

The Diverse Universe of Adolescents, and the Girls and Boys Left Behind: A Note on Research, Program and Policy Priorities*

* Revised title

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Background paper to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*

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This background paper was prepared for the UN Millennium Project, and has been assembled by bringing together commentary, published pieces, and policy briefs from a number of different sources in which the Population Council had a strong or sole hand. We ask readers to check the footnotes, as these will guide you to the basic sources used, where there is much more detail, text, and tabular information available.

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1. Rationales for Investing in Adolescents¹

There are over one billion adolescents between the ages of 10 and 19, accounting for about 20 percent of the world's total population. More than 85 percent of these young people live in the developing world. In 1998 the Population Council published *The Uncharted Passage*, an inquiry into adolescents' experience in the developing world, with an emphasis on adolescent girls. We opened that monograph with the following observation:

“What happens between the ages of 10 and 19, whether for good or ill, shapes how girls and boys live out their lives as women and men—not only in the reproductive arena, but in the social and economic realm as well. Yet, despite its impact on human development, adolescence has been sidelined as a research and policy subject in developing countries. As a result, we know little about young people's lives in these societies.”²

Fortunately, over the last five years, there has been impressive intensification of policy and programmatic efforts focusing on adolescents. The objects of these interventions are variously referred to as “teenagers,” “adolescents,” “youth,” and “young people” – language which, as we will see below, misleadingly homogenizes a group of vast internal diversity. The associated age spans are variously 13-19, 10-19, 15-24, even 10-24. This note will give most of its emphasis to policies and programs affecting those between the ages of 10 and 19 (the second decade of life). It is important to keep in mind, however, that what happens in the 5–9 and 20–24-year age periods is also enormously important to understand and observe.

Over the last decade, support has grown at national and international levels for strengthening gender equity, improving reproductive health, and protecting the rights of all people—including adolescents—to make informed decisions regarding reproductive matters and other important aspects of their lives. The Convention on the Rights of the Child (CRC), which defines childhood as ending at age 18, and the Convention to End All Forms of Discrimination Against Women (CEDAW) jointly provide a comprehensive foundation for efforts to define and respect the rights of adolescents. Both documents acknowledge the close relationship between human rights and human development. Both understand the necessary relationship between rights and capabilities: without social and economic capabilities, adolescents will be unable to make choices, access services, and have productive lives. Finally, both recognize the impossibility of protecting human rights without promoting gender equality.

The broad foundations provided by the CRC and CEDAW were further refined in the historic accord signed in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The ICPD Programme of Action gave special attention to the condition of adolescents, and the gender equity dimension of reproductive health and rights. The Cairo vision was further affirmed at the Beijing International Conference on Women in 1995, and re-affirmed and

¹ This section draws substantially on: Bruce, Judith. 2003. “Preparing the Twenty-First Century's First Generation of Adults: Policy and Program Perspectives,” in *Adolescent and youth sexual and reproductive health: Charting directions for a second generation of programming*, background document for a UNFPA/Population Council workshop, 1-3 May 2002. New York: Population Council, pp.9-28. Available online at <http://www.popcouncil.org/pdfs/AYSRH/1.pdf>

² Mensch, Barbara S., Judith Bruce, and Margaret E. Greene. 1998. *The Uncharted Passage*. New York: Population Council. Out of print but available on the web at: <http://www.popcouncil.org/pdfs/passage/passage.pdf>, p. 1.

broadened later at the conferences ICPD+5, Beijing+5, and the UNGASS meeting and MDG processes.

The documents that emerged from these international conferences include formal recommendations to governments and monitoring committees to give close attention to the protection of adolescents' reproductive and sexual rights. They highlight the special stake of young people in development processes and the relationship between health, social and economic development measures.

Before turning to the programmatic discussion, it is useful to review some of the most powerful rationales and international agreements promoting greatly expanded investments in adolescents.

Box 1. Rationales for investments in adolescents

Investments in adolescents are vital for:

1. Implementing the United Nations Convention on the Rights of the Child;
2. Defending girls' rights to legal, later (to exact age 18 or above), informed, and voluntary marriage;
3. Protecting reproductive health and establishing positive health habits;
4. Realizing investments in human capital, including health investments made in early childhood, which are undermined without attention to adolescent development and observance of adolescents' rights;
5. Intervening at a crucial point to reduce or reverse gender disparities in health, social, and economic resources;
6. Building an effective economic base in poorer economies (adolescence is the period in which most males and females begin their economic life, however properly or ill prepared they are for it); and
7. Contributing to the reduction in rapid population growth by increasing the span between generations.

1.1 Implementing the United Nations Convention on the Rights of the Child

This convention, ratified by all of the members of the United Nations – with the exception of the United States – provides the broadest possible foundation for cross-cultural concern for those in late childhood. It acknowledges the special capacities of young people in this age group and identifies their rights, while also urging continuing protections of them so that they may safely develop their capabilities.

Children aged 10–18 can have their rights violated in a number of ways. In the case of girls, the arrival of puberty brings the possibility of forced departure from school, economic and sexual exploitation, involuntary removal from the home for unchosen marriage, imminent childbearing, fostering (i.e., being sent to live in another household), migration for work, and increasing

limitations placed on their participation in public and civic life. For boys, particularly in the lower income classes, there is also the possibility of being withdrawn from school under pressure to provide income for their families, as well as the risk in some settings of being drawn into armed conflicts as soldiers.

1.2 Defending girls' rights to legal, later (exact age 18 or above), informed, and voluntary marriage

Perhaps the most widespread human rights violation of children in the adolescent age group is child marriage. If present patterns continue, *over the next decade over 100 million girls will be married as children.*³ The passage to marriage is often a significantly negative experience for girls because of their loss of mobility and access to schooling; limited legal rights (in some settings, a married girl may require her husband's consent to travel or work; in other settings a girl who has been 'abducted' may be forced to marry her captor); removal from supportive family and social networks; and subjugation to uninformed, obligatory sexual activity, albeit with a nominal husband, who is often considerably older and a relative stranger.⁴

The health threats associated with child marriage were in past decades largely confined to early childbearing, but have in the last few decades grown to include exposure to increasingly dangerous sexually transmitted infections (STIs), including HIV/AIDS.

1.3 Protecting reproductive health and establishing positive health habits

HIV/AIDS. Tragically, recent surveillance data provide a picture of rapid increases in HIV among 15–24-year-olds, especially girls. This requires an immediate response. Young people between the ages of 15 and 24 account for half of all new cases of HIV globally. In sub-Saharan Africa *75 percent of infections in this age group are among females.*⁵ In 19 African countries, 5 or more percent of females aged 15–24 are infected with HIV⁶; ratios of new female-to-male infections among those aged 15–24 are as high as 8:1 in South Africa.⁷ In the age of HIV, unprotected sexual relations for girls—always a rights and safety issue—are directly life threatening.

The rapidly expanding HIV prevention youth effort has been directed at the situation of potentially or currently sexually active unmarried adolescent girls and boys. They will need to be aware of both sexual and nonsexual routes of transmission (in Europe and parts of Southeast Asia, the epidemic is still driven by intravenous drug users, who are predominantly young males), as well as assisted in adopting safe, voluntary sexual behaviors.

³ 2002 Population Council analysis of United Nations country data on marriage.

⁴ Haberland, Nicole, Erica Chong, and Hillary Bracken. 2003. "Married Adolescents: An Overview." Paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9-12 December.

⁵ UNAIDS. 2004. *2004 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

⁶ The UNAIDS 2002 *Report on the Global AIDS Epidemic* reports low and high estimates of HIV prevalence among girls and boys aged 15-24. Low estimates were used in determining the 19 countries with a prevalence of 5 percent or higher; the actual number of countries is likely slightly higher.

⁷ Shisana, O. et al. 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Cape Town: HSRC Press.

Crucially missing in initiatives to date is attention to *married girls*, who make up the vast majority of sexually active adolescent girls, and who are also often under intense pressure to become pregnant, often before they would choose to and before they are prepared to insure their pregnancy will be a healthy one. At this point, there are *virtually no realistic HIV protection strategies, messages, or technologies to support girls as they cross the marital boundary*.

In two settings with mature HIV epidemics and available biomarker data (Kisumu, Kenya and Ndola, Zambia), married girls have alarmingly high rates of HIV, higher than that of their unmarried sexually active counterparts.⁸ The sources of this elevated infection are still under study, but they could include the characteristics of married girls' partners (often older, and in one study shown to be more than twice as likely to be HIV positive than the partners of unmarried girls), the higher coital frequency of married girls, and their limited ability to negotiate condom use. Data also suggests that young women who experienced a coerced first intercourse compared with those who did not were significantly less likely to use condoms at last intercourse (13 percent versus 33 percent); significantly less likely to have consistently used condoms over the last six months (7 percent versus 25 percent); and were more likely to report that they had never used condoms (75 percent versus 59 percent).⁹ Recent research in Ethiopia reveals extremely high levels of coerced sex in child marriages, and among girls married before age 18 in Amhara region, 69 percent reported experiencing intercourse before their menarche.¹⁰

Health risks of adolescent childbearing. Adolescent childbearing has always carried special risks — some based on physiological factors (most of these found in girls 15 and under) and parity, and others on related social and economic factors that typically characterize adolescent mothers — such as their educational status, their poverty, and their autonomy. First births, particularly to the youngest mothers, deserve special attention as positive outcomes for mother and child depend on factors such as the timing of pregnancy (in relation to other health factors including other pregnancies), the mother's age of menarche, nutritional status, HIV status, physical and cognitive preparedness, and often her socioeconomic status.

Emphasis on supportive care for the youngest, first-time mothers may be particularly strategic for three reasons. Due to declining fertility and decreases in later-parity births (at one time carrying risks comparable to first births), a rising proportion of all births will be first births, with their special needs and opportunities. Establishing positive habits among first-time mothers and their partners (choices made about attended delivery, infant feeding, birth spacing) are likely to shape their subsequent reproductive behavior. With respect to policy, given the inertia of health services, if interest in first-time mothers translates into positive changes in maternal and infant care, these changes are likely also to be extended to later parity births.

⁸ Clark, Shelley. 2004. "Early Marriage and HIV Risks in Sub-Saharan Africa," *Studies in Family Planning* 35[3]: 149-160; and, Bruce, Judith and Shelley Clark. 2004. "The Implications of Early Marriage for HIV/AIDS Policy," brief based on background paper prepared for the WHO/UNFPA/The Population Council Technical Consultation on Married Adolescents. New York: Population Council. Available online at www.popcouncil.org/pdfs/CM.pdf. See also Clark, Shelley, Judith Bruce, and Annie Dude. Forthcoming 2006. "Protecting girls from HIV/AIDS: The case against child and adolescent marriage."

⁹ Koenig, M., et al. 2004. "Coerced first intercourse and reproductive health among adolescent women in Rakai, Uganda," *International Family Planning Perspectives*, 30,156-163.

¹⁰ Erulkar, Annabel, Tekle Ab Mekbib, Negussie Simie and Tsehai Gulema. 2004a. "The experience of adolescence in rural Amhara region, Ethiopia." Accra: Population Council. Available online at <http://www.popcouncil.org/pdfs/Amharabook.pdf>.

Colleagues Suellen Miller and Felicia Lester gave some thought to what might be a package of care suited to the special needs of married first-time mothers, summarized in the box below.

**Box 2. Meeting the special needs of married young first time mothers:
The IDEALS model¹¹**

The existing messages, procedures, and plans developed under the Safe Motherhood Initiative are plausibly inadequate for the cognitive and psychological development of adolescents and the low social, family, and community status that married girls hold. Accordingly, any approaches designed to meet the special health needs of married young first time mothers must also include their husbands, families, and other gatekeepers. Miller and Lester (2003) focused on the fundamental elements of approaches to help married adolescent girls achieve better maternal and infant health in constructing their “IDEALS” model. This model includes:

(I) = **Immunize**: Mount school-based and community-based programs for immunization, tetanus, iron/vitamin supplementation, and malaria identification, treatment and control.

(D) = **Delay** marriage and **Delay** first birth: Early marriage often increases a girl’s social isolation and places her in a position of low power in a new, extended, marital household, potentially affecting maternal health in negative ways. Delaying a first birth may decrease the likelihood of pregnancy induced hypertension, obstructed labor, and anemia.

