Early Childbearing in Honduras: A Continuing Challenge

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Key Points

- Honduras has the highest adolescent birthrate in Central America, at 137 births for every 1,000 15–19-year-olds. This rate has remained unchanged over the past two decades, despite declines in the birthrate among women in all other age-groups. In absolute numbers, births to adolescents increased by 50% between 1987 and 2001.
- As of 2001, only one-third of all women aged 20–24 (and only one-seventh of those in rural areas) had completed primary school; less education is associated with a higher likelihood of early childbearing.
- One-half of 20–24-year-olds give birth by age 20; this proportion is higher among the least-educated women (70%), the poorest women (64%) and those in rural areas (60%).
- In 2001, 40% of all recent adolescent births were unplanned, and the highest proportion was among those with the most education (48%). Most sexually active 15–19-year-olds (70%) do not want to have a child in the next two years.
- Despite these reproductive preferences, just one in three sexually active adolescents uses a modern contraceptive method. Overall, 48% of adolescents have an unmet need for effective contraception.
- High levels of early childbearing coexist with low rates of professional prenatal and delivery care. In 2001, one-third of recent 15–24-year-old mothers did not make a single prenatal care visit. The same proportion gave birth without a medical professional in attendance.
- Policies and programs that aim to promote adolescents' reproductive health and support their childbearing preferences exist, but they are often not fully implemented and need more official commitment and resources.

Early Childbearing in Honduras: A Continuing Challenge

Early childbearing is recognized worldwide to have a profound impact on the well-being and reproductive health of young women, as well as the overall pace and direction of a country's development.[1] Early childbearing can derail a young woman's educational prospects, reduce her long-term social and economic autonomy, and endanger both her health and that of her newborn. In Honduras, one of Central America's poorest countries, reducing high levels of adolescent childbearing is therefore critical to improving the lives of women and their families and society in general.

In light of the strong and persistent links between adolescent childbearing and the perpetuation of poverty and social marginalization, the Programme of Action from the 1994 International Conference on Population and Development (ICPD) held in Cairo established two important goals. The first is "to address adolescent sexual and reproductive health issues, including unwanted pregnancy, . . . through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counseling specifically suitable for that age group." The second is to substantially reduce levels of adolescent pregnancy.[2]

Along with 178 other countries, Honduras endorsed the 1994 ICPD Programme of Action, thereby agreeing that, "with the support of the international community, [it would strive to] protect and promote the rights of adolescents to reproductive health education, information and care."[3] It also agreed that, "in collaboration with non-governmental organizations, [it would

strive to] meet the special needs of adolescents and to establish appropriate programs to respond to those needs."[4]

Honduras has the highest adolescent fertility rate in Central America, and that rate has not declined in the recent past. In 2001, there were 137 births for every 1,000 Honduran women aged 15–19,[5] compared with 119 in Nicaragua,[6] 114 in Guatemala,[7] 104 in El Salvador,[8] 95 in Belize,[9] 89 in Panama[10] and 78 in Costa Rica.[11] Between 1987 and 2001, Honduras's adolescent fertility rate remained virtually unchanged, while fertility declined among women in every other age-group.[12]

Two-fifths of all births to adolescents in Honduras are unplanned, and a large majority of adolescent women do not want to have a child until later on in their lives. Nevertheless, most sexually active young women fail to use the modern contraceptive methods that would enable them to postpone childbearing.

Information from recent national surveys permits close examination of childbearing behavior among Honduran adolescents[*] (FN A) (see box). This report provides a picture of the current sexual, union formation and childbearing experience of adolescent women in Honduras, and explores the factors associated with the country's very high level of early childbearing. It also identifies the reproductive health and educational needs that must be addressed if young Honduran women are to avoid unplanned births, and examines the associations between early childbearing and enduring disadvantage.

The context underlying adolescent childbearing is key.

Understanding the context and consequences of adolescent sexual and reproductive behavior is critical for many reasons. First, young people make up a very large proportion of Honduras's population: Currently, one-quarter of the total population is aged 10–19.[13] The consequences of life choices made by the women in this age-group will continue to resonate through Honduran society for many years to come. Second, the timing of marriage and motherhood has profound implications for young women themselves and for the country's economic and social development. If young women in Honduras are to prepare themselves adequately for the future and play an active role in their country's development, they require education, training and job opportunities—needs that may go unmet if they assume the responsibilities of marriage and motherhood at an early age.

Adolescent women from the country's most disadvantaged groups are much more likely than young women of higher socioeconomic status to become mothers before adulthood. Birthrates are much higher than average among adolescents living in rural areas (162 births per 1,000 women aged 15–19) and among those with little or no schooling (194 among those with 1–3 years and 254 among adolescents with no schooling).[14] By comparison, the rates among adolescents in urban areas and those with seven or more years of education are 114 and 69, respectively.

Women who first give birth as teenagers are likely to be disadvantaged even before they have a child, but early motherhood can exacerbate and prolong existing disadvantage. Childbirth that occurs before a girl has fully developed physically (that is, before age 17) is dangerous to her

health, and infants born to mothers aged 18 or younger have an increased risk of poor health outcomes and of dying in infancy.[15] These risks are compounded by inadequate nutrition and limited access to medical care. Early childbearing also limits educational opportunities, thereby reducing young women's chances of joining the paid labor market.[16] Women who delay their first birth may be able to go to school longer, enabling them to improve their children's wellbeing and have a more direct role in determining the course of their own futures.[17]

Poverty is severe and widespread in Honduras.

