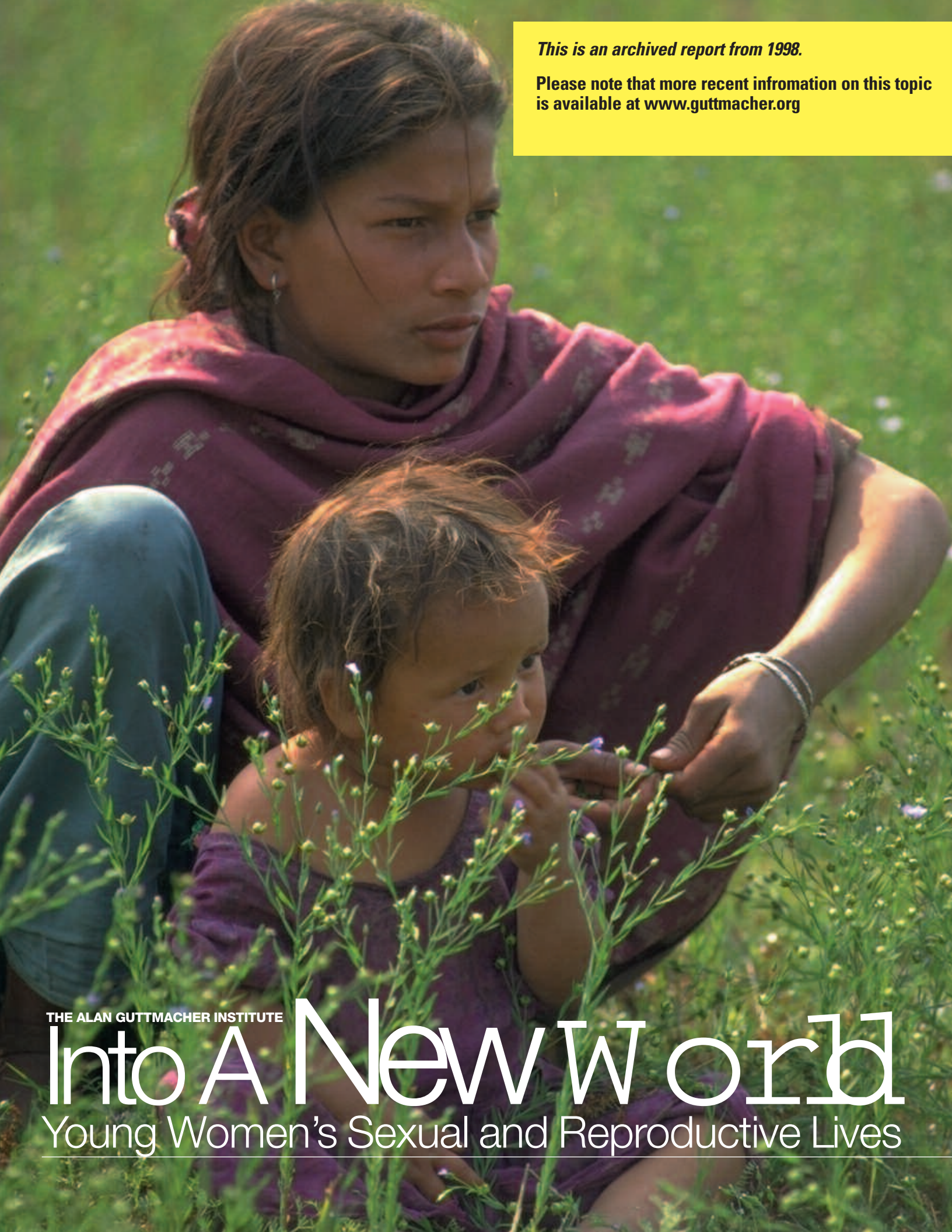

THE ALAN GUTTMACHER INSTITUTE

Into A New World

Young Women's Sexual and Reproductive Lives

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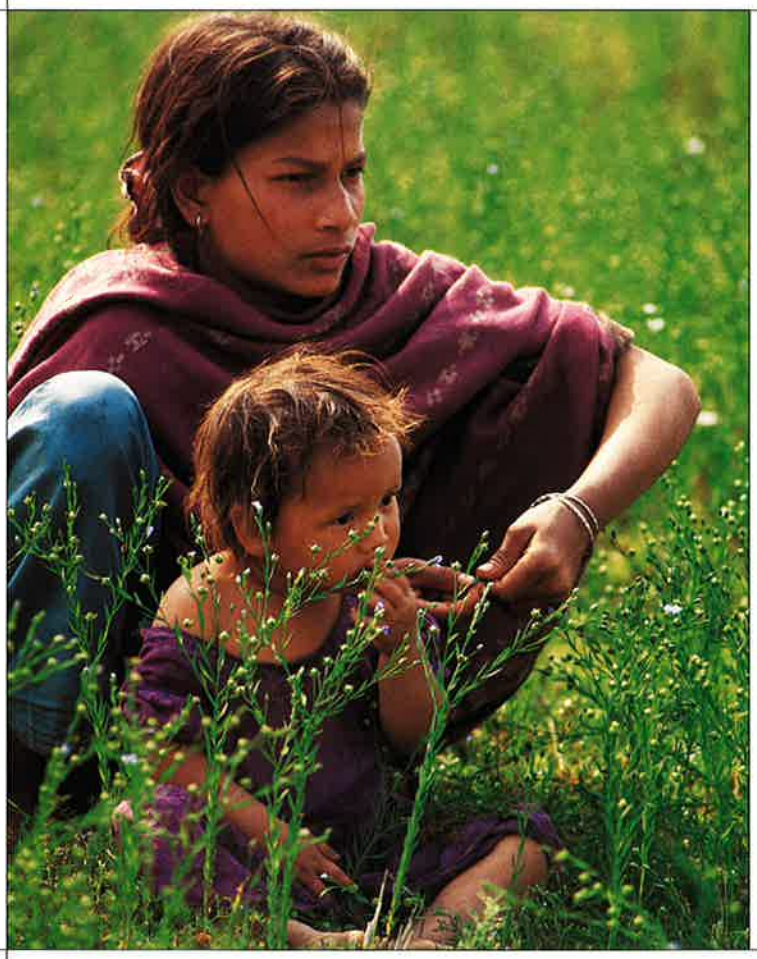

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The Alan Guttmacher Institute
120 Wall Street
New York, New York 10005

1120 Connecticut Avenue, N.W.
Washington, D.C. 20036

www.agi-usa.org

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Young Women in a Changing World

Over the last several decades, the world has changed radically: Continued movement toward a more urban, industrialized and media-saturated environment is a global reality. These changes have altered the type of future that young people must prepare to meet as they make the transition to adulthood. Irrevocably affected in particular has been the life course of young women the world over. Sexual relationships, marriage and childbearing have always been central areas of women's lives and the foundation of families and societies. But these intimate behaviors must adapt to modern life, too, and as the timing and context of marriage and childbearing change, the impact will be felt by young women in particular. This report documents the conditions of young women's lives and the scope of their needs. It challenges the nations of the world, through their governments, policymakers, parents and all who come in contact with youth, to commit the energies and resources required to meet these needs—or forfeit an opportunity to shape for the better the contours of society and our global future.

Youth around the world stand poised on the brink of a new millennium. The current generation of 10–19-year-olds are more than a billion strong, and will be the largest generation in history to make the transition from children to adults. They are coming of age in societies engaged in their own rapid, sometimes chaotic, transitions. How these adolescents take their place in a world evolving at breakneck speed will determine not only the future of their individual lives but that of the entire planet.

To prepare adequately for the future, they will need education, training and job opportunities. They must be free of widespread disease, violence and discrimination. Even in the richest countries of the world, these requirements are sometimes difficult to meet. In poorer countries, the task facing governments and societal institutions is indeed formidable—although considerable progress has been made in recent decades, particularly in regard to health and education.

Advances in these two areas have often pulled young people in opposite directions, however. While better health and nutrition have lowered the age at which young people mature physically, the growing emphasis on education and the demands of the job market have raised the age at which they are considered mature socially.

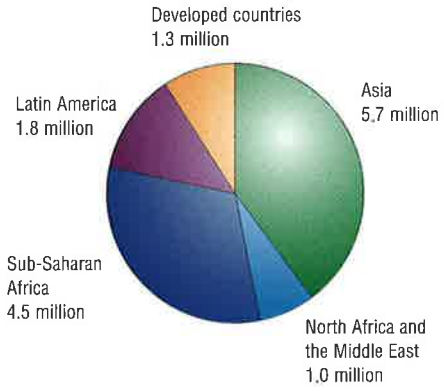
Biologically and Socially, the Adolescent Years Have a Marked Effect upon Women

For young women, the years of adolescent transition are especially telling, for they are typically when sexual relationships, marriage and childbearing are likely to begin. The initiation of sexual activity during adolescence is, of course, an experience common to young men as well, but for them, marriage and parenthood are usually postponed until their 20s or even later. Both biologically and socially, the consequences of sexual activity in adolescence are considerably more onerous for young women than for their male peers. In fact, they may determine the course of a young woman's life, and in the aggregate, they powerfully shape the very contours of society.

If the physical and social transitions to adulthood do not have the same impact on men and women, neither do they follow a uniform and simple path for this age-group of women as a whole. Some in the decade between ages 10 and 20 are children beginning to experience the changes that come with puberty; others attained sexual maturity long ago. Some young women have entered into sexual relationships or are already married, and roughly 14 million become mothers each year (Chart 1.1, page 6), often not for the first time.

Unfortunately, what is known about crucial aspects of adolescence is largely confined to reproductive behavior. This is not very surprising, given that birth is a measurable event recorded in some way in all societies. But crucial gaps in knowl-

Chart 1.1: Adolescent women have more than 14 million births each year.



▲ *Source:* Special tabulations based on United Nations projections of the number of women aged 15–19 and of age-specific birthrates for women aged 15–19, by region.

edge still exist. What experiences precede each birth; what complex physical, familial and cultural factors determine who will marry and when; who will begin sexual activity while still unmarried; who will start bearing children during adolescence; who will delay marriage and childbearing until much later in life; who will become parents first and marry later or remain unmarried—all are issues largely unknown or poorly understood.

Well known, however, is that this period of transition called adolescence has had similar characteristics through the ages. Its key features are also similar in the developed and less developed countries of the world: It is a period of challenge and testing, when the upcoming generation begins to question the ways of their elders and when parents both cherish their growing children's vigor and idealism and decry their lack of wisdom and realism. In less turbulent periods, these tensions were resolved over time, as both generations adjusted but settled along predictable and traditional paths.

The Contours of Society Will Be Shaped by the Course of Young Women's Lives

For the current generations, the adjustment to each other may not be easy. The world is changing at a breathtaking pace. As societies become more urban, more industrialized, as the media extend their reach to the far regions of the globe, the chores of daily life may become less burdensome and the opportunities for a better future may seem closer at hand. But change also brings new pressures, pressures that require individuals and communities to reexamine cherished beliefs, question traditional roles and reconsider established priorities.

As movement to the cities accelerates, for example, the desirability of large families diminishes. For a young woman, pregnancy and childbearing at very early ages are no longer considered as desirable as they were only a generation ago. As skilled labor becomes more important, the need for education becomes urgent. Once considered a luxury for rural children—and especially for girls—education is increasingly viewed as a necessity for all.

Social changes that encourage women to obtain more education and to marry and bear children somewhat later are largely positive for women and for societies as a whole. Women have greater opportunity to realize their rightful aspirations and attain their full potential to contribute to the economic, social and political life of their communities. At the same time, delays in marriage raise fears that women may enter into sexual relationships outside marriage, which will defy or undermine their communities' religious and cultural norms.

Such relationships can clearly place young women at risk for out-of-wedlock births and increase their exposure to sexually transmitted diseases, including HIV, the virus that causes AIDS. This, of course, highlights the imperative to provide young women with the information, skills and necessary services to protect themselves against accidental pregnancy, and to protect themselves, their partners and their unborn children against disease. While the AIDS epidemic has moved the issue of sexual health to the forefront of many national agendas, young people—and young women in particular—have other urgent and broader reproductive health needs that require attention.

A nation's fate lies in the strengths and aspirations of its youth. But its investment in them must be based on the best and most authoritative information. This report is presented with that goal in mind. It describes the conditions of life for adolescent women—those aged 15 through 19—around the globe, in developed and developing countries alike. It provides comparative information on the education they receive; their patterns of marriage, sexual activity and childbearing; their needs for contraception and reproductive health care; and the risks they confront as they grapple with the complexities of sexuality in a modern world.

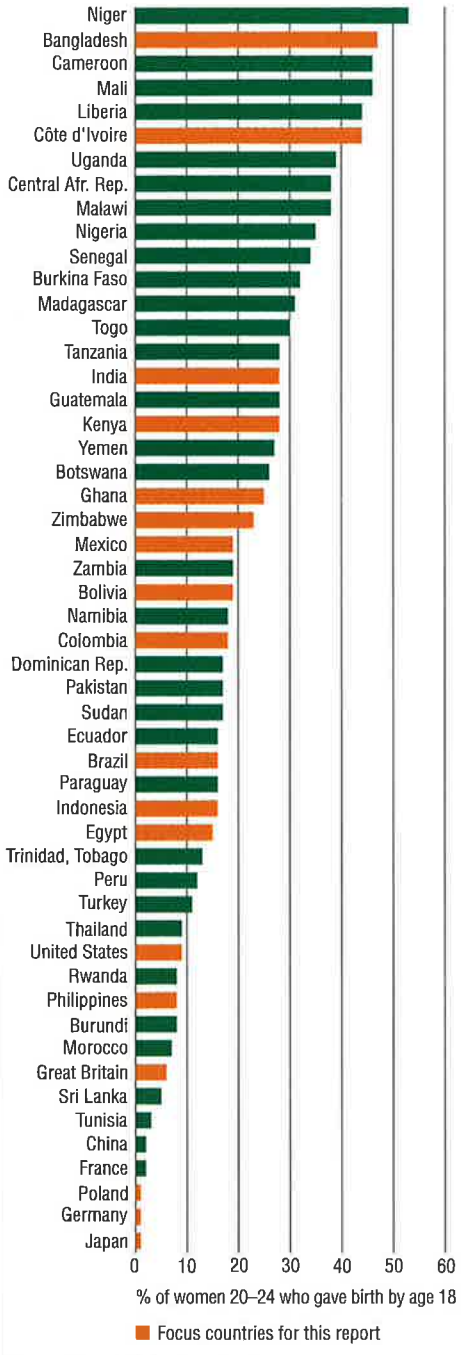
"A nation's fate lies in the strengths and aspirations of its youth."

The information contained in this report also documents the many ways in which increased education for young women plays a pivotal role in building and maintaining a society's overall well-being, and it makes evident that committing resources to meet the needs of adolescent women will have dramatic repercussions for their lives and the lives of future generations as well. If nations recognize the importance of making such commitments, enormous changes in the conditions of life for all are possible.

Information from Around the World Highlights the Similarities in Experiences and Needs

This report brings together information from 53 countries, covering five major regions or groups—Asia, Latin America and the Caribbean, North Africa and the Middle East, Sub-Saharan Africa and the developed countries—and about 75% of the world's total population. The countries were chosen because they have comparable data that are readily accessible from recent national fertility surveys. Notably, information is lacking for the countries of eastern Europe and the former Soviet Union. For the developing countries, the principal sources of data are the Demographic and Health Surveys (DHS), a major international data collection effort. The six developed countries and China each had survey data comparable to those from the DHS (see Data Sources, page 9).

Chart 1.2: The proportion of women who have their first child by age 18 ranges from 1% in Japan to 53% in Niger.



Source: Appendix Table 4, column 3.

The text of the report draws on information from all the individual country data, which are presented in six appendix tables. On occasion, smaller national or regional studies that bring more depth to the analysis are consulted. The charts that accompany the text, however, focus on 18 countries, including some from each of the major regions. Focus countries were selected on the basis of recency and completeness of their survey data, availability of information on change over time, representation across geographic regions and their respective subregions, and large population size.

The charts are organized according to the proportion of women in each country who have had a child before age 18 (Chart 1.2). This measure was chosen because, more than any other aspect of reproductive behavior, having a child before age 18 can have a profound and long-lasting impact on the course of a woman's life. Thus, Bangladesh, the focus country with the largest proportion of women giving birth before age 18, is always represented at the top of a chart, and Japan, the focus country with the smallest proportion of women doing so, is always at the bottom.

We examine both developed and developing countries, not only to demonstrate their differences, but to highlight the many ways in which the experiences and needs of adolescents are similar across national and regional boundaries. This report depicts the circumstances in which young people around the world live, and provides a comprehensive picture of their sexual and reproductive behaviors. Despite its breadth, the omission of many countries naturally limits the global generalizations that can be drawn.

In a similar vein, this report is limited in scope by the availability of reliable data. Thus, while the experiences and needs of all adolescents are important, most national surveys concentrate primarily on women and on those aged 15 and older; this report necessarily shares those limitations. Whenever possible, we include information on adolescent men and on adolescents younger than 15. Moreover, the experiences of young people are, of course, a reflection of the larger culture in which they live. So, while this report specifically refers to adolescents, many of the trends it illustrates apply to the lives of adult women and men as well.

Lastly, some types of information are basically reliable and easy to obtain. For example, data on joyous events such as marriages and births are reported relatively accurately in fertility surveys or in official vital statistics. Shame, social disapproval or illegality, however, make some data more difficult to obtain. Sexual activity among the unmarried, abortion rates and the incidence of sexually transmitted diseases are all likely to be incompletely reported or measured. Therefore, scarcity of information also limits our ability to examine in depth some critical issues affecting adolescents. Nonetheless, they are vital aspects of young women's reproductive lives, and are covered to the extent the data allow.

DATA SOURCES

The data in this report derive mainly from the Demographic and Health Surveys (DHS), an international research effort coordinated by Macro International in cooperation with national governments and organizations, and funded by the United States Agency for International Development. Forty-six countries that participated in the DHS are covered in this report: 22 in Sub-Saharan Africa, five in North Africa and the Middle East, eight in Asia, and 11 in Latin America and the Caribbean. If a country has been surveyed more than once since the surveys began in 1984, the most recent data were used.

In all countries, the surveys covered women aged 15–49, except in Brazil and Guatemala, where the age range was 15–44. In Latin America, the Caribbean and Sub-Saharan Africa, as well as in Morocco and the Philippines, data were collected on both married and unmarried women. In the rest of Asia, North Africa and the Middle East, however, the surveys sampled only ever-married women. To make estimates for all women in these instances, it was assumed that adolescent women who have never been in a union have not been sexually active and have not had any births.

Supporting this assumption, the DHS data for other countries in these regions indicate very low levels of premarital births among ever-married women. Nevertheless, calculations based on such assumptions are obviously conservative estimates. Even in countries where data on sexual behavior among unmarried women are collected, societal proscriptions against such behavior may be strong, and women may underreport sexual experiences that occur outside marriage.

The measures presented in this report are derived either from special analyses of the DHS data files, carried out by The Alan Guttmacher Institute, or from already published reports. Because the 46 countries took part in the DHS over a 10-year time span (1985–1995), the information used in making comparisons is not equally current for all countries.

In addition to the DHS countries, seven others are included—China, France, Germany, Great Britain, Japan, Poland and the United States. The main sources of data in each instance are as follows:

- For China, the 1987 Fertility Survey, which contains data on ever-married women aged 15–49, and the 1988 Two per 1,000 Sample Survey, which includes both married and unmarried women aged 15–49.
- For France, the 1994 Survey on Families and Employment, carried out among all women aged 20–49.
- For Germany, the 1992 German Family and Fertility Survey of women and men aged 20–39.
- For Great Britain, the 1991 National Survey of Sexual Attitudes and Lifestyles and the 1991 General Household Survey.
- For Japan, the 1992 National Fertility Survey, a study of couples in their first marriage, supplemented by data from the 1987 National Fertility Survey, the 1992 Mainichi Survey on Family Planning Censuses and other sources.
- For Poland, the 1991 Family and Fertility Survey of women and men aged 18 and older.
- For the United States, special analyses of the 1995 National Survey of Family Growth, representative of women aged 15–44, supplemented by data from other national sources.

This report also draws upon a number of published statistical compilations of indicators for economic, social, educational and health conditions. Exact sources for each of the indicators included are cited in the appendix tables or text.

The Context of Young People's Lives

Searching for a better life, young people are among the rural poor streaming into urban areas looking for work. Often frustrated in their pursuit of better economic conditions by a lack of education and marketable skills, young people everywhere are also being exposed to changing values and heightened aspirations. Improved transportation and new modes of communication bring even isolated rural youth in contact with people of different traditions, customs and values than those of their family. Strikingly, however, the desire for a better life seems to be universal. Education is thought to hold the key to that better life, although it, too, may expose young people to ideas that challenge existing customs and assumptions. Nevertheless, over the short span of a generation, substantial increases in school enrollment and educational attainment have occurred virtually worldwide. Some countries still lag behind, and with noteworthy exceptions, girls continue to be disproportionately disadvantaged in their access to education.

Adolescents are growing up in a world that is fundamentally different from the one that existed when their parents were young. Their world is considerably more urban and industrialized, and they must prepare to earn their living in ways that increasingly require some education and formal training. Mass media connect individuals around the globe, exposing all to a profusion of ideas, values and lifestyles. Society is in a constant state of transformation, and the rapid and unstoppable change poses a dramatic challenge to parents, communities and governments, who must prepare the world's youth for the future.

For increasingly industrial or modernizing economies, education is critical to meeting the emerging demand for more refined and specific skills, a demand that is being driven to some extent by the new technologies that are transforming society. Greater dependence on wage-based, rather than on family- or farm-based, work means that basic skills like reading and math have become a priority for young people who want to compete for jobs. The increased emphasis on schooling—especially for girls and young women—also reflects a growing recognition that access to education for all benefits the nation's common good, and is an essential step in achieving equality between men and women.