(E) = **Educate** beyond early marriage and early childbirth if they occur: Keep married, pregnant, and parenting girls in school.

(A) = Ensure **Access** to youth friendly, high quality maternal services, antenatal care, birth planning (involving husbands and community members), skilled attendance, emergency obstetric care, postpartum care and child spacing.

(LS) = Impart **Life Skills** that last for a lifetime: Helping married girls acquire life skills (such as communication and negotiation skills, literacy, entrepreneurial skills, and legal and financial literacy) is critical in reducing some of the social disadvantage they face, and vital to maximizing more medical/health-based interventions. Further, it improves their parenting skills and enriches their communities.

Substance abuse. Harmful habits, if they are established in adolescence—including cigarette, alcohol, and other drug use – are extremely hard to break later on. The use and abuse of these substances not only absorbs vital cash resources, it also does immeasurable and devastating harm to adolescent health in the short run, and greatly increases the burden of disease and cost of treatment in the adult population later on.

1.4 Realizing investments in human capital, including health investments made in early childhood, which are undermined without attention to adolescent development and observance of adolescents’ rights

The needs of children under the age of 5 in particular, and even up to the age of 10, have been better defined by specific health policies and more subject to technological innovations (e.g., vaccines, oral rehydration therapy) than the needs of those aged 10–19. Children under 5 are

¹¹ Box adapted from Miller, Suellen and Felicia Lester. 2003. “Married young first-time mothers: Meeting their special needs,” paper prepared for WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9-12 December.

more compliant than older children, virtually all of their health-seeking behavior and health care is managed by their families, and these services are widely supported by communities who view early childhood health as a community priority.

But the child survival revolution raises a key question: Survival for what? Girls' and boys' survival rates are improved and relatively equal after the age of 5. What entitlements and social processes ensure that these children in which we have invested so much will realize their development potential and make productive contributions to society? *Adolescent policy must be seen as bringing to fruition decades of investment in early childhood*, and take into account their evolving capacities and desire to be in charge of their bodies and manage their own health.

1.5 Intervening at a crucial point to reduce or reverse gender disparities in health, social, and economic resources

Though the ground is prepared in early childhood for gender disparities and confining gender roles, their consequences are not fully realized until adolescence. At puberty, many girls' mobility in the public sphere and access to schooling are often dramatically curtailed. Removal from school also means that girls are cut off from the well-documented benefits of schooling: delays in the timing of marriage and first birth, lower life time fertility, and higher earnings in the labor market.¹² The recent National Research Council report, *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*¹³ demonstrate the positive links between reproductive health behaviors and school enrollment, and highlight the importance of getting girls to primary school on time and keeping them there for the duration, assuring a timely progression to secondary school.

Beginning at this stage, girls' self esteem and sense of agency or worth may be increasingly centered on their marriageability, sexuality, and fertility. A girl's body – its ability to reproduce, to give pleasure, and to undertake domestic work, may be seen by others and girls themselves as their sole social and economic asset. Boys may take on a masculine identity which emphasizes risk taking, aggressive and dominating behaviors hazardous to themselves and to girls and women.¹⁴ Adolescence may be close to the last moment at which society can effectively address gender disparities and disabling gender norms.

¹² Summers, Lawrence H. 1994. "Investing in all the people. Educating women in developing countries." *Economic Development Institute of the World Bank*. An Edi Seminar Paper. No. 45, and Odago, Adhiambo and Ward Heneveld. 1995. "Girls and schools in sub-Saharan Africa: From analysis to action." *World Bank Technical Paper No. 298*. Washington, DC: World Bank.

¹³ National Research Council and Institute of Medicine. 2005. *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*. Cynthia B. Lloyd, ed. Washington, DC: The National Academies Press.

¹⁴ For a discussion of male socialization and building programs that reach boys see: Barker, Gary. 2003. "Engaging Adolescent Boys and Young Men in Promoting Sexual and Reproductive Health: Lessons, Research, and Programmatic Challenges," in *Background Document for the UNFPA Workshop on Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming*. New York: Population Council, pp. 109-153. Available online at <http://www.popcouncil.org/pdfs/AYSRH/6.pdf>.

For a discussion of a program designed to support boys in developing more positive views of themselves and young women, see a Nigerian example in: Barker, Gary, and Francoise Girard. 2003. "My Father Didn't Think This Way: Nigerian Boys Contemplate Gender Equality," *Quality/Calidad/Qualité* Vol.14. New York: Population Council. Available online at <http://www.popcouncil.org/publications/qc/qc14.pdf>.

Other resources include Barker, Gary. 2000. *What about boys? A literature review on the health and development of adolescent boys*. Geneva: World Health Organization. Available online at <http://www.who.int/reproductive->

Box 3. Guidance on how to engage young males and address masculinity norms¹⁵

It is during adolescence that boys and girls internalize and rehearse the gender roles they will assume as men and women. Traditional gender norms, however, are linked to increased risk of HIV, violence, and (for girls) early unwanted intercourse and pregnancy. In hopes of fostering more equal relationships between males and females, and to reduce the risks that young men themselves currently face, some programs are now focusing on helping boys question traditional male socialization. Such programs tend to organize relatively small groups of boys and meet with them weekly over at least 3-6 months. The curricula often emphasize social themes over health information, addressing such issues as violence and sexual coercion, what it means to be a man, homophobia, and women's rights as human rights. A cross-cutting concern is to identify boys' own rationale for change and to teach critical thinking skills. Innovative programs in Nigeria, Brazil, Mexico, and South Africa are among those documenting positive outcomes related to sexual and reproductive health.

1.6 Building an effective economic base in poorer economies

Adolescence is the period in which most males and females begin their economic life, however properly or ill prepared they are for it. The subject of adolescent work has fostered a complicated debate. There are two parallel concerns—one about the working conditions of adolescents, including those employed underage in abusive circumstances, and the other, focused on whether young people, once of appropriate age, will find decent work.¹⁶

According to the International Labour Organization (ILO), the minimum age for relatively full-time employment and wage work “shall not be less than the age of completion of compulsory schooling and, in any case, shall not be less than 15 years.” (ILO 1973) While adolescents may work legally at age 15, they may not necessarily have the skills—or access to skill-building resources—needed to enter the modern economy.

Given the interest in and pressure for work at early ages, for those young people that begin full time work at 15, much more thought and attention must be given to how they can combine work with continuing learning, defining appropriate work standards (perhaps ones that evolve with age), enforcement of young workers’ rights, and the creation of accessible complaint mechanisms when their rights are violated.

health/publications/cah_docs/cah_00_7.html. Another valuable resource is the Helping Involve Men (HIM) CD-ROM, which brings together hundreds of documents from around the world about men's participation in reproductive health. The Men and Reproductive Health Committee of the Interagency Gender Working Group, supported by USAID's Office of Population, commissioned the Johns Hopkins Center for Communication Programs to produce the CD-ROM, which can be ordered by e-mailing popline@jhucpp.org.

¹⁵ Debbie Rogow, editor of *Quality/Calidad/Qualité*, personal communication, 2004, based on a variety of texts including Barker and Girard 2003 (see footnote 14). The Brazilian and Mexican programs have produced positive attitude and behavioral outcomes in a rigorous evaluation design; the Nigerian program has strong but anecdotal documentation of attitude and behavior change, and the South African program has quantitative reports on attitude change only.

¹⁶ For more information see: Population Council. 2005. *Adolescent Girls' Livelihoods: Building Assets for Safe, Productive Lives*. New York: Population Council. Available online at http://www.popcouncil.org/pdfs/BuildingAssets_Oct05.pdf. For more information on the ILO's Decent Work Initiative, see <http://www.ilo.org/public/english/decent.htm>.

At the same time, the content of education needs to be better aligned with the realities of modern and globalized livelihoods. Increasingly the face of the global worker is a young person – especially a female young person. For example, of the 1.2 million workers in Bangladesh’s garment industry (the leading segment of the country’s export industries), 90 percent are female, and the vast majority of these are unmarried girls aged 15–24.¹⁷ Schooling, both formal and informal, needs to better prepare young people for the world of earning by building marketable skills and financial literacy, and empowering them to benefit from emerging financial systems such that young workers can not only earn adequately, but—given that in many countries the youngest age at which one is allowed to have a bank account is 18—also control their income.¹⁸

1.7 Increasing the span between generations and reducing rapid population growth

Finally, and not fully appreciated in recent years (as reproductive health concerns have dominated the discourse within the population community), is the *demographic impact that would be achieved by deferring first births*, which take place primarily within marriage in developing countries. In less developed countries, half of all future population growth is attributable to population momentum—the tendency of populations to keep growing, even after fertility rates fall, in societies with a young age structure (i.e., many young people in or entering their childbearing years).

In the countries with the highest fertility rates and lowest average age at marriage (concentrated in South Asia and sub-Saharan Africa), *a sizeable proportion of future population growth can be addressed by delaying marriage and closely associated childbearing*. For example, *if the mean age of childbearing in Bangladesh were to rise by 5 years—from 18 to 23 years—approximately 36 percent of future population growth would be averted*.¹⁹ Similarly, delayed childbearing (raising the age of first birth by five years) would reduce population growth in countries such as Egypt and India (where fertility rates have substantially declined and population momentum is now the primary cause of demographic growth) by about a third. Though the most direct impact of delayed marriage on population growth may be seen through delayed first births and increased span between generations, *there are likely powerful and synergistic effects on the other sources of population growth*. As older, better prepared and schooled brides negotiate child spacing and contraceptive use with husbands closer to them in age, smaller family sizes will be achieved and increased intergenerational investments, especially in schooling, will be made in both male and female children.

¹⁷ Amin, Sajeda, Ian Diamond, Ruchira T. Naved, and Margaret Newby. 1998. “Transition to adulthood of female garment-factory workers in Bangladesh,” *Studies in Family Planning*, 29[2]: 185-200. Available online at <http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP292Amin.pdf>.

¹⁸ Bruce, Judith. 2000. “Controlling earned income and savings opportunities: A right for all-A revolution for young working women,” in *Global Alliance for Workers and Communities Progress Report* 1(3): 6-7.

¹⁹ Calculations by John Bongaarts, Population Council. 1998. In the Bangladesh case, 80 percent of future growth will come from population momentum, and 40 percent of that would be averted with an upward shift in females’ age at first birth.

2. Adolescent Policy: Moving Beyond the Western Problematique²⁰

The activist population/family planning community was among the earliest champions of an adolescent agenda *per se*. The strength of the community's contribution was the depth of its commitment, its network of activists on the ground who were accustomed to dealing with controversial subjects, and its genuine concern with the well being of young people. The weaknesses of the family planning/population base as a springboard for adolescent policy and programming are the narrow confinement of its concepts and action plans to the health (and reproductive health within health) sector, an insufficient capacity to deal with the structural determinants of key gender issues that emerge in adolescence, and an overemphasis on the Western construction of adolescence.

Adolescent policy and popular program approaches (family life education, youth centers, youth-friendly health services, and peer education) were developed in contexts where the transition to marriage typically took place post-adolescence, the vast majority of adolescents attended secondary school, and health systems were by and large functional. Many of the programmatic interventions in these contexts are concerned about generating increased trust between adults and adolescents, and call for services to be more 'youth friendly' in their interpersonal approach, their venues, and their flexibility.

Much energy was directed towards offering unmarried school-age and/or school-going youth information, protection strategies, and technologies – all important, but not geared to the realities of the second decade of life in poor and traditional societies. Outside of this paradigm have been the needs of young adolescents living apart from the presumptive protection of family or school, girls in societies where child marriage is common and/or the HIV epidemic is disproportionately affecting young females, and married adolescents.

Promisingly, this monolithic approach to adolescent programming has begun to shift. Over the last five years, this agenda has broadened into one of social development with emphasis also on economic elements more appropriate to the rising adolescent generation in the poorest countries. A broad-gauged social development agenda for adolescents has been endorsed by UNFPA, WHO, UNICEF, UNIFEM, and many private foundations. Diversification of adolescent programming on the ground however, has followed more slowly, and has often been incremental. Experimental efforts with vulnerable and hard to reach subsets of young people through non-health interventions (e.g., education, social protection, and livelihoods programs for out of school youth) have begun to appear.

2.1 Responding to the vast internal diversity of adolescents: Variety, variety, variety

Perhaps the greatest current challenge in adolescent programming is to move the field away from overly generalized efforts directed at an ageless, genderless mass variously described as "adolescents," "youth," "teenagers," and "young people," towards the identification of subgroups of special interest. Much adolescent programming is designed to help adolescents or youth (with no further specification) achieve very generalized goals such as "acquisition of life skills" or

²⁰ A fuller discussion is found in *The Uncharted Passage*, chapter 4, "Charting a Positive Future for Girls in Developing Countries: An Agenda for Policy, Programs, and Research." See footnote 2.

“better reproductive health” or the “ability to make better choices.” Youth serving organizations and national programs may represent themselves as serving all young people - simultaneously responsible, in theory, for reaching the in-school, unmarried, 10-year-old girl, the school-going urban boy of 17, the out-of-school employed boy of 14 in a peri-urban area, and the married 16-year-old girl in a remote rural area.

Investments in adolescents will have limited yield unless they are more specifically targeted to subsets of adolescents, differentiated by age, gender, marital and schooling status, social status, economic class, living arrangements, and urban/rural residence. It should be noted that policies can be both inclusive and sensitive to distinctions among young people. For example, South Africa’s draft national adolescent policy was promoted as part of cohesive nation-building, yet simultaneously underscored the distinctive situations of males, females, and different age, ethnic, and language groups. It even acknowledged the unique situation of many young people whose schooling was disrupted because of the conjunction of their adolescence and the national struggle for independence when schools were often closed.²¹ There is no one ideal process for developing an evidence-based program responsive to the internal diversity of young people. Section V offers perspectives and a potential learning sequence, in brief.

2.2 Data sources and challenges

At a practical level, addressing adolescent diversity requires a disaggregated data base. In most settings there are rudimentary databases through which to view some of the key dimensions of adolescent life, though this information is not always conveniently organized. In a few exceptional settings, such as Egypt, Jordan, Mongolia, Pakistan, and South Africa, nationally representative surveys of adolescents have been conducted.²² As such dedicated national adolescent surveys are rare, the Population Council has compiled 14 standard tables on adolescents from Demographic and Health Survey (DHS) data on adolescents in 46 countries.²³

²¹ Bruce, Judith. 1999. Presentation in Drakensburg, South Africa, Annual Conference on Reproductive Health Priorities.

²² A) el-Tawila, Sahar, Omaima el-Gibaly, Barbara Ibrahim, Fikrat el-Sahn, Sunny Sallam, Susan M. Lee, Barbara Mensch, Hind Wassef, Sarah Bukhari, and Osman Galal. 1999. *Transitions to Adulthood: A National Survey of Adolescents in Egypt*. Cairo, Egypt: Population Council. Available online at: <http://www.popcouncil.org/ta/transitions/index.html>.

B) Salem-Pickartz, Josi. 2002. *Jordanian Youth: Their Lives and Views*. Jordan: UNICEF.

C) Esumunkh, Myagmar. 2000. *Mongolian adolescents’ needs assessment survey report*. Commissioned by the Mongolian Ministry of Health, UNFPA Mongolia, WHO Mongolia, UNICEF Mongolia, and the Mongolia UN Resident Coordinator.

D) Sathar, Zeba A., Cynthia B. Lloyd, Minhaj ul Haque, Judith A. Diers, Azeema Faizunnissa, Monica Grant and Munawar Sultana. 2003. *Adolescents and youth in Pakistan 2001-02: A nationally representative survey*. Pakistan: Population Council. Available online at: <http://www.popcouncil.org/pdfs/wp/188.pdf>.

E) Pettifor, A.E., H.V. Rees, A. Steffenson, L. Hlongwa-Madikizela, C. MacPhail, K. Vermaak, I. Kleinschmidt. 2004. *HIV and sexual behaviour among young South Africans: A national survey of 15-24 year olds*. Johannesburg: Reproductive Health Research Unit, University of the Witwatersrand.

²³ See Annex 1 of this paper for a listing of countries on which there are tables. These tables were created drawing on three DHS sources of data: household surveys, interviews with females of reproductive age, and (where available) interviews with males.

Box 4. Population Council tabulations of DHS data on adolescents

The Population Council adolescent tables, **“Facts About Adolescents from the Demographic and Health Survey”** gathers information on young people aged 10-24 on the following areas:

- Residence status (urban/rural)
- Population distribution
- Living arrangements
 - Parental survival status and residence in household
 - Characteristics of head of household
- Educational enrollment and attainment (urban/rural)
- Marital status
 - Current marital status
 - Married by ages 15, 18, 20
- Adolescent schooling and work status, by marital and childbearing status
- Sexual activity and childbearing
- Reproductive health knowledge, behavior, and special risks
 - Awareness and use of modern contraceptive methods
 - Awareness of HIV/AIDS
 - Experience with sexually transmitted infections
- Female genital circumcision (only collected for certain countries)

A second series of tabulations were compiled on very young adolescents (aged 10-14) in response to increased interest in learning more about this subgroup. **“Selected DHS Data on 10-14-year-olds”** covers many of the dimensions above (residence, living arrangements, schooling) but focuses in addition on:

- Mapping girls and boys by living arrangement and school enrollment, to see what proportion are without both protective structures of parents and school
- The relationship between living arrangements and school enrollment, and how this differs by gender
- The proportion of girls who had sex, married, or gave birth before age 15
- Exposure to radio and television (urban/rural)

See Annex 1 for listing of countries or download the reports at www.popcouncil.org/gfd/gfdcountries.html

Collecting data on adolescents is not easy and techniques used with adults may not be applicable. Current DHS procedures collect information through the household survey on 10-14-year-olds but do not interview them directly. It may be difficult to find and interview married girls who may not be reported in their natal or marital home as “adolescents” or at all. Very young adolescents may be uncomfortable responding to conventional interviewing formats. Adolescents living under the close control of their parents or employers may actually face threats to their well-being if consent is not secured adequately, and interviews are not conducted in private and with sensitivity.

There are sometimes significant local, regional, and national differentials in the experience of adolescent girls and boys—e.g., employment rates and educational rates in urban vs. rural areas, marriage rates, access to media, and so forth. Some databases allow for disaggregation of data by region, which is highly desirable for some planning purposes. A striking example is child marriage rates. In many places there has been a gradual increase in the national average of age at marriage, yet in some regions the proportions of girls married by age 15 and age 18 remain high

and are clearly out of step with the national picture. (For an example of these contrasts within countries, see Table 3 on p.20).

3. Adolescent Subgroups Often Left Behind and Deserving Special Attention

Many adolescents are in need, and all adolescents have the right to a safe and healthy transition to adulthood. Yet, some adolescent subgroups of significant size may be more neglected than others, and what happens to them may be particularly consequential to the shape of poverty, demographic change, and the HIV epidemic. Judgments regarding vulnerability and significance of adolescent sub-populations must be made within each country setting. For the purposes of illustration the authors have selected four groups—often overlapping—that may deserve special attention. They are:

1. Very young adolescent boys and girls (aged 10-14) living outside the presumptively protective structures of family and school
2. Poor girls on their own or managing HIV affected families, under pressure to engage in sex for gifts or money
3. Girls at risk of child marriage
4. Married adolescent girls

3.1 Young adolescents living outside the protective structures of family and school

Early adolescence may be the calm before the storm – for many it is marked by relatively good health, going to school, and stable family circumstances – the foundation of a safe transition to adulthood. But for some young adolescents the years between ages 10 and 14 mark a period of vulnerability and intense transition. A young adolescent progresses from clearly being a child at age 10, through the onset of puberty, to being perceived in some societies as a young woman ready for sexual relations, marriage, and child-bearing, or a young man ready to take on the role of family bread-winner or soldier.

Young adolescents are more likely than older adolescents to be in residence with parents and in school; however their absence from school or lack of parental support (e.g. a surprisingly high proportion of 10-14-year-olds live with one or neither parent in many parts of sub-Saharan Africa) may be cause for concern. While some of these young people not residing with parents may be with their extended family, or in positive fostering or protective living arrangements, it is plausible that many are vulnerable to sexual exploitation, unsafe work, and substance abuse.²⁴

It is important to note that in some countries (Ethiopia and Mali, for example), one simultaneously has some regions characterized by a very high prevalence of child marriage, and in urban areas – often not far away – a high concentration of girls aged 10-14 living with neither parent. It may be, as recent research in these two countries suggest, that these are two sides of the same problem. Some girls are voluntarily seeking to leave their villages to avoid early

²⁴ Chong, Erica, Kelly Hallman and Martha Brady. Forthcoming 2006. *Investing When It Counts: Generating the evidence base for policies and programmes for very young adolescents, Guide and toolkit*. New York: UNFPA and Population Council.

marriages and other confinements. Others – more commonly older adolescent girls (aged 15-19) in nominal domestic service and living with neither parent may be either avoiding or escaping unwanted marriages. Based on work in Ethiopia which focused on Amhara, a region with a high prevalence of child marriage, and receiving parts of Addis Ababa, where large numbers of girls live both without parents and in shadowy employment, Erulkar reports that 19 percent of girls cited the threat of marriage as their reason for migration.

I wanted to work and at the same time pursue my education. So I decided to come to Addis Ababa. Also, I came when I heard they were about to abduct me [into marriage]. (Age 15, migrated from Amhara region at age 14, working as domestic worker, 1 year of education)²⁵

“Unpacking” the 10-14-year-old’s transition. The 10-14-year-old cohort is largely arbitrary, an artifact of demographic analyses which typically (when dealing with adults) group experiences in 5-year cohorts. *The intense transitions of adolescence, particularly around puberty, may warrant analyzing data in one year or even six-month intervals.* Within given contexts diagnostic work must define how adolescents themselves and their families view the key transitions, and how these are related to their evolving capacities, risks and opportunities. These transitions are likely to vary substantially not only by setting, but also by gender, schooling, family background, and marital status.²⁶

As highlighted above, gathering data on very young adolescents is a significant challenge. Gaining access to this age group (through gatekeepers and parents) requires careful negotiation of sensitive social situations and community norms concerning young adolescents and sexuality. Crafting consent procedures that are both protective of young adolescents and understandable to them is vital.²⁷ And finally, what they know and how they know it may be difficult to capture. Though some research with young adolescents has been successfully conducted, the experiences of 10-14-year-olds are more commonly gleaned from questioning older adolescents about what their lives were like at earlier ages. The youngest adolescents (ages 10 to 12) are often highly reticent and cannot be drawn out sufficiently in focus groups.²⁸ Provided appropriate consent and access have been obtained, repeated one on one interviews has proven to be an effective strategy with them.²⁹ Information-gathering activities that are more participatory and engaging such as community mapping exercises or visual methodologies have also been shown to be successful in some settings.³⁰

²⁵ Erulkar, Annabel, Tekle-Ab Mekbib, Negussie Simie, and Tsehai Gulema. 2004b. “Adolescent life in low income and slum areas of Addis Ababa, Ethiopia.” Accra, Ghana: Population Council.

²⁶ UNESCO-International Bureau of Education/Right to Education Project has published a very helpful compendium entitled, “At What Age?” written by Angela Melchiorre (2nd ed., 2004). Also, the recent National Academy of Sciences report *Growing Up Global* places great emphasis on looking at trends in the timing of the transitions of adolescents throughout the world. See footnote 13.

²⁷ For more information, see Schenk, Katie and Jan Williamson. 2005. *Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and Resources*. Washington, DC: Population Council.

²⁸ Helitzer-Allen, D., M. Makhambere, and A.M. Wangel. 1994. “Obtaining sensitive information: The need for more than focus groups,” *Reproductive Health Matters* (3):75-82.

²⁹ Personal communication, Annabel Erulkar 2004.

³⁰ Chong, Hallman and Brady 2006.

In sub-Saharan Africa, and particularly among girls, we find that a great many young people do not live with their parents or in their natal home – as a result of marriage, migration for work, family breakdown, or disease and death of parents – or have left school before the bulk of their adolescence is completed. *Strategies for learning more about these young people should be a priority.* Data from 17 countries is presented below revealing a surprisingly high proportion of girls aged 10-14 who are living with neither parent.