With a population of about 7.5 million and per capita gross national income of $2,900 a year (adjusted for purchasing power parity).[1] Honduras is one of the poorest countries in Central America. High unemployment rates and severe deforestation in rural areas have contributed to the migration of many young male workers to urban areas, where housing is in short supply. In 1994, 73% of young Honduran men aged 15–19 years and 69% of similar women were unemployed or underemployed. Large numbers of Honduran workers have left the country—most migrating to the United States in search of work—a situation that has contributed changing social and economic conditions throughout Honduras.[2] In 1998, Hurricane Mitch seriously damaged the country's already weak infrastructure and economy.[*3]

Income distribution is very unequal, as is land distribution in this fundamentally agrarian economy. In 2003, the richest quintile of households accounted for 54% of the country's total income, whereas the poorest quintile earned just 3%.[4] An estimated 64% of the population (and 70% of the rural population) lives below the poverty line (defined as being unable to afford basic goods and services), and 45% lives in extreme poverty (unable to buy a basic basket of food).[5]

Among rural Hondurans (54% of the total population), more than eight in 10 live in homes with no access to drinking water, toilets or electricity.[6] Rural and indigenous Hondurans (7% of the population) are the country's most disadvantaged peoples.

*Hurricane Mitch, which battered Central America from October 22 through November 5, 1998, was one of the most powerful hurricanes ever observed, with maximum sustained winds of 180 miles per hour. It was the second deadliest Atlantic hurricane in history, killing as many as 18,000 people. It also caused billions of U.S. dollars in damages (source: reference 3).

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Honduran women suffer from poor reproductive health.

Honduras has a number of serious problems in the area of reproductive health.

• The overall maternal mortality ratio in Honduras was an estimated 108 maternal deaths per 100,000 live births in 1997—down from 182 deaths per 100,000 in 1990, but still high.[18]

Although we lack a ratio that corresponds to Honduran adolescents only, most studies indicate

that the risk of dying from maternity-related causes is higher among women younger than age 20 than among women in their 20s and 30s.[19]

• The infant mortality rate of 34 deaths per 1,000 live births in 2001 was higher than the average for all of Latin America and the Caribbean (28 per 1,000).[20] The rate was higher in rural areas than urban areas (38 vs. 29). It was especially high—63 per 1,000—among infants born to women with no schooling.[21]

• Honduras accounts for about 60% of all HIV/AIDS cases in Central America; nationally, the prevalence rate among adults aged 15–49 is 1.8%.[22]

Educational levels among adolescent women are very low.

In 2001, only slightly more than one-third (36%) of 20–24-year-old women had completed at least seven years of school (i.e., started secondary school) (Table 1, row 1). In rural areas, just 15% had had at least seven years of education, compared with 54% in urban areas.

Young women's educational attainment has improved slightly in recent years. Between 1996 and 2001, the proportion of women 20–24 with seven or more years of schooling rose from 51% to 54% in urban areas and from 10% to 15% in rural areas (Chart 1).

Sexual activity and union begin early, especially among women with little schooling.

In 2001, almost six in 10 women aged 20–24 reported having entered a union (formal or consensual) before age 20 (Table 1, row 2). (Honduran adolescents far more commonly form consensual than formal unions: Among 15–19-year-olds in 2001, 23% were in a consensual union, whereas only 3% were formally married.[23]) Early union was especially common in rural

areas (70%) and among women with three or fewer years of schooling (79%), findings that provide evidence of the close link between disadvantage and the likelihood of early union. The fact that one in five young women enter a union before their 16th birthday suggests that very early union formation is widely accepted in Honduras (Figure 2).

Not all women begin their sexual lives within a union, however. Among women aged 20–24, 21% first had sex as adolescents and while they were still single (Table 1, row 3). This proportion was higher among women in urban than in rural areas (26% vs. 14%), and among those with seven or more years of schooling compared with those with 0–3 years (28% vs. 16%). These findings suggest that one of the outcomes of growing modernization in Honduras (as reflected in slight improvements in educational attainment and increasing urbanization) might be an increase in sexual activity among young women prior to entering a consensual union.

Overall, one in four Honduran women aged 20–24 in 2001 had experienced sexual intercourse before age 16, 47% had done so before age 18 and 66% before age 20 (Figure 2).

Half of women become mothers before age 20.

Unless they use an effective (i.e., modern) contraceptive, many young women who enter into a union or begin sexual relationships during adolescence are likely to become pregnant. Indeed, many do: Three in 10 women aged 20–24 in 2001 had had a child before the age of 18, and half had done so before their 20th birthday (Figure 2). Among 15–19-year-olds interviewed in the same year, nearly three in 10 either had given birth or were currently pregnant (Table 1, row 7).

In rural areas, six in 10 women aged 20–24 became mothers before the age of 20 (Figure 3). And among women with three or fewer years of schooling, seven in 10 had done so, compared with about three in 10 among those with at least seven years of education. These differences in early childbearing by educational achievement suggest that completing primary school encourages adolescents to postpone motherhood.

Socioeconomic status is an important determinant of becoming a teenage mother. Nearly two-thirds (64%) of women aged 20–24 in the lowest socioeconomic bracket gave birth before age 20, compared with 32% among young women in the highest socioeconomic category (Table 2).[24]

Since rural residence, low educational level and poverty are all associated with early childbearing in Honduras, young women who fall into all three of these groups have the very highest risk of beginning their reproductive lives during adolescence.

Premarital childbearing is infrequent.

A very small proportion of young women—6% of those aged 20–24 in 2001—acknowledged having had a premarital birth before age 20 (Table 1, row 8). This low proportion varied remarkably little by subgroup. Several factors may account for infrequent reports of premarital childbearing: Single women might be particularly careful to avoid pregnancy by using an effective contraceptive method, or they may underreport any births that precede a union. Alternatively, some single adolescents who become pregnant may marry the father before the child is born. While there is little available data on abortion in Honduras, other young women

might decide to end the pregnancy by abortion, which is illegal and generally available only clandestinely.* (FN B)

Adolescent childbearing has not declined over the past two decades.

Although older women have experienced substantial declines in fertility since 1987, the birthrate among adolescents has not changed (Table 3). What is more, very high fertility in the recent past means that the number of 15–19-year-old women increased by 45% between 1987 and 2001; the annual absolute numbers of births among adolescents increased by nearly 50% over this period. About one in five births that occurred were among adolescent women.

Four in 10 adolescent births are unplanned.

Not all pregnancies—even those among adolescents in union or those that lead adolescents to marry—are planned. In fact, women who had had a child before age 20 reported in 2001 that 40% of their adolescent births were unplanned (Table 1, row 9). This proportion was somewhat higher for births to women living in urban areas compared with those to women in rural areas (45% vs. 37%), and for births to women with seven or more years of schooling compared with those to women with three or fewer years (48% vs. 41%).

Of course, since six in 10 adolescent births were planned, young women's own desires to have children once they marry cannot be discounted. The determinants of women's early reproductive decisions, especially in rural areas, are often deeply rooted in the values of their community and in the lives and examples they see around them.

In some communities, early childbearing may not be perceived to limit adolescent women's life options.

What might explain the persistently high levels of adolescent childbearing in rural areas and among the country's poorest and least-educated women? The association between low levels of schooling and early motherhood is complex and multidirectional. Some adolescent women who are already mothers may be poorly educated because their pregnancy and motherhood forced them to drop out of school. Or, their families and communities may expect and support early marriage and parenthood. Finally, young women who are poor and have little schooling may feel that they have few other prospects and thus see marrying and starting a family as their best option. In that case, early motherhood would not necessarily be perceived as limiting their future.

Early union and early motherhood are often inextricably linked.

Comparing the proportions of young women who are in union by age 20 with those who have had a child by that age shows how closely the two behaviors are linked (Table 1, rows 2 and 6). For most adolescent women, including the most educated, union formation is strongly associated with having children. Discouraging very early unions could thus be an effective strategy for reducing high adolescent birthrates. However, such an approach would not be feasible unless adolescent girls were offered viable alternatives in their lives.

Most adolescent mothers do not plan to have a child in the next two years.

As often happens when young women are asked whether they had planned the births of their children, young women in 2001 described the majority (60%) of their adolescent births as having been planned. However, when 15–19-year-old mothers in union were asked whether they wanted to have another child soon, the answer was most often "no." Furthermore, 84% of all adolescent

women, irrespective of union status, who had had at least one child, did not want another child in the next two years. Nearly one-half of similar women who had not yet had a child also wanted to postpone starting a family for at least two years.[25] Lastly, in 2001, 70% of all 15–19-year-old women in union, regardless of their childbearing status, wanted to delay having a child for at least two years, compared with 62% in 1996 (Table 1, row 10).

It is clear that the majority of all sexually active* (FN C) adolescents, regardless of their union and motherhood status, did not want a child soon and will need effective contraception to achieve this goal. How many of these sexually active adolescent women were actually using effective contraceptives to ensure this?

Contraceptive use among sexually active adolescent women is very low.

Knowledge of contraception is consistently high in Honduras: Among adolescents of all backgrounds, virtually all (99%) reported knowing at least one modern contraceptive method* (FN D) (Table 1, row 13). The fact that familiarity with modern methods was virtually identical among both rural and urban adolescents and varied little by educational attainment is striking and encouraging.

Although adolescents are aware of modern contraceptive methods, they do not necessarily know where to obtain them, how to use them properly or consistently, and may not use them at all. Slightly fewer than one-third of all sexually active adolescent women were using a modern method in 2001 (Table 1, row 14). This low overall level of modern contraceptive use with relatively little variation by subgroup is disturbing because it suggests a high risk of pregnancy

among sexually active adolescent women.

Contraceptive prevalence increased between 1996, when only 19% of sexually active adolescent women were using a modern method of contraception, and 2001. Moreover, increases occurred among all subgroups of women, with the sole exception of the group with the highest prevalence in 1996—those with at least some secondary education—for whom it remained about the same.

Modern contraceptive use differs greatly between adolescent women in union who have already had a child and those who have not. In 2001, only 8% of 15–19-year-olds in union who had yet to start childbearing reported using a modern method, compared with 45% of those who had had a child.[26]

Half of sexually active adolescent women need but do not use contraceptives.

Given that, in 2001, 70% of all sexually active adolescent women did not want a child in the near future, and that only three in 10 were using an effective contraceptive method, it is unsurprising that 48% of adolescents had an unmet need for contraceptives (Table 1, row 17). That is, nearly one-half of all sexually active adolescent women did not want a child in the next two years, yet were not using a modern contraceptive method to prevent unintended pregnancy.

Unmet need for contraceptives among sexually active adolescents was somewhat higher in rural than in urban areas (51% vs. 44%), but was highest among those who had had at least seven years of schooling (56%). This finding is consistent with our expectation that sexually active women with the most education have the greatest motivation to delay early motherhood but may

lack the means to do so. Furthermore, unmet need is growing among this subgroup, as their desire to postpone childbearing outpaces their adoption of contraceptives: Unmet need rose by nearly one-third among the most educated adolescents between 1996 and 2001.

Many young rural women and those with little schooling do not receive adequate prenatal and delivery care.

To ensure the survival, health and well-being of mothers and their infants, quality prenatal and delivery care are basic public health necessities. Meeting these basic needs will be a great challenge for Honduras, which currently has a lower overall rate of prenatal care than any of the three Central American countries with comparable data (El Salvador, Guatemala and Nicaragua), and that rate has declined over time.[27]

In Honduras, two-thirds of women aged 15–24 who had given birth had received professional prenatal care during their most recent pregnancy in the five years preceding the 2001 survey,* (FN E) and a similar proportion had had a professionally trained doctor or nurse in attendance when they gave birth (Table 1, rows 20 and 21). This means that one-third of these young women did not make a single prenatal visit (at least four are recommended by the Secretaría de Salud[28]) or have a professional present at delivery. Further, one-half of women aged 15–24 living in rural areas received no professional prenatal or delivery care, in stark contrast to the 13–14% of young women in urban areas who lacked professional care.

Young women with three or fewer years of schooling were the group with the lowest rate of professional delivery care: Only 41% had a doctor or nurse in attendance, less than half the proportion among those with seven or more years of schooling (94%).

Living in a rural area of Honduras heightens reproductive health risks for young women. Rural adolescents, who are more likely than their urban counterparts to become pregnant in the first place, are also less likely to be aware of the importance of professional care during gestation and at delivery. More importantly, they lack access to such care, and many rural teenagers deliver at home.

The public sector plays an important role in family planning provision.

The Honduran government is well aware of the interrelationships between poverty, large family size and poor reproductive health. Through its Poverty Reduction Strategy Paper and National Plan for Reconstruction and Transformation, Honduras is committed to combining population policy with sustainable development, incorporating reproductive health and family planning delivery systems, and promoting gender equality and equity.[29]

The major providers of family planning in the country are the Honduran Secretaría de Salud and the local International Planned Parenthood Federation organization, ASHONPLAFA. The responsibilities of the Secretaría de Salud include planning, regulating, coordinating and evaluating all public health programs. It is also responsible for strengthening the provision of health services and focusing special attention on marginalized sectors of the population. In 2001, the Secretaría de Salud served 41% of family planning users and ASHONPLAFA provided services to another 29%.[30]

However, providing key reproductive health services and supplies will prove a major task in the coming years.

Until recently, most contraceptive commodities were donated by international donors—primarily the U.S. Agency for International Development and the United Nations Population Fund. This longstanding support is scheduled to be phased out in the next few years, however, and the Secretaría de Salud has yet to determine how it will be able to purchase an adequate supply of contraceptives. The projected growth in population over the next decade will continue to increase the demand for contraceptive methods and the total number of users is expected to double. To meet this demand, the public health system will need to increase its budget for contraceptives by 18% per year until 2015.[31]

Youth policies have been adopted but are widely dispersed and inadequately implemented. Although national youth policies have been introduced in the past two decades, often they are not viably linked to implementing institutions. In other cases, existing infrastructure is not equipped to coordinate such policies. For example, the directives set out by both the Ley del Consejo Nacional de la Juventud (1983) and the Ley del Instituto Hondureño de la Niñez y la Familia (1997) sometimes overlap, while at other times they contradict each other.[32] Further, the Programa de Atención Integral a la Adolescencia (PAIA) articulates the country's National Youth Plan and focuses attention on adolescents' special needs; however, although sexual and reproductive health is recognized as the first of PAIA's five essential health components, the program is charged solely with raising awareness of adolescents' needs and does not partner with organizations that offer services to meet those needs.

Moreover, only 46% of 15–24-year-old women—and only 33% of young men in the same age-group—have attended sex education talks or classes.[33] Honduras already has policies in place that can provide the political and institutional framework for improving sex education—both the Código de Salud (1991, Article 10) and the Ley Especial sobre VIH/SIDA (1999, Articles 14 and 15) establish the state's obligation to provide formal and informal education to young people to preserve and protect their sexual and reproductive health. However, sex education curricula are woefully inadequate in all three recommended educational settings (primary, secondary and vocational schools).

Adolescents' sexual and reproductive health is in jeopardy.

Nearly one-fifth (18%) of AIDS cases reported in Honduras in 2001 were among young people aged 15–24.[34] Honduras's national AIDS commission, CONASIDA, needs to better target prevention and education services to adolescent women, whose heightened vulnerability stems from a confluence of factors, including pervasive poverty, persistent machismo and sexual violence, low educational attainment and inadequate sex education.[35]

These young women also have an unacceptably high risk of medical complications from early pregnancy and childbearing. Although the country has made admirable progress in reducing overall maternal mortality by 40% in less than a decade (and in meeting a Millennium Development Goal in the process), much remains to be done to help young women get adequate prenatal care and institution-based delivery and postnatal care.[36] Advocates for increased prenatal coverage can point to provisions in the Código de la Niñez y de la Adolescencia (1996, Article 13), which guarantees adolescents' access to adequate prenatal and delivery care. Further,

the fact that women are accounting for an ever-growing share of HIV-infections means that getting young women into prenatal care—and thus into the formal medical system where they can be tested for and educated about HIV—is more important than ever.

Modernization is changing values, but early motherhood continues to be culturally supported.

In Honduras, as in many of the poorer countries in Latin America and the Caribbean, modernization, urbanization, higher educational levels and increased exposure to the mass media are changing attitudes and values about marriage and family. Indeed, the evidence that Honduran women who have completed their families have fewer children than in the recent past indicates that smaller family size preferences are beginning to take hold: In the decade between 1991 and 2001, the total fertility rate among women aged 15–49 declined from 5.2 lifetime births to 4.4.[37] On the other hand, the fact that many young women want to become mothers during adolescence—more than one-half of 15–24-year-olds who first gave birth before age 15 and two-thirds of those who first gave birth at ages 15–19 described those births as planned[38]—points to the difficulty in addressing the problem of early childbearing and its well-documented links to entrenched intergenerational poverty.

The reasons why adolescent fertility rates have hardly budged in the past decade are probably related to a variety of factors, including low educational levels, limited job prospects, widespread poverty, a sense of fatalism and immutable gender roles that encourage young women to prove their value through motherhood. However, mass media campaigns dedicated to instilling the benefits of postponing very early childbearing can be an effective starting point for changing prevailing norms.

Addressing the thorny issue of early childbearing will require coordinated, concerted efforts.

Several interrelated steps are required to begin to address the challenge of early childbearing in Honduras.

- ∞ All youth sexual and reproductive health-related legislative and policy initiatives (more than 11 laws have been passed) need to be better coordinated and integrated into a coherent national policy. Nongovernmental organizations working in Honduras can be called on to provide a greater service-delivery role.
- ∞ Government educational officials and policymakers need to initiate efforts to encourage adolescents of both sexes to stay in school for as long as possible and target media messages to those already out of school.
- ∞ Since many adolescent mothers are in union, their partners and families should be involved in efforts to support them and to reduce the negative social and health consequences of early childbearing.
- ∞ The government needs to better educate young women about family planning methods and the importance of professional care, both throughout pregnancy and at delivery.
- ∞ Adolescents' need for family planning to avoid unintended pregnancy overlaps with their need for services to prevent the spread of HIV. These services should be integrated to make them as effective as possible and to maximize their impact. The mass media can be more widely used to inform adolescents about both family planning and HIV/AIDS prevention.
- ∞ Finally, the government needs to commit more resources to implementing existing policies aimed at protecting the health of Honduras's future—its adolescents.

Footnotes

FN A

*Because of constraints on data availability, in this report we define adolescence as ages 15–19. Many experts, however, delineate adolescence as ages 10–19.

FN B

* The penal code in Honduras makes no explicit exception to the general prohibition of abortion. The country's Medical Code of Ethics, which does not carry the weight of law, allows therapeutic abortions to save the life of the pregnant woman (sources: Center for Reproductive Rights, *The World's Abortion Laws,* 2005, <http://www.reproductiverights.org/pub_fac_abortion_laws.html>, accessed May 10, 2006; and UN Population Division, *Abortion Policies: A Global Review,* 2002, <http://www.un.org/esa/population/publications/abortion/profiles.htm>, accessed May 10, 2006).

FN C

*Sexually active women include all women in union and those not in union but who had had intercourse in the three months prior to the survey.

FN D

*Modern methods include the pill, IUD, condom, injectables, vaginal methods, and male and female sterilization.

FN E

*Although, in order to have a large enough sample, these prenatal care data include 20–24-year-olds who have given birth, any issues of access to care would likely be similar for adolescents and for women in their early 20s.

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25. Special tabulations of 2001 ENESF data.

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38. Monteith RS, Stupp PW and McCracken SD, 2005, op. cit. (see reference 8).

Data Sources

Data presented in this report are extracted mainly from the two most recent national reproductive health surveys in Honduras—the 1996[1] and the 2001 Encuestas Nacionales de Epidemiología y Salud Familiar (ENESF)[2] carried out, in part, by the Secretaría de Salud and Asociación Hondureña de Planificación de Familia (ASHONPLAFA). The sample for the 1996 ENESF consisted of 7,505 women of childbearing age (15–49), who were married (or in consensual union) or single; in the 2001 survey, 8,362 similar women were interviewed. Both surveys obtained information on sexual activity, partnership, reproductive preferences, fertility experience, contraceptive use, and maternal and child health indicators. Both ENESF surveys have large enough samples to permit analyses of adolescents by urban or rural residence, level of education and socioeconomic status. The report also draws on earlier national surveys of Honduras—the 1987[3] and 1991–1992 ENESF.[4] Population estimates come from the United Nations Population Division.

1. Monteith R et al., *Honduras: Encuesta Nacional de Epidemiología y Salud Familiar—1996 (ENESF–96), Informe Final*, Tegucigalpa, Honduras: Secretaría de Salud, Asociación Hondureña de Planificación de Familia (ASHONPLAFA) and USAID/Honduras; and Atlanta, GA, USA: Centers for Disease Control and Prevention (CDC), 1997.

2. Corrales G et al., *Honduras: Encuesta Nacional de Epidemiología y Salud Familiar—2001 (ENESF-01)*, *Informe Final,* Tegucigalpa, Honduras: ASHONPLAFA; and Atlanta, GA, USA: Centers for Disease Control and Prevention (CDC), 2002.

3. Honduran Ministry of Public Health et al., *Epidemiology and Family Health Survey Honduras—1987 (1987 EFHS), Final Report*, Tegucigalpa, Honduras: Honduran Ministry of Public Health and ASHONPLAFA, 1989.

4. Ministerio de Salud Pública et al., *Encuesta Nacional de Epidemiología y Salud Familiar—1991–1992 (ENESF-91–92), Informe Final*, Tegucigalpa, Honduras: ASHONPLAFA, 1992.

Table 1. Selected Demographic and Reproductive Measures

Honduran women's experiences often vary over time and with their residence and level of schooling.

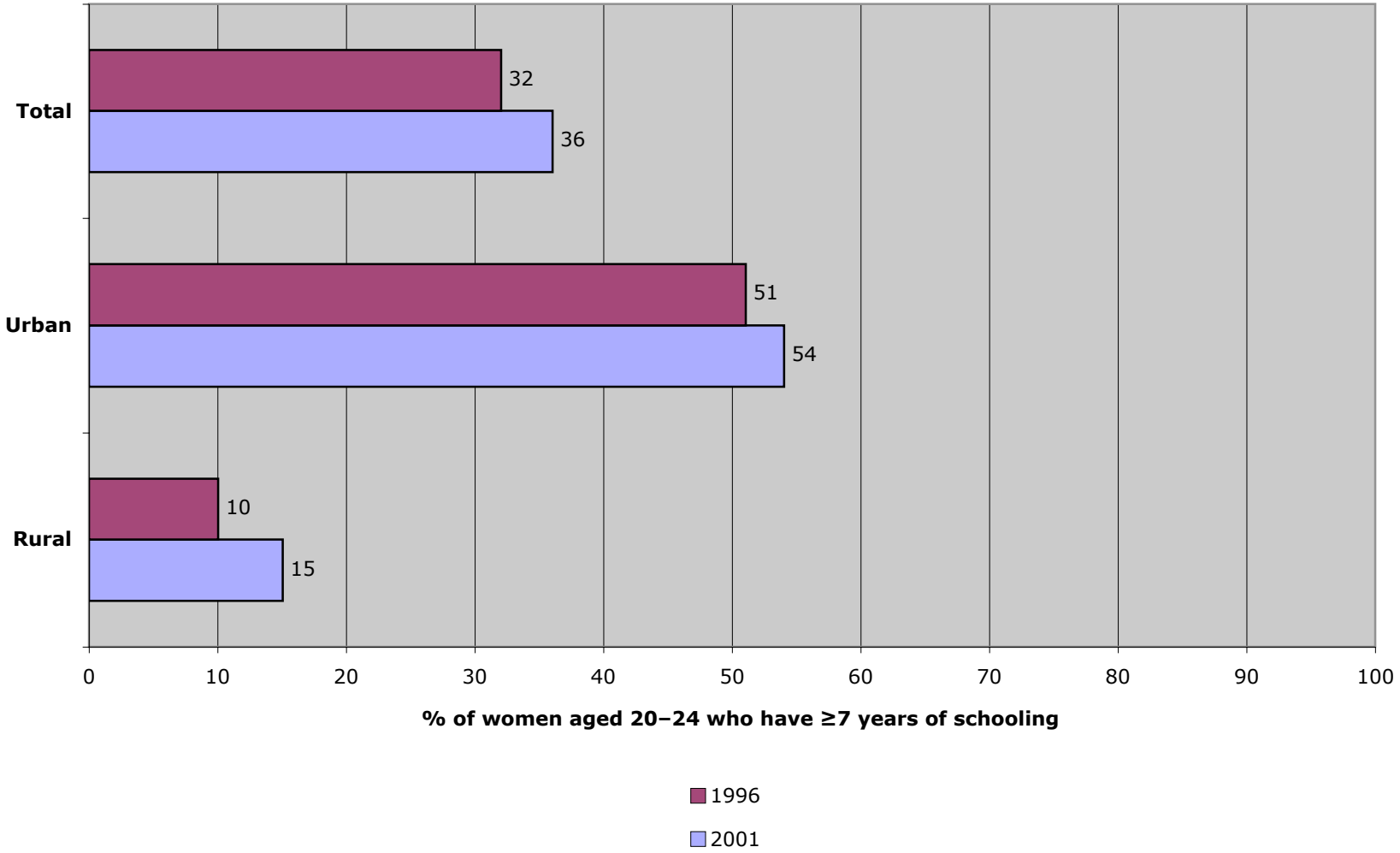
Measure	All		Residence				Years of education					
			Urban		Rural		0–3		4–6		≥7	
	1996	2001	1996	2001	1996	2001	1996	2001	1996	2001	1996	2001
Unweighted Ns												
Women 15–19	1,456	1,512	631	722	825	790	367	299	719	720	370	493
Women 20–24	1,374	1,627	642	803	732	824	412	406	602	719	360	502
(1) **% aged 20–24 who have ≥7 years of education**	31.6	35.8	50.9	54.3	9.9	15.4	na	na	na	na	na	na
(2) **% aged 20–24 who entered a union before age 20***	55.8	57.6	46.1	46.3	66.6	70.1	73.9	79.1	62.0	67.1	32.2	33.3
(3) **% aged 20–24 who had premarital sex before age 20**	18.4	20.6	20.1	26.3	16.4	14.4	15.9	16.2	21.9	16.7	15.8	28.0
% aged 20–24 who gave birth before specific age												
(4) Age 20	48.6	49.3	41.1	39.8	57.1	59.7	62.8	69.7	57.1	55.4	25.4	29.4
(5) Age 18	26.7	28.1	22.3	21.0	31.7	36.1	40.8	50.2	29.9	29.2	10.7	13.3
(6) Age 15	2.8	3.3	2.2	2.8	3.5	3.8	6.9	8.9	2.4	2.8	0.0	0.4
(7) **% aged 15–19 who have given birth or are pregnant**	27.7	28.5	22.9	25.3	32.2	31.8	43.3	45.9	27.9	34.0	15.0	12.5
(8) **% aged 20–24 who had a premarital birth before age 20**	8.0	5.5	7.5	6.1	8.5	4.8	10.6	6.8	9.2	4.7	4.2	5.7
(9) **% of adolescent births that were unplanned†**	na	39.8	na	44.6	na	36.5	na	40.8	na	36.5	na	48.2
% aged 15–19 and sexually active‡ who do not want a child soon§												
(10) All	63.2	69.5	66.4	70.4	61.2	68.9	58.6	63.6	62.8	69.9	74.3	78.4
(11) In union	62.2	70.1	68.1	71.9	58.8	68.9	57.6	64.2	61.3	69.5	78.5**	83.6
(12) Not in union	70.0**	66.4**	††	65.1**	††	68.8**	††	††	††	71.8**	††	††
(13) **% aged 15–19 who know of any modern method of contraception‡‡**	96.2	98.7	99.2	99.5	93.4	97.8	89.2	95.7	97.4	98.8	99.8	100.0
% aged 15–19 and sexually active using a modern method												
(14) All	18.8	30.6	28.7	37.8	12.9	24.9	10.3	22.1	20.5	35.5	32.7	29.7
(15) In union	19.3	32.4	30.0	40.0	13.3	27.2	8.4	22.8	21.9	37.5	38.0**	34.5
(16) Not in union	15.9**	20.6**	††	30.1**	††	4.2**	††	††	††	25.6**	††	††
% aged 15–19 and sexually active with an unmet need for effective contraception§§												
(17) All	50.9	47.9	43.7	44.2	55.1	50.7	54.5	51.0	50.7	43.5	42.9	56.1
(18) In union	50.4	46.7	45.4	43.4	53.0	49.0	56.0	51.3	48.8	41.1	41.8**	56.0
(19) Not in union	54.1**	54.2	††	47.0**	††	66.7**	††	††	††	55.1**	††	††
(20) % aged 15–24 who received professional prenatal care***	66.1	67.0	81.1	86.3	53.7	52.0	50.3	47.7	67.7	68.3	90.1	89.9
(21) % aged 15–24 who received professional delivery care***	57.5	65.7	84.1	87.1	35.7	49.0	35.4	40.9	60.7	67.7	88.4	94.4

*All measures referring to union or marital status include formal and consensual unions. †Denominator is all births to women younger than 20 in the five years prior to the interview. ‡All women in union and not in union who have had intercourse in the past three months. §Want no children or want to wait two or more years before next birth. **Unweighted N is small (25–49). ††Suppressed because the unweighted N is less than 25. ‡‡The pill, injectables, implants, male and female sterilization, the IUD, the diaphragm, spermicides, the condom or the sponge. §§Women are considered to have an unmet need if they are sexually active, do not want a birth in the next two years and are not using an effective contraceptive method. ***Refers to most recent birth within the last five years. Professional care is care provided by doctors and nurses at public- and private-sector hospitals and clinics. *Note:* na=not applicable. *Sources:* 1996 and 2001 ENESF.

Table 2. Childbearing and Socioeconomic Status	
Adolescent childbearing is most common among the least advantaged.	
Household socioeconomic level	% of women 20–24 who gave birth before age 20
Low	64
Middle	51
High	32
Note: Household socioeconomic level is based on an index of household amenities and characteristics. *Source:* Special tabulations of the ENESF, 2001.	

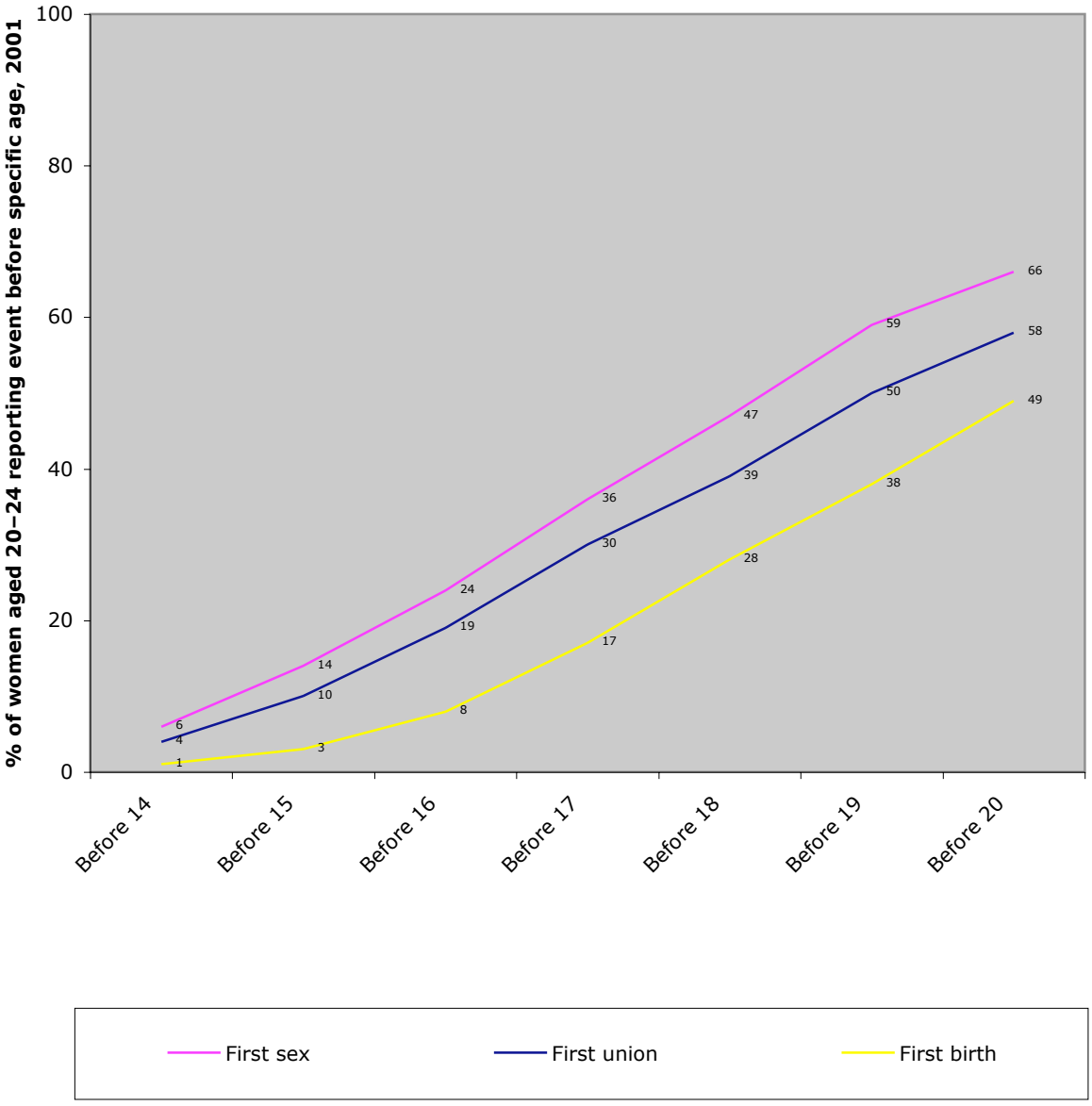
Table 3. Adolescent Childbearing Trends				
The birthrate among adolescents has not improved since the 1980s.				
Year	Birthrate (births per 1,000 women 15–19)	No. of births to women 15–19 (in 000s)	No. of women 15–19 (in 000s)	% of all births that are to adolescents
1987	135*	33	243	18.0
1996	136†	42	307	19.7
2001	137†	48	354	21.2
*Annual rate based on births that occurred in the two years prior to the survey. †Annual rate, based on births that occurred in the three years preceding the survey. *Sources:* **Birthrate**—1987, 1996 and 2001 ENESF. **Number of women**—United Nations 2003, (reference 10).				

Figure 1. Schooling
Educational levels among young women rose slightly between 1996 and 2001, but remain low.



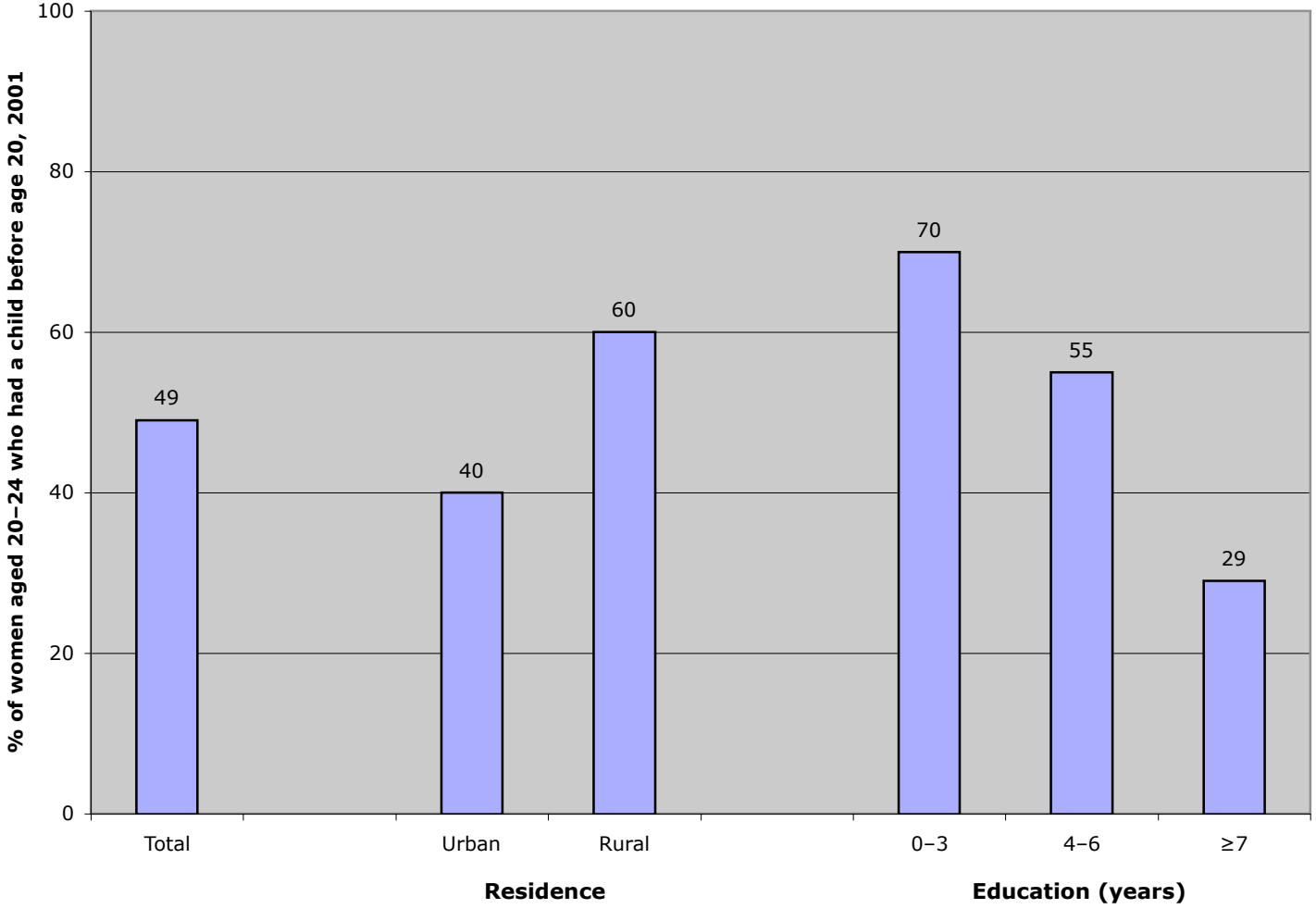
Sources: 1996 and 2001 ENESF.

Figure 2. Transitions to Adulthood
First sex, first union and first birth occur very early among Honduran women.



Source: 2001 ENESF.

Figure 3. Early Motherhood
The proportions of women giving birth as teenagers are highest among among rural women and those with the least schooling.



Source: 2001 ENESF.

Credits

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