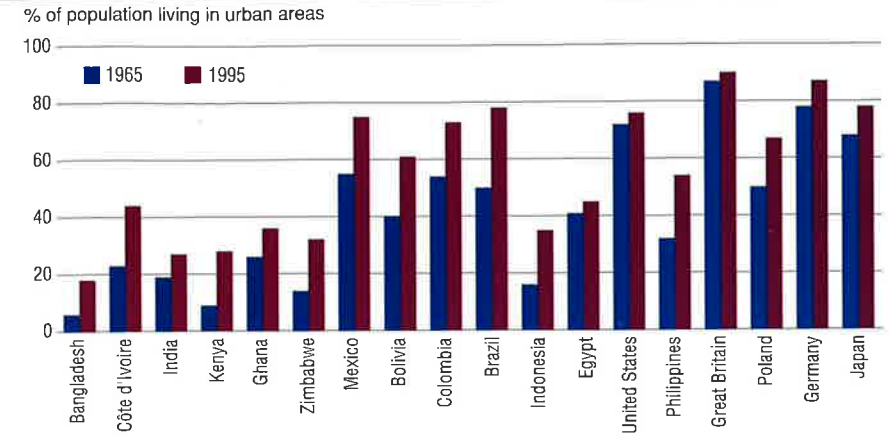
Urbanization and Economic Change, Along with the Media, Have Transformed Society

Urban dwellers have increased dramatically in the developing world (Chart 2.1). Between 1965 and 1995, for example, the proportion of Kenya's population who reside in urban areas tripled—from 9% to 28%—and that of Zimbabwe more than doubled—from 14% to 32%. In Mexico, Colombia and Brazil, more than 70% of the population live in urban areas. Living in cities and towns has been characteristic of life in developed countries for several decades.[1]

As people move to towns and cities, they abandon family-based agricultural work to pursue employment in the manufacturing or service sector, or in the growing informal economy. Among the many lures of urban life are increased job opportunities and access to basic services and medical care. However, without education or technical skills, these advantages remain largely out of reach.

Both the developed and the developing worlds are now blanketed by communication networks. Worldwide, more than 40% of women aged 15–19 listen to the radio on a regular basis; in many countries of North Africa, Asia, Latin America and the Caribbean, two-thirds or more do so.[2] Television is nearly universal in industrialized nations, and it is increasingly common in other parts of the world, too (Chart 2.2). Even somewhat remote communities now get local and global news

Chart 2.1: The population of most countries increasingly resides in cities and towns.



◀ *Note:* In this and all other charts, countries are ranked by the proportion of women 20–24 who had a child by age 18, as shown in Chart 1.2. *Source:* Appendix Table 1, columns 3 and 4.

and can be influenced by new ideas, some of which may run counter to their prevailing values. CNN, for example, reaches some 120 million homes worldwide, while MTV has 70 million viewers in Asia and Latin America alone.[3] In addition, records, cassettes and other audio and video material of multiple origins are freely and widely distributed around the world and across frontiers.

For better or worse, the values and lifestyles depicted in movies, on television and through music videos have a powerful influence on the aspirations and desires of young people. Unfortunately, adolescents may not be prepared to judge effectively the accuracy or value of what they see or hear, and may simply emulate styles and habits, both good and bad.

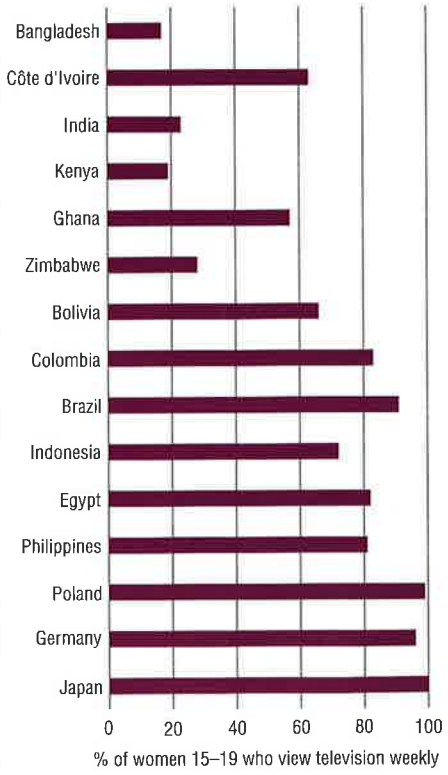
Living Conditions Improve, Yet Extreme Poverty and Glaring Social Disparities Endure

Economic and social change do not automatically lead to declines in poverty, and they do not assure uniform access to a nation's resources. Economic transitions may deepen poverty for some, and broaden the gulf between rich and poor. Indeed, many countries have glaring disparities in income distribution: Often only a small proportion of people control the majority of a nation's resources (Table 2a, page 12). Thus, measures that describe a nation's overall social and economic achievements may mask enormous differences in the access that social groups and individuals have to goods, services and education.

Poverty is prevalent in developing countries, where the average income on which a family must survive is typically a fraction of that earned by those in the industrialized world.[4] To be sure, poverty afflicts the developed world as well, and destitute communities exist alongside those with an abundance of wealth and resources. In general, however, the widespread poverty in developing countries limits the actions that governments and families can take to improve their own living conditions.

As income varies widely within and among the nations of the world, so do the conditions of everyday life. Such conditions may be especially harsh in rural communities and in the slums that grow around urban centers. These areas frequently lack adequate housing, transportation, electricity, sanitation services and easy access to safe drinking water.[5] This dearth of basic amenities makes completing life's daily tasks extremely burdensome. As a result, some impoverished families may sacrifice their child's education because the child's labor is needed at home to help provide for the family.

Chart 2.2: The mass media are a major source of ideas and information among young people around the world.



Note: Data are not available for Great Britain, Mexico and the United States. *Source:* Appendix Table 1, column 11.

Most Young People Attend School, but the Number of Years Is Often Limited

In all regions of the world, getting an education has become key to a hopeful future: Earning a living depends on a young person's ability to learn the skills that modernizing industries and service providers seek. Obtaining at least basic reading and math skills is clearly a necessity, and indeed, in all but a handful of the world's most impoverished countries, some 70–100% of children now enroll in primary school.[6]

In the poorest countries, though, fewer than half of young women are able to get a basic education—at least seven years of schooling in developing countries. This is especially true in Sub-Saharan Africa: In Burundi, the Central African Republic, Mali and Niger, fewer than 10% of girls receive at least seven years of schooling; in another eight countries, the proportion is no more than 25%. In Ghana, Kenya and Tanzania, it rises above 60%, but only in Botswana and Zimbabwe do 75% or more of girls receive a basic education.[7]

In North Africa, the Middle East and Asia, typically one-fourth to one-half of girls attend school for at least seven years. The Philippines, where at least 80% of girls have this much schooling, is an exception among developing countries in Asia. Most countries in Latin America and the Caribbean have also been moderately successful in providing basic education to girls: More than 60% in Bolivia, Colombia, the Dominican Republic, Mexico, Peru, and Trinidad and Tobago have at least seven years of schooling. Overall, girls living in developed countries fare better than their peers in the developing world; typically, more than 75% complete 10 or more years of school.

Despite the persistence of low levels of schooling among young women in many countries, the forces of social change are evident; in all but one country covered in this report, young women get more schooling than their mothers did.[8] In Morocco, for example, having completed seven years of schooling is four times as common among women aged 15–19 as among women aged 40–44, and in Sudan, it is nine times as likely as a generation ago. Throughout much of Asia and Sub-Saharan Africa, young women are two to three times as likely as their mothers were to finish seven years of schooling (Chart 2.3).

Table 2a. Large income disparities exist between the poorest and wealthiest residents of a country.

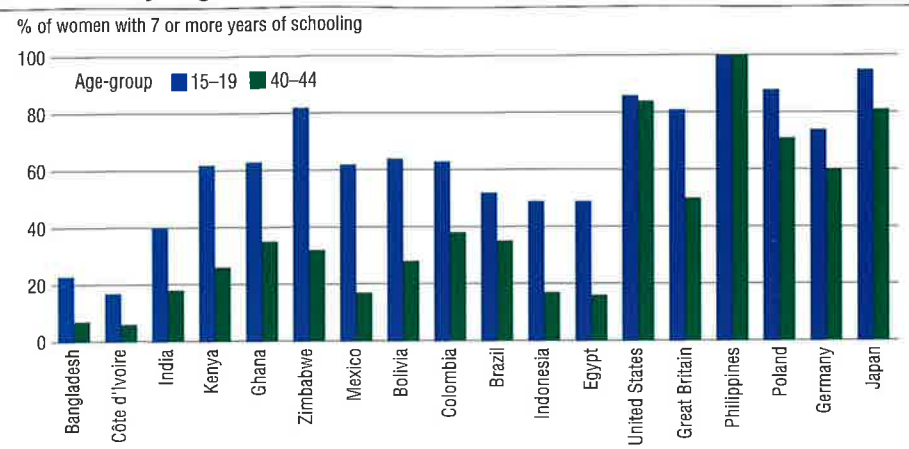
Country and year	% of national household income received	
	Bottom fifth of population	Top fifth of population
Bangladesh, 1992	9	38
Côte d'Ivoire, 1988	7	44
India, 1992	9	43
Kenya, 1992	3	62
Ghana, 1992	8	42
Zimbabwe, 1990–1991	4	62
Mexico, 1992	4	55
Bolivia, 1990	6	48
Colombia, 1991	4	56
Brazil, 1989	2	68
Indonesia, 1993	9	41
Egypt, 1991	9	41
United States, 1985	5	42
Philippines, 1988	7	48
Great Britain, 1988	5	44
Poland, 1992	9	37
Germany, 1988	7	40
Japan, 1995	11	30

Sources: All countries except Japan—The World Bank, *World Development Indicators*, Washington, DC: International Bank for Reconstruction and Development/World Bank, 1997, Table 2.6, pp. 54–56; Japan—Statistics Bureau, *Japan Statistical Yearbook, 1997*, Tokyo: Management and Coordination Agency, 1997, Table 16–2, pp. 570–571.

Remote Communities, Gender and Lack of Resources Hinder Educational Attainment

Governments have clearly taken strides toward making basic education more widely available. Nonetheless, young people in many parts of the world are not always able to attend school, because of their gender or the economic status of their family,

Chart 2.3: More young women get a basic education than did their mothers.



◀ *Note:* For the United States, percentages are for women with 12 or more years of education; for Great Britain, the percentages are for women with 11 or more years of education; and for Germany, Japan and Poland, the percentages are for women with 10 or more years of education. *Source:* Appendix Table 1, columns 7 and 8.

or because they live in remote or underserved communities. These inequalities often exist in basic education, and are even greater for secondary schooling.

Rural youths face a disadvantage. While the nations of the industrialized world have largely closed the gap in the ability of rural and urban residents to get an education, disparities still exist in many developing countries, especially for young women (Chart 2.4). Throughout Latin America, and in many African and Asian nations, the proportion of adolescent women in rural areas who have seven or more years of education is one-half to one-third the proportion in urban areas.[9]

In some countries, educational disparities between urban and rural areas are even larger. In Pakistan, for instance, 56% of urban girls have at least seven years of schooling, while in rural areas the proportion who have gone to school for seven years is 9%. In Tunisia, 62% of urban girls receive this level of education, while among rural girls, the proportion is negligible. The gap between rural and urban youths' access to education may be slightly overestimated because some rural children travel to urban areas to attend school.

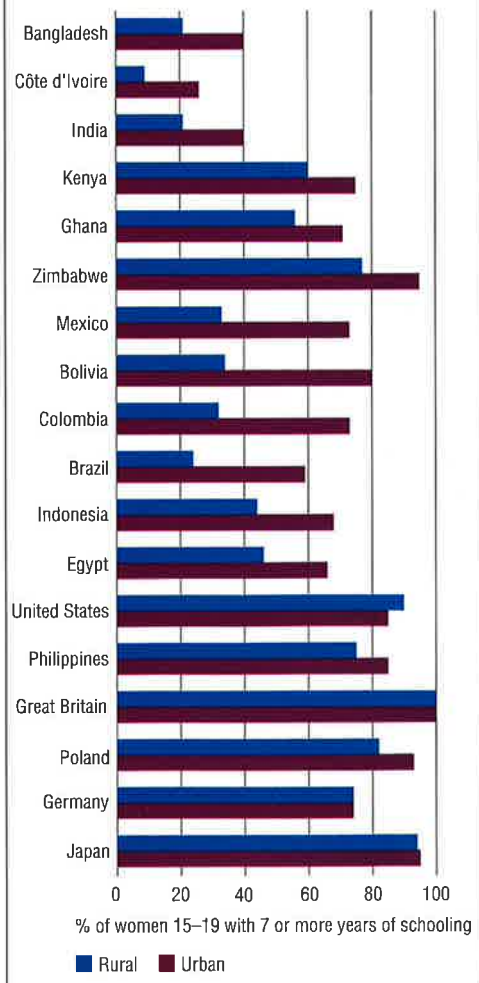
Gender differences persist. For many of the world's young women, a secondary education is out of reach: In half the countries examined in Sub-Saharan Africa, six or fewer young women attend secondary school for every 10 young men enrolled. Gender disparity in secondary education is also common throughout North Africa and the Middle East (Chart 2.5, page 14). These differences may arise because the school is in a neighboring village or town, and parents may be more likely to allow a boy to make the trip than a girl. Likewise, if a family is poor, they may choose to send only their male children to school. Such decisions make it harder for young women to get the skills demanded for good jobs, thus limiting their ability to attain economic self-sufficiency.

Girls in Latin America and the Caribbean, however, are much more likely than those in other developing regions to receive schooling on a par with boys. Indeed, in Brazil, Colombia, the Dominican Republic and El Salvador, girls attending secondary school outnumber boys,[10] possibly because families need a son's labor or income.

Lack of economic resources is a barrier. Regardless of where adolescents live, their family's social status and the economic resources available to them may determine what level of education young people receive. In Niger, for example, children from families in which the household head is relatively well educated are enrolled in school at three times the rate of those from homes with a less educated head of household, but boys still benefit more than girls.[11] In Thailand and Vietnam, a family's wealth and the amount of schooling the parents have are much more important in predicting a child's educational attainment than is gender.[12]

Socioeconomic differences in educational attainment are apparent in the developed world as well. Among higher income groups in the United States, the propor-

Chart 2.4: Young women in rural areas get less schooling than do those in urban communities.



Note: For the United States, percentages are for women with 12 or more years of education; for Great Britain, the percentages are for women with 11 or more years of education; and for Germany, Japan and Poland, the percentages are for women with 10 or more years of education. *Source:* Appendix Table 2, columns 5 and 6.

tion of young people who have completed their secondary education is almost 100%, while among economically disadvantaged groups, the proportion is about 70%.[13]

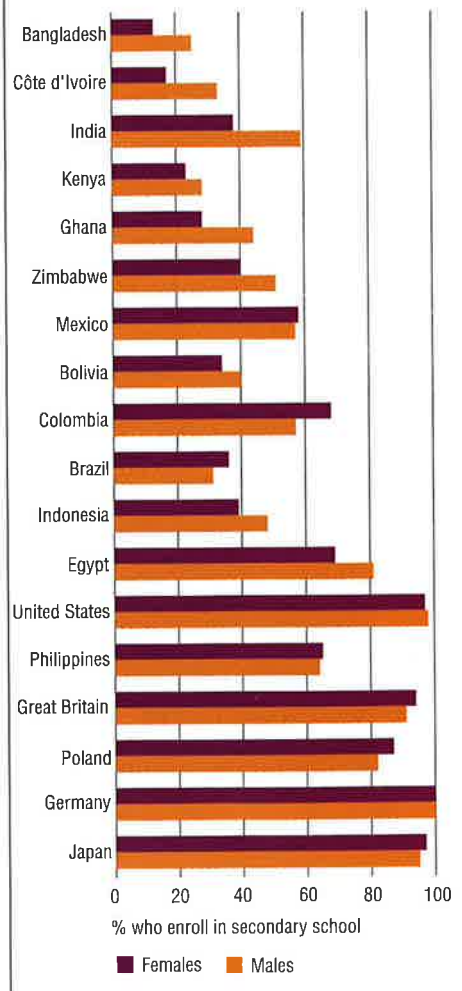
The Benefits of Education May Compete with Economic Realities and Traditional Values

In some cultures, providing education equally to boys and girls clashes with traditional ways of life or interferes with a need to have children contribute labor or other resources to the family. In countries where resources are inadequate or poorly distributed, even public schooling can be associated with additional costs: Families may need to provide the books, uniforms or transportation that their child uses, and in some cases, they must pay school fees as well. For families with limited means, undertaking this additional expense can create a financial strain that families may be less likely to endure for girls than boys.[14]

Yet when young people get more schooling, they develop skills and acquire information that prepare them to thrive in a changing job market. In addition, they are likely to gain practical knowledge that they can apply in all areas of their lives.

This may be particularly relevant for young women.[15] An adolescent woman who is educated may be able to get medical care more readily than her less educated peers, and she may be more likely to take steps to maintain her health and the health of her family. When she becomes sexually active, for example, she is more likely to obtain contraceptives and use them effectively. Increased knowledge may also raise her status within her family and the community, and provide the young woman with a sense of self-esteem that enables her to alter situations that affect her—for instance, by participating in decisions about when and whom she will marry.[16]

Chart 2.5: In many developing countries, girls are less likely than boys to attend secondary school.



Note: Data are for 1990–1993, except in the Philippines (1985) and Brazil (1980). *Source:* Appendix Table 2, columns 1 and 2.

The Timing of Sex and Marriage

Early marriage among young women is universally associated with low levels of schooling. School attendance is a function of familial poverty, societal resources and community values, factors that often limit the education of young women. A woman who marries as an adolescent lacks the experience and skills that a slightly older woman brings to her marriage and family. Subject to the will of an older partner and family elders, she may have little say in deciding when to have children and how many to have. While most sexual activity among adolescent women occurs within marriage, sexual experimentation before marriage is tolerated or even expected in some cultures. In countries where the time between sexual maturity and marriage spans a number of years, sexual activity is increasingly likely to precede marriage. In these settings, unplanned pregnancies may result in such serious consequences as abortions or births out of wedlock.

In all societies, marriage marks an important transition in a person's life. Moreover, the timing of the event and the other circumstances that surround the formation of a union can have a dramatic impact on a young person's future.

Nonetheless, whom a woman marries and when she does so are decisions over which she may have little control. In many parts of the world, a woman marries during her adolescent years, sometimes cutting short her education. Her husband is likely to be several years older, since a man is usually expected to have achieved some measure of economic stability before he marries. In such instances, a man will have a considerably higher status than his adolescent wife, and she may have little say in decisions that profoundly affect her life.

In many societies, a woman's first sexual experience is likely to be with her husband, occurring either as a prelude to marriage or as its consummation. However, initial sexual activity and marriage are not so closely tied in all societies, and in these, young people may have sexual relationships that do not lead to formal unions. Differing expectations surrounding relationships and sexual behavior lead to a variety of ways in which marriage is recognized and families are formed (see page 16). These expectations—and a society's way of adapting to changes in them—can have a serious and lasting impact on young people, their families and society as a whole.

In Some Regions of the World, Adolescent Marriage Remains Common Among Women

Many women around the world marry as adolescents, although forming a union during these years is much more common in developing than in developed countries (Chart 3.1, page 16). Among the countries of Sub-Saharan Africa, where marriage is often a process that entails many phases rather than a discrete event marked by a ceremony, union formation commonly begins during adolescence. In Mali and Niger, more than three-quarters of young women enter a marriage or consensual union before age 18, and in many other countries in this region, about half do so. In Ghana, Kenya and Zimbabwe, around one-third of women marry before age 18, while in Botswana, Namibia and Rwanda, the proportion is no more than 15%.[1]

In Latin America and the Caribbean, some 20–40% of young women form their first union before age 18. In North Africa and the Middle East, fewer than 30% of women marry this young, except in Yemen, where nearly half do so. Across Asia, the likelihood of marriage during the adolescent years is quite varied. In Bangladesh, for example, almost three-fourths of women marry before age 18, while in the Philippines and Sri Lanka, only 14% do so. In China, where the government has set a strict minimum age for marriage, only 5% of women wed before age 18.

Chart 3.1: Many women enter their first union during their adolescent years.

Source: Appendix Table 3, column 3; and special tabulations.

DIVERSITY IN MARRIAGE

Formal marriage. Formal monogamous marriage, a union between two people that is legally or religiously sanctioned, is but one of several types of socially accepted unions into which a young woman or man may enter. In many parts of the world, alternative types of arrangements are recognized as an acceptable basis for family formation. Two of the most common are cohabiting unions and polygynous unions.

Cohabiting unions. In many countries, individuals may enter cohabiting or consensual unions, rather than legally or religiously sanctioned marriages. In these unions, the couple live together, often as a precursor to formal marriage. Such unions are quite common in Sub-Saharan Africa and in Latin America and the Caribbean. In Liberia, Namibia and Rwanda, for instance, 50–84% of married women aged 15–19 are in such unions; in Colombia, the Dominican Republic, Peru, and Trinidad and Tobago, the proportion is 70–86%.[1]

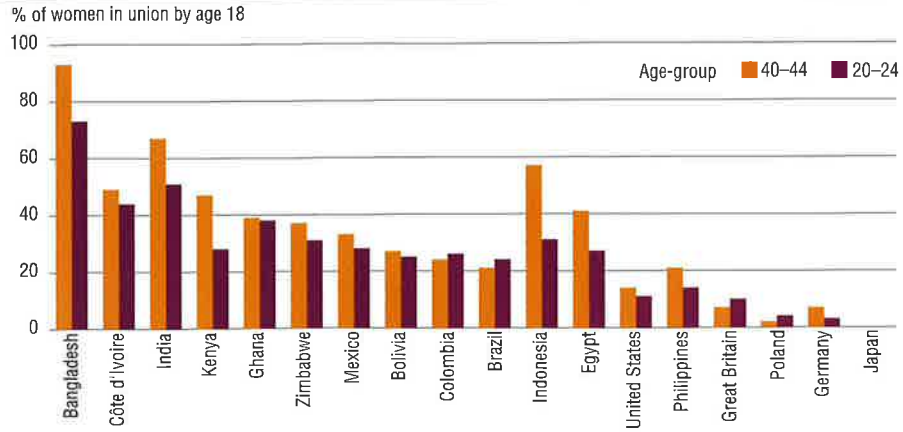
Informal unions have become more common in the developed world over the last several decades as a result of changes in social mores and the decreased influence of tradition. These unions, which are more likely than legally or religiously sanctioned marriages to dissolve after a few years,[2] may be advantageous to a young woman if she lives in a country where divorce is difficult to obtain[3] or if her legal rights to property are forfeited once she enters a legal marriage, as is the case in Botswana.[4] In general, though, an informal marriage offers a woman less legal protection and financial support than does a legal union. In some countries, such as Brazil, women who have been in a cohabiting union for at least five years acquire the same rights that legally married women have.

Polygyny. Polygyny, a system wherein one man has several wives, is one of the most distinctive features of marriage in Sub-Saharan Africa, particularly in the western part of the region. In Uganda, one in every five currently married women aged 15–19 are in a polygynous union; in Cameroon, Nigeria and Senegal, one in every four such women are; and in Liberia and Togo, one of every three married adolescent women are in a polygynous marriage.[5]

In cultures where polygyny is practiced, young men are likely to find themselves competing for eligible young women with older men who are likely to have more prestige and power in the community (traits that are themselves associated with the number of wives a man has). Thus, young men are at a relative disadvantage in finding wives—a situation that worsens if local economic conditions deteriorate and jobs become scarce. Therefore, the age at which men marry is relatively high.

In contrast, young women become the objects of male competition for wives around the time they reach puberty. Even if they do not marry at this very young age, they are likely to marry a man who is much older. In West Africa, for example, the age difference between spouses typically exceeds seven years.[6]

Chart 3.2: Marriage before age 18 is less common than it was a generation ago.



◀ *Source:* For women 20–24, Appendix Table 3, column 3; for women 40–44, special tabulations and published country reports from the Demographic and Health Surveys.

Marriage during adolescence is not customary among young men anywhere in the world, largely because a man's marriageability is dependent on his being able to support a family. In our 53-country sample, the proportion of men who marry as adolescents is a fraction of that among women—3% vs. 11% in Great Britain, for example, and 6% vs. 38% in India.[2]

Clearly, then, adolescent women are likely to marry men who are older than they are. In Asia, Latin America and the Caribbean, the average age difference between spouses is 3–6 years, while in Sub-Saharan Africa, North Africa and the Middle East, the average difference is 5–10 years.[3] In marrying a man who is considerably older than she is, a woman may enter a relationship in which she has little power and is not included in decision-making. She may also have limited control over her daily activities, such as the ability to travel freely in her village or maintain contact with her family of origin. Indeed, the age difference between spouses tends to be large in regions where women's status is relatively low.[4]

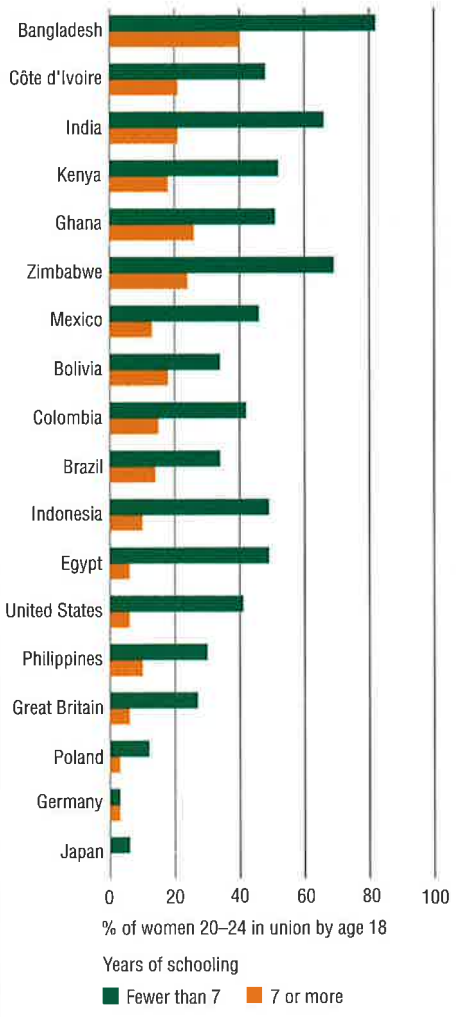
Overall, Levels of Early Marriage Have Declined from Those Found a Generation Ago

Overall, marriage during adolescence is less common than it was a generation ago (Chart 3.2). However, there is considerable variation among and within regions in the degree of change. In Côte d'Ivoire, for example, the change has been quite modest—49% of women 40–44 years old married by age 18 compared with 44% of those 20–24 years old. Ghana shows almost no change, from 39% of older women to 38% of younger women. In contrast, a significant decrease occurred in Kenya, where the proportion married by age 18 dropped from 47% to 28%.[5]

Sizable change appears to be a consistent phenomenon across Asia. Compared with what they were a generation ago, levels of early marriage have decreased by one-quarter in Bangladesh and India, by one-third in the Philippines, and by about one-half in Indonesia. In Latin America and the Caribbean, young women have retained the moderate levels of early marriage that prevailed 20 years earlier. Proportions entering marriage during adolescence have declined only modestly in Mexico, for example, from 33% among women in their early 40s to 28% among women in their early 20s. In Colombia and Brazil, proportions have actually risen 8–14%. In the developed countries, marriage before age 18 was relatively uncommon among the older group of women and remains so among young women.[6]

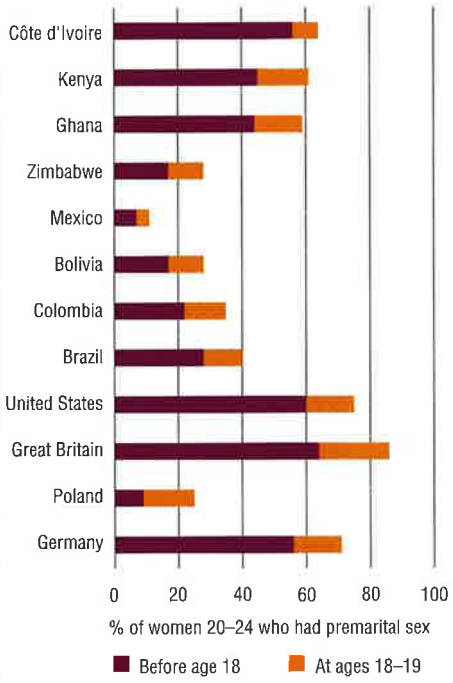
The timing of a first union or marriage is strongly associated with a woman's educational attainment (Chart 3.3). In all countries examined in this report, women who have completed their basic education—those who have finished at least

Chart 3.3: Women who do not obtain a basic education tend to marry at a younger age than those who do.



Note: For the United States, percentages are for women with 12 or more years of education; for Great Britain, the percentages are for women with 11 or more years of education; and for Germany, Japan and Poland, the percentages are for women with 10 or more years of education. *Source:* Appendix Table 3, columns 4 and 5.

Chart 3.4: Young women frequently enter sexual relationships outside marriage.



Source: Appendix Table 3, columns 7 and 8. *Note:* Data are not available for Bangladesh, Egypt, India, Indonesia, Japan and the Philippines.

seven years of school in developing countries and 10–12 years in developed societies—are more likely to wait until after they have reached age 18 to marry than are women without a basic education.[7]

In Burkino Faso, Cameroon, Malawi and Zimbabwe, for example, two-thirds or more of women with fewer than seven years of education marry before age 18, while one-quarter of those with seven or more years do so. A threefold difference in rates of early marriage between women with a basic education and those without is not unusual across Sub-Saharan Africa, and is common throughout Latin America and the Caribbean as well.

Low educational attainment is associated with early marriage in the developed countries, too. In France and the United States, for example, where basic education typically entails at least 10 years of schooling, almost 30% of women who have not completed this level of education marry before age 18, compared with fewer than 10% of their better-educated peers.

Many Young Women Become Sexually Active During Adolescence, Even If Not Married

When a young woman enters a union during her adolescent years, she also becomes sexually active. However, in some parts of the world, young women become sexually active during adolescence whether or not they are married (Chart 3.4). For example, in several Sub-Saharan African countries, a young women must demonstrate her fecundity before a man will make a marriage commitment. In much of the developed world, many young people engage in a series of dating relationships that may involve sex before finding a long-term partner.

Different cultures have vastly different attitudes toward sexual activity among unmarried people. Often, societies have different standards for men than for women, tolerating or sometimes even encouraging sexual behavior among unmarried men, while restricting or harshly condemning it among unmarried women. If societal disapproval is strong, women may be especially unlikely to acknowledge such behavior. Therefore, survey data assessing sexual activity among unmarried women may underestimate actual levels.

In most of the countries of Sub-Saharan Africa examined in this report, sexual activity during the adolescent years is common: More than 70% of young women begin sexual activity during adolescence. Although much of this behavior occurs prior to marriage, these sexual relationships typically lead to formal unions.[8]

Throughout the nations of North Africa and the Middle East, and in most Asian countries, a young woman is expected to have sexual intercourse only after she has

married. National surveys from these countries do not even collect data on the proportion of unmarried women who are sexually experienced. Other studies do, and their results suggest that rates of sexual activity among unmarried adolescent women are indeed low, though some women may not have reported nonmarital relationships because of strong social disapproval. Fewer than 10% of young unmarried women in India report sexual activity during adolescence; in Japan, 11% of female college students report having had sex before age 17, although 26% have done so by age 18.[9]

Young men are often not included in surveys of sexual and reproductive behavior, so much less information is available about them. What does exist suggests that men are more likely to become sexually active outside marriage and that they do so at a younger age than do their female peers (Table 3a). In Japan, for example, about 43% of young men have sex by age 18, compared with 26% of young women, and in Brazil, 77% of men do so before age 18, compared with 43% of women.

In Great Britain, gender differences in sexual behavior are characteristic of younger adolescents, but among 18-year-olds, sexual activity is equally common for men and women. In some Sub-Saharan African countries, such as Ghana, rates of sexual activity are higher among adolescent women than among their male peers, partly because young women tend to marry early.

Table 3a. The timing of first sexual intercourse varies greatly from country to country.

Country	% sexually active by age 18	
	Males	Females
Brazil	77	43
Ghana	43	66
Great Britain	64	64
Japan	43	26
United States	73	63
Zimbabwe	38	38

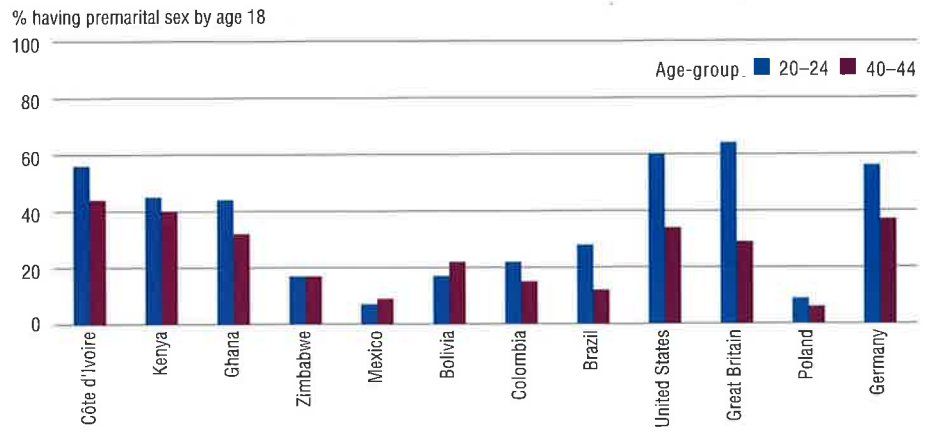
Note: Data are from respondents aged 20–24 and include sexual activity before marriage and within marriage. *Sources:* Special tabulations of fertility surveys (see Data Sources, p. 9), except Japan—Retherford RD, Ogawa N and Sakamoto S, Values and fertility change in Japan, *Population Studies*, 1996, 50(1):5–25, Table 2; and the United States, males—The Alan Guttmacher Institute (AGI), *Sex and America's Teenagers*, New York: AGI, 1994, p. 20, Figure 10.

Delaying Marriage Beyond Adolescence Has Advantages as Well as Possible Hazards

If a woman delays her marriage—even for a few years—she may gain both personal and social advantages. She may be able to pursue her education further, obtaining skills that increase her access to employment or her family's access to health care and other community resources. A woman whose marriage is postponed until after her adolescent years is also likely to have a greater role in deciding when and whom she will marry, and she may have more influence over what happens within her marriage and family as well.[10]

In the developed countries, as the age at first marriage has risen and as values have changed over the last several decades, so has the likelihood that a woman will begin to have premarital sexual relationships during her adolescence. In the United States, Great Britain and Germany, one-third of women currently in their 40s had premarital sex before age 18, while more than half of women currently in their 20s did so. A trend toward premarital sex is apparent also in Côte d'Ivoire, Kenya, Ghana and Colombia, but it has not become a widespread phenomenon throughout

Chart 3.5: Premarital sex has become more common among young women in most countries.



Note: For Bangladesh, Egypt, India, Indonesia and the Philippines, data are not available; for Germany, data are for 35–39 rather than 40–44 age-group. *Source*: Appendix Table 3, column 7, for age-group 20–24; special tabulations for age-group 40–44.

the less developed countries (Chart 3.5). Nonetheless, later marriage among women and changing societal values and attitudes may lead to increases in premarital sexual behavior and some of its negative consequences.

A young woman who is sexually active outside marriage, for example, could experience an unintended pregnancy. If marriage is not possible or desirable, the adolescent woman faced with such a pregnancy will have to decide whether to seek an abortion or to bear her child out of wedlock. Desperate adolescents who live in one of the many countries where the termination of pregnancy is illegal or not provided in local health facilities often select the dangerous, and sometimes tragic, route of a clandestine abortion.

An unmarried adolescent woman who is sexually active is also at risk of being exposed to infection with HIV and other sexually transmitted diseases. While married women are also vulnerable to such dangers—because their partners were exposed before marriage or because they or their spouses are not monogamous—unmarried women may be more likely to have several partners, and thus be at greater risk. Sexually transmitted diseases can have serious implications for a woman's health and for her subsequent fertility.

Young men can also suffer serious consequences from these infections. Sexual mores are usually more permissive for men than they are for women, and adolescent men who are sexually active tend not to be monogamous (Table 3b). Therefore, it is easy for men to become infected and to transmit the infection to others.

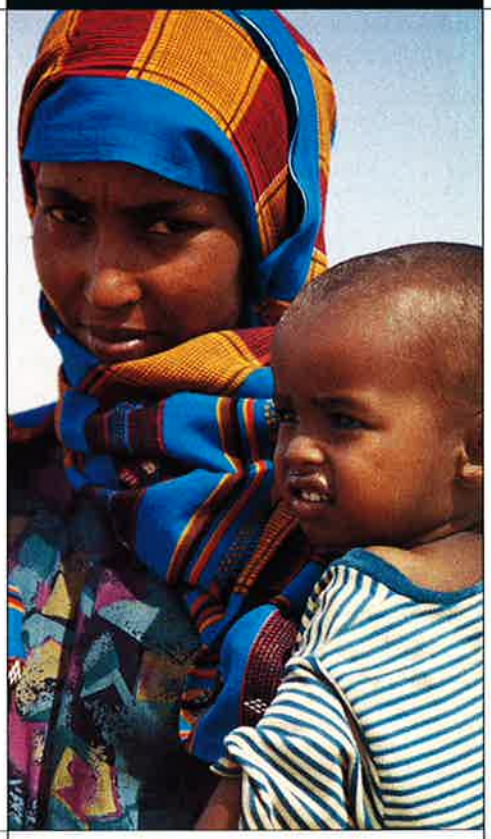
Table 3b. Unmarried adolescent men who are sexually active are likely to have several partners over a year's time.

Country	% sexually active	Number of partners in 12 months
Brazil (Rio de Janeiro)	61	2.6
Côte d'Ivoire	43	2.4
Kenya	54	1.6
Philippines (Manila)	15	1.8
Tanzania	37	2.5
Thailand	29	3.8
Togo	18	2.0

Source: Cleland J and Ferry B, *Sexual Behaviour and AIDS in the Developing World*, London: Taylor and Francis, 1995, Tables 4.1 and 4.2.

Childbearing During the Adolescent Years

An array of social and cultural factors lead substantial proportions of young women to marry and have their first baby soon after marriage, and often before age 18. The incidence of adolescent childbearing is diminishing, though, as access to education increases and as the social, health and economic advantages of delaying births become more widely recognized. Early childbearing is particularly common among young women who live in rural or impoverished areas and who have comparatively little education. Early, repeated and unplanned childbearing curtails a young woman's ability to improve the condition of her life and that of her children, even if she is married and has the benefit of close family ties. Further, a substantial minority of births to adolescents occur among the unmarried, and while such births are rare in some countries or regions, they are quite common in others. The disadvantages inherent in early childbearing are compounded for young unmarried mothers and their children by a lack of economic and social support.



A young woman will often have her first child shortly after she marries,[1] but the wishes of her family, the values of her culture and the economic circumstances of her life all strongly influence when she marries and begins childbearing. Some societies believe that the time for a woman to begin her family is while she is still an adolescent. Childbearing may be one way a young woman seeks to ensure the stability of her marriage and acquire status within her community; proving her fertility may even be required before a woman is accepted into a union.[2]

In other societies, having a child during adolescence is frowned upon, and a young woman is expected to complete her education and gain some work experience before starting a family. Some adolescents in this situation, however, may see becoming a mother as a way of asserting their independence and rejecting expectations they feel they cannot meet anyway.

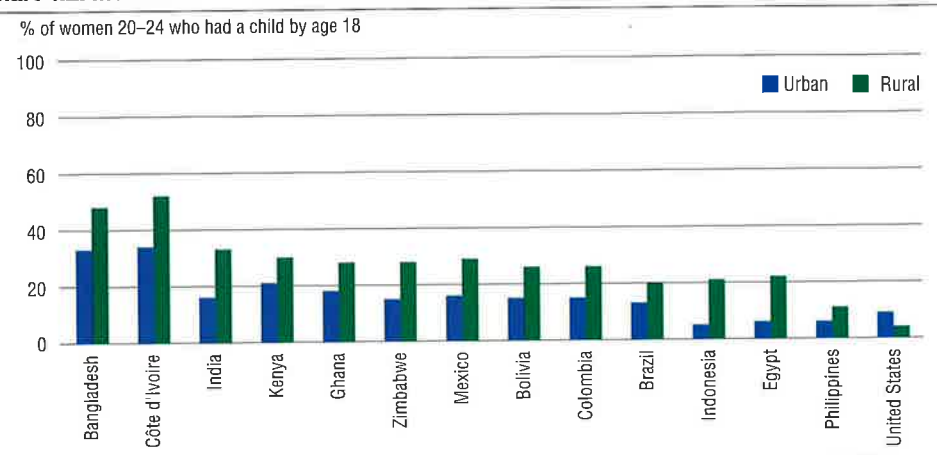
But around the world, the economic and social transitions of the last several decades have so fundamentally changed the rhythms of life that childbearing during the adolescent years is increasingly seen as disadvantageous for a young woman and for society as a whole. Because education has become increasingly important to improving one's life, a woman who delays the birth of her first child until after her adolescence may be able to significantly enhance her child's welfare, as well as have a more direct role in determining the course of her own life.

In Many Parts of the World, Women Have Their First Child Early, Often Before Age 18

Throughout much of the world, having a child before age 15 is rare; typically, fewer than 3% of women in developing countries give birth by this age (Chart 4.1, page 22). In Bangladesh, however, it is not unusual for a young woman to marry before age 15, and a little more than 10% of women also have their first birth by this age. Having a child at a very young age is somewhat more likely in Sub-Saharan Africa than in other regions; in Cameroon, Côte d'Ivoire, Liberia, Mali, Niger and Nigeria, the proportion of women giving birth before age 15 exceeds 10%.[3]

Bearing a child at 15, 16 or 17 years of age, however, is a more common experience, especially for women in the developing world. Some 12–28% of young women in Latin America and the Caribbean give birth before age 18, and 3–27% in the countries of North Africa and the Middle East do so. While childbearing before age 18 is uncommon in Burundi and Rwanda (8% of women this age have had a child), it is fairly common in other Sub-Saharan countries; about one-fifth of women in Namibia, and slightly more than half in Niger, have given birth by age 18. In most Asian countries, fewer than 20% of women have their first birth before age

Chart 4.2: More rural women than urban women have their first birth during adolescence.

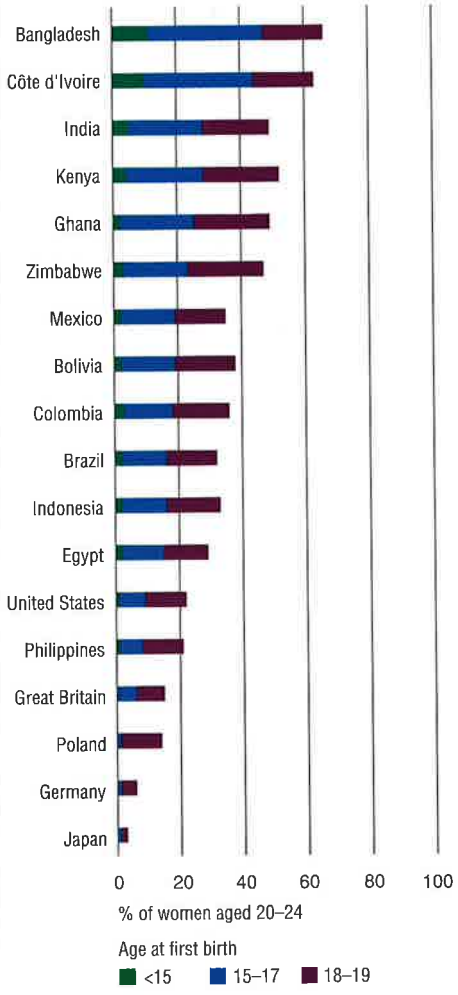


Note: Data not available for Great Britain, Poland, Germany and Japan. *Source:* special tabulations.

18, although about 30% in India and almost 50% in Bangladesh do.[4]

A substantial proportion of women who have their first child before age 20 do so at 18–19 years of age. For instance, while 7–12% of women in Morocco, Peru and Thailand have a child before age 18, 19–27% do so before age 20. This pattern is apparent in the developed countries as well; fewer than 10% of women in the United States, Great Britain and Poland give birth before age 18, but 14–22% do so before age 20.[5]

Chart 4.1: Most young women wait until after their adolescent years to have their first child.



Source: Appendix Table 4, columns 3 and 6, and special tabulations.

Women in Rural Areas and Those with Little Education Are Unlikely to Delay Childbearing

A young woman who lives in a rural area is often much less likely than her urban counterpart to wait until she is at least 18 to have her first child (Chart 4.2). Among women in Ghana, Kenya and Zimbabwe, for example, about 30% of those in rural areas have their first child before age 18, compared with 15–21% of those living in urban areas. In Egypt, 22% of rural women have their first birth before age 18, compared with 6% of urban women, and in Bangladesh, the level of adolescent childbearing in rural settings is 15 percentage points higher than the rate in urban areas.

Urban women may delay the birth of their first child because they have better access than rural women do to education and jobs, and thus more reason to wait before starting a family. Moreover, as a woman's level of education increases, she becomes more likely to obtain accurate information about health care and contraception, and thus better prepared to plan her pregnancies. Indeed, in every region of the world, women who have completed their basic education are far more likely than those who have not done so to have their first baby after their adolescent years (Chart 4.3).

In Sub-Saharan Africa, for example, one-fifth of women with seven or more years of education in Kenya, Malawi, Tanzania and Zimbabwe have their first child before age 18, while almost one-half of those with fewer than seven years of schooling do so.[6] The proportions are smaller but the differences are of greater magnitude throughout North Africa and the Middle East. In Egypt, Sudan and Yemen, about 5% of women with more than a basic education give birth before age 18, compared with approximately 30% of women with less education.

Education is associated with differences in adolescent childbearing among women in the developed countries as well. In the United States, for example, about 10% of all young women have a child before age 18; however, one-third of those with less than a basic education (considered roughly 10–12 years of schooling in the developed world) give birth before age 18, compared with 5% of those who have completed at least 12 years of education.[7]

Childbearing During the Adolescent Years

Premarital Sexual Activity Among Adolescents Often Leads to Births Outside Marriage

Most adolescents who have a child are married, but a considerable proportion give birth as unmarried women (Chart 4.4, page 24). The emotional and financial strains of motherhood are great for an adolescent who has a birth out of wedlock; she must cope with the stress of raising a child without the support of a spouse and, possibly, without the support of her family.

In Sub-Saharan Africa, births to unmarried adolescents are common; in many countries, one-third of births to women aged 15–19 occur among adolescents who have never married (or who are no longer married). In Botswana and Namibia, at least three-fourths of adolescent births are outside marriage, but in Burkino Faso, Mali, Niger and Nigeria, the proportion is only 4–6%.[8] In most countries of Latin America and the Caribbean examined in this report, 12–25% of adolescent births are to unmarried women, but the proportion is close to one-third in Brazil, Colombia and Paraguay.

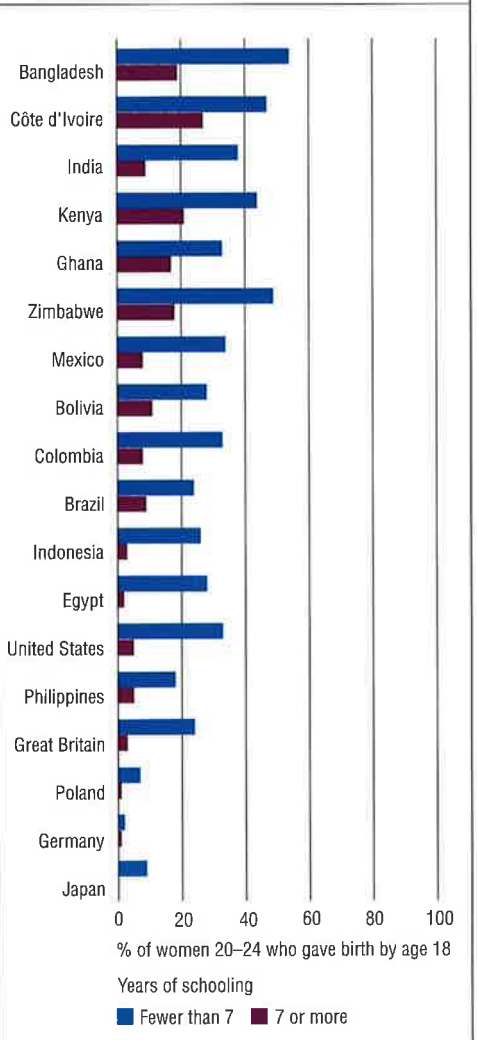
More than half of all adolescent births in France, Germany, Great Britain and the United States are to women who are unmarried; these births are part of a general trend toward higher levels of childbearing among all single women, not just adolescents. Among the developed countries, nonmarital adolescent childbearing is atypical only in Japan, where only 10% of adolescent births occur outside a union.[9] However, reflecting recent increases in premarital sexual activity, the proportion of married Japanese women who conceive their first child prior to marriage has tripled—from 9% to 27%—since the 1960s.[10]

Births to Both Married and Unmarried Adolescent Women Are Often Unplanned

Regardless of marital status, some adolescent women who do not want to bear a child become pregnant, and many of these young women go on to have their baby. An unplanned birth is likely to be emotionally distressing, and it may place a heavy financial burden on a woman and her family. Such births are likely to be particularly difficult for unmarried adolescents, who face disapproval in many communities along with economic hardship.[11] An unplanned pregnancy may propel a young woman into marriage, and pregnant students are usually required to leave school, with little hope of returning after they give birth.[12]

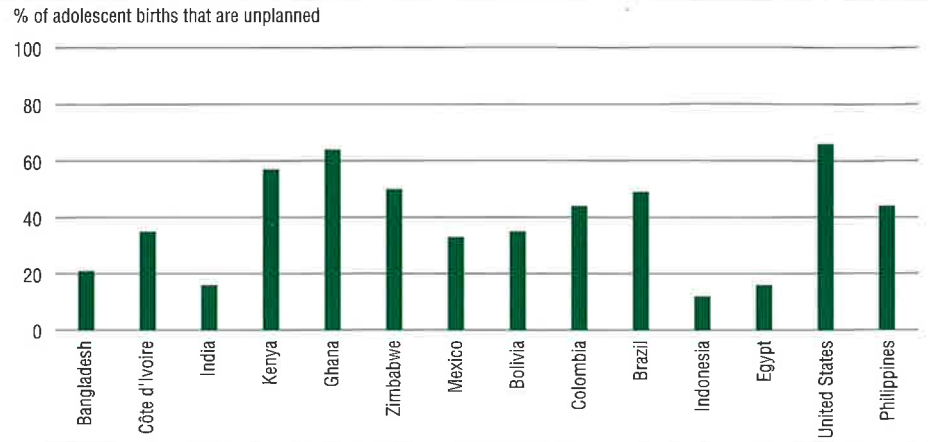
Survey data indicate that the majority of births to adolescent women are wanted. However, young mothers might be reluctant to acknowledge that a recent birth

Chart 4.3: Women who receive a basic education wait longer than women with less schooling to begin a family.



Source: Appendix Table 4, columns 4 and 5.

Chart 4.5: Many adolescents who give birth did not plan to have a child as soon as they did.



Note: Data are not available for Germany, Great Britain, Japan and Poland. *Source*: Appendix Table 4, column 9.

Chart 4.4: A large proportion of adolescents who give birth do so outside marriage.

Note: Data are not available for Bangladesh, Egypt, India, Indonesia and the Philippines. *Source*: Appendix Table 4, column 8.

was not joyfully anticipated, and reports of wanted births are likely to be somewhat inflated. Regardless, the level of unplanned childbearing reported among adolescent women is high in many parts of the world (Chart 4.5).

Levels of unplanned childbearing among adolescents in Latin America and the Caribbean range from one-fourth of all adolescent births in Guatemala to one-half in Peru. In the countries examined across North Africa and the Middle East, the proportion of unplanned births among adolescents is 15–30%. As for Asia, 10–16% of adolescent births in India, Indonesia and Pakistan are unplanned, while the proportion is 20–45% in the remaining countries.[13]

In Sub-Saharan Africa, rates of unplanned adolescent childbearing vary widely, ranging from a relatively low 11–13% in Niger and Nigeria to half or more of all adolescent births in Botswana, Ghana, Kenya, Namibia and Zimbabwe. Levels of unplanned adolescent childbearing are also high in the developed countries—66% in the United States, for example.

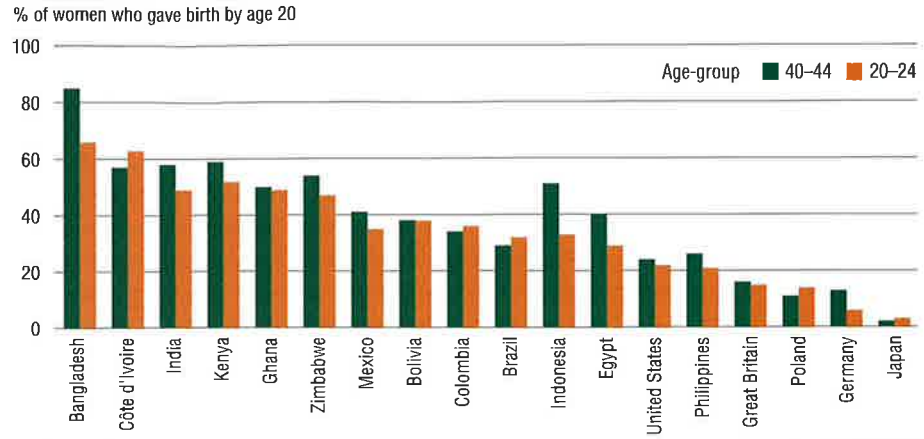
Adolescent Childbearing Is Declining in Countries Where It Had Been Common

Across Asia, North Africa and the Middle East, young women are less likely than women of their mother's generation to have their first child during adolescence (Chart 4.6). In Bangladesh, India, Pakistan, the Philippines and Thailand, levels of adolescent childbearing among women aged 20–24 are about 80% of those found among women 40–44, while in China, Indonesia, Sri Lanka and Turkey, levels are one-half to two-thirds those of the previous generation.[14] Adolescent childbearing has declined by one-fourth among Egyptian women and by more than half among women in Morocco, Sudan and Tunisia.

Having a baby during the adolescent years is slightly more common now than it was about a generation ago in many of the Sub-Saharan African countries examined. Declines in the age at which women begin menstruation, increases in sexual activity and improvements in the overall health, and thus the fertility, of young women in these countries may account for increases in adolescent childbearing.[15] Declines of about one-third, however, are evident in Burundi and Rwanda, as are declines of at least 10% in Kenya, Madagascar, Tanzania, Zambia and Zimbabwe.

Both increases and decreases in the level of adolescent childbearing have occurred over the last 20 years in Latin America and the Caribbean. In Ecuador and Mexico, for instance, the level has decreased 10–15%, and in the Dominican Republic, Peru, and Trinidad and Tobago, adolescent women are 25–37% less likely to give birth than were their counterparts a generation ago. Meanwhile, there has

Chart 4.6: Giving birth as an adolescent is declining in a number of countries.



◀ *Source*: Appendix Table 4, columns 6 and 7.

been either little change or a slight increase in adolescent childbearing among women in Brazil, Colombia, Guatemala and Paraguay.[16]

Throughout this region, the esteem gained by women through fulfilling their maternal role at a young age continues to be a powerful influence. These cultural expectations may counteract other societal forces, such as increased education, that would be expected to make childbearing during the adolescent years less desirable.

Postponing Childbearing Beyond Adolescence Has Benefits for Women and Societies

A woman who delays childbearing postpones the joys that come with motherhood. If few educational or economic opportunities to better her life exist, she will have little motivation to put off her first birth, even though opportunities for school and work may be out of reach once a woman has started to raise a family. A woman who delays the birth of her first child until after her adolescent years may gain several important advantages. She will have more opportunity to acquire education and skills that will enable her to better care for her family and compete more successfully in the job market than if she had taken on the responsibilities of motherhood during adolescence.

Delaying childbearing can also have a dramatic impact on the rate of global population growth (Table 4a). A woman who begins having children at a young age is likely to have a larger family than a woman who is older when she begins childbearing. Across Sub-Saharan Africa, Asia, Latin America and the Caribbean, a woman who has her first child before age 18 will have an average of seven children by the time she has completed her family. If she waits until her early 20s to begin childbearing, her family will average five or six children, and if she postpones childbearing until her late 20s, she will typically have three or four children over the course of her childbearing years.[17]

While the effect on population size is important, even more important are the positive associations between later age at first birth and increases in education, work opportunity and aspirations for one's family and oneself.

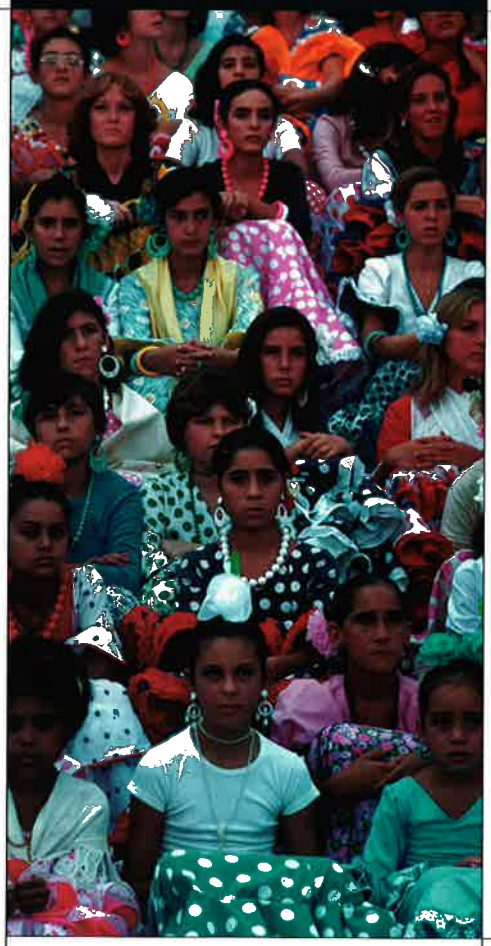
Table 4a. Childbearing delayed beyond adolescence helps to reduce population growth.

Component of growth	Billions
Total projected growth, 1995–2100	5.7
Population momentum*	2.8
Reduction if age at first birth increased	
2.5 years	0.6
5.0 years	1.2

*Population momentum is the tendency of population size to increase even after fertility has reached a level consistent with long-range stability. *Source:* Bongaarts J, Population policy options in the developing world, Science, 1994, 263(5148):771–776.

Initiating Contraceptive Practice

In all societies, women bear most of the responsibility for pregnancy prevention and most of the consequences if a method of contraception is not used or if it fails. Adolescent women face unique problems in practicing birth control and in doing so effectively. They may confront social ostracism for their acknowledgment of sexual activity outside marriage, or if married, from their failure to conform to norms of early and frequent childbearing. Adolescent women may find it nearly impossible to negotiate the use of contraception—particularly the use of condoms—with their older, more influential partners. They may also be prohibited by law or by custom from obtaining contraceptive information and services. Consequently, young women are likely to lack accurate knowledge about the advantages and disadvantages of various methods and about their proper use, and they may be frustrated by an inability to secure confidential attention and help from providers geared to serving married, adult women.



Pregnancy prevention is a major concern among sexually active young people. More than ever before, women are postponing the birth of their first child. Even those who marry during adolescence may want to wait before starting a family, and women who have already started their family are giving thought to how long they should delay their next birth. Young people who begin sexual relationships prior to marriage obviously wish to prevent an unwanted pregnancy.

The widespread and increasing prevalence of sexually transmitted diseases (STDs)—especially HIV—has made disease prevention a concern that rivals pregnancy prevention among sexually active young people. These dual concerns make selecting and using a contraceptive method a difficult and challenging process. Those methods that best protect against pregnancy do not offer protection against STDs, while the method that most reliably prevents STD infection—the condom—is less effective at preventing pregnancy, and harder to use consistently, than are other modern methods (see page 27).

Women typically take responsibility for birth control, and they most often bear the consequences if a method is not used or if the chosen method fails. These realities, however, collide with the fact that a young woman may have little power within a relationship to determine whether contraceptives are used or to insist on a method that offers her protection from STDs as well as pregnancy. In some settings, a woman who requests that a condom be used is considered promiscuous. A man's preference for a particular contraceptive—if he decides that the couple should use one at all—can determine what method a young woman must use.

Birth Control Is Widely Practiced by Adolescents in Some Regions, While Unlikely in Others

Many factors influence whether an adolescent woman uses birth control. Her marital status and her desire to have a child are important determinants, although in some settings, the expectations of a woman's family or the norms in her community may have an even greater influence. Access to birth control methods and to health care is critical as well; a young woman may wish to practice contraception, yet not be able to obtain the supplies and services she needs.

Across Sub-Saharan Africa, where women generally want many children and family planning services are relatively scarce, few married adolescent women practice contraception. Although one-third do so in Zimbabwe, the proportion is no greater than one-fifth in the other countries of the region (Chart 5.1).

Among married adolescent women in North Africa and the Middle East, rates of contraceptive use are also low—23% in Morocco and no more than 14% in the other

CONTRACEPTIVE METHODS

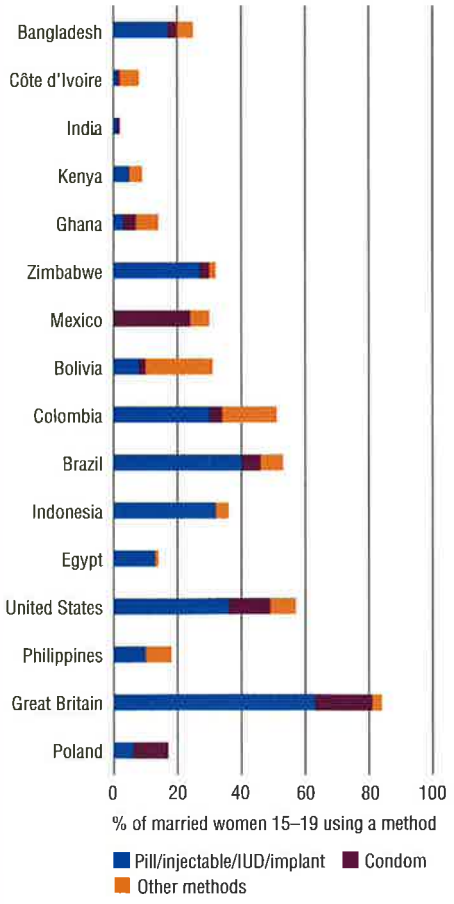
A variety of contraceptive methods are available for individuals who wish to avoid pregnancy. Throughout history, couples have relied upon traditional birth control methods such as periodic abstinence (the avoidance of intercourse during a woman's fertile period) or withdrawal to prevent unwanted conceptions. Periodic abstinence can be quite effective if a woman's time of ovulation can be reliably predicted, and if the couple is willing to abstain from intercourse during her fertile period. However, since there often is no reliable way to determine the fertile part of a woman's cycle, and because a partner may not cooperate in abstaining from sex, traditional methods of birth control have high failure rates.

Modern methods of birth control—the contraceptive pill, the hormonal implant, the injectable, the IUD, spermicides and barrier methods, such as the diaphragm and the condom—are more effective contraceptive methods. However, some modern methods, such as spermicides and barrier methods, must be used at each act of intercourse; therefore, they are less likely to be used consistently than are the pill, the injectable or the IUD, whose use is independent of sexual activity. All modern methods, with the exception of the condom, rely upon the woman to initiate and control use. However, only the condom also provides protection against sexually transmitted diseases.

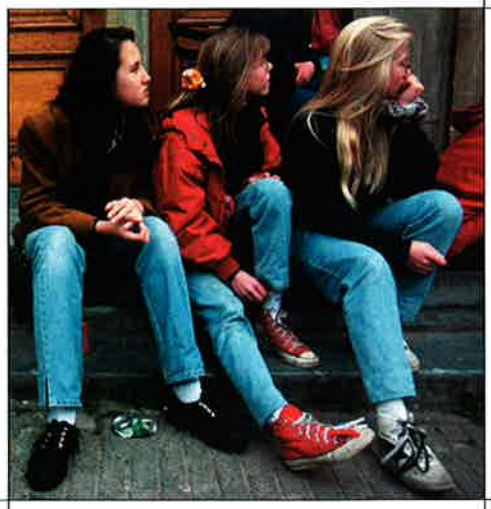
Sterilization may be an option for both women (tubal ligation) and men (vasectomy). However, because sterilization is a permanent form of birth control, it is rarely considered appropriate for adolescents and typically is used only by people who have had the number of children they want.

Both traditional and modern methods of contraception can be effective if used perfectly. However, individuals are imperfect in their use of all methods, and any method can fail even with careful and consistent use. Nonetheless, hormonal methods (the pill, the injectable and the implant) and the IUD provide the best contraceptive protection for adolescent women, 90% of whom will experience a pregnancy over the course of a year of unprotected intercourse.[1]

Chart 5.1: In some countries, few married adolescent women practice contraception.



Note: Data are not available for Germany and Japan. *Source:* Appendix Table 5, columns 7, 8 and 9.



countries of the region.[1] In Asia, use is very low in India and Pakistan (fewer than 5% of married adolescent women use a method) but more common in Indonesia and Thailand (36% and 43%, respectively).

Use of birth control among married adolescents in Latin America and the Caribbean is relatively common. Although no more than 22% of married adolescent women report using contraceptives in the Dominican Republic, Ecuador, El Salvador and Guatemala, 30–53% do so in the remaining countries examined.

Indicating their desire to avoid pregnancy, sexually active unmarried adolescents are more likely than married adolescents to practice birth control throughout Sub-Saharan Africa.[2] In Côte d'Ivoire, for instance, where 8% of married adolescent women practice contraception, 47% of unmarried adolescents do so (Chart 5.2).

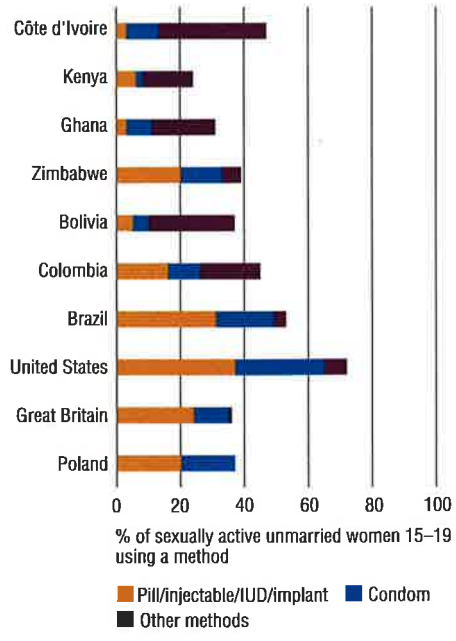
In the few countries of Latin America and the Caribbean for which information is available, sexually active unmarried adolescents are as likely as their married counterparts to practice contraception. Similarly, in the United States, more than half of both married and unmarried adolescents use some form of contraception.

The majority of married young women in North Africa and the Middle East who practice contraception use either the pill, the injectable, the IUD or the implant. These methods prevail among users in most Asian countries as well. In Sub-Saharan Africa, use of traditional methods—mostly periodic abstinence—is often more common than modern method use, and in Latin America and the Caribbean, a sizable minority of married adolescent users in particular also rely on traditional methods.

Few married adolescent women in the developing world rely on the condom as their contraceptive method. Indeed, there is no developing country where the condom is used by more than 8% of married adolescent women; frequently, the proportion who use this method is negligible.

But messages about the dangers of HIV and the effectiveness of condom use as a preventive strategy are apparently being heeded in some areas of the world. In Bolivia, Brazil, Colombia and Peru, for example, sexually active unmarried adolescents are more than twice as likely as married adolescents to use the condom. In the United States as well, condom use is more than twice as prevalent among young unmarried women as among married adolescent women.

Chart 5.2: Unmarried adolescents in developing countries rely heavily on traditional methods of birth control.

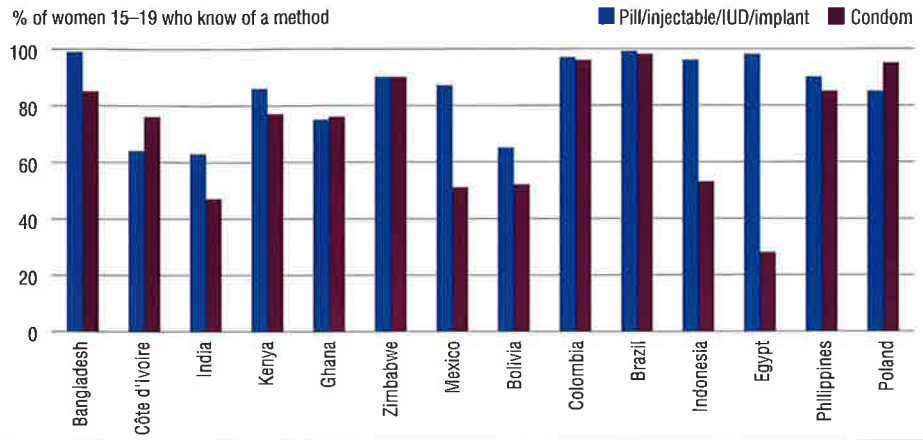


Note: Data are not available for Bangladesh, Egypt, Germany, India, Indonesia, Japan, Mexico and the Philippines. *Source:* Appendix Table 5, columns 10, 11 and 12.

Young People Know of Modern Methods, but May Lack Access or Information on Proper Use

Whether or not a young woman hoping to avoid pregnancy practices birth control will depend upon both her awareness that contraceptive methods exist and the degree to which these methods are available to her. In general, adolescent women

Chart 5.3: The majority of young women know about modern contraceptive methods.



◄ *Note*: Data are not available for Germany, Great Britain, Japan and the United States. *Source*: Appendix Table 5, columns 2 and 3.

are most likely to know about modern methods of birth control, such as the pill, the injectable and the IUD. A large proportion of adolescent women also know about the condom as a method of birth control.

In most countries of Asia, Latin America, the Caribbean, North Africa and the Middle East, more than 60% of adolescent women—and frequently more than 80%—report that they have heard of at least one modern contraceptive method (Chart 5.3). Similarly high levels of contraceptive knowledge are reported among adolescent women in many Sub-Saharan African nations, but in Burkino Faso, Burundi, Madagascar, Mali, Niger, Nigeria and Tanzania, fewer than half of adolescent women are familiar with any modern methods of contraception.[3]

The data on contraceptive knowledge among young men are limited. However, data from Sub-Saharan Africa indicate that more than 70% of male adolescents in the Central African Republic, Côte d'Ivoire, Ghana, Mali and Tanzania know of at least one modern method.[4]

Knowing that a particular contraceptive method exists does not mean that a young person knows how to use the method properly. In a survey of secondary school students in Kenya, for example, only one in three male students and one in four females knew that birth control pills had to be taken by the young woman—not the young man—and even fewer students knew that pills had to be taken daily, rather than prior to intercourse, to prevent pregnancy.[5]

Lack of knowledge or skill in using contraceptives is a prime cause of method failure among young people. Consequently, adolescents are more likely than adults to experience accidental pregnancies during their first year of contraceptive use (Table 5a).

Even young people who are knowledgeable about birth control methods may not know where to obtain them. Further, adolescent women in rural areas are not as likely as those in urban areas to know a source of modern contraceptive methods. For example, 10–17% of rural adolescent women in Bolivia, Mali and Yemen know where to get a modern method of birth control, compared with 42–60% of their urban counterparts.[6]

Table 5a. Adolescents experience contraceptive failure more often than do adults.

Country	% of women who become pregnant during the first year of contraceptive use	
	Younger than 20	20 or older
Bangladesh	5	4
Colombia	17	13
Egypt	12	6
Indonesia	4	3
Peru	32	18
Zimbabwe	6	3

Note: Includes all methods except sterilization; does not take abortion into account. *Source:* Blanc AK and Way AA, Contraceptive knowledge and use and sexual behavior: a comparative study of adolescents in developing countries, paper presented at the National Academy of Sciences Workshop on Adolescent Sexuality and Reproductive Health in Developing Countries, Washington, DC, Mar. 24–25, 1997, Table 6.4, p. 47.

Contraceptive Use by Married and Unmarried Adolescents Is More Common Than in the Past

The use of modern methods of birth control is increasing among adolescent women, as it is for all women around the world.[7] In some countries (Bangladesh, Colombia, Indonesia, Mexico and Thailand, for example), the growth in contraceptive prevalence results in part from strong nationwide efforts to increase access to family planning services. In addition, it has become more acceptable for a woman to use a contraceptive

Table 5b. The use of modern contraceptives is increasing among married adolescent women.

Country	% of married women aged 15–19 using a modern method	
	1970s	1990s
Bangladesh	2	20
Kenya	1	5
Ghana	2*	7
Zimbabwe	28*	30
Mexico	11	24†
Bolivia	2*	10
Colombia	21	34
Brazil	46*	46
Indonesia	11	32
Egypt	6*	13
United States‡	59	65
Philippines	5	10
Thailand	15	40†

*The mid- or late 1980s. †1987. ‡Percentage is of all sexually active women aged 15–19; the earlier period is 1982. *Sources:* Developing countries, earlier period—McDevitt TM et al., *Trends in Adolescent Fertility and Contraceptive Use in the Developing World*, Washington, DC: U.S. Bureau of the Census, 1996, Table 15, pp. A20–A23; later period—Appendix Table 5, columns 7 and 8; the United States—special tabulations of 1982 and 1995 National Survey of Family Growth.

method to delay having her first child and to space subsequent pregnancies.

These increases in contraceptive use are most notable among married adolescent women in several Asian countries. In Indonesia, the Philippines and Thailand, for example, current rates of contraceptive use range from 10% to 40%, and are 2–3 times as high as rates in the early 1970s; in Bangladesh, the increase has been 10-fold (Table 5b). While contraceptive use among married adolescents is still uncommon in Ghana and Kenya, current levels are 3–5 times what they were 20 years ago. In Colombia, use of birth control among married adolescent women has increased 62% over the last 20 years, and in the United States, sexually active adolescents—both married and unmarried—are using contraceptives at a rate 10% higher than they did in the early 1980s.

A Large Number of Young Women Are Without Reliable Protection Against Pregnancy

Not all sexually active young women who wish to avoid or postpone pregnancy are using a contraceptive method. Others are, but are dependent on traditional methods, such as withdrawal or periodic abstinence, which may not offer reliable contraceptive protection (Chart 5.4). The proportion of adolescent women needing contraceptive protection, or better protection, is especially large in Sub-Saharan Africa, where modern method use is low, use of traditional methods is high and a sizable proportion of unmarried adolescents are sexually active. In Côte d'Ivoire and Ghana, for example, about one-third of adolescent women lack adequate protection against pregnancy.

The proportion is also notable in Bangladesh and India, where 15–18% of adolescent women need contraceptive protection, probably because many married adolescents have had one child and would like to delay the birth of their second. Approximately 10% of adolescent women in many countries of Latin America and the Caribbean are risking an unwanted pregnancy because they are not using any method or are depending on a traditional method to protect them.

Of the almost 260 million women aged 15–19 worldwide, about 11%, or 29 million, are thought to lack the contraceptive protection they need to prevent an unwanted pregnancy.[8] Most of these—16.2 million—are married women who want to delay the birth of a child but are not using a contraceptive method; 9.8 million are sexually active, unmarried women who are not using a method; and 3.2 million are married and unmarried adolescents who are using traditional methods to prevent pregnancy.

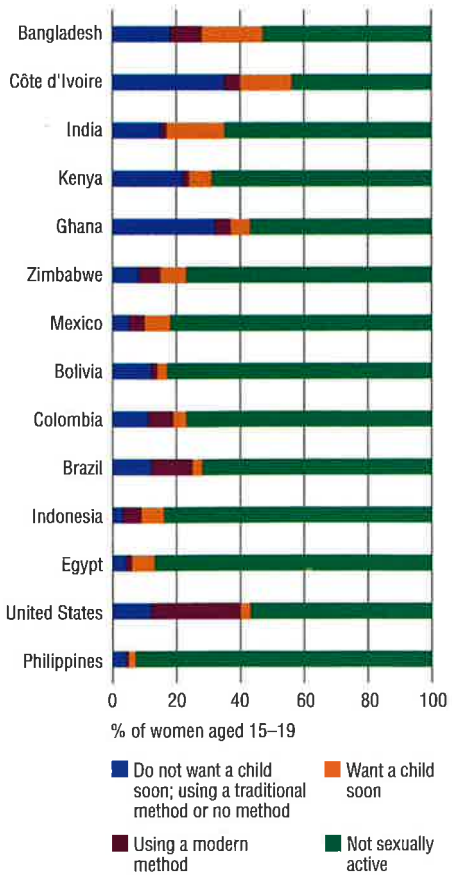
Adolescents Who Want to Practice Contraception Face Many Obstacles When Seeking a Method

Clearly, many young women do not have accurate or adequate information about effective contraceptives, and far too often, those who have the knowledge cannot obtain the services and supplies they need. Where poverty is deeply entrenched and transportation networks are sparse or nonexistent, information and supplies may not reach everyone. Moreover, in some settings where fertility among adolescent women is highly valued or where sexual activity among the unmarried is strongly discouraged, young women seeking to obtain birth control may be denied access to available methods.[9]

The view that sexual activity among unmarried adolescents is wrong or immoral has resulted in laws in some countries that limit young people's access to contraceptives, to reproductive health services or to basic information. Even if written statutes or local practices do not prevent adolescents from obtaining contraceptive services or information, sexually active adolescents may fear discovery of their behavior, and may avoid seeking needed care rather than risk scorn or punishment from parents, service providers or other community members. Adolescents also experience the same barriers faced by adult women, although sometimes more acutely: They often do not have the money to obtain health care or contraceptive supplies, they may not have the ability to travel freely or they may lack access to reliable transportation.

A young woman may also have to persuade her spouse or partner to agree to contraceptive use. Sexual relations among young people who are unmarried may be sporadic and unplanned, making inexperience and lack of preparation additional barriers to contraceptive use, as well as rendering many contraceptive methods unsuitable for their needs.[10]

Chart 5.4: Many adolescents who do not want to become pregnant need an effective contraceptive.



Note: Data are not available for Germany, Great Britain, Japan and Poland. *Source*: Appendix Table 6, columns 2–8.

Exposure to Reproductive Health Risks

Sexual activity, in and out of marriage, always poses certain risks, especially among adolescents. For young women who become pregnant at an early age, physical immaturity may make childbearing both difficult and dangerous. Some young women, ill prepared or not ready for the rigors and responsibilities of raising a family, will be confronted with unwanted pregnancies. Abortion, which in many countries is inaccessible, illegal or unsafe, will attract many young women who feel it is their only recourse when they have an unplanned pregnancy. While sexually transmitted diseases, including HIV, threaten both men and women, married and unmarried, the risk of infection is disproportionately great for young women. Women are more susceptible to the transmission of infection than men, and biologically, adolescent girls are more susceptible than adult women. Such infections can lead to infertility in both men and women, and have a devastating impact upon the life course of an adolescent.

As a young woman begins to have sexual relationships and enters her childbearing years, she truly steps into the adult world. Along with the many satisfactions of this transition into sexual maturity come important responsibilities as well as serious risks. Indeed, a young woman who is sexually active—whether married or unmarried—faces a variety of hazards that threaten her sexual and reproductive health. Many of these risks are associated with the broader social and economic conditions of a young woman's life: Her basic health, her standard of living, her status and autonomy, and the access she has to information and medical services all help determine her reproductive health and overall well-being.

Having a Child at a Young Age Heightens the Dangers That Childbearing Presents

Having a baby always carries potential health risks, and for all women, first births generally pose greater dangers than do subsequent births. However, the risks of childbearing are heightened, and new hazards emerge, when a young adolescent—a girl not yet 17—gives birth. For example, adolescents this age often have not reached complete physical maturity, and their pelvis may not be wide enough to accommodate a baby's head. In such circumstances, obstructed delivery and prolonged labor are likely, and these difficult deliveries can result in hemorrhage and even death of both mother and child if a young woman does not have access to medical care that provides the option of surgical intervention.

Worldwide, the potential for such a disaster is far too common: In India, Egypt, Indonesia and the Philippines, for example, no more than 25% of adolescent mothers give birth in a hospital or health facility; in Bangladesh, the proportion is only 3% (Chart 6.1).

Young adolescents, especially those younger than 15, experience distressing or even tragic pregnancy outcomes more often than do older adolescents or adult women.[1] Young adolescents are more likely to experience premature labor, spontaneous abortion and stillbirths than are older women, and they are up to four times as likely as women older than 20 to die from pregnancy-related causes.[2] The infants of very young mothers also face health risks. They are more likely to be of low birth weight, and their risk of death during the first year of life is 30% higher than the risk faced by infants of adult mothers.[3]

Pregnancy-related illnesses such as hypertension and anemia are also more common among adolescents than among adult women.[4] While these risks can be avoided or lessened with proper nutrition, or managed through prenatal care, many young women live in poverty, have only limited access to health care or cannot get basic

information about reproductive health care. In Bangladesh, Bolivia and Egypt, for example, fewer than half of all pregnant adolescents obtain any prenatal care (Chart 6.1). In the absence of proper care, treatable conditions become life-threatening.

Even in affluent populations, a pregnant young adolescent—especially if she is unmarried—may not obtain proper care. Out of shame or fear, she may not acknowledge her pregnancy, or she may try to keep it hidden from others. If she does obtain prenatal care, it is likely to be late in her pregnancy.[5]

Faced with an Unwanted Pregnancy, a Young Woman May Seek a Clandestine Abortion

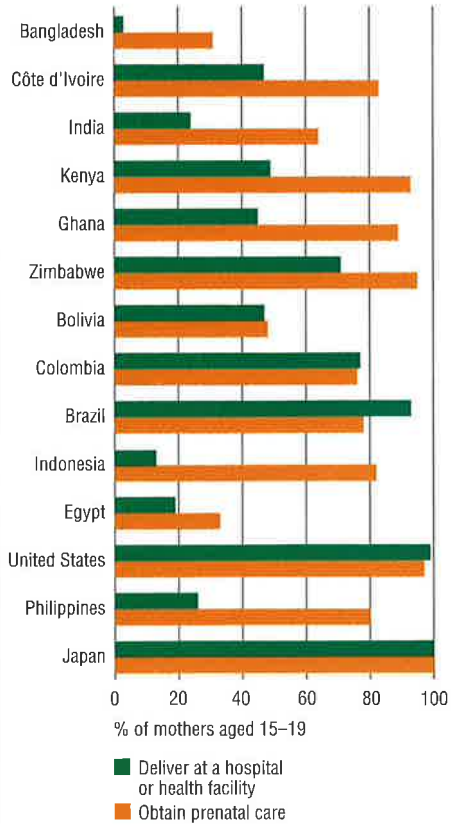
An unplanned pregnancy can be an emotionally wrenching experience for any woman, and it can be frightening for an adolescent, who may be unprepared to raise a child. In such circumstances, a young woman may choose to terminate an unwanted pregnancy. In many countries, though, abortion may be legally restricted (Table 6a, page 34), or it may not be available to all women because of their age, financial resources or simply where they live. These are formidable obstacles, and an adolescent faced with an unplanned pregnancy may seek out an abortion provider who will perform a clandestine procedure. Such a practitioner may be unskilled and practice under unsanitary conditions.

Even where legally available, abortion remains a highly controversial procedure in much of the world, making accurate information on its prevalence difficult to obtain. Providers may be reluctant to admit they perform abortions, and women, even those who have obtained abortions safely and legally, may be unwilling to report that they have undergone the procedure.

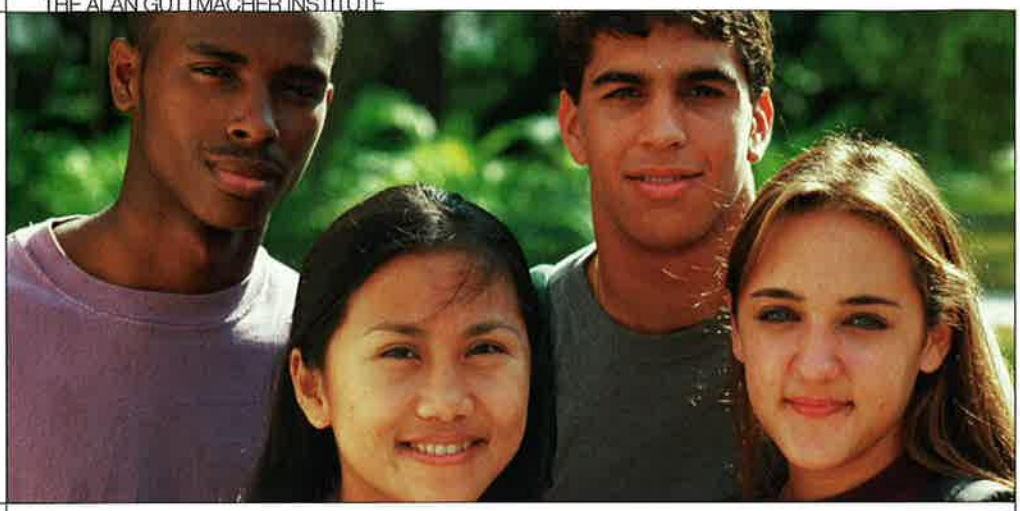
Data on abortion rates in Latin America and the Caribbean, where the procedure is available legally only when the mother's life is in danger, indicate that its actual availability is far less restricted. Estimates range from about 13 procedures annually for every 1,000 women aged 15–19 in Mexico to about 36 per 1,000 adolescent women in the Dominican Republic. Rates reported by industrialized nations, where abortion is available legally under a wider range of circumstances, vary greatly. They range from three procedures annually per 1,000 women aged 15–19 in Germany—official statistics that are believed to underreport abortion—to 36 per 1,000 adolescents in the United States (Table 6b, page 35).

Unsafe clandestine abortions endanger the health—or the very life—of young women. Adolescents frequently make up a large proportion of patients who are hospitalized for complications from such procedures. In Malawi, Uganda and Zambia, adolescent women represent one-fourth to one-third of patients suffering from

Chart 6.1: Adolescent mothers often have their baby outside a hospital and may not obtain prenatal care.



Note: Data are not available for Germany, Great Britain, Mexico and Poland. *Sources:* Published country reports from the Demographic and Health Surveys, except for the United States (National Center for Health Statistics) and Japan (special tabulations from 1995 vital statistics data).



complications, and in Kenya and Nigeria, more than half of women with the most severe abortion complications are adolescents.[6] In Latin America and the Caribbean, about one-tenth of all women hospitalized subsequent to an abortion are younger than 20, and among those experiencing serious infections, adolescents make up nearly one-third of the patient population.[7]

Even in circumstances where abortion is legally available, a young woman may face a heightened health risk. Because an adolescent may not quickly recognize that she is pregnant, may deny her condition or may not have money readily available to pay for an abortion, she is more likely than an adult woman to wait until a later stage in her pregnancy, when the procedure carries a greater health risk.[8]

Table 6a. Abortion is restricted in many countries to instances necessary to preserve the mother's life or health.

Country	A woman can have an abortion		
	To save her life or preserve her physical health	To preserve her mental health	For economic or social reasons, or upon request
Bangladesh	X		
Côte d'Ivoire	X		
India	X	X	X
Kenya	X		
Ghana	X	X	
Zimbabwe	X		
Mexico	X		
Bolivia	X		
Colombia	X		
Brazil	X		
Indonesia	X		
Egypt	X		
United States	X	X	X
Philippines	X		
United Kingdom	X	X	X
Poland	X		
Germany	X	X	X
Japan	X	X	X

Source: United Nations Department for Economic and Social Information and Policy Analysis, Population Division, *World Abortion Policies, 1994*, wall chart, New York: United Nations, 1994.

Various Infections, Including AIDS, Threaten the Future Fertility, and the Lives, of Young People

Young women may suffer from infections of the reproductive tract that can have a major impact on their ability to bear children. Many infections are the consequence of nonstertile conditions during childbirth. Poor hygiene and unsanitary living conditions, generally associated with poverty and with limited access to well-trained health care providers, will increase a woman's exposure to reproductive tract infections.[9] Abortion-related infections are especially common in countries where abortion is legally restricted, which may cause women of all ages to resort to unsafe procedures.

Sexually transmitted diseases (STDs) are a major cause of reproductive tract infections. More than 300 million cases of curable STDs—trichomoniasis, chlamydia, gonorrhea and syphilis—are estimated to occur worldwide each year.[10] Current estimates from North America and western Europe indicate that eight or nine of every 100 persons aged 15–49 are infected with a curable STD each year; further, rates of infection in some regions of the developing world are as much as three times as high (Table 6c, page 36). Worldwide, STDs (including AIDS) account for 16% of the time that women of reproductive age lose to disability—about the same as time lost as a result of maternal conditions.[11]

While people of all ages can be affected by STDs, young women are especially susceptible to STD transmission. They have fewer protective antibodies than older women do, and the immaturity of their cervix increases the likelihood that exposure to the infectious agent will result in the disease's being transmitted. In a rural area in Kenya, for example, 41% of women aged 15–24 who attend maternal and child health or family planning clinics have an STD. The level among all women of reproductive age, by contrast, is about 16%.[12]

Exposure to Reproductive Health Risks

A young woman's low social status can also raise her risk for infection with STDs. In cultures where women have little decision-making power over many aspects of their lives, an adolescent woman—married or unmarried—who fears infection from her partner may nonetheless be unable to refuse his sexual advances or insist that a condom be used. Marriage may not offer protection from STDs: In settings where men are likely to have sexual relationships before marriage or in cultures where extramarital sex is common, a woman who has had no partner other than her husband may still be at risk for infection.

Adolescents who are homeless and those living or working on the streets are especially at risk because their desperate circumstances often lead them to engage in dangerous behaviors. Having multiple sex partners, engaging in prostitution and using drugs and alcohol are all common among these youths, and all increase the risk of STD infection.[13] Moreover, these young people and their partners are unlikely to get medical treatment when they are infected. Among adolescents living on the streets in one Brazilian city, 21% of boys and 15% of girls report a history of STDs.[14]

Untreated STDs can have devastating health effects. Untreated gonorrhea, for example, can lead to sterility in men and to ectopic pregnancy, tubal infertility and chronic pelvic pain in women. Infection with human papilloma virus is associated with the development of cervical cancer.[15] STD infections during pregnancy affect the newborn's health as well, potentially resulting in low birth weight, prematurity and increased susceptibility to infections and diseases.

Young women frequently bear the most serious consequences of STDs, because infections in women often cause no symptoms initially; young women do not recognize they are infected, and so they do not seek treatment. However, even those who do realize they have been infected may be reluctant to seek help; they may be embarrassed, or they may be fearful of being stigmatized because STDs are associated with promiscuity. Also, young people may simply not know where to obtain testing and treatment, or they may not be able to afford services.

Moreover, individuals infected with an STD will increase their risk of contracting or transmitting HIV, which progresses to AIDS and results in death for all victims of the disease.[16] Young women appear to be at greater risk of HIV infection than are young men. Consequently, in Uganda, for example, approximately 7% of males aged 15–19 are infected with HIV, while the proportion among females is more than 15%.[17] HIV prevalence is also very high among pregnant young women in several Sub-Saharan countries (Table 6d, page 37).

AIDS has become tragically common in many regions of the world, decimating entire villages and leaving behind large numbers of orphaned children. Half of HIV infections occur among people younger than 25; recent estimates indicate that

Table 6b: The number of adolescents who obtain an abortion varies from country to country.

Country	Annual number of abortions per 1,000 women 15–19
Brazil	32
Colombia	26
Dominican Republic	36
Mexico	13
Peru	23
United States	36
Great Britain*	19
Germany	3
Japan	6

*Includes only England and Wales. *Sources:* Latin America—estimates of The Alan Guttmacher Institute (AGI) based on methodology described in Singh S and Wulf D, Estimated levels of induced abortion in six Latin American countries, *International Family Planning Perspectives*, 1994, 20(4):4–13; United States—Henshaw SK, Teenage abortion and pregnancy statistics by state, *Family Planning Perspectives*, 1997, 29(3):115–122; Great Britain and Japan—AGI, *Sex and America's Teenagers*, New York: AGI, 1994, p. 76; and Germany—Council of Europe, *Recent Demographic Developments in Europe, 1996*, Belgium: Council of Europe, 1996.

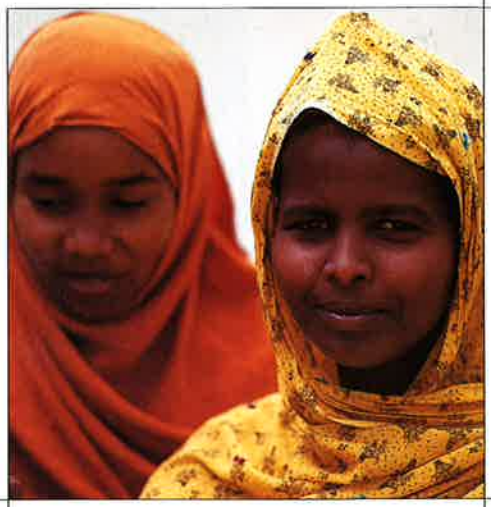


Table 6c. Each year, a sizable proportion of people contract a sexually transmitted disease.

Region	% of people aged 15–49 infected annually
Sub-Saharan Africa	25
North Africa and Middle East	6
East Asia and Pacific	3
South and Southeast Asia	16
Eastern Europe and Central Asia	11
Western Europe	8
Latin America and Caribbean	15
North America	9
Oceania and Australasia	9

Note: Data include trichomoniasis, chlamydia, gonorrhea and syphilis. *Source:* World Health Organization, Global Programme on AIDS, *An Overview of Selected Curable Sexually Transmitted Diseases*, Geneva: World Health Organization, 1995.

FEMALE GENITAL MUTILATION

Female genital mutilation, the ritual cutting of a young woman's clitoris or external genitalia, is estimated to affect some 130 million girls and women worldwide.[1] It is largely practiced in the central, western and eastern regions of Africa and in the Middle East.

Nearly all young women in some regions of Sub-Saharan Africa undergo being cut: In Sudan and Mali, 87–93% of young married women aged 15–19 have been cut, while in Côte d'Ivoire and the Central African Republic, the proportion is 35%.[2] Although the age at which a young woman typically undergoes the procedure varies across cultures, cutting most commonly occurs when a girl is between the ages of four and 12.[3]

The two most common types of genital cutting—clitoridectomy and excision—account for roughly 85% of all cases. In clitoridectomy, part or all of the clitoris is removed; in excision, both the clitoris and the labia minora are removed. The other 15% of procedures involve infibulation, an extensive procedure in which all of the clitoris and some or all of the labia minora are removed and incisions made in the labia majora. The raw surfaces of the labia are either stitched together or held together by tying the legs until the skin heals; the resulting scar tissue creates a cover over the urethra and the vagina. A small hole is left or reconstructed for the flow of urine and menstrual blood.

In many cultures, female genital mutilation is a recognized and accepted ritual that marks the transition to adulthood. In such instances, it is considered an important means for the socialization of women, curbing their sexual appetites and preparing them for marriage. Muslims, Christians, some animists and one Jewish sect are among the diverse religious groups on the African continent that practice it.[4] Despite its cultural importance, female genital mutilation has drawn considerable criticism because of its potential for both short- and long-term medical complications and harm to reproductive health.

Exposure to Reproductive Health Risks

some 7,000 young people aged 15–24 are newly infected with HIV each day.[18] In some regions, the AIDS epidemic has reached startling proportions; for example, nearly 13% of all urban youths aged 14–20 in Rwanda are infected with HIV.[19]

Cultural Practices May Involve Sexual Abuse or Exploitation, Particularly of Young Women

Certain cultural practices are associated with reproductive health risks among adolescent women. Female genital mutilation, in which part or all of a young woman's genitalia are removed, is probably the most common such practice (see page 36). Usually performed as a rite of initiation, female genital mutilation also serves to control women's sexual behavior by reducing pleasure and sexual desire. Not only do infections occur as a consequence of the cutting, but hemorrhage, shock and even death can result. The lifelong aftermath of the most extreme form of cutting is severe, and results in chronic pain during intercourse, recurrent pelvic infections and prolonged, obstructed labor.[20]

For some young women, sexual relationships are not entered into willingly, but come about as a result of force, coercion or abuse. Although the young and powerless of either sex may fall victim to such abuse, young women are most likely to encounter sexual exploitation (see page 38). Young people who are sexually abused are obviously at risk of infection and unwanted pregnancy, and they may also suffer other trauma and psychological distress.

Often the norms of a particular culture involve sexual behavior that can endanger the reproductive health of young people. In many Asian, Latin American and Caribbean countries, for example, sexual initiation with a prostitute is a long-held tradition among young men. In several Sub-Saharan African countries, a young woman's initial sexual experiences may be with a "sugar daddy," an older man who will provide her with clothes or other necessities in exchange for sex. In both cases, a young person is having sexual relations with a partner who is likely to have an STD; moreover, for the young woman, the relationship is likely to be based on coercion and need, rather than choice.

Table 6d. In some Sub-Saharan countries, many pregnant young women test positive for HIV.

Location	Year	% of pregnant women with HIV	
		Aged 15–19	Aged 20–24
Botswana (Francistown)	1992	23	25
Burundi (Bujumbura)	1991–1992	3	19
Malawi (4 rural sites)	1987–1990	8	10
Nigeria (Lagos State)	1990–1991	20	10
Rwanda (Kigali)	1992–1993	27	37
South Africa	1994	5	3
Swaziland	1992	5	3
Togo (Dapaong)	1993	2	4

Sources: U.S. Bureau of the Census, Center for International Research, Health Studies Branch, *Trends and Patterns of HIV/AIDS Infection in Selected Developing Countries*, Research Note, Washington, DC: US Bureau of the Census, 1994, No. 14; and US Bureau of the Census, Center for International Research, Health Studies Branch, *HIV/AIDS in Africa*, Research Note, Washington, DC: U.S. Bureau of the Census, 1995, No. 20.

SEXUAL ABUSE AND COMMERCIAL SEXUAL EXPLOITATION

Sexual abuse, incest and rape are tragic realities that affect young people in developing and developed countries alike. The extent to which young people worldwide fall victim to nonconsensual sex and sexual coercion is difficult to measure because surveys vary greatly in the way they define involuntary sex. Nonetheless, the limited data available demonstrate evidence of widespread abuse:

- In the United States, four in 10 women who have sex before age 15 report having had sex involuntarily.[1]
- In Santiago, Chile, nearly 3% of young women who have sex before age 18 say that rape is their first experience of sexual intercourse.[2]
- National surveys from Canada, the Netherlands, New Zealand, Norway and the United States indicate that roughly 30% of women are abused as children.[3]
- In Uganda, half of sexually active primary school girls report being forced to have sexual intercourse, and 22% anticipate receiving gifts or money in exchange for sex.[4] The latter may be expecting to enter ongoing sexual relationships with wealthy older men who provide a place to live and money for food, tuition and school-related expenses.[5]
- A study of Guatemalan street youths indicates that all have been sexually abused: 53% by family members (often stepparents), 6% by friends, 3% by neighbors and 46% by people they did not know. These youths frequently cite physical, emotional and sexual abuse as their reasons for leaving home.[6]

In many parts of the world, youths are victims of sexual exploitation for commercial gain. According to UNICEF, sexual exploitation of children and adolescents is a multibillion-dollar illegal industry.[7] The commercial sex industry relies on economic inequality and cultural and social disadvantage to supply sex workers. Youths who become involved—typically those aged 15 and older[8]—are disproportionately poor and female. Often they lack the skills and education to compete for nonexploitive paid employment.

In some instances, young people turn to prostitution as a source of income. In Bangladesh, Brazil, Nepal, the Philippines and Thailand, however, youths have been lured into prostitution by recruiters who promise jobs in restaurants or as domestic workers; instead, these young people have been sold to brothel owners and treated as virtual slaves.[9] In Nepal and Thailand, parents may sell their daughters into prostitution as a source of family income,[10] or daughters may choose this route to fulfill an economic obligation.

Although the roads leading to commercial sex work vary, all are paved by economic need and social disadvantage.

Easing Entry into a New World

The opportunities that growing and modernizing economies offer young people are potentially vast. But the national resources and energies that must be mobilized to allow them to exploit that potential have yet to be fully committed. Increasing access to education for all young people, and especially for girls, is of primary importance. But the reproductive health needs of adolescents, which require a distinct set of services, have long been neglected. Regardless of their marital or childbearing status, all young men and women need information about sexuality and reproduction, and sexually active young women in particular need access to a wide array of services, from contraceptive supplies and counseling to postpartum care. To be effective, services must be provided in an environment in which adolescents feel comfortable and by caregivers who have been trained to work with young people—the next generation of parents, workers and leaders.

Most adolescent women are coming of age in a world that has yet to fully comprehend the dramatic social and economic changes that will shape the course of their lives and the future of their societies. Not only will these young women assume the responsibilities that women have traditionally fulfilled—the care and nurturing of children—but more and more of them will work in offices, factories, commercial endeavors and social agencies, as well as participate actively, and as equals, in the life of their communities and nations.

Nonetheless, despite their vast numbers and the enormous contributions they stand to make as citizens, workers and mothers, the unique needs of young women and girls still receive too little attention among policymakers. This neglect was acknowledged in the deliberations of the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing; both conferences offered recommendations that were endorsed by an overwhelming number of the world's governments.

As this report has documented, economic modernization, urbanization and mass communications are having a substantial impact on the expectations and behaviors of adolescents. Nevertheless, young women are still subject to many constraints derived from the past and reinforced by the laws, policies and practices of their societies' most powerful institutions. This tension between the past and the future is nowhere more evident than in changes in attitudes toward marriage and sexual relationships, changes that often challenge long-held beliefs and traditions. In many parts of the world, young women are marrying later than their mothers did and demanding a greater voice in the selection of their husbands. In others, they are increasingly likely to enter into sexual relationships before or outside marriage, whether or not their sexual activity is acknowledged or condoned by their families and communities.

Change, however, is sure to encounter resistance, sometimes well-founded. Young people are often unwise or ill prepared to make major decisions, and parents and societal institutions understandably want to protect them from the potentially adverse consequences of their actions. Parents, while wishing for a better life for their children, are likely to feel ambivalent at seeing sons and daughters grow up in ways that contrast so sharply with their own upbringing and that may distance them physically and emotionally.

Societal institutions—religious, cultural or governmental—often view change as a threat to tradition and a disturbance of the established order. Some societies may attempt to shield themselves from the influence of the outside world, and they may succeed for a time—but only for a time. More often, they will simply delay confronting the growing social changes that are occurring in their midst. When change involves something as fundamental as the position of women and

Table 7b: The patterns of marriage and sexual behavior formed by young women vary among regions of the world.

% of women who by age 20	Sub-Saharan Africa	Asia, North Africa, Middle East	Latin America, Caribbean	Five developed countries*
Are not sexually active	17	52	44	23
Have had first intercourse	83	†	56	77
Before marriage	38	†	28	67
Within marriage	45	48	28	10
Have had a child	55	32	34	17

*Excludes Japan. †Comparable national information is not available on sexual activity among unmarried women for all countries in these regions. *Source:* Calculations by The Alan Guttmacher Institute; regional averages are based on values for the countries with survey data, weighted by the size of the adolescent female population of each country.

girls in society, as well as their roles in the intimate confines of the family, adaptation to new ways is likely to be slow and sometimes painful. But adaptation is also inevitable and inescapable.

Investing in Equal Access to Education for Girls Should Be a Fundamental Global Priority

Most, if not all, countries have come to recognize the necessity and the value of education for young women, although many are still unwilling or unable to provide girls with an education equal to that of boys. When provided, increased education is strongly associated with a girl's postponement of marriage and childbearing until after her adolescent years (Table 7a). It contributes to the health of a woman's children and family, and it facilitates her own use of available health care information and services.[1]

Government and other social institutions must guarantee girls access to basic education. They must find new ways to enable and, indeed, encourage families to enroll girls in school and to encourage young women to stay in school and delay premature marriages.

Table 7a: By increasing education, nations can increase the age at which a woman marries and has her first child.

Level of education	Median age at marriage	Median age at first birth
None	17.6	19.3
Primary	19.1	20.2
Secondary	21.7	22.8

Note: Averages are for women aged 30–34 in 23 developing countries, based on Demographic and Health Survey data. *Source:* Bongaarts J, Population policy options in the developing world, *Science*, 1994, 263(5148):771–776.

Young Women Require Services That Address the Full Range of Their Reproductive Health Needs

Few countries—of the developed or developing world—have given adequate attention to the reproductive and sexual health of adolescents generally, and of adolescent women in particular. In some cases, resources—whether financial or professional—are extremely scarce and, to the extent available, devoted to mothers and young children. In most, however, lack of attention and fear of controversy have resulted in policymakers' ignoring the specific reproductive and sexual health needs of young women.

The extent and the nature of reproductive and sexual health needs is individual, of course, and depends on age and circumstances (see page 41). And because the patterns of marriage and sexual behavior vary among different regions of the world (Table 7b) or among distinct cultural groups, the proportion of young women with specific needs varies as well (Table 7c). However, the need for accurate sexual and reproductive health information and education is universal—not only for girls, but for the boys and young men who will become their husbands and sexual partners.

Sexual and reproductive health education. Young children and adolescents learn

Table 7c: Regardless of sexual activity or childbearing status, all young women need reproductive health services.

Sexual activity and childbearing status	Services needed during adolescent years					
	Sexuality education	Contra-ceptive services	STD screening and treatment	Prenatal care	Delivery services	Programs for students who are pregnant or mothers
Not sexually active	X					
First sex before marriage	X	X	X			
First sex within marriage	X	X	X			
Pregnant or a parent	X	X	X	X	X	X

RESEARCH NEEDS

Young men have sexual and reproductive health needs that affect both their partnerships with women and their own health and welfare. Nonetheless, in-depth information on men's sexual and reproductive lives is currently not available. There has been growing interest in recent years, however, regarding the role of men in sexual and reproductive decision-making, and some large-scale fertility surveys are beginning to include men in their national samples. If the health of adolescents is to be assured, greater effort to document the lives and needs of young men is essential.

In a similar vein, the lives of very young adolescents—those younger than 15—are typically not documented, and the specific needs of this group have not been assessed. Little is known about their sexual attitudes and behaviors, even though the years leading up to and encompassing puberty are a highly impressionable time. Many of a young person's beliefs and expectations are formed during these crucial years. Because young people this age are still in school in most parts of the world, these years are a prime target for educational campaigns and curricula providing basic information about sexuality and reproductive health. Consequently, developing a means to assess the needs and behaviors of the youngest adolescents should be a priority.

Finally, some data on adolescents of both sexes and all ages are lacking. Measures of sexual activity among the unmarried tend to be scarce, as are measures of abortion and the incidence of sexually transmitted diseases. Inadequate information in these areas limits the ability to examine critical aspects of adolescent life and to draw conclusions from which policymakers can reach informed decisions.

about sexual matters and reproduction by observing the behavior of the adults around them, by listening to the talk of peers and older siblings, by absorbing the themes of the media in all its forms and, of course, by acquiring the knowledge of parents or other trusted mentors. Such information, however, is typically limited, sometimes erroneous and, in the case of the media, often unduly glamorized. Thus, formal instruction is an important source of accurate information about physical maturation and puberty, sexuality, pregnancy and childbearing, contraception and disease prevention. And it can be tailored to the age of the young people involved and to the cultural and religious background of their community.

Such education exists in some form in school settings in practically all developed countries, where the length of formal schooling is extensive. Formalized curricula for sexuality education are much less common in the developing world, and they are typically not implemented on a national level. In many instances, the average period of school enrollment is so short as to preclude this possibility. Even in countries with nearly universal secondary education, some of the most disadvantaged adolescents are likely to drop out of school prematurely. Thus, helpful as school-based programs are, they are not sufficient to reach all young people, and they need to be supplemented by various community-based educational programs.

However, strong religious or political opposition may greet the introduction of such programs, and at times, their very existence is challenged out of fear that they will encourage sexual activity among the young. Yet, studies indicate that sexuality education does not encourage young people to engage in sex; most work shows that education about reproductive and sexual health is associated with the postponement of the first sexual experience and with the use of contraceptives among those who are sexually active.[2]

Nevertheless, parents, educators, health care providers and government officials often find it difficult to achieve consensus as to the need for sexual and reproductive health education or, more likely, as to the nature of the education itself. At issue are the subjects to be covered, the age-groups for which these might be appropriate, the training required for teachers and the methods of instruction. Accordingly, programs vary greatly in quality and in content. The most comprehensive ones not only cover the biological facts but provide young people with information about dating, relationships, marriage and contraception. They help them recognize the merits of abstinence, develop the skills necessary to resist peer pressure and inappropriate sexual advances, and instill the confidence to negotiate the use of contraception with their partner.

Contraceptive and sexually transmitted disease services. In most regions of the world, the majority of women have their first sexual experience as adolescents, usually after they have married. Some may wish to have a child right away, but world-

Easing Entry into a New World

wide, 29 million women younger than 20—married and unmarried—are sexually active and do not want to have a child soon.[3] Many will be exposed to sexually transmitted diseases. To plan the children they want to have, to safeguard their ability to bear children, and to protect their own health and sometimes their very lives, they must have access to effective contraception as well as protection against sexually transmitted infections, including HIV.

Protection against infection, however, requires the active cooperation and use of condoms by the young woman's partner, cooperation that many women find difficult if not impossible to negotiate. Thus, special efforts are needed, by governments, the media and, indeed, all appropriate health and social institutions, to educate and motivate men to protect their wives and partners from the possibility of infection. Clearly, also, the availability of services to both accurately diagnose and treat sexually transmitted diseases is essential. Information about the risk of infection and about the often unnoticed progression of these infections, especially among young women, is also critical, since curable conditions may become chronic and debilitating ones if treatment is delayed.

Those adolescent women who wish to avoid pregnancy or plan births require access to a range of contraceptive services. The circumstances of a young woman's life will influence her contraceptive needs: Whether she is in a union or unmarried, whether her relationship is long-term or recently begun, whether she has one partner or more than one, and whether she would like a child soon or prefers to wait several years will all affect the type of contraceptive protection she needs.

Abortion. Some young women who experience an unwanted pregnancy will seek an abortion, whether or not it is legally available. In countries where abortion is an accepted medical service, efforts must be made to improve access to these services for all young people, regardless of where they live or their ability to pay. Where opposition to abortion is strong and the procedure cannot be provided legally, young women will nevertheless experience unwanted pregnancies and many will seek to terminate them, often under clandestine and unsanitary circumstances. These women must have access to postabortion care, since serious medical complications are often the consequence. Postabortion care must incorporate contraceptive counseling so young women can reduce their chances of experiencing another unplanned conception.

Services for pregnant and parenting young women. Adolescents, perhaps even more than their adult counterparts, need to be informed about the importance of prenatal care, and they need easy access to these services. Young women also need social support during their pregnancies; they need information and guidance about what to expect as the birth nears, and they must be assured that their baby will be delivered by a knowledgeable and skilled birth attendant.

"...special efforts are needed, by governments, the media and, indeed, all appropriate health and social institutions, to educate and motivate men to protect their wives and partners from the possibility of infection [by sexually transmitted diseases]."

As new mothers, they will continue to need support and health care for themselves and their infants. They may need assistance with breastfeeding, advice about nutrition or information about immunizations. Many will also need contraceptive counseling and services to help them delay their next pregnancy.

This range of services for pregnant and parenting women is not readily available in many developing countries, even to adult women. Adolescent women, who may have more specialized needs because of youth, lack of resources or difficulty communicating effectively, usually have even less access to quality prenatal or postpartum care. Indeed, a review of more than 100 adolescent health projects throughout the developing world found that contraceptive services were the only services typically provided specifically for young people.[4]

"In many parts of the world, [adolescent girls] are still expected to marry and bear children when they are barely out of childhood themselves."

Effective Services Need to Accommodate the Unique Developmental Stage of Adolescence

Adolescents may find it difficult to use services targeted to adult women. They often fear that doing so will reveal their sexual activity to parents or the community at large, perhaps precipitating condemnation of their behavior, punishment or even a violent reaction. If they are unaccustomed to speaking about sexual matters, they may be intimidated by the indifference, insensitivity or even hostility of health care providers who have received no training in serving youth. This may be especially true if a sexually active young woman is unmarried, but married adolescents who are not yet willing to begin childbearing may also fear that their wishes will be regarded as unacceptable. Accordingly, privacy and confidentiality are important aspects of service provision for adolescents.

Many, perhaps most, young women need assistance and support in communicating with partners. It may be difficult for a young woman to discuss her wishes with her spouse or partner, especially if he is older or if she had little influence in choosing her mate. Comprehensive reproductive health services for adolescent women emphasize skills for negotiating with partners, as well as decision-making around sexuality and reproduction.

Services that are provided specifically for adolescents must also be sensitive to young women's limited access to transportation and their often meager financial resources. The geographic accessibility of the clinic or health center, the availability of services at little or no cost and the degree to which the environment welcomes young women will all determine the extent to which adolescents can truly avail themselves of reproductive health care.

Easing Entry into a New World

Society Must Prepare Young People to Face a World Far Different from That of Their Parents

Today's adolescents—boys and girls, young women and young men—are the next generation of parents, workers and leaders. To be able to fill these roles to the best of their ability, they need the guidance and support of their family and their community, and the attention of a government committed to their development.

At one billion strong, adolescents are a formidable demographic force, and their pattern of childbearing has major implications for the size of the world's population. If today's young women have their first baby two and one-half years later than is currently the average age at first birth, population growth by the year 2100 will be 10% lower than if no change occurs. If they postpone that first birth by five years, it will be 20% lower—a decrease of 1.2 billion people.[5]

But the importance of investing in the lives of young men and women—of rethinking policies and priorities, committing financial resources and implementing programs—reaches far beyond sheer numbers. How well communities and nations meet the needs of young people not only will determine the kinds of lives these young people have, but also has ramifications for the lives of the children they bring into the world and for the societies they will build and maintain.

Although all adolescents need help in making an effective transition to adulthood, adolescent girls face unique challenges. In many parts of the world, they are still expected to marry and bear children when they are barely out of childhood themselves. The extent of their schooling or their choice of mate is often decided by others. Their status in the family hierarchy, and in the community, leaves them with little autonomy or authority about the direction of their lives or that of their children.

Where young women do have access to education and are likely to postpone marriage until their 20s, they still confront disapproval for the kinds of sexual expression generally expected from their male peers. They may face an unwanted pregnancy and its harsh choices—legal abortion, a clandestine procedure fraught with danger or raising a child on their own, usually with few financial resources.

Yet, the future rests heavily on their welfare—on how well they will perform as mothers, as contributors to the economy, as teachers of the next generation and as sources of strength for their communities and nations. To achieve their full and legitimate place in the world, young women face hardship and challenge. But the challenge for communities and nations—to give young women the helping hand they need and deserve—is even greater.

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2. Appendix Table 1, column 10.

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6. The World Bank, *Social Indicators of Development, 1996*, Baltimore, MD, USA, and London: Johns Hopkins University Press, 1996, Table 1.1, pp. 8–9.

7. Appendix Table 1, column 7.

8. Appendix Table 1, columns 7 and 8.

9. Appendix Table 2, columns 5 and 6.

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5. For women aged 20–24, Appendix Table 3, column 3; for women aged 40–44, special tabulations of fertility surveys for each country.

6. Ibid.

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ception that is calculated for study countries in a region is assumed to apply to all adolescent women in that region. The study countries with this information represent 71% of the world's adolescent women. Representation is strongest for Asia, Latin America and Sub-Saharan Africa. It is weaker for North Africa and the Middle East, and weakest for the developed countries. Because direct information on sexual activity among unmarried women in Asia, North Africa and the Middle East is lacking, 1% of all adolescent women are assumed to be unmarried and sexually active in these regions. To allow for the underreporting of sexual activity among unmarried women in Latin America, the estimated level of 4.1% was adjusted to 6.1%. Among the six developed countries, the necessary information was available only for the United States. The level of "unmet" need in the United States was applied to all developed countries, under the assumption that the level estimated for the United States falls within the range of other developed countries: The level of 12% found in the United States is likely to be higher than that of one large group of developed countries (e.g., western and northern Europe), given what is known about sexual activity and contraceptive use in those countries, but it is likely to be lower than the level of "unmet" need for contraceptive services in another large group of developed countries (the former Soviet republics and eastern European countries).

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Appendix Table 1. The Adolescent Population and Demographic, Social and Economic Conditions in 53 Countries

Country and survey year	Adolescents aged 10–19, 1997		% of population living in urban areas		United Nations Human Development Index, 1995[1]	Gross national product per capita, 1989–1994 (US $)	% of women with 7 or more years of schooling[2]	
	% of population	Number	1965	1995			15–19	40–44
	1	2	3	4	5	6	7	8
Sub-Saharan Africa								
Botswana, 1988	24	371,200	4	28	0.763	2,800	75	21
Burkina Faso, 1992–1993	22	2,417,400	5	27	0.228	300	11	2
Burundi, 1987	23	1,542,600	2	8	0.286	150	1	2
Cameroon, 1991	23	3,248,800	16	45	0.503	680	40	8
Central African Rep., 1994–1995	22	770,600	27	39	0.361	370	9	4
Côte d'Ivoire, 1994	23	3,576,400	23	44	0.369	510	17	6
Ghana,1993	23	4,311,800	26	36	0.482	430	63	35
Kenya, 1993	25	7,422,400	9	28	0.481	250	62	26
Liberia, 1986	23	735,000	22	45	0.325	460[5]	22	7
Madagascar, 1992	24	3,697,400	12	27	0.432	230	19	11
Malawi, 1992	23	2,662,200	5	14	0.330	140	19	8
Mali, 1987	23	2,632,000	13	27	0.222	250	8	1
Namibia, 1992	23	367,200	17	37	0.611	2,030	44	26
Niger, 1992	23	2,251,600	7	17	0.207	230	5	0
Nigeria, 1990	23	26,989,800	17	39	0.406	280	34	4
Rwanda, 1992	25	2,054,800	3	6	0.332	80	36	3
Senegal, 1992–1993	23	2,049,400	33	42	0.340	610	11	6
Tanzania, 1991–1992	24	7,405,000	5	24	0.364	90	62	10
Togo, 1988	23	1,005,000	11	31	0.409	320	15	4
Uganda, 1995	23	5,297,600	7	13	0.329	200	25	15
Zambia, 1992	25	2,452,600	23	43	0.425	350	48	23
Zimbabwe,1994	24	2,788,200	14	32	0.539	490	82	32
North Africa & Middle East								
Egypt, 1992	22	14,668,000	41	45	0.613	710	49	16
Morocco, 1992	22	6,190,600	32	48	0.554	1,150	28	7
Sudan, 1989–1990	23	6,925,000	13	25	0.379	300	46	5
Tunisia, 1988	22	2,011,600	40	57	0.763	1,800	39	6
Yemen, 1991–1992	23	3,597,200	11	34	0.424	280	14	1
Asia								
Bangladesh, 1993–1994	23	29,134,800	6	18	0.364	230	23	7
China, 1992	17	205,834,000	18	30	0.594	530	56	21
India, 1992–1993	21	200,540,000	19	27	0.439	310	40	18
Indonesia, 1994	21	42,650,800	16	35	0.637	880	49	17
Pakistan, 1990–1991	23	33,800,000	24	35	0.483	440	22	8
Philippines, 1993	22	15,651,600	32	54	0.677	960	81	50
Sri Lanka, 1987	20	3,805,200	20	22	0.704	640	u	u
Thailand, 1987	19	11,468,000	13	20	0.828	2,210	34	11
Turkey, 1993	20	12,651,200	34	69	0.792	2,450	27	12
Latin America & Caribbean								
Bolivia, 1994	22	1,730,200	40	61	0.588	770	64	28
Brazil, 1996	20	33,698,000	50	78	0.804	3,370	52	35
Colombia, 1995	21	7,551,800	54	73	0.836	1,620	63	38
Dominican Republic, 1991	21	1,699,800	35	65	0.705	1,320	65	35
Ecuador, 1987	22	2,636,200	37	58	0.784	1,310	56	26
El Salvador, 1985	24	1,441,800	39	45	0.579	1,480	36	8
Guatemala, 1987	24	2,669,600	34	42	0.591	1,190	21	9
Mexico, 1987	22	20,853,400	55	75	0.842	4,010	62	17
Paraguay, 1990	22	1,143,200	36	53	0.723	1,570	42	21
Peru, 1991–1992	22	5,375,200	52	72	0.709	1,890	69	46
Trinidad & Tobago, 1987	21	281,400	64	72	0.872	3,740	91	52
Developed countries								
France, 1994	13	7,710,200	67	73	0.931	23,470	82	67
Germany, 1992	11	9,104,800	78	87	0.921	25,580	74	60[8]
Japan, 1992	12	15,321,000	68	78	0.937	34,630	95	81
Poland, 1991	17	6,456,600	50	67	0.855	2,470	88	71
Great Britain, 1991[9]	13	7,337,200	87	90	0.916	18,410	100	100
United States, 1995	14	36,957,600	72	76	0.938	25,860	86	84

% of women 15–19		
Whose homes have electricity	Who listen to the radio every week	Who view television every week
9	10	11
8	79	6[3]
12	43	18
2[4]	33	1[3]
41	46	46
7	67	20
50	44	63
38	50	57
12	68	19
u	69	u
14	40	14
5	58	u
10	52	6[3]
19	79	22
7	39	21
31	58	34
4	39[3]	u
33	69	51
9	15	4
16[4]	30	18[3]
12	42	8
27	56	27
27	41	28
92	63[6]	82[6,7]
47	75	66
23	68	15[3]
73[4]	52	80
45[4]	34[6,7]	37[6,7]
17	42	17
92	51[3,7]	71[3,7]
43	41	23
52	72	72
50	32	25
75	93	81
10	76[6]	20
65	53[6]	57
u	79	84
72	79[6]	66
94	81	91
93	86[6]	83
84	62[6]	59
81	93	73
63	83[3]	48[3]
55	64	31[6,7]
87	u	u
53	85[6]	81[6]
78	93	80
92	76[6]	66[6,7]
98	90[7]	93[7]
100	100[3]	96[3]
100	100	100
100	74[3]	99[3]
100	u	u
100	u	u

Sources and Notes to Appendix Table 1

Sources

For all columns lacking a citation, the correct reference will be: Special tabulations of fertility surveys for each country (see Data Sources, p. 9). **Columns 1 and 2:** United Nations (UN), *The Sex and Age Distribution of the World Populations, 1994 Revision*, New York: UN, 1995, pp. 158–855. **Columns 3 and 4:** UN, *World Urbanization Prospects, 1994 Revision*, New York: UN, 1995, Table A.2, pp. 78–85. **Column 5:** UN Development Programme, *Human Development Report, 1995*, New York: Oxford University Press, 1995, Table 1.1, p. 18. **Column 6:** The World Bank, *Social Indicators of Development 1996*, Baltimore, MD, USA: The Johns Hopkins University Press, 1996. **Column 9:** France—The Alan Guttmacher Institute (AGI), *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, New York: AGI, 1995. Germany—Federal Statistical Office, *Sample Survey of Households, Income and Expenditure, 1993*, Wiesbaden, Germany: Federal Statistical Office, 1994. **Columns 10 and 11:** China and France—see source for France in column 9. Germany—see source for column 9. Poland—*The 1995 Household Budget Surveys*, Warsaw: Central Statistical Office, 1996.

Notes

u=unavailable. **1.** The index is a measure combining life expectancy, educational attainment and income, with possible values ranging from zero to one. **2.** Figures are based on 10 or more years of education for the developed countries except Great Britain (11 or more) and the United States (12 or more). In France, Germany, Poland and the United States, the figure is for age-group 20–24; in Japan, for age-group 18–19; in Great Britain, for age-group 16–19. **3.** Household owns a television or radio, but no information on frequency of viewing or listening. **4.** Based on information indicating that electricity is the source for lighting or the fuel used for cooking rather than on a direct question about whether the house has electricity. **5.** Circa 1983. **6.** Every day or regularly. **7.** Refers to 15–49-year-olds. **8.** Refers to 35–39-year-olds. **9.** Columns 1–6 refer to the United Kingdom—Great Britain (England, Scotland and Wales) and Northern Ireland. Columns 7–11 refer to Great Britain alone.

Appendix Table 2. Education and Employment Among Adolescents in 53 Countries

Country and survey year	Secondary school enrollment ratio, circa 1990[1]			% of women 15–19			% of women 18–19 with 10 or more years of education	% of women 15–19 who are employed[4]
	Males	Females	Girls per 100 boys	Who can read easily[2]	With seven or more years of schooling[3]			
					Urban	Rural		
	1	2	3	4	5	6	7	8
Sub-Saharan Africa								
Botswana, 1988	49	55	113	85	82	72	25	10
Burkina Faso, 1992–1993	11	6	54	16	34	3	5	47
Burundi, 1987	8	5	63	28	25	0	0	8
Cameroon, 1991	32	23	71	52	58	27	15	33
Central African Rep., 1994–1995	17	6	40	21	18	1	2	54
Côte d'Ivoire, 1994	33	17	52	33	26	9	5	43
Ghana,1993	44	28	64	66	71	56	18	34
Kenya, 1993	28	23	82	78	75	60	24	24
Liberia, 1986	31	12	39	28	32	13	7	u
Madagascar, 1992	14	14	100	60	46	11	7	66
Malawi, 1992	6	3	50	38	u	u	4	19
Mali, 1987	12	6	50	14	24	1	0	17
Namibia, 1992	49	61	123	82	67	34	11	11
Niger, 1992	9	4	48	9	24	1	1	33
Nigeria, 1990	32	27	85	42	60	23	24	27
Rwanda, 1992	11	9	79	64	54	35	10	81
Senegal, 1992–1993	21	11	53	23	22	2	4	30
Tanzania, 1991–1992	6	5	78	68	74	57	6	35
Togo, 1988	34	12	34	28	25	8	4	55
Uganda, 1995	14	8	59	40	51	19	8	48
Zambia, 1992	25	14	59	48	66	27	5	28
Zimbabwe,1994	51	40	80	86	95	77	38	29
North Africa & Middle East								
Egypt, 1992	81	69	80	49	66	46	23	8
Morocco, 1992	40	29	70	42	54	7	10	19
Sudan, 1989–1990	24	19	79	46	48	45	9	2
Tunisia, 1988	55	49	84	59	62	0	6	3
Yemen, 1991–1992[5]	64	14	21	36	49	5	0	1
Asia								
Bangladesh, 1993–1994	25	13	49	32	40	21	5	9
China, 1992	60	51	79	91	93	48	17	u
India, 1992–1993	59	38	59	56	60	35	21	26
Indonesia, 1994	48	39	78	90	68	44	8	26
Pakistan, 1990–1991	28	13	41	29	56	9	19	17
Philippines, 1993	64	65	100	90	85	75	63	22
Sri Lanka, 1987	71	78	105	u	u	u	u	9
Thailand, 1987	38	37	95	76	75	18	25	47
Turkey, 1993	74	48	62	88	33	16	13	23
Latin America & Caribbean								
Bolivia, 1994	40	34	85	81	80	34	45	39
Brazil, 1996	31	36	116	89	59	24	28	33
Colombia, 1995	57	68	116	91	73	32	40	28
Dominican Republic, 1991	30	43	138	84	73	47	40	24
Ecuador, 1987	54	56	99	84	73	31	40	14
El Salvador, 1985	27	30	109	74	47	21	26	u
Guatemala, 1987	25	23	88	52	44	8	12	19
Mexico, 1987	57	58	98	94	73	33	25	46
Paraguay, 1990	36	38	103	82	63	20	26	31
Peru, 1991–1992	66	60	88	90	79	35	51	30
Trinidad & Tobago, 1987	74	78	101	95	94	89	82	7
Developed countries								
France, 1994	104	107	98	u	84	72	82[6]	3
Germany, 1992	101	100	93	u	74	74	74[6]	28
Japan, 1992	95	97	97	u	95	94	95	16
Poland, 1991	82	87	101	u	93	82	88[6]	6
Great Britain, 1991[7]	91	94	99	u	100	100	100	45[8]
United States, 1995	98	97	94	u	85	90	86[6]	42

For sources and notes, see page 53.

Appendix Table 3. Sexual Activity and Marriage Among Adolescents in 53 Countries

Country and survey year	% of persons 15–19 who are married or cohabiting		% of women 20–24 who began their first marriage or union before age 18			% of women 20–24 sexually active by age 20				
	Males	Females	All	If had fewer than 7 years of schooling[1]	If had 7 or more years of schooling[1]	All	Before marriage		Within marriage	
							Before 18	18–19	Before 18	18–19
	1	2	3	4	5	6	7	8	9	10
Sub-Saharan Africa										
Botswana, 1988	1	6	10	15	8	91	59	22	7	3
Burkina Faso, 1992–1993	3	44	62	65	25	92	21	4	51	16
Burundi, 1987	4	6	17	18	9	46	4	6	13	24
Cameroon, 1991	3	41	58	79	26	94	33	7	47	7
Central Afr. Rep., 1994–1995	6[2]	39	57	60	42	94	41	6	39	9
Côte d'Ivoire, 1994	3	26	44	48	21	95	56	8	26	4
Ghana,1993	2	20	38	51	26	88	44	15	22	7
Kenya, 1993	3[2]	15	28	52	18	80	45	16	13	6
Liberia, 1986	3[2]	32	48	57	30	98	63	4	29	2
Madagascar, 1992	9	21	37	45	14	80	37	14	24	6
Malawi, 1992	6	36	55	63	25	u	u	u	u	u
Mali, 1987	1	72	78	80	61	95	18	2	65	10
Namibia, 1992	u	7	12	21	5	67	33	23	8	3
Niger, 1992	14	57	84	87	12	92	4	1	82	6
Nigeria, 1990	u	37	52	69	14	83	18	9	46	11
Rwanda, 1992	3	8	15	21	4	43	6	6	13	18
Senegal, 1992–1993	1	29	48	54	6	70	9	5	46	10
Tanzania, 1991–1992	3	26	37	58	28	83	35	10	26	13
Togo, 1988	2[2]	27	44	50	16	92	53	15	18	6
Uganda, 1995	8[2]	47	54	62	31	91	40	8	33	11
Zambia, 1992	2	27	43	60	31	87	41	9	28	9
Zimbabwe,1994	2	19	31	69	24	66	17	11	21	17
North Africa & Middle East										
Egypt, 1992	3[2]	14	27	49	6	u	u	u	u	u
Morocco, 1992	2	12	18	23	4	u	u	u	u	u
Sudan, 1989–1990	3[2]	15	27	41	9	u	u	u	u	u
Tunisia, 1988	0	4	10	12	4	u	u	u	u	u
Yemen, 1991–1992	13[2,3]	24	49	54	17	u	u	u	u	u
Asia										
Bangladesh, 1993–1994	7	48	73	82	40	u	u	u	u	u
China, 1992	1	3[2]	5	8	2	u	u	u	u	u
India, 1992–1993[4]	6	38	51	66	21	u	u	u	u	u
Indonesia, 1994	2	17	31	49	10	u	u	u	u	u
Pakistan, 1990–1991	4	24	32	38	7	u	u	u	u	u
Philippines, 1993	4	7	14	30	10	u	u	u	u	u
Sri Lanka, 1987	1	7[2]	14	u	u	u	u	u	u	u
Thailand, 1987	4	16	20	25	8	u	u	u	u	u
Turkey, 1993	5	13	23	30	6	u	u	u	u	u
Latin America & Caribbean										
Bolivia, 1994	3	15	25	34	18	58	17	11	18	11
Brazil, 1996	2	14	24	34	14	62	28	12	15	7
Colombia, 1995	6[2]	14	26	42	15	62	22	13	19	9
Dominican Republic, 1991	6[2]	18	30	64	18	50	7	3	26	14
Ecuador, 1987	4	17	26	42	15	51	13	6	20	13
El Salvador, 1985	4[2]	24	38	48	16	49	10	4	23	11
Guatemala, 1987	8	24	41	48	10	64	12	4	34	14
Mexico, 1987	7	18	28	46	13	46	7	4	21	14
Paraguay, 1990	1	14	24	33	13	61	21	13	18	10
Peru, 1991–1992	3	10	18	43	9	45	17	10	11	7
Trinidad & Tobago, 1987	1	20	34	42	33	57	8	6	27	17
Developed countries										
France, 1994	1	4	11	29	7	73	30	8	23	12
Germany, 1992	0	2[5]	3	3	3	81	56	15	2	8
Japan, 1992	0[6]	2[6]	0	6	0	u	u	u	u	u
Poland, 1991	1[7]	8[7]	4	12	3	40	9	16	2	12
Great Britain, 1991	3[8]	11[8]	10	27	6	87	64	22	0	1
United States, 1995	1	8	11	41	6	81	60	15	3	3

For sources and notes, see page 53.

Appendix Table 4. Adolescent Childbearing in 53 Countries

Country and survey year	Fertility rate per 1,000 women 15–19[1]	Number of children born to women 15–19, 1997	% of women 20–24 who gave birth by age 18[2]			% of women 20–24 who gave birth by age 20[2]	% of women 40–44 who gave birth by age 20[2]	% of adolescent births to unmarried women	% of adolescent births that are unplanned[4]
			All	If had fewer than 7 years of schooling	If had 7 or more years of schooling[3]				
	1	2	3	4	5	6	7	8	9
Sub-Saharan Africa									
Botswana, 1988	129	11,200	26	37	21	55	50	85	77
Burkina Faso, 1992–1993	149	82,100	32	34	10	62	58	5	29
Burundi, 1987	51	17,700	8	8	4	27	39	34	36[5]
Cameroon, 1991	164	123,200	46	61	24	67	64	25	28
Central African Rep., 1994–1995	155	28,200	38	40	28	61	59	27	25
Côte d'Ivoire, 1994	151	120,000	44	47	27	63	57	42	35
Ghana,1993	116	112,600	25	33	17	49	50	29	64
Kenya, 1993	110	187,700	28	44	21	52	59	44	57
Liberia, 1986	188	30,800	44	42	49	64	59	47	36[5]
Madagascar, 1992	157	130,600	31	38	11	53	60	43	24
Malawi, 1992	161	97,100	38	42	20	63	56	22	42
Mali, 1987	206	123,000	46	48	25	67	62	4	18[5]
Namibia, 1992	109	9,300	18	26	12	42	38	75	56
Niger, 1992	215	109,400	53	55	9	75	63	6	13
Nigeria, 1990	146	895,700	35	46	10	54	49	6	11
Rwanda, 1992	60	29,000	8	11	4	25	36	33	41
Senegal, 1992–1993	127	59,700	34	38	5	52	54	14	31
Tanzania, 1991–1992	144	243,200	28	45	22	57	65	36	20
Togo, 1988	131	29,900	30	34	13	56	59	19	44[5]
Uganda, 1995	204	244,400	39	46	21	66	65	15	27
Zambia, 1992	156	86,000	34	42	28	61	68	34	38
Zimbabwe,1994	99	63,700	23	49	18	47	54	29	50
North Africa & Middle East									
Egypt, 1992	63	208,800	15	28	2	29	40	u	16
Morocco, 1992	40	59,900	7	9	1	19	39	u	24
Sudan, 1989–1990	65	103,700	17	27	5	26	61	u	15[5]
Tunisia, 1988	27	12,900	3	4	1	13	36	u	29
Yemen, 1991–1992	102	82,100	27	30	6	41	35	u	u
Asia									
Bangladesh, 1993–1994	140	940,500	47	54	19	66	85	u	21
China, 1992	11	524,500	2	3	1	14	22	u	u
India, 1992–1993	121	5,536,700	28	38	9	49	58	u	16
Indonesia, 1994	61	636,500	16	26	3	33	51	u	12
Pakistan, 1990–1991	84	620,300	17	21	2	31	38	u	11
Philippines, 1993	50	183,500	8	18	5	21	26	u	44
Sri Lanka, 1987	32	29,400	5	u	u	16	31	u	30
Thailand, 1987	53	152,000	9	12	3	24	28	u	32
Turkey, 1993	55	161,500	11	15	2	25	42	u	22
Latin America & Caribbean									
Bolivia, 1994	94	38,000	19	28	11	38	38	23	35
Brazil, 1996	86	709,100	16	24	9	32	29	29	49
Colombia, 1995	89	163,000	18	33	8	36	34	31	44
Dominican Republic, 1991	88	35,400	17	42	8	33	52	25	40
Ecuador, 1987	89	56,200	16	27	8	35	39	15	30
El Salvador, 1985	134	46,900	u	u	u	u	u	24	48
Guatemala, 1987	134	81,500	28	33	6	50	48	13	23
Mexico, 1987	86	428,400	19	34	8	35	41	12	33[5]
Paraguay, 1990	97	24,800	16	21	10	37	34	32	25
Peru, 1991–1992	61	79,500	12	32	6	27	36	25	52
Trinidad & Tobago, 1987	82	5,400	13	26	10	30	40	14	40
Developed countries									
France, 1994	8	15,100	2	8	0	6	13	78	42[6]
Germany, 1992	11	24,200	1	2	1	6	13[7]	57	u
Japan, 1992	4	16,000	1	9	0	3	2	10	u
Poland, 1991	26	41,600	1	7	1	14	11	31	u
Great Britain, 1991	29	41,700	6	24	3	15	16	87	u
United States, 1995	57	502,900	9	33	5	22	24	62	66

% of married women 15–19 who do not want a child soon	Mean family size desired by women 15–19
10	11
62	3.7
66	5.5
75	5.2
64	5.9
59	5.4
62	4.7
83	3.7
66	3.5
63	5.3
59	5.2
73	4.4
68	6.6
28	4.1
57	6.9
62	5.6
74	4.1
64	5.5
64	4.9
74	4.7
67	4.5
68	5.2
70	3.4
64	2.5
56	2.9
59	5.5
70	3.2
14	5.0
71	2.8
73	2.9
65	3.0
70	2.8
57	5.2
81	2.9
76	2.5
76	2.2
71	2.3
91	2.2
88	2.1
83	2.2
66	2.7
80	2.6
82	2.9
79	3.6
63	2.7
74	3.3
90	2.2
87	2.5
18[6]	2.2[6]
87[6]	2.2[6]
77[8]	2.2[8]
u	2.2[9]
u	u
70	2.2

Sources and Notes to Appendix Tables 2, 3 and 4

Table 2

Sources

For all columns lacking a citation, the correct reference will be: Special analyses of fertility surveys from each country (see Data Sources, p. 9). **Columns 1 and 2:** United Nations Educational, Scientific and Cultural Organization (UNESCO), *Statistical Yearbook, 1995*, Lanham, MD, USA: Bernan Press, 1995, Table 3.2, pp. 3-17–3-72. **Column 3:** For Côte d'Ivoire, Ghana, Kenya, Madagascar and Yemen, this is estimated from the ratio of column 1 to column 2. For all other countries, see sources for columns 1–2, Table 3.7, pp. 3-155–3-203. **Column 8:** Gissot C, *Enquête sur l'emploi de 1994: résultats détaillés,* INSEE Résultats 415–416, Emploi Revenus 92–93, Paris: Institut National de la Statistique et des Etudes Economiques, 1995; Germany—Federal Statistical Office, *Microcensus, 1994,* Wiesbaden, Germany: Federal Statistical Office, 1995, Table 1.2.1; Great Britain—Office of Population Censuses and Surveys, *General Household Survey, 1993*, London: Her Majesty's Stationery Office, 1995; Japan—Statistics Bureau, *1990 Population Census of Japan,* Tokyo: Management and Coordination Agency, n.d.; Poland—special tabulations of the 1995 microcensus.

Notes

u=unavailable. **1.** Data are for 1990–1993 except for Central African Republic (1989), Liberia (1980), Zambia (1988), Philippines (1985), Brazil (1980) and Peru (1985). The enrollment ratio (columns 1–2) is the total enrollment, regardless of age, divided by the population of the age-group that corresponds to secondary school for each country. **2.** For countries with ever-married samples (Egypt, Sudan, Tunisia, Yemen, Bangladesh, India, Indonesia, Pakistan, Sri Lanka, Thailand and Turkey), this is an estimate of reading proficiency for all women. Direct information for ever-married women was combined with an estimate for never-married women. This estimate was based on never-married women's years of schooling and the relationship between years of schooling and reading proficiency for ever-married women. **3.** See Appendix Table 1, note 2. **4.** Data for Egypt, Sudan, Tunisia, Yemen, Bangladesh, Indonesia, Pakistan, Sri Lanka, Thailand and Turkey are for ever-married women. **5.** Data for Yemen are for the entire country (the former People's Democratic Republic of Yemen and the former Yemen Arab Republic combined). **6.** Refers to 20–24-year-olds. **7.** Columns 1–3 refer to the United Kingdom—Great Britain (England, Scotland and Wales) and Northern Ireland. Columns 4–8 refer to Great Britain alone. **8.** Refers to 16–17-year-olds.

Table 3

Sources

For all columns lacking a citation, the correct reference will be: Special tabulations of fertility surveys for each country (see Data Sources, p. 9). **Column 1:** United Nations (UN), *Demographic Yearbook, 1990*, New York: UN, 1992, Table 41, pp. 894–946; UN, *Demographic Yearbook, 1987*, New York: UN, 1989, Table 29, pp. 630–873; Kenya, Liberia, Niger, Togo, Uganda, Yemen, Colombia, Dominican Republic and El Salvador—UN, *Patterns of First Marriage*, New York: UN, 1990, Annex Table A1, pp. 296–322; France—Toulemon L, La cohabitation hors mariage s'installe dans la durée, *Population*, 1996, 51(3): 675–716; Central African Republic, Ghana, Zimbabwe, Sudan, India and Pakistan—Demographic and Health Survey published reports. **Column 2:** France—See source for column 1; Germany—UN, *Demographic Yearbook, 1990*, New York: UN, 1992, Table 41, pp. 922–924.

Notes

u=unavailable. **1.** Figures are based on 10 or more years of education for the developed countries except Great Britain (11 or more) and the United States (12 or more). In France, Germany, Poland and the United States, the figure is for age-group 20–24; in Japan, for age-group 18–19; in Great Britain, for age-group 16–19. **2.** Percentage who have ever been married or cohabited. **3.** Percentage is for the former Yemen Arab Republic only. **4.** Age at cohabitation, which may follow formal marriage by months or even years. **5.** Figures for the former German Democratic Republic and Federal Republic of Germany in 1988 have been combined. **6.** Refers to 18–19-year-olds. **7.** Refers to 17–19-year-olds. **8.** Refers to 16–19-year-olds.

Table 4

Sources

For all columns lacking a citation, the correct reference will be: Special tabulations of fertility surveys for each country (see Data Sources, p. 9). **Column 1:** Germany—*Recent Demographic Developments in Europe*, Belgium: Council of Europe Press, 1995, Table GER-3, p. 120; Poland—ibid., Table PL-3, p. 207; Japan—United Nations, *Demographic Yearbook, 1994*, New York: United Nations, 1996, Table 11, p. 352; France—Couet C and Tamby I, *La situation démographique en 1993: mouvement de la population*, INSEE Résultats 469–470, Démographie-Société 49–50, Paris: Institut National de la Statistique et des Etudes Economiques, 1996; Great Britain—Office of Population Censuses and Surveys, Birth statistics, *Population Trends*, 1996, No. 84; United States—National Center for Health Statistics, Births and deaths: United States, 1995, *Monthly Vital Statistics Report,* 1996, Vol. 45, No 3. **Column 2:** The annual number of children is estimated by multiplying the age-specific fertility rate in column 1 by the number of women in the age-group 15–19 in 1997. France and Great Britain—see sources for column 1. **Column 8:** France—see source for column 1. Germany—Federal Statistical Office, *Vital Statistics, 1994*, Wiesbaden, Germany: Federal Statistical Office, 1996, Table 9.23; Great Britain—see source for column 1; Japan—Statistics and Information Department, *Vital Statistics of Japan, 1994,* Tokyo: Ministries of Health and Welfare, 1996; Poland—Central Statistical Office, *1994 Demographic Yearbook*, Warsaw: Central Statistical Office, 1995.

Notes

u=unavailable. **1.** Rates are for 0–3 years prior to the survey, with the following exceptions: In Pakistan, the rate is for 0–5 years before the survey. In developed countries, the rate is for the most recent year available—1992 in Great Britain (England and Wales only) and 1993–1995 elsewhere. **2.** In North Africa, the Middle East and Asia, never-married women are assumed to have had no births. **3.** Figures for developed countries are based on 10 or more years of education, except for Great Britain (11 or more years) and the United States (12 or more years). **4.** Except where otherwise noted, this tabulation is based on all births at ages 15–19 that occurred during the five years prior to the survey. **5.** Among women 15–19 who have had one or more births, the proportion whose most recent birth was unplanned. **6.** Refers to 20–24-year-olds. **7.** Refers to 35–39-year-olds. **8.** Refers to 18–19-year-olds; the value is based on 22 women. **9.** Refers to 17–19-year-olds.

Appendix Table 5. Contraceptive Knowledge and Use Among Adolescents in 53 Countries

Country and survey year	% of women 15–19 who know[1]			% of women 15–19 who know where to obtain a modern method[1]			% of married women 15–19 using[2]		
	Fertile days in the menstrual cycle	About the pill, injectable, IUD or implant	About the condom	Total	Urban	Rural	Pill, injectable, IUD or implant	Condom	Other methods[3]
	1	2	3	4	5	6	7	8	9
Sub-Saharan Africa									
Botswana, 1988	4	93	83	93	96	92	12	3	3
Burkina Faso, 1992–1993	7	45	48	24	54	13	1	1	12
Burundi, 1987	6	39	3	36	60	35	1	0	4
Cameroon, 1991	28	53	45	48	66	35	0	1	17
Central African Rep., 1994–1995	11	37	55	28	45	11	0	2	11
Côte d'Ivoire, 1994	32	64	76	u	u	u	1	1	6
Ghana,1993	16	75	76	58	69	49	3	4	7
Kenya, 1993	15	86	77	72	77	71	5	0	4
Liberia, 1986	5	60	28	63	71	55	2	0	0
Madagascar, 1992	18	30	20	25	48	19	0	0	6
Malawi, 1992	11	58	59	73	u	u	1	2	4
Mali, 1987	10	25	10	21	49	10	1	0	7
Namibia, 1992	3	72	61	61	88	50	17	0	4
Niger, 1992	7	43	20	24	51	17	1	0	1
Nigeria, 1990	19	35	20	29	44	22	0	0	1
Rwanda, 1992	12	91	78	72	68	72	7	0	4
Senegal, 1992–1993	5	54	39	30	45	18	0	0	2
Tanzania, 1991–1992	6	47	33	40	54	35	1	0	4
Togo, 1988	23	60	31	70	78	65	1	1	16
Uganda, 1995	9[4]	75	75	33	49	30	3	1	6
Zambia, 1992	9	60	64	63	68	57	2	2	5
Zimbabwe,1994	7[4]	90	90	u	u	u	27	3	2
North Africa & Middle East									
Egypt, 1992	9	98	28	83	91	81	13	0	1
Morocco, 1992	2	94	45	91	95	89	22	0	1
Sudan, 1989–1990	23	67	10	55	77	47	2	0	2
Tunisia, 1988	19	97	43	88	93	84	6	0	5
Yemen, 1991–1992	u	51	8	24	60	17	1	0	0
Asia									
Bangladesh, 1993–1994	u	99	85	70	68	70	17	3	5
China, 1992	u	83	26	u	u	u	24	1	0
India, 1992–1993	u	63	47	80	89	78	3[5]	1	3
Indonesia, 1994	6[4]	96	53	95	97	94	32	0	4
Pakistan, 1990–1991	3	59	18	32	48	28	1	1	1
Philippines, 1993	15	90	85	78	77	78	10	0	8
Sri Lanka, 1987	25	85	48	90	95	90	9	1	11
Thailand, 1987	7	99	89	99	98	99	39	1	3
Turkey, 1993	11	98	69	90	92	87	7	3	15
Latin America & Caribbean									
Bolivia, 1994	24[4]	65	52	32	42	14	8	2	21
Brazil, 1996	21[4]	99	98	u	u	u	40	6	7
Colombia, 1995	38	97	96	81	85	69	30	4	17
Dominican Republic, 1991	14	97	92	91	93	87	13	0	5
Ecuador, 1987	18	77	31	73	81	61	11	0	4
El Salvador, 1985	u	73	60	67	74	57	18	2	2
Guatemala, 1987	7	50	25	50	71	37	2	1	3
Mexico, 1987	u	87	51	u	u	u	23	1	6
Paraguay, 1990	21	83	46	73	80	65	25	1	10
Peru, 1991–1992	29	87	72	79	86	51	10	1	19
Trinidad & Tobago, 1987	13	88	85	90	90	90	19	8	15
Developed countries									
France, 1994	u	u	u	u	u	u	u	u	u
Germany, 1992	u	u	u	u	u	u	u	u	u
Japan, 1992	u	u	u	u	u	u	u	u	u
Poland, 1991	u	85[6]	95[6]	u	u	u	6[7]	11[7]	36[7]
Great Britain, 1991	u	u	u	u	u	u	63[8]	18[8]	3[8]
United States, 1995	u	u	u	u	u	u	36	13	8

	% of unmarried, sexually active women 15–19 using		
	Pill, injectable, IUD or implant	Condom	Other methods[3]
	10	11	12
	29	4	1
	2	9	20
	u	u	u
	1	3	68
	1	7	19
	3	10	34
	3	8	20
	6	2	16
	8	1	3
	1	1	19
	u	u	u
	u	u	u
	30	1	2
	11	1	20
	7	2	27
	14	7	14
	0	15	13
	1	2	8
	1	3	49
	5	19	14
	1	1	3
	20	13	6
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	5	5	27
	31	18	4
	16	10	19
	11	0	13
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	8	1	7
	3	10	31
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	u	u	u
	24[9]	11[9]	1[9]
	37	28	7

Sources and Notes to Appendix Tables 5 and 6

Table 5

Sources

For all columns, the correct reference is: Special tabulations of fertility surveys for each country (see Data Sources, p. 9).

Notes

u=unavailable, either because data were not collected or because the number of women was less then 20. **1.** Includes only ever-married women in all countries in North Africa, the Middle East and Asia except the Philippines. **2.** Includes women who are legally married or in cohabiting unions. **3.** Diaphragm, spermicides, periodic abstinence, withdrawal and other traditional methods. **4.** Data are from the first or second Demographic and Health Survey (DHS); data were not available from the most recent DHS. **5.** Includes women who have been sterilized (1% of currently married 15–19-year-olds). **6.** Refers to 17–19-year-olds. **7.** Refers to 17–24-year-olds. **8.** Refers to 16–19-year-olds. **9.** Proportions are based on all unmarried women 16–19, rather than on unmarried, sexually active women, because data on current sexual activity are not available.

Table 6

Sources

For all columns lacking a citation, the correct reference will be: Special tabulations of fertility surveys for each country (see Data Sources, p. 9). **Column 1:** United Nations, *The Sex and Age Distribution of the World Populations, 1994 Revision*, New York: United Nations, 1995, pp. 158–855.

Notes

u=unavailable. **1.** Includes a small number of women who report that they are infecund. **2.** Includes women who are currently pregnant and who wanted the pregnancy. **3.** Married women were asked about their fertility preferences; this information was not available for unmarried women, who are assumed to not want a child soon. **4.** Modern methods are the pill, diaphragm, condom, IUD, spermicides, sterilization, injectables and implants. **5.** Traditional methods are periodic abstinence, withdrawal and other traditional methods. **6.** Includes women who are currently pregnant and did not want to be.

Appendix Table 6. Current Reproductive Status of Women Aged 15–19 in 53 Countries

Country and survey year	Number of women 15–19, 1997 (in 000s)	% not sexually active	% sexually active						Total
			Are abstaining postpartum[1]	Want a child soon[2]	Do not want a child soon[3]				
					Use a modern method[4]	Use a traditional method[5]	Use no method[6]		
							Married	Unmarried	
	1	2	3	4	5	6	7	8	9
Sub-Saharan Africa									
Botswana, 1988	87	40	13	4	14	0	1	28	100
Burkina Faso, 1992–1993	551	47	12	22	2	2	9	5	100
Burundi, 1987	347	92	1	4	0	0	2	1	100
Cameroon, 1991	751	32	14	20	2	19	7	6	100
Central African Rep., 1994–1995	182	39	12	24	2	4	7	12	100
Côte d'Ivoire, 1994	795	32	12	16	5	12	5	18	100
Ghana,1993	971	47	10	6	5	6	6	20	100
Kenya, 1993	1,706	62	7	7	2	3	5	14	100
Liberia, 1986	164	22	15	23	4	1	7	28	100
Madagascar, 1992	832	50	8	15	0	5	6	16	100
Malawi, 1992	603	u	u	u	u	u	u	u	100
Mali, 1987	597	24	14	33	1	3	23	2	100
Namibia, 1992	85	59	8	4	10	0	2	17	100
Niger, 1992	509	40	7	31	1	1	19	1	100
Nigeria, 1990	6,135	47	9	20	2	4	9	9	100
Rwanda, 1992	483	87	2	4	1	1	4	1	100
Senegal, 1992–1993	470	65	7	14	1	1	9	3	100
Tanzania, 1991–1992	1,689	51	10	14	1	2	7	15	100
Togo, 1988	228	39	11	14	3	15	4	14	100
Uganda, 1995	1,198	43	7	25	3	2	16	4	100
Zambia, 1992	551	44	11	14	1	1	8	21	100
Zimbabwe,1994	643	73	4	8	7	0	4	4	100
North Africa & Middle East									
Egypt, 1992	3,315	86	1	7	2	0	4	0	100
Morocco, 1992	1,498	88	1	6	3	0	2	0	100
Sudan, 1989–1990	1,596	84	1	10	1	0	4	0	100
Tunisia, 1988	477	96	0	2	0	0	2	0	100
Yemen, 1991–1992	805	76	0	21	1	0	2	0	100
Asia									
Bangladesh, 1993–1994	6,718	51	2	19	10	2	16	0	100
China, 1992	47,679	u	u	u	u	u	u	u	100
India, 1992–1993	45,758	61	4	18	2	1	14	0	100
Indonesia, 1994	10,435	83	1	7	6	0	3	0	100
Pakistan, 1990–1991	7,298	75	2	14	1	0	8	0	100
Philippines, 1993	3,670	92	1	2	1	1	3	0	100
Sri Lanka, 1987	919	93	0	3	1	1	2	0	100
Thailand, 1987	2,867	83	1	5	7	0	4	0	100
Turkey, 1993	2,937	87	1	7	1	1	3	0	100
Latin America & Caribbean									
Bolivia, 1994	404	79	4	3	2	4	6	2	100
Brazil, 1996	8,245	70	2	3	13	1	4	7	100
Colombia, 1995	1,832	74	3	4	8	3	3	5	100
Dominican Republic, 1991	402	76	2	7	3	1	7	4	100
Ecuador, 1987	631	80	3	7	2	0	7	1	100
El Salvador, 1985	350	70	7	8	5	0	9	1	100
Guatemala, 1987	608	72	6	9	1	1	10	1	100
Mexico, 1987	4,981	80	2	8	5	1	4	0	100
Paraguay, 1990	256	74	4	6	5	1	3	7	100
Peru, 1991–1992	1,303	83	3	2	2	3	4	3	100
Trinidad & Tobago, 1987	66	76	2	4	7	3	7	1	100
Developed countries									
France, 1994	1,890	u	u	u	u	u	u	u	100
Germany, 1992	2,199	u	u	u	u	u	u	u	100
Japan, 1992	3,988	u	u	u	u	u	u	u	100
Poland, 1991	1,599	u	u	u	u	u	u	u	100
Great Britain, 1991	1,751	u	u	u	u	u	u	u	100
United States, 1995	8,824	57	0	3	28	2	1	9	100

For sources and notes, see page 55.

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