Table 1. Percentage of girls aged 10-14 living with neither parent, by area of residence

Country	Percentage of girls 10-14 living with <u>neither</u> parent	
	Urban	Rural
Benin	42	25
Burkina Faso	35	19
Central African Republic	29	27
Chad	24	17
Comoros	39	26
Cote d'Ivoire	41	29
Dominican Republic	27	23
Ethiopia	30	16
Ghana	35	26
Guinea	36	20
Haiti	46	26
Malawi	38	30
Niger	21	22
Rwanda	45	22
Senegal	25	19
Togo	37	25
Uganda	43	28

Demographic and Health Survey data, analyzed by Erica Chong. Survey years 1994-2001.

Many programs for adolescents of all ages but especially the youngest, implicitly assume that boys and girls are living with parents, and/or are enrolled in school. We thus thought it would be useful to do a composite calculation of girls and boys 10-14 in these conditions to characterize more accurately the social assets available to this group. We found a surprisingly high proportion of very young adolescents in selected countries who *do not have both protective factors* present; that is they are either not in school or not living with both parents, or both situations apply. Being out of school and/or living with one or no parents may not only increase their social isolation and the economic pressures on a young person, it may also remove them from the reach of entitlements, information, and services vital to their well-being. In the era of intense civil disruption, street violence, and HIV, young people that fall in either or both of these categories should be the subject of diagnostic research and their undoubtedly substantial and diverse needs given priority.

Data in Table 2 include a subset of the 49 countries for which the Council did these tabulations.³¹

Table 2. Percentage of girls and boys aged 10-14 lacking potentially protective factors

Country	Girls lacking <u>either</u> protective factors of school or dual parental residence (%)	Girls not in school <u>and</u> not living with both parents (%)	Boys lacking <u>either</u> protective factors of school or dual parental residence (%)	Boys not in school <u>and</u> not living with both parents (%)
Bénin	83	38	67	18
Dominican Republic	57	5	55	7
Egypt	28	3	22	2
Ethiopia	79	28	71	25
Haiti	70	14	66	13
Indonesia	26	3	26	3
Morocco	68	13	53	7
Turkey	46	6	27	3
Zimbabwe	65	6	62	6

Demographic and Health Survey data, analyzed by Erica Chong. Survey years 1992-2000.

On reaching very young adolescents, programmatic advice is thin. It is clear that many programs assume that very young adolescents have the potential support of both school and parents. Indeed programs often spend considerable time outlining roles for teachers and parents in providing social support to adolescents. Where parents and schooling are active parts of adolescents' lives, this is of course helpful, but when young people are out of school, or one or both parents are absent or under tremendous stress, we will have to look to creating alternative structures or spaces to provide social support.

It is likely that the nature of social support required will vary for girls and boys, as do the adult roles prematurely thrust on them. The challenges for girls are slightly different than for boys. Girls face exploitation both inside and outside the household. The eldest girls in single parent, usually mother-only households, are the children most likely to be forced out of school, to take the mothering roles, and sometimes the earning and family support roles that their mothers cannot carry alone. Those living apart from their parents are also at risk of an uncompensated work burden, unsafe work, and sexual coercion. Boys face risks as well - although they have greater mobility than girls and may have spaces in which to gather, these spaces are not necessarily safe. They also may be called upon (like their sisters) to support themselves and/or their families and thus engage in exploitative, illegal, and/or risky livelihoods.

In settings where there is a high density of such "disconnected" youth, a priority for future work should be the *creation of age and gender specific spaces* in schools after hours, and community and youth centers.³² For example, in the urban areas of sub-Saharan Africa, creating meeting

³¹ For a listing of the percentage of young adults living with *neither* parent and not in school, see column 8 in Annex 2 at the end of this paper. That table summarizes key dimensions of the lives of boys and girls 10-14 years old for 49 countries.

³² UNICEF's experience working in the 1990s working with 'children in extremely disadvantaged circumstances,' generated a number of useful models. Some kinds of approaches that may be applicable to socially disconnected, very young adolescents.

spaces for girls could attract those in domestic service, those without stable family situations, and increasingly, those in AIDS-affected households. These girls need a venue where they can reliably meet each other, find mentors, receive health information and services, and develop the skills and relationships necessary to longer-term asset building (such as functional literacy, numeracy, financial education, and participation in microfinance organizations and savings clubs).³³ For boys, some of these same prescriptions will apply. In some settings they have plausibly easier access than their female age-mates to existing youth centers. Yet younger boys may also feel excluded when youth centers are dominated by older males (whether owing to having participated since they were young, the lack of recreational and work opportunities as they age, or otherwise). To be inclusive, youth centers' content, supervision, and participation should be reviewed to make them appropriate supportive spaces for younger boys, and younger and older girls.

3.2 Poor girls on their own or managing HIV affected families, under pressure to engage in sex for gifts or money³⁴

“Poor girls” is a cross-cutting category; a high proportion of girls living apart from parents and not in school are, in most settings, in the lowest wealth quintiles of their communities. Girls at risk of child marriage or those already married are typically poor as poverty is an underlying factor in both their low levels of schooling and their young age at marriage.

A growing body of evidence is establishing the links between girls' poverty, social isolation, and the experience of exchanging sex for gifts, money, or shelter in the context of a mature HIV epidemic. Exchanges can take place as part of culturally accepted gift giving in a sexual relationship or in order to meet the survival needs of oneself or one's family – in either case coercion and gender power imbalances are likely to be in play.

South Africa has one of the most severe HIV epidemics in the world, with an HIV prevalence of 10.2 percent among 15-24-year-olds; there are three infected girls for every infected boy in this age group.³⁵ Hallman and colleagues³⁶ explored the relationship between girls' schooling, social isolation, orphan status, and economic vulnerability and exchanges of sex for gifts or money and

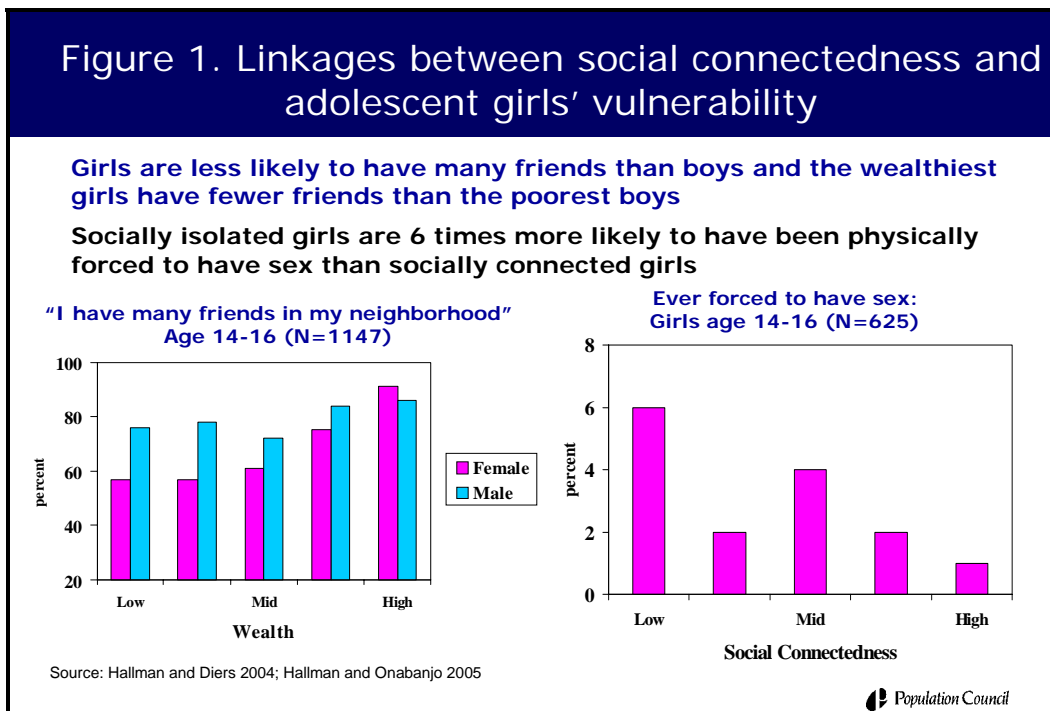
³³ Sebstad, Jennefer. “Placing adolescent livelihoods in context: How do adolescent livelihoods initiatives fit into the theoretical and programmatic map of economic development?” and Bruce, Judith. “The learning curve: Brief discussion of comparative features and issues in the Council-assisted livelihoods' portfolio.” Presentations at *Adolescent girls' livelihoods: Building assets for safe, productive lives*, New York, 7-8 April 2004.

³⁴ This section draws substantially on Population Council. 2006. “The Girls Left Behind: The failed reach of current schooling, child health, youth-serving, and livelihoods programs for girls living in the path of HIV.” Judith Bruce and Amy Joyce (eds.) Paper commissioned by The Futures Group.

³⁵ Pettifor, A.E., H.V. Rees, et al. 2004. And the situation may be even grimmer now as the new incident data from the Mandela national survey reports new incident ratios among 15-24-year-old females and males of 8:1. See Shisana, O. et al. 2005 (footnote 7).

³⁶ Hallman, Kelly. 2004. “Socioeconomic disadvantage and unsafe sexual behaviors among young women and men in South Africa.” *Policy Research Division Working Paper* No. 190. New York: Population Council. Hallman, K. 2005. “Gendered socioeconomic conditions and HIV risk behaviours among young people in South Africa,” *African Journal of AIDS Research* 4(1):37-50. Hallman, K. and J. Diers. 2004. “Social isolation and economic vulnerability: Adolescent HIV and pregnancy risk factors in South Africa,” presentation at the Annual Meeting of the Population Association of America, Boston, MA. Hallman, K. and J. Onabanjo. 2005. “Reducing girls' HIV risk through social support and livelihood skills,” presentation at the UN 49th Session of the Commission on the Status of Women, *What can you give a 12-year-old girl that no one can take away?*, 28 February.

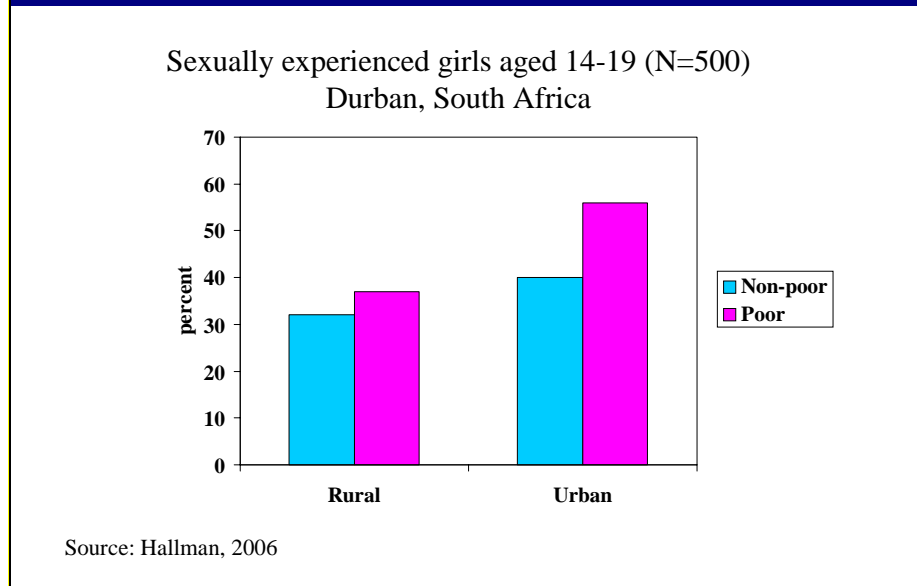
sexual coercion in KwaZulu-Natal. The analysis considered all four factors independently, and found that although all were linked to both sexual coercion and exchanges of sex, the intensity of that connection varied. Girls in the highest wealth quintile were more socially connected than poor girls, but for all wealth categories, girls were less socially connected than boys. **Strikingly, girls in the highest wealth group still had fewer friends than boys in the lowest wealth group.** Social connectedness across wealth categories for girls was significantly correlated with having experienced sexual coercion (Figure 1)



Hallman (2006) further explores the influence of economic disadvantage on the willingness of girls' sexual experiences by examining the multiplicative effect of living in a poor household in an urban area.³⁷ The findings are telling: poor urban girls aged 14-19 appear to be more likely than poor rural girls to report ever having sex (55 percent versus 41 percent), ever exchanging sex for gifts or money (9 percent versus zero percent), and reporting that their first sexual experience was non-consensual (56 percent versus 37 percent) (Figure 2).

³⁷ Hallman, K. 2006. "HIV vulnerability of urban poor and non-enrolled girls in KwaZulu-Natal, South Africa." Powerpoint presentation. New York: Population Council.

Figure 2. Percentage of girls for whom first sex was not willing, by wealth and area of residence



Studies of girls' social and economic conditions were conducted in two poor urban areas with generalized HIV epidemics: Kibera, Kenya (the Embakasi and Pumwani divisions) and Addis Ababa (the Merkato and Kazanchis districts). Baseline data developed prior to the initiation of a livelihoods program in Kibera noted only twelve percent of girls were living with both parents. Forty-five percent reported that their first sexual encounter was forced or tricked and 69 percent of girls in relationships did not know the HIV status of their partner. Twenty-eight percent of girls had experienced a death in the family due to HIV. The relationship between personal economics and HIV risk are apparent in the comments of the girls. One girl discussed trying to leave a relationship that felt unsafe:

I didn't leave because I didn't know where to start... because I didn't have money and I had children to take care of [and] no home to go to." Age 20, married, 3 years of education.³⁸

A study of the conditions of young people in two low income neighborhoods in Addis Ababa painted a stark picture of girls' vulnerability in comparison to boys' situations. Forty-seven percent of boys reported that they had a place in the neighborhood other than home or school to meet same sex friends in contrast to 13 percent of the girls. Thirty-three percent of the boys responded yes to the question, "If you didn't have a place to sleep, there is someone in your neighborhood who would take you in?" in contrast to 19 percent of girls. The interviews with both boys and girls highlighted the lack of physical security and the active threats with which they lived. Seventeen percent of the boys reported that they had sexual relations they did not want in comparison to 32 percent of the girls; 14 percent of girls reported having been raped. They also reported high levels of harassment on the street and a lack of any public response.

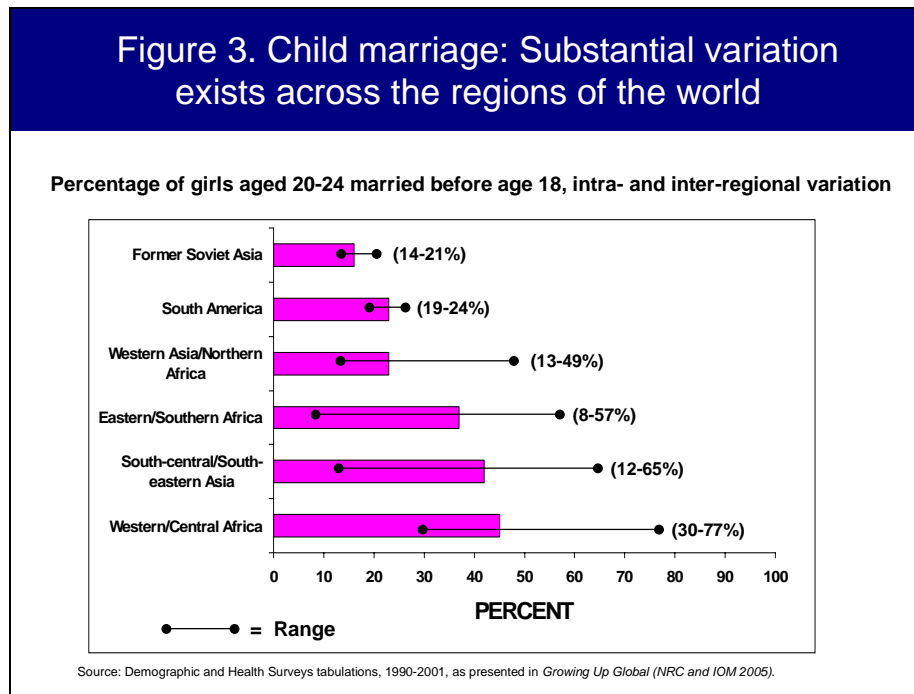
³⁸ Erulkar, Annabel, Judith Bruce, and Aleke Dondo. Forthcoming 2006. "Tap and Reposition Youth (TRY): Providing social support, savings, and micro-credit opportunities for young women in areas with high HIV prevalence." Population Council.

A 12-year-old girl who had migrated from Oromiya at age 10 commented on the risk of trafficking that children living apart from parents face:

I hate it when children are raped, when they get beaten up and are forced to do things that are beyond their capabilities and cause them physical disability. There are some people who steal people away from their parents and use them for begging and also make them prostitutes and use them as their means of income. All this terrifies me.³⁹

3.3 Girls at risk of child marriage

Child marriage, marriage of a girl or boy before their 18th birthday, is still with us. Demographic and Health Survey data indicate that about 38% of young women aged 20 to 24 in fifty less developed countries were married before age 18.⁴⁰ If present patterns continue, over 100 million girls will be married as children in the next decade. Although the proportion of women who marry early is declining in most, but not all parts of the world, it is vital to underscore that millions of girls are currently married, with many more in the pipeline. Child marriage is a practice that mainly affects girls (56 percent of women aged 20-24 versus 14 percent of men the same age were married by age 20).⁴¹



As substantial variation in the prevalence of child marriage exists within regions (Figure 3), there is also significant variation within countries. Some subnational regions, particularly those that are predominantly rural, show starkly elevated levels of child marriage (Table 3).

³⁹ Erulkar et al. 2004b, p.16.

⁴⁰ Mensch, B., S. Singh, and J. Casterline 2005. "Trends in the timing of first marriage among men and women in the developing world." *Policy Research Division Working Paper No.202*. New York: Population Council.

⁴¹ DHS data from 51 countries as reported in NRC and IOM 2005.

Table 3. Percent of 20-24-year-old women married by age 15, age 18, and median age at marriage

Country, region	Married by 15 (%)	Married by 18 (%)	Median age at marriage (years)
Ethiopia	19	49	18.1
Amhara	50	80	15.0
Affar	20	70	16.2
Mali	25	65	16.7
Kayes	39	83	15.5
Koulikoro	32	79	15.8
Niger	35	77	15.7
Zinder/Diffa	52	91	14.9
Maradi	41	92	15.3
Nigeria	20	40	19.6
South-central regions	8	23	a
Northern regions	45	73	15.3
India	24	50	18.0
Rajasthan	36	68	16.0
Bihar	40	71	15.7
Nepal	19	60	17.1
Far-western region	---	---	15.9
Bangladesh	38	65	16.1
Rajshahi division	---	---	15.1
Khulna division	---	---	15.4
Dominican Republic	11	38	19.5
Enriquillo	18	54	17.7
El Valle	19	56	17.5
Guatemala	9	34	19.5
Indigenous persons	16	45	18.4
Non-indigenous persons	6	29	19.9
Nicaragua	16	50	18.0
Jinotega	25	63	17.0
Región autónoma atlántico norte	19	67	17.2

^a Less than half of girls were married by age 20.

Demographic and Health Survey data, analyzed by Erica Chong. Survey years 1996-2001.

The processes that make girls vulnerable to child marriage begin early. Figuring in this equation are plausibly socio-economic status, family type (with girls being particularly vulnerable in single-parent, mother-only households), and schooling experience (no schooling experience, late entry into school, frequent grade repetition, or leaving before the end of secondary school). Substantial progress has been made in the proportion of boys and girls in primary school worldwide, and the gender gap is closing. But pockets remain, especially in sub-Saharan Africa, where the progress of boys in primary school has stagnated, and both boys and girls from poor families are being schooled at insufficient levels.⁴²

⁴² Lloyd, Cynthia B. 2006. "Schooling and adolescent reproductive behavior in developing countries." Paper commissioned by The United Nations Millennium Project.

Generally, countries where sizeable proportions of young women marry early are the same ones with poor educational attainment, thus there is usually a substantial gap between school leaving and marriage. Although evidence that large numbers of girls are withdrawn directly from school to get married is lacking, investments in girls' schooling are the most powerful way to address the conditions of poverty, low status, and norms that drive the marriage timing decision.⁴³ An emerging body of research is confirming that school enrollment is an important determinant of girls' health and well-being: globally, enrolled girls are less likely to have had sex, and if they are sexually active, they are more likely to use contraception than non-students of the same age.⁴⁴ In many settings there is pressure around the time of puberty to withdraw girls from school in order to prepare for marriage or deal with the family workload, or when secondary school requires monetary costs, travel, or other "social costs" to the girl's perceived marriageability. A recent analysis from Guatemala suggests dramatic shifts in girls' schooling around the time of puberty (See Box 5).

⁴³ For a fuller discussion see Mensch, Barbara, Susheela Singh, and John Casterline. 2005. They examined changes in the age of marriage as a function of the change in educational attainment, and found that for 15 countries, the decline in early marriage between cohorts (20-24-year-olds and 40-44-year-olds) is less than would be expected given the increase in schooling. However, for the majority of countries, the observed decline exceeds the expected decline.

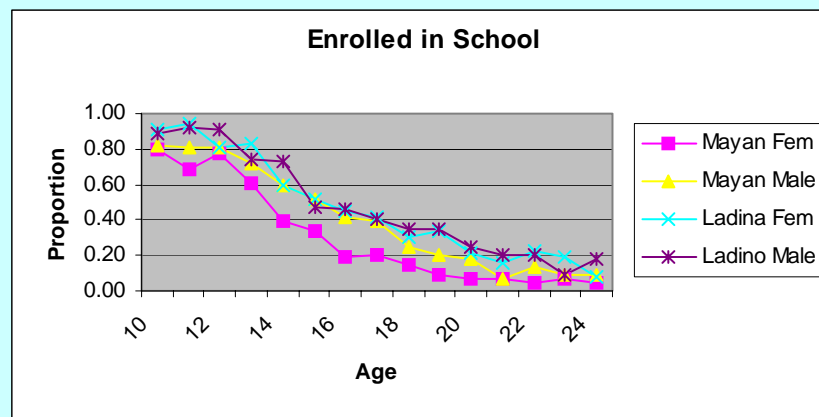
⁴⁴ NRC and IOM 2005.

Box 5. Schooling and the transition to adulthood in Guatemala⁴⁵

In Guatemala, poverty, rigid gender roles, and ethnic discrimination disempower Mayan women and limit their opportunities. As a result, Mayan girls and women often lead lives characterized by early marriage, frequent childbearing, inferior social status, and social isolation. As part of the Population Council's and their partners' efforts to break this cycle and enable indigenous girls to reach their full potential, they undertook a quantitative situation analysis of the needs of Mayan young people, performed a national inventory of adolescent programs, and conducted a community-based qualitative study.

Findings included:

- Mayan girls start school later and drop out earlier than their male Mayan and female non-Mayan counterparts.
- By age fifteen, only one-third of Mayan girls are still enrolled in school, compared to just over half of Mayan boys and non-indigenous girls.
- Enrollment drops abruptly in early adolescence for Mayan girls; between ages 12 and 14 it drops from 77 percent to 40 percent. Another large drop occurs between ages 15 and 16, where enrollment declines from 33 to 19 percent.
- Girls who are not in school face severe restrictions on their physical mobility and social interactions, largely due to parents' fear of premarital pregnancy.
- Early marriage is closely associated with no or low levels of schooling for girls in Guatemala; 2 percent of married girls versus 40 percent of unmarried girls aged 15-19 are in school.



Measures to eliminate child marriage must be context specific and engage parents and community members. Essential elements of any strategy will be schooling in some form and giving girls better access to their peers. This can be achieved either through programs that promote primary to secondary school progression or pick up girls who have not been in school and purposely create group structures for them through which they can receive functional literacy training and mentoring (see Box 7 below for details on an innovative program in Egypt targeting out of school girls in an early marriage setting).

⁴⁵ Hallman, Kelly, Sara Peracca, Jennifer Catino, and Marta Julia Ruiz. 2004. "Causes of low educational attainment and early transition to adulthood in Guatemala." Guatemala City: Population Council. And Colom, Alejandra, Marta Julia Ruiz, Jennifer Catino, Kelly Hallman, Sara Peracca, and Kristen Schellenberg. 2004. "Voices of vulnerable and underserved adolescents in Guatemala." Guatemala City: Population Council.

3.4 Married adolescent girls

Married girls are a world unto themselves, sharing some of the risks of low age with their unmarried sexually active counterparts and the responsibilities of marriage with their older married counterparts. Married girls are often subject to high levels of unprotected sexual relations, have large age gaps with their marital partners, are under intense pressure to become pregnant, are typified by low educational attainment, face highly limited or even absent peer networks, experience restricted social mobility and freedom of movement, and have little access to schooling options or modern media (TV, radio, and newspapers).⁴⁶

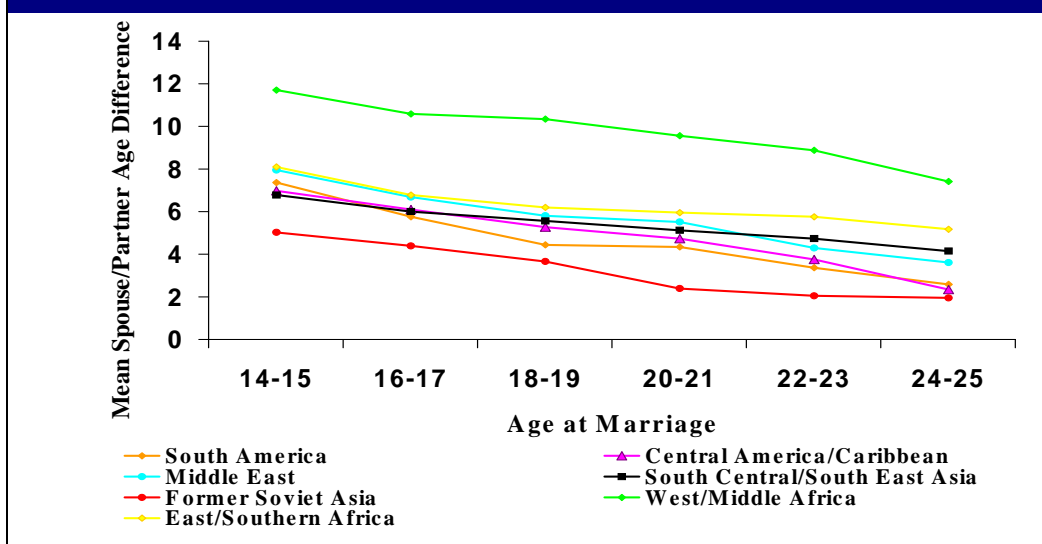
The profile of married girls as disadvantaged and of relatively low status contrasts with the perceptions and value systems of many societies. Community leaders, parents, and girls themselves may view marriage as a safety zone – a protected sanctuary within which voluntary sexual relations takes place, and social seniority is achieved. However, contrary to the images in mass media, married girls have more frequent sexual relations than their unmarried sexually active counterparts. In many settings with mature HIV epidemics, a very high proportion of adolescent girls' unprotected sexual relations takes place within the context of marriage (Table 4).

Table 4. Percentage of girls who are married among 15-19-year-old sexually active girls, and girls who had unprotected sex in the past week		
Country	Percentage married among sexually active girls	Percentage married among girls who had unprotected sex last week
Ethiopia	94	98
Haiti	52	83
Kenya	36	72
Mozambique	67	82
Nigeria	61	89
Rwanda	51	97
South Africa	7	13
Tanzania	50	77
Uganda	80	96
Zambia	44	82

Source: Bruce and Clark 2003

⁴⁶ Haberland, Chong, and Bracken 2003.

Figure 4. Mean spouse/partner age difference, by woman's age at first marriage (women aged 25-34)



The partners of married girls on average are older than the partners of unmarried girls; indeed, the younger the girl the larger the age gap with the spouse (Figure 4).⁴⁷ A recent analysis by Clark (2004) also found that in two high-HIV urban settings, Ndola Zambia, and Kisumu, Kenya, married girls' husbands were more than twice as likely to be HIV positive than the partners of unmarried sexually active girls.⁴⁸

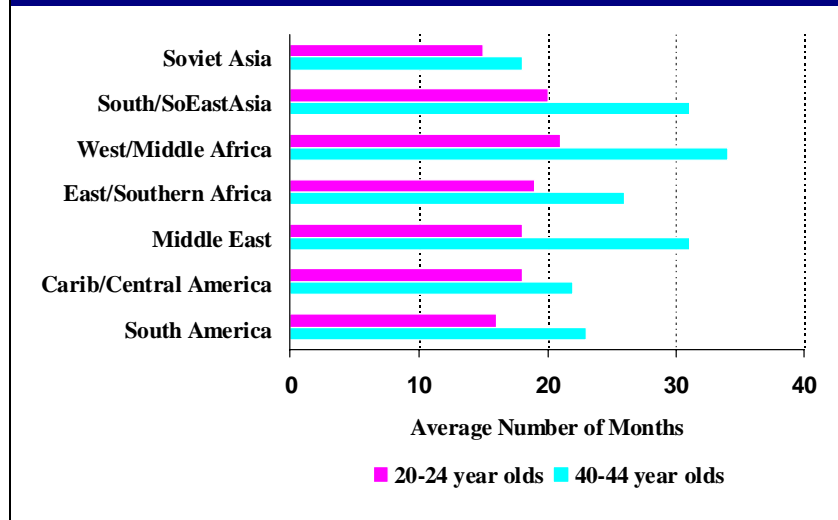
An important piece of married girls' vulnerability is the intense pressure under which they are placed to become pregnant, facing social rejection and even violence in some circumstances if they do not bear a child rapidly (usually within the first 20 months after marriage). Mensch (2003) found not only a short gap between marriage and first birth but that it had changed downward between two generations; women aged 40-44 had longer gaps between marriage and first birth than young women aged 20-24 (Figure 5).⁴⁹

⁴⁷ Mensch, Barbara. 2003. "Trends in the timing of first marriage," presentation at the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, WHO, Geneva, 9-12 December.

⁴⁸ Clark 2004.

⁴⁹ Mensch 2003. The explanation for this reduction requires some further analysis. It is likely that the very youngest girls are no longer in the pool, as age of marriage has increased, and therefore there are fewer 14-year-olds having sexual relations and sub-fecund. The ideal analysis would pair the average months between marriage and first births of those girls married at age 15 or above, but below 24, between cohorts. Striking to this author, however, is that even as the desired family size has declined, and there is no immediate need to get pregnant because of requirements to have many pregnancies and many children, and child survival has improved, the pressure on young brides to reproduce rapidly to secure the marital relationship persists. This could be seen as an almost pure gender effect – women and girls still under pressure to prove their fertility even as demographic regimes modernize.

Figure 5. Average number of months between marriage and first birth



Adolescent mothers tend to be poorer, less educated, and less adequately nourished than older mothers; they also face greater social disadvantage.⁵⁰ While maternal mortality and morbidity data are notoriously inadequate, it is clear that first births, relative to second and third parity births, carry special risks for both mother and child, regardless of the age of the mother. The issue is of particular relevance to married girls because the vast majority of births to adolescent girls are first births that occur within marriage.⁵¹ Adverse outcomes associated with first birth include obstructed labor (which can result in obstetric fistula in settings where access to care is limited⁵²), pre-eclampsia/eclampsia, malaria and infant mortality⁵³. The youngest first time mothers (15 and under) face a special risk of obstructed labor, owing in part to the immaturity of their pelvic structure, nulliparity and malnutrition. Among first births, infant death appears to be elevated among young mothers 15 and under.⁵⁴ Among older adolescents (16 and older) the effect of age is unclear. In some recent maternal mortality studies there is no difference by age when comparing 16-19 year olds to somewhat older females, and in other studies there may be a difference but it is not clear if the cause is age, parity, or interactions with socioeconomic factors.⁵⁵ Debates regarding the effects of age and parity notwithstanding, girls who give birth during adolescence require special attention because they are less mature and are simultaneously coping with their own and their baby's physiological, emotional, and economic needs.⁵⁶

⁵⁰ Miller and Lester 2003.

⁵¹ Seventy-eight percent of births that occur before age 18 are first births, and 90 percent of first births that occur before age 18 occur within marriage. DHS data analyzed by Monica Grant, Policy Research Division, Population Council. DHS surveys covered 60% of developing country populations.

⁵² For a discussion of a programmatic response see Chong, Erica. 2004. *Healing Wounds, instilling hope: The Tanzanian partnership against obstetric fistula*. Quality/Calidad/Qualité Vol. 16. New York: Population Council.

⁵³ Kiely, Michele (ed) 1991. *Reproductive and Perinatal Epidemiology*. Boca Raton, FL: CRC Press.

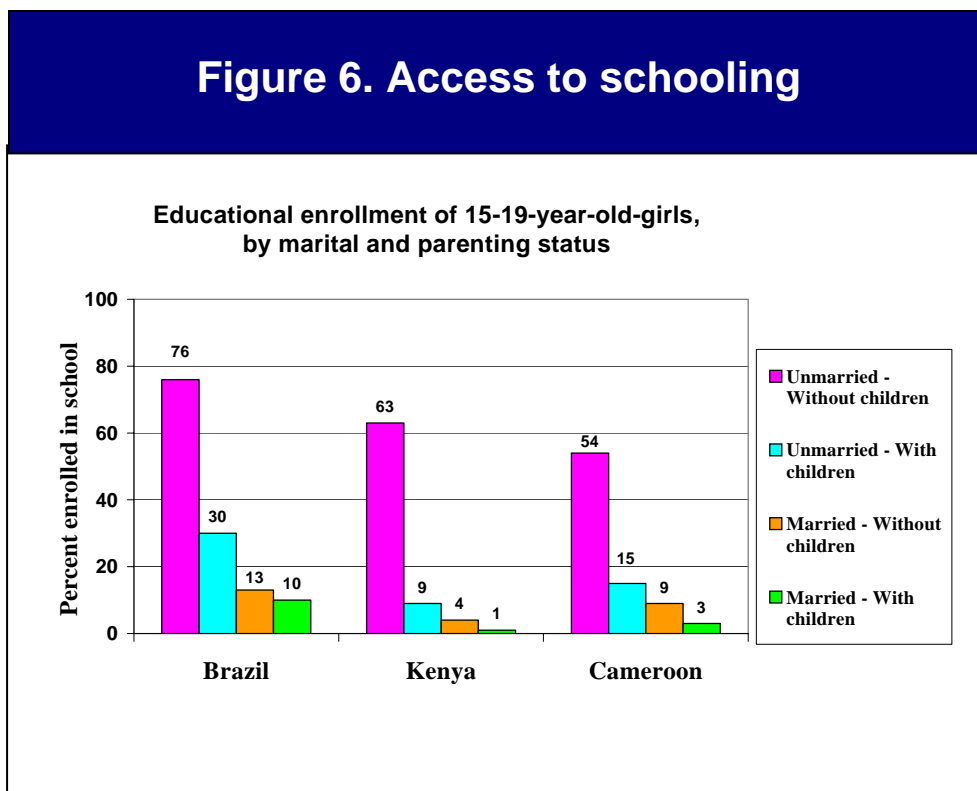
⁵⁴ Olausson P., S. Cnattingius and B. Haglund. 1999. "Teenage pregnancies and risk of late fetal death and infant mortality," *British Journal of Obstetrics and Gynecology* 106(2); 116-21; Phipps, M.G. and M. Sowers. 2002. "Defining Early Adolescent Childbearing," *American Journal of Public Health* 92: 125-8.

⁵⁵ Miller and Lester 2003.

⁵⁶ Nancy Sloan, personal communication, 2004.

Recent research into couples' perspectives on marriage suggests that numbers of young couples would prefer to wait and get to know each other better before having a first birth.⁵⁷ Yet, the pressure for a first child remains strong across cultures. Thus, the best means of delaying a first birth may well be to delay marriage, arguing that an older mother is physically and emotionally mature, ready to function in a partnership and family, and better prepared to ensure that the first birth is safer for both her and her child.

Another striking characteristic of married girls' lives is their lack of access to schooling, even those without children. Whereas special efforts have been made in some settings to support pregnant unmarried girls to stay in school and return after birth, no particular policy measures have been taken to assure or support married girls' access to schooling.⁵⁸ In this regard, the case of Brazil is of interest - unmarried girls with children have more than double the school-going rates of married girls without children (Figure 6).



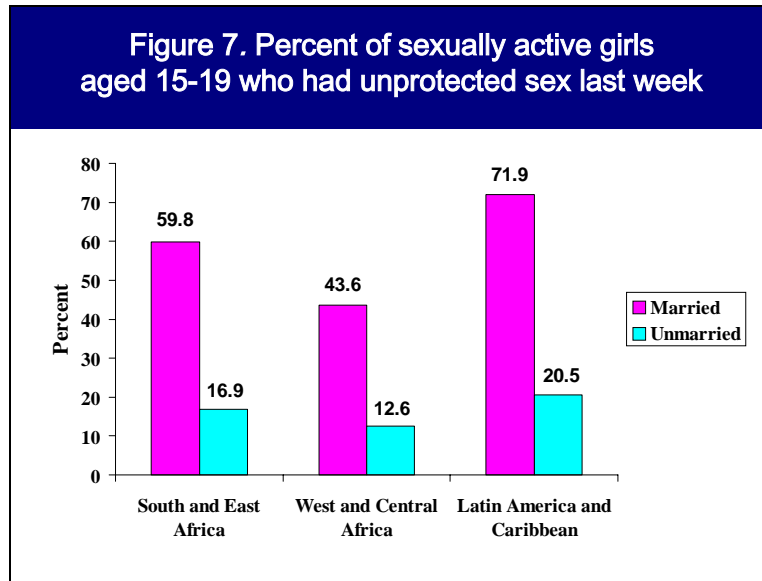
Schooling is not the only entitlement that married girls cannot access. As will be described in the section below, married adolescents fall outside of current adolescent programs. A recent analysis of the reach of 15 youth-serving organizations in Ethiopia (including some operating in the Amhara region where half of girls are married by age 15), found that less than 3% of the 10,000 contacts tracked were with married girls.⁵⁹

⁵⁷ Haberland, Nicole, Elizabeth McGrory, and K.G. Santhya. 2001. "First Time Parents Project: Supplemental Diagnostic Report – Baroda," Unpublished paper.

⁵⁸ Haberland, Chong and Bracken 2003.

⁵⁹ Mekbib, T.A., A. Erulkar, and F. Belete. 2005. "Who are the targets of youth programs: Results of a capacity building exercise in Ethiopia," *Ethiopian Journal of Health Development* 19(1):60-2.

Arguably, married adolescent girls face special risks given the level of their sexual activity and the pressure for pregnancy. Figure 7 indicates the percentage of sexually active girls aged 15-19 who had unprotected sex last week (that is, sex without condoms, which are the only method available to provide protection against both pregnancy and HIV).⁶⁰



Conventional HIV prevention measures are in the main either impossible (given the nature of marriage) or extremely difficult to implement given the low power and relative immaturity of married girls. Married girls cannot abstain, reduce sexual frequency, change partners (to safer partners), they have great difficulty negotiating condom use, and have little control over their spouse's extramarital activities. Married girls, even those who do not desire pregnancy, are much less likely (11 times less likely in Kenya and Uganda, for example) to be able to negotiate condom use than their unmarried sexually active counterparts.⁶¹

A policy concern that is sometimes raised is that delaying marriage will increase the proportion of unmarried girls engaged in risky sexual relationships. Analyses of Demographic and Health Survey data indicate, however, that while premarital sex has increased as early marriage has declined, the prevalence of girls' sexual initiation by age 18 has for the most part declined or remained unchanged. An investigation by Mensch, Grant, and Blanc (2005) of 27 sub-Saharan African countries indicates that in the 24 countries where there was a significant decline in early marriage, the overall proportion of women reporting having had sex before age 18 declined significantly in 13 countries, remained unchanged in 8 countries, and increased in 3 countries.⁶² Bongaarts (2005) notes that the length of the period of premarital exposure to the risk of HIV infection is key, and that "very early marriage raises the risk of infection for young girls, because

⁶⁰ Bruce and Clark 2003. Regional figures were weighted by the population of girls aged 15-19 in each country. United Nations 2002 population estimates were used; data on sexual activity are from the DHS. DHS countries cover 86% of the population of South and East Africa, 59% of West and Central Africa, and 54% of Latin America and the Caribbean.

⁶¹ Clark, Bruce and Dude Forthcoming 2006.

⁶² Mensch, Barbara, Monica Grant, and Ann Blanc. 2005. "The changing context of sexual initiation in sub-Saharan Africa," *Policy Research Division Working Paper No.206*. New York: Population Council.

they would otherwise not be at risk, but marriage after the age at first intercourse raises exposure to risky premarital sex.”⁶³

In sum, millions of married adolescent girls may be at substantial risk for HIV infection. In assessing married girls’ risks of HIV infection and developing supportive strategies, consideration should be given to the girl’s age (her physical and emotional maturity), her social networks, the age and premarital sexual behavior of her partner, the power differential between them in terms of the ability of the bride to communicate and negotiate with her partner, and the frequency of sexual relations and the pressure for pregnancy. Targeted evaluations as well as programmatic initiatives are urgently needed to assist married girls in making and sustaining safer marriages.

4. Evidence Based Programming for Adolescents and Youth: A Brief Discussion

4.1 The neglected transition

In many poor countries there are few purposeful plans for adolescents between the ages of 10 and 19 to provide a safe transition between childhood and adulthood. Even where adolescent and youth policy is well articulated, it is often relatively new, incompletely implemented, and poorly resourced. Though most governments have benchmarks of support for children through at least their early child immunizations, define an ideal age of school entry, ideal number of school years to be completed, legal age at marriage, legal age of consent, and legal age of national service (often applicable for boys and not for girls), societal interest in children wanes after immunizations and early schooling. Thus in many circumstances adolescent rights are often not enforced, and adolescent entitlements under-funded and difficult to access among the most vulnerable youth. Even officially reported schooling data should not necessarily be accepted *prima facie* evidence of compliance with schooling norms. For example, recent work in Kenya conducted by the Population Council in cooperation with the Ministry of Education discovered striking differences in enrollment figures collected from observations in schools and those reported by districts for the purpose of collecting revenues.⁶⁴

While governments continue to elaborate the means to meet their obligations to young people through a number of established sectors, there is a vital need to develop new structures to reach adolescents at the community level with mixed content – social support, livelihoods skills, health information and services. Rising to the challenge, there has been a proliferation of youth communication and service initiatives, often school-based and concentrated in urban areas. The next generation of youth programs must engage the government effectively as a full partner, give more concerted attention to rural areas, target underserved populations of young people, and build the case for investments in adolescents through careful planning, implementation, and evaluation.

⁶³ Bongaarts, John. 2005. “Late marriage and the HIV epidemic in sub-Saharan Africa.” Unpublished manuscript.

⁶⁴ Hewett, Paul C. and Cynthia B. Lloyd. 2005. “Progress towards ‘Education for All’: Trends and Current Challenges for sub-Saharan Africa” in Jere Behrman, Barney Cohen, Cynthia B. Lloyd, Nelly Stromquist (eds). *The Transition to Adulthood in Developing Countries: Selected Studies*. Washington, DC: National Academies Press.

4.2 Planning a second generation of adolescent programming

The Population Council and UNFPA collaborated in 2002 on a several day process to chart directions for a second generation of programming and proposed five key steps, summarized below.⁶⁵

1. Gather and schematize data on adolescents – grouped by age, gender, marital and schooling status, residence, and other relevant variables – through careful situation analyses and other research methodologies.

The matrix below is illustrative of non-exclusive cells (for example, some out-of school girls will be living with neither parent, or married and with children), and could be applied separately to urban and rural populations, but gives a sense of important dimensions and subsets of adolescents whose life experiences need to be understood and addressed by programs.

Figure 8. A basic map of adolescent diversity

	Attending primary school	Attending secondary school	Out of school	Married, w/ or w/o children	Living w/ one or neither parent
Girls 10-14	A	B	C	D	E
Girls 15-19	F	G	H	I	J
Boys 10-14	K	L	M	N	O
Boys 15-19	P	Q	R	S	T

2. Conduct a review among major players – key Ministries of Youth and Sports, Education, Health, youth-serving NGOs, municipalities, as well as *consultation with important subsets of young people* (e.g. out of school girls, in school boys, etc.). Without careful preparation, stakeholder and participatory exercises may give disproportionate attention to urban, in school youth, as these represent the most empowered young people, those most likely, without special effort, to be present at such consultations, and those most familiar to leadership groups. It is key that such consultations give voice to less visible adolescents, and that these subjective discussions be supplemented by “objective” information – such as the size of different populations of adolescents (e.g. rural or out of school youth) and their social and economic conditions.

⁶⁵ These steps were drawn from: Bruce, Judith. 2003. “Steps in Building Evidence-Based Programs for Adolescents,” in *Adolescent and youth sexual and reproductive health: Charting directions for a second generation of programming*, background document for a workshop of the UNFPA in collaboration with the Population Council. New York: Population Council, pp. 29-42. Available online at <http://www.popcouncil.org/pdfs/AYSRRH/2jb1.pdf>.

3. Through coverage exercises, determine the number and characteristics of the adolescents reached (age, gender, schooling status, etc.) and not reached by government and nongovernmental policies and programs.⁶⁶

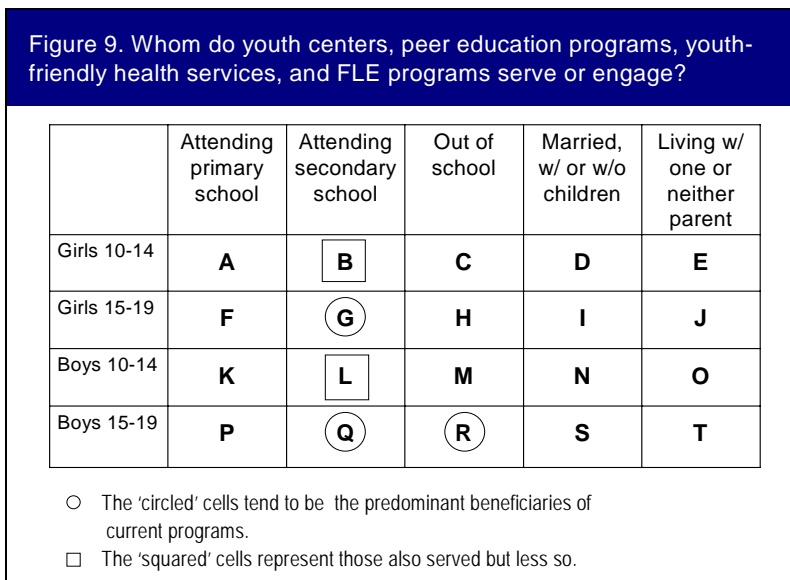
4. Review the relevance and scope of program content with respect to various subgroups of adolescents (differentiated by age, gender, marital and schooling status, residence, and other relevant categories).⁶⁷

5. Combine the information about the demographic distribution of young people and the coverage of current programs as a basis for program planning, developing program plans for underserved subgroups, as well as evaluating the effectiveness of majority strategies (e.g. peer education or youth centers that may dominate the ‘youth’ investment).

4.3 Whom do adolescent and youth programs actually serve?

Some countries with relatively well-advanced adolescent agendas have completed some version of steps 1 and 2 as described above but may still be *lacking a picture of beneficiaries of their programs*. Second generation efforts urgently need to conduct steps 3 to 5, wherein they learn whom they are reaching and how effective their programs are. Few adolescent and youth-serving programs have been subject to rigorous, or any, evaluation.

As calls for expanded investments in adolescent programming are being made, the coverage of current programs are coming into focus. Without such exercises we can neither look back effectively nor plan for the future, as these require reliable data on the profile of current beneficiaries. To date the most popular strategies used to reach young people have been youth centers, school-based life skills and family life education programs, youth-friendly health services, and peer-to-peer education. Figure 9 below raises the question, “Whom do youth centers, peer education programs, youth-friendly health services, and FLE programs serve or engage?”



⁶⁶ For a description of what information a coverage exercise might garner, see Box 6, p.32.

⁶⁷ See Figure 9 and related text on page 31 for a fuller discussion and graphic representation of the challenges of such a review.

Based on what few details the current literature affords, circles are placed around those subgroups that appear to be best served, and squares around those receiving some attention. The other groups, without circles or squares, are very often virtually left out by current strategies.

Youth centers have perhaps been subject to the most evaluation in terms of the audiences they reach. Based on studies of youth centers in four sub-Saharan African countries, Erulkar (2003) reported that they were generally under-utilized and that their beneficiaries tended to be male, older, and often non-youth.⁶⁸ Family life education programs are usually school-based, and therefore by their nature exclude out-of-school youth. Some programs have begun to remedy this, and experiment with community-based activities.⁶⁹

Youth friendly health services have frequently been directed at the needs of unmarried sexually active youth, though increasingly these seem to be incorporating pregnancy support, which in turn brings them into more contact with married adolescents. Peer education is possibly the most elusive program concept. Young people reaching out to each other with information as friends is logical and appealing, but has been subject to little evaluation. Important questions to consider are: Who are the peers? Are they matched by age, gender, schooling, and marital status? Which peers are most effective with mixed audiences? Can boys speak to girls, older to younger? Where would adults, mentors, or family members be more effective? Are some youth better served by peer education approaches than others? A recent evaluation of peer education programs in Ghana concluded that the greatest effect was found among secondary school students. No evidence of any effect was found among out of school youth.⁷⁰

In addition, some evidence shows that more boys are reached than girls. Studies from Ghana, Nigeria, Kenya and South Africa suggest that two factors behind differential participation in peer education programs are girls' greater concerns about confidentiality and selectivity about whom they speak to on sensitive issues⁷¹, and their desire (despite wanting to keep a dialogue channel open with peers) to learn about reproductive health issues from someone older than themselves,

⁶⁸ Erulkar, Annabel. 2003. "Examining the gender dimensions of popular adolescent programming concepts: What do they offer adolescent girls and boys?," in *Adolescent and youth sexual and reproductive health: Charting directions for a second generation of programming*, background document for a workshop of the UNFPA in collaboration with the Population Council. New York: Population Council, pp.93-109. Available online at <http://www.popcouncil.org/pdfs/AYSRH/5a1.pdf>.

⁶⁹ See Askew, Ian, et al. 2004. "A multi-sectoral approach to providing reproductive health information and services to young people in Western Kenya: Kenya Adolescent Reproductive Health Project." *Frontiers in Reproductive Health/Population Council (FRONTIERS), Program for Appropriate Technology in Health, USAID and Government of Kenya*; and Diop, Nafissatou J., et al. 2004. "Improving the reproductive health of adolescents in Senegal." *FRONTIERS, WHO, Centre de Formation et de Recherche en Santé de la Reproduction, Family Health International, Ministry of Health, Division of Reproductive Health, Groupe d'Etude et d'Enseignement de la Population.*

⁷⁰ Brieger, William, Grace Delano, Catherine Lane, Oladimeji Oladepo and Kola Oyediran. 2001. "West African Youth Initiative: Outcome of a Reproductive Health Education Program," *Journal of Adolescent Health*, 29(6):436-446.

⁷¹ Oyediran, K., et al. 1997. "West African Youth Initiative: Outcome of a reproductive health education program." Unpublished report.

such as slightly older female mentors.⁷² Studies in Sri Lanka and Thailand of peer education showed the value of single-sex, gender-specific peer programming.⁷³

To generate a picture of the reach of existing youth-serving efforts, a recent exercise was undertaken in Ethiopia with 15 youth-serving organizations (many of which were coordinated by an umbrella group administered by PACT Ethiopia and the German Foundation for Population). Participating organizations listed youth aged 10-24 as their target group, with a few targeting specific subgroups of adolescents, including commercial sex workers and HIV-positive youth. The organizations were using peer educators, forming HIV clubs, and mounting reproductive health information campaigns. Jointly, a simple recording matrix was developed for the peer educators to use as they conducted their daily activities, which collected information on contacts' age, school status, work status, marital status, living arrangement, and the content of the information given during the session.

Box 6. Results of a coverage exercise with Ethiopian youth-serving organizations⁷⁴

A coverage exercise in Ethiopia was undertaken to discover whom adolescent programs actually reached. A study of the contacts over a six week period of fifteen of the largest youth-serving organizations in Ethiopia found:

- Programs reached more males than females, with nearly 60 percent contacts being boys or men;
- Older boys and men dominated the programs, with 45 percent of contacts being boys ages 15 and older, and 1 out of 5 being men aged 20 and older. Fourteen percent of contacts were over the desired age of 24, and three organizations had 30 percent of contacts outside the age range;
- Programs were reaching the more advantaged in-school population, while most Ethiopian adolescents are out of school. The vast majority of adolescents reached were in-school (90 percent among contacts aged 10 to 19), despite the fact that the vast majority of Ethiopian adolescents are out-of-school;
- While 68 percent of contacts received information on HIV/AIDS, only 19 percent of contacts received information on condoms;
- Only 3 percent of female contacts were married, despite the fact that the majority of girls in Ethiopia are married during adolescence, and the vast majority of girls' sexual activity during adolescence takes place in the context of marriage (94 percent);
- Less than half a percent of all contacts were with girls 10-14 living apart from parents – despite the fact that in Addis Ababa (where most of the programs are concentrated) 37% of girls aged 10-14 live without either parent;
- Eighty-five percent of Ethiopian adolescents live in rural areas; all the programs were operating exclusively in urban areas.

⁷² Erulkar, Annabel, Mags Beksinska, and Queen Cebekhulu. December 2001. "An assessment of youth centres in South Africa." *Population Council and Reproductive Health Research Unit*, and Erulkar, Annabel, Linus I.A. Ettyang, Charles Onoka, Fredrick K. Nyagah, and Alex Muyonga. 2004. "Behavior change evaluation of a culturally consistent reproductive health program for young Kenyans." *International Family Planning Perspectives*, 30(2):58–67.

⁷³ Kerrigan, Deanna and Ellen Weiss. 2000. "Peer education and HIV/AIDS: Past experience, future directions." Horizons/Population Council.

⁷⁴ Mekbib, Erulkar, and Belete 2005.

Overall, if the Ethiopia case and the youth center analyses are any guide, *there is a mismatch, sometimes substantial, between the needs of specific and large subgroups - like married adolescents and very young adolescents living apart from parents - and the coverage of these programs.* Further, the Ethiopia case suggests though labels like life skills and HIV programs are applied, much more needs to be done to learn what is actually offered to and received by young people. For example, in the Ethiopia case, the highest proportion of young people received “HIV information,” but a relatively low proportion among them were told about condoms (let alone were offered them). Very few youth contacts dealt with life skills, gender dynamics, livelihoods, and the social and economic factors that often frame the decision-making processes of adolescents in poor countries. Whether this mismatch between need and beneficiaries has arisen as a result of poor design, lack of participatory inputs, absence of targets to be monitored, lack of management information systems, inadequate supervision and so forth, remains to be disentangled. Many youth-serving organizations, now through their first-generation efforts, are eager to learn whom they reach, whom they don’t, and how they can do their work better.

5. Closing thoughts

As we engage with the great unknown of adolescence, grappling with its rapid-fire transitions, vast internal diversity, and the inextricably linked social, economic, and health elements, **we must experiment.** Much of what we have learned from past development efforts – including developed country adolescent strategies – if uncritically adopted, will not meet the needs of the most vulnerable young people in the poorest countries:

- Adolescents are very different from younger children and adults, and are much less settled; their families, livelihoods, schooling, community bases, and identities are in intense transition.
- Conventionally configured programs which rest on unexamined assumptions about adolescents’ schooling, residence, resources, and safety and comfort in the public space, are not reaching major segments of the poor adolescent population.
- There is often a very brief window of time in which to make a difference; adolescent transitions are measured in years, even months, and the changes are often abrupt, and permanent.

Adolescence for many is one extended crisis and the situations they face are either life-changing, life-threatening, or both. Given the velocity of their lives and the threats in their environment (HIV/AIDS, globalization, civil conflict), information and the protection that caring adults seek to offer are simply insufficient. Young people need substantial **new decision-making power**, safe spaces and peers, mentors and resources to find alternatives to and resist pressures for school-leaving, for illegal or unsafe work, substance abuse, early marriage, exchanges of sex for gifts or money, and unsafe sexual relations inside or outside of marriage.

Because the rising cohorts of young people in the developing world are the largest in history (and will be for another 25 years to come) **experimentation must be of substantial scale, build practically on existing initiatives**, and operate mindful of the current sectoral approach of most governments and indeed, many of the large nongovernmental organizations. This note, with appropriate modesty, seeks to suggest some of the ways in which we can better connect existing structures with disadvantaged adolescents.

The first cross-cutting recommendation is that **adolescent programming question the conventional wisdom**. The adolescent agenda has moved quickly from being “new” to being at risk of over-reliance on a few approaches, largely adopted from the Western experience (youth centers, youth-friendly services, peer education, and family life education in schools). Most all fields have a tendency to become supply-driven, perforce of the pressure to “go to scale,” carry a simple message, and attract funding through a convenient channel (such as a specific sector). That tendency may be the current greatest threat to a fully responsive youth agenda, and the largest impediment to programs’ ability to reach the neediest beneficiaries whose conditions may be the most consequential to the overall health, demographic, and poverty alleviation agenda.

The second cross-cutting recommendation is that **adolescent programming be much more effectively targeted**. Youth-serving programs, whether governmentally or nongovernmentally sponsored, should be offered the technical and financial support needed to evaluate their efforts, including developing a profile of their participants. Large numbers of extremely deserving and needy youth are outside the reach of the current effort – the youngest adolescents; rural, unschooled females; married adolescent girls; and working girls and boys living apart from their parents. Specific efforts need to be designed to reach these groups.

Schooling remains the overarching priority and lays the foundation for much of the advantage and disadvantage in the second decade of life and beyond. We must fully explore what can be done to expand benefits under existing schooling entitlements, and make fuller use of existing school personnel and facilities – as spaces to provide social connection, learning skills, and support for both health promotion and building active citizenship.

We need specific strategies to pick up poorer, younger, and rural adolescents and girl children who might otherwise be left behind. Critical analyses should be conducted within each context to reveal the most likely moments when boys and girls drop out of school (such as the Mayan girls in Guatemala example, given above), when interventions can target age and gender groups to encourage a continuity of schooling from primary to secondary. Much more needs to be done to **get boys and girls to school on time**, reduce grade repetition, **keep them there through secondary schooling, and guarantee universal access by removing user fees**. For adolescents who have either never been in school or are currently out of school, informal schooling and one room options might be beneficially directed to their needs and have been successful in large scale programs—such as through BRAC in Bangladesh.⁷⁵

Where nationwide *youth centers* exist (or where there is an unyielding determination to create them) age and gender specific sessions should be established. Younger boys and older boys, younger girls and older girls need distinct spaces and times and content appropriate to their needs. Without a purposeful plan to create equal access for youth of different categories, some centers have been transformed into non-youth, older male spaces, not by policy but by inertia. Disadvantaged boys may start to use these spaces at appropriate ages but – absent other life choices or recreational venues – stay on. But it may be possible to **reorient their utilization and dedicate specific hours and days to specific gender and age groups** – as has been done

⁷⁵ Ahmed, Manzoor, Colette Chabbott, Arun Joshi, Rohindi Pande and Cynthia J. Prather. 1993. *Primary Education for All, Learning from the BRAC Experience: A Case Study*. Washington DC: Project ABEL (Advancing Basic Education and Literacy).

recently in Egypt as an outcome of the Ishraq program⁷⁶ which reaches out of school girls at risk of early marriage. The Egyptian Ministries of Education, Youth and Sports have designated existing community youth centers as girls' spaces for specific times several days a week, and with NGO partners, have tailored a program of functional literacy, sports, and savings to meet their interests and needs (Box 7).

Box 7. The *Ishraq* program: Spaces to play, grow and learn

In four villages in traditional Minya governorate of Upper Egypt, Save the Children and the Population Council joined forces with CEDPA, Caritas, and the Egyptian Ministries of Youth and Sports, and Education to create an innovative two and a half year program for out of school girls aged 13-15. Using youth centers and local schools, girls meet four times a week for three hours a day for a program of literacy, life skills, and sports. Girls learn to read and write, make educational visits to neighboring villages, learn about their rights, develop confidence and ownership over their bodies, and begin to envision new roles for themselves in Egyptian society. With strong support of parents and community leaders (indicated by the waiting lists for girls wