has

been estimated to cost the world – in one year alone – the equivalent of 46 million years of productive, disability-free life.

During a child's early years, low birthweight, recurrent illnesses, a lack of psychosocial stimulation, poor nutrition and the stresses of poverty can lead to poor health and a general lowering of intellectual, behavioural and social abilities.

Creating and revitalizing basic social services and building strong partnerships with poor communities are crucial aspects of ensuring a good start to life for children.

These are preventable losses, for which the solutions are known, available, fairly inexpensive and highly cost effective. The answer is to invest in children – time, energy, care and resources – and to do this from the earliest possible time, from birth and even before, when the investments will have the greatest impact on later human development. Creating and revitalizing basic social services and building strong partnerships with poor communities are crucial aspects of ensuring a good start to life for children.

Investing in children

A child whose mother has access to the care and services she needs during pregnancy and childbirth, a child born into a community with a competently staffed and adequately stocked primary health care centre, where information about nutrition and help for common ailments and infections are available, is a child off to a good start.

When there is time for the stimulation and early learning that lead to better formal school achievement later, where there is access to clean water and adequate sanitation systems and 'child-friendly' primary schools – these too are vital factors in a good start in life.

An additional global expenditure of approximately \$70 billion to \$80 billion each year would help extend basic services that provide this kind of vital foundation to all. This is by no means an exorbitant amount, particularly in light of the benefits that would accrue, but it is one that developing countries on their own could not muster.

However, if developing countries devoted about 20 per cent of national budgets and donor nations a similar proportion of official development assistance (ODA) to basic social services, then the resources, for the most part, would be available. Such allocations are the basis of the 20/20 Initiative, advocated by UNICEF and other partners and endorsed by many nations at the World Summit for Social Development in 1995.

There are many reasons why countries do not honour the most basic rights of children. In some, war has destroyed infrastructure, economies and communities; AIDS is rampant, particularly in Africa, and it is very dangerously eroding already fragile social structures and the abilities of communities and nations to respond. Corruption drains the coffers in many others. And in far too many, the spiral of increasing and self-perpetuating debt strains already threadbare budgets and translates into disaster for children.

It is an enormous blot on the conscience of the world that in the 41 heavily indebted poor countries (HIPCs) – where human development indicators are the worst in the world – debt service consumes three to five times

the amount of resources spent on basic services. In almost half of those same countries, nearly 50 per cent of people lack access to adequate sanitation and clean drinking water; 26 of the 31 countries with the highest numbers of child deaths in the world are in the HIPC group.

Not only is debt relief still stymied, but development assistance has also fallen from an average of 0.33 per cent of gross national product (GNP) in 1990 to an average of 0.24 per cent in 1998. This is happening in the context of a global economy that has grown to more than \$30 trillion today and in donor countries where average GNP per person increased from \$20,900 to \$27,000 over the course of the last decade.

There is no question that the resources exist, but too little money is allotted for children's survival, growth and development, and too few people understand the implications for all societies of missed opportunities in early childhood.

When care in early childhood is made a priority, much can be achieved. The accomplishments of the past 10 years are significant. Immunization alone saves the lives of 2.5 million children each year. The conditions for unleashing these children's full human potential, however, remain largely unchanged in poor communities.

Simple transforming steps

We no longer have the excuse of ignorance. We know of good working examples of the integrated approach that ensures children's survival and brings out their potential. Programmes in India, Jamaica, Kenya, Peru and Turkey, for example, offer important lessons and hold out promise for similar gains elsewhere.

So too does an evolving integrated early childhood care and development approach in the



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A child is weighed on a sling scale in a rural health post in Kenya. Low birthweight is a major factor in the deaths each year of 4 million infants worldwide in their first month of life.

Philippines, which demonstrates the success communities have had in weaving together health, nutrition, psychosocial care and early education services for young children. This programme aims to cut infant and child mortality, malnutrition and elementary school drop-out rates by half. These are crucial objectives in a country where nearly one third of children are underweight or stunted, and the under-five mortality rate is 44 deaths per 1,000 live births.

Around the country children in child-care centres, like the ones in the Philippine village of Capagao, play with well-worn toys and with musical instruments improvised from discarded bottles and bamboo slats, leaf through books and learn from brightly coloured posters about animals, the alphabet and hygienic hand-washing practices. Health and nutrition workers in the village are trained to counsel parents on better early childhood care, including exclusive breastfeeding and oral rehy-

dration therapy (ORT). Children receive their routine immunizations at the health station. Health workers maintain a map of all houses in the community in which is recorded every child's growth, access to iodized salt and other micronutrients and the availability of clean water and sanitation.

These are simple steps; they are also life-saving and life-transforming ones. More importantly, the services are accessible within communities and are locally run. They include health care, day care, primary education and parent-effectiveness training. In typical villages, day-care workers, midwives, health workers and child development workers focus on multiple areas, so that health and nutrition workers now understand how children best begin to learn, and day-care workers are now aware of health issues.

UNICEF is supporting these efforts with local governments in 20 provinces and five cities by bolstering basic social services in

rural communities through the establishment of community health and nutrition posts. In Capiz Province alone, 200 such posts are to be in place by the end of 2000. These health and nutrition posts provide mothers with a venue to meet, discuss health, nutrition and psychosocial needs of their babies, to be counselled by the village health worker and to have access to basic services such as vitamin A and iron supplements.

In the tiny island province of Guimaras, where child poverty rates exceed 70 per cent, a child-minding centre exists for poor families, allowing both parents to work. Day-care centres are being built village by village. Nationwide, the number of accredited new centres increased by 11 per cent in 1998, to more than 20,000.

UNICEF is helping improve the health of mothers and the capacity of parents and other caregivers to provide a loving and stimulating home environment for young children. Through a community-based parent-effectiveness service programme, organized parent groups learn about child health, psychosocial care, nutrition protection and even gender relations. UNICEF also supports training of day-care and local health workers and distributes parent-counselling cards and other information materials to grass-roots service providers.

In three regions in the Philippines, an integrated early childhood care and development project is being funded by the World Bank and the Asian Development Bank, with support from UNICEF and in partnership with local and national governments.

Efforts such as these are vitally needed all over the world, and a broad and vocal alliance – a truly global movement – is needed to support them, to help give voice and visibility to what is being done. The efforts of governments, all sectors of civil society, religious

and grass-roots organizations, the media and international organizations are crucial in helping make children's rights the priority.

Putting children first

There can never be a single model of early childhood care, nor is one desirable. Experience shows that there are about as many effective approaches as there are needs.

We do know, however, that the best programmes are those concerned with the overlapping physical, intellectual and emotional needs of children. They approach child development as a holistic process and the child's needs as interrelated. We also know that each community has to have the freedom and the resources to create, refine and improve its own best practices, because policies and practices that relate to the way people live their lives are the ones children and parents need.

The world can take great pride in the succession of extraordinary steps made over the past decade in adopting the Convention on the Rights of the Child – now ratified virtually universally – and working to achieve the goals agreed upon at the 1990 World Summit for Children.

Now, as we look ahead to the UN General Assembly's Special Session on Children next year on those goals, it seems a very good time to rededicate ourselves to keeping up the momentum. We must continue arguing for, negotiating for and creating the best for children. Their needs should be given priority in the allocation of resources. Nations should commit themselves in principle, in policies, in law and in budgeting.

What is good for children is and must be a human development priority for everyone. Making it such a priority is the surest proof that a society is committed to ensuring the well-being of its people and stemming the tide of poverty, suffering and death that threatens to engulf us all. ■

The success the world has had in protecting children's rights and realizing human potential is captured far more eloquently in flesh and bone than in concrete or steel, far more tellingly in the height of children than in that of skyscrapers.

This league table presents stunting rates among children under five, which are unconscionably high. In six countries of East and South Asia, at least half of the children are stunted, as are 40% of children in sub-Saharan Africa.

Stunting does not come easy. It happens over time, and means that a child has endured painful and debilitating cycles of illness, depressed appetite, insufficient food and inadequate care. Many children do not survive such rigours, many of those who do survive carry long-term deficits in mental capacity along with losses in stature.

Short-changing children

Low weight at birth, insufficient feeding, inadequate care and nutrient depletions caused by repeated bouts of illness culminate over time in a child whose height is less than that of other children of the same age. Such stunting is a standard marker of a failure in early growth.

Deprivations in feeding and care that impair growth in the critical first years may also reduce a child's cognitive development and learning ability, often leading to poor school performance and dropping out.

Some 39% of children under five in the developing world are stunted – around 209 million children. Stunting rates are highest in Asia and sub-Saharan Africa.

Inadequate feeding and repeated illness are the immediate causes of stunting in the young child. This vicious cycle is itself a result of poverty and the consequent inability of families to adequately care for their children. A lack of clean water supply in a poor community, or a long distance between home and health clinic, for example, affects the level of care that can be given.

Stunting also occurs when babies are born underweight because the mother was poorly nourished or because she was herself stunted.

Once established, stunting and its effects typically become permanent. Stunted children may never regain the height lost and most will never gain the corresponding weight. And when the window of early childhood is closed, the associated cognitive damage is often irreversible.



SUB-SAHARAN AFRICA



MIDDLE EAST AND NORTH AFRICA

Ethiopia	64	Yemen	52
Angola	53	Sudan	33
Madagascar	48	Iraq	31
Malawi	48	► Regional average	25
Congo, Dem. Rep.	45	Egypt	25
Lesotho	44	Morocco	23
Mauritania	44	Oman	23
Burundi	43	Tunisia	23
Nigeria	43	Syria	21
Rwanda	42	Turkey	21
Tanzania	42	Saudi Arabia	20
Zambia	42	Iran	19
Niger	41	Algeria	18
► Regional average	40	U. Arab Emirates	17
Chad	40	Libya	15
Eritrea	38	Lebanon	12
Uganda	38	Jordan	8
Mozambique	36	Israel	No data
Sierra Leone	35	Kuwait	No data
Central African Rep.	34		
Kenya	33		
Zimbabwe	32		
Gambia	30		
Mali	30		
Botswana	29		
Burkina Faso	29		
Cameroon	29		
Guinea	29		
Namibia	28		
Ghana	26		
Benin	25		
Côte d'Ivoire	24		
Senegal	23		
South Africa	23		
Togo	22		
Somalia	14		
Mauritius	10		
Congo	No data		
Gabon	No data		
Guinea-Bissau	No data		
Liberia	No data		





CENTRAL ASIA



EAST/SOUTH ASIA AND PACIFIC



AMERICAS



EUROPE

Afghanistan	52
► <i>Regional average</i>	37
Uzbekistan	31
Kyrgyzstan	25
Azerbaijan	22
Kazakhstan	16
Armenia	No data
Georgia	No data
Tajikistan	No data
Turkmenistan	No data

Korea, Dem.	62
Cambodia	56
Bangladesh	55
Nepal	54
India	52
Pakistan	50
Lao PDR	47
Myanmar	45
► <i>Regional average</i>	44
Viet Nam	44
Indonesia	42
China	34
Philippines	30
Mongolia	22
Sri Lanka	18
Thailand	16
Australia	No data
Bhutan	No data
Japan	No data
Korea, Rep.	No data
Malaysia	No data
New Zealand	No data
Papua New Guinea	No data
Singapore	No data

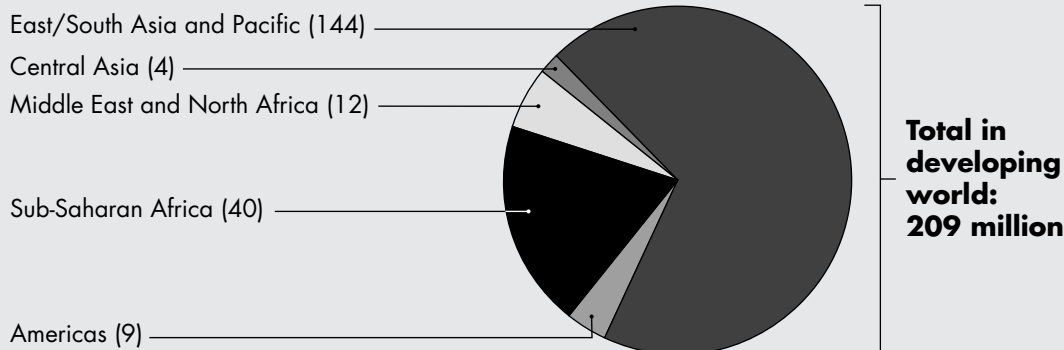
Guatemala	46
Honduras	40
Haiti	32
Bolivia	26
Peru	26
Nicaragua	25
El Salvador	23
Mexico	18
Paraguay	17
Colombia	15
Venezuela	13
► <i>Regional average</i>	13
Brazil	11
Dominican Rep.	11
Panama	9
Uruguay	8
Costa Rica	6
Jamaica	6
Chile	2
United States	2
Argentina	No data
Canada	No data
Cuba	No data
Ecuador	No data
Trinidad/Tobago	No data

Russian Fed.	13
► <i>Regional average</i>	11
Romania	8
Yugoslavia	7
Czech Rep.	2
Croatia	1
Albania	No data
Austria	No data
Belarus	No data
Belgium	No data
Bosnia/Herzegovina	No data
Bulgaria	No data
Denmark	No data
Estonia	No data
Finland	No data
France	No data
Germany	No data
Greece	No data
Hungary	No data
Ireland	No data
Italy	No data
Latvia	No data
Lithuania	No data
Moldova, Rep.	No data
Netherlands	No data
Norway	No data
Poland	No data
Portugal	No data
Slovakia	No data
Slovenia	No data
Spain	No data
Sweden	No data
Switzerland	No data
TFYR Macedonia	No data
Ukraine	No data
United Kingdom	No data

WHAT THE TABLE RANKS

Percentage of children under five who are stunted

Number of stunted children under age five (in millions)



Source: DHS, multiple indicator cluster surveys (MICS), WHO and UNICEF, 1990-1998.

Victory possible against iodine deficiency

Just two short decades ago, iodine deficiency was a major global problem, impairing the growth and mental development of large numbers of children and retarding social and economic progress in developing and industrialized nations.

Now, because of salt iodization, some 70% of the world's population is protected from iodine deficiency. More than 90% of the population in 29 countries uses adequately iodized salt, and in another 36 countries at least half of the population is protected.

As a result, millions of people are spared iodine deficiency's more evident effects such as goitre and cretinism, and societies as a whole are spared the serious economic and social consequences, including an overall reduction in the mental capacities of their populations.

But while progress has been im-

pressive, there are still 34 countries with a combined total of about 1 billion people where 50% or less of the population uses iodized salt. These include the majority of countries in Central and Eastern Europe, where progress has slipped in recent years, and Pakistan, the Philippines and Turkey, which have greater resources but poorer track records than many other countries. In 14 of the 34 countries, 10% or less of salt is iodized.

Salt iodization is simple and inexpensive. Making it happen calls for government commitments to put legislation and monitoring mechanisms in place and to build partnerships with local salt producers.

Creating public awareness of the problem of iodine deficiency, thereby building a constituency for iodized salt, is another key to reaching the target of universal salt iodization.

Low levels, high risk

	% of households consuming iodized salt		% of households consuming iodized salt
Cuba	0	Turkey	18
Ethiopia	0	Pakistan	19
Mauritius	0	Equatorial Guinea	20
Sudan	0	Tajikistan	20
Turkmenistan	0	Burkina Faso	23
Mauritania	3	Swaziland	26
Ukraine	4	Kyrgyzstan	27
Korea, Dem.	5	Ghana	28
Cambodia	7	Russian Fed.	30
Gambia	9	Fiji	31
Mali	9	Belarus	37
Senegal	9	Guinea	37
Angola	10	Yemen	39
Iraq	10	Syria	40
Dominican Rep.	13	Sri Lanka	47
Philippines	15	Guatemala	49
Uzbekistan	16	Thailand	50

Sources: UNICEF, DHS, MICS (1992-2000).

Weighing in for better child health

A baby's weight at birth is a good indicator of both the mother's health status and the infant's chances of survival and development. Infants who weigh less than 2.5 kg at birth face high immediate and long-term risks. But this key indicator is not well monitored as many of the 116 million children born each year in developing countries are not weighed at birth. Over 20 million – more than one in every five children – are low-birthweight babies.

Low birthweight (less than 2.5 kg, about 5.5 pounds) is a major factor in the deaths each year of 4 million infants before the age of one month and in illnesses affecting millions more. Evidence is mounting that low birthweight leads to a 50% greater risk of diabetes, heart disease and cancer later in life.

Data from 34 countries show that in 16 of them (*see list*), more than

The unweighed % of infants not weighed at birth

Chad	89
Pakistan	88
Egypt	84
Haiti	82
Niger	80
Rwanda	74
Nigeria	73
Uganda	73
Mali	69
Madagascar	64
Comoros	55
Mozambique	55
Togo	55
Kenya	54
Zambia	53
Senegal	51

Sources: DHS (1990-1999) and additional analysis.

half of infants are not weighed at birth. In Chad, Egypt, Haiti, Niger and Pakistan, 80% or more of newborns are not weighed.

Nearly half of all births in developing countries are not attended by doctors, nurses or midwives. Traditional birth attendants, who assist deliveries in the absence of trained health personnel in their communities, can play useful roles by encouraging weight gain during pregnancy and weighing the babies they deliver.

Antenatal care could save millions

Ten years ago, leaders attending the World Summit for Children pledged to ensure universal access by women to maternal health care by the year 2000. Yet 44 million women in the developing world still receive no antenatal care.

Insufficient maternal care during pregnancy and delivery is largely responsible each year for nearly 600,000 maternal deaths and an estimated 5 million infant deaths either just before or during delivery or in the first week of life.

Out of the 88 countries for which data are available, the situation is particularly desperate in 13 countries (*see list*). The lowest rates of maternal care were found in Bangladesh, Chad, Mali, Nepal and Pakistan.

The surveys also contained the good news that in 27 countries – including Kenya, Rwanda, Uganda and Zambia – more than 90% of women received skilled care at least once during their pregnancies.

Contact with a doctor, nurse or midwife facilitates maternal immunization and allows health personnel to manage the pregnancy, detect complications and promote good eating, hygiene and adequate rest.

Maternal care rates tend to be low and maternal mortality rates high in countries where women's status is low, a consequence of women having fewer economic and educational opportunities and little access to social services. Also, fewer people have access to routine health services, including skilled maternity care, in impoverished, remote geographical areas than in urban areas.

The national percentages do not reveal the entire picture, as they mask huge rural/urban disparities.

Where antenatal care is lowest

% of women (aged 15-49) attended by skilled health personnel at least once during pregnancy

Chad	23
Nepal	24
Mali	25
Bangladesh	26
Pakistan	26
Cambodia	34
Yemen	34
Niger	39
Morocco	42
Mauritania	48
Eritrea	49
India	49
Tanzania	50

Sources: DHS, WHO and UNICEF (1990-1999).

Health care vital in stopping ARI

Too few parents in the developing world seek professional health care when a child has an acute respiratory infection (ARI) – despite the high risks associated with ARI – according to data from recent surveys.

In eight countries – Bangladesh, Benin, Cameroon, Chad, Haiti, Mali, Niger and Togo – the situation is

particularly worrisome. In those countries, only up to a third of children who had had ARI within two weeks of the survey had been seen by a doctor or other health care provider. Overall, in 18 of the 29 countries surveyed, fewer than half of the children with ARI were taken to a health care provider.

The surveys showed that children in eastern and southern African countries were somewhat better off than those in West Africa, as more than half of those with ARI were taken to health care providers, compared with fewer than a third of children in West African countries.

ARI is a leading cause of mortality in young children, killing nearly 2 million children under the age of five in developing countries every year. Of crucial importance in preventing these deaths is the fact that when a child develops ARI, he or she needs to be seen by a health care provider. Whether or not this happens depends on a number of variables, including whether family members can recognize the signs of ARI – a cough accompanied by rapid breathing – and know to seek expert care. Other factors include

whether good care and drugs are easily available and accessible and whether women's status prevents children from receiving the professional health care they need.

An analysis of survey results shows that educated mothers are more likely to seek professional health care when a child has ARI than are mothers with no education. In Cameroon, for example, children whose mothers are educated are three to four times more likely to be seen by a health provider than are children whose mothers are not educated.

UNICEF is working with the World Health Organization (WHO) and other partners to improve home and community health care for children as part of the Integrated Management of Childhood Illness (IMCI) strategy.

Where the lucky few are treated

% of children with ARI taken to a health care provider*

Chad	19	Madagascar	37	Nicaragua	58
Mali	22	Côte d'Ivoire	39	Uganda	61
Niger	26	Mozambique	39	Comoros	62
Togo	26	Central African Rep.	41	Egypt	62
Haiti	27	Bolivia	43	Indonesia	69
Benin	32	Malawi	46	Viet Nam	69
Bangladesh	33	Dominican Rep.	48	Tanzania	70
Cameroon	33	Colombia	49	Zambia	71
Eritrea	37	Zimbabwe	52	Jordan	76
Guatemala	37	Kenya	57		

*Within two weeks of the survey date.

Source: DHS (1994-1999).

Teen mothers and their children at risk

When an adolescent becomes a mother, her health and that of her child are threatened. Early childbearing also means girls lose out on schooling and have few employment options, thus perpetuating circumstances that disadvantage girls. The risks associated with adolescent motherhood make it a clear violation of children's right to health and survival – for both the young mother and her child.

Children of adolescent mothers are more likely to be born underweight and to die within their first month of life compared to those whose mothers are older. If they survive the first month, these children are still more likely to die before their fifth birthdays.

For the young mothers, the risk of dying during childbirth is heightened. Teenage girls over 15 years of age are twice as likely to die from childbirth as are women in their 20s, while girls under 15 are at five times

greater risk. Early sexual activity also increases the risk of infection with HIV/AIDS.

Data from 54 countries show that in Bangladesh, Chad, Guinea, Mauritania and Nigeria more than 1 in every 10 women have their first child before age 15. In Mauritania, the rate is especially high: Nearly a quarter of women have their first child before the age of 15 and over half have their first child before age 18. In 20 other countries, more than one out of every four women give birth before age 18.

Women who begin bearing children during adolescence typically have more children over the course of their reproductive years.

In both Chad and Côte d'Ivoire, for example, where 10% or more of girls become mothers by the age of 15, the average woman will give birth to six children. That is twice the average fertility rate in the developing world.

% of women* who gave birth by age 15 or 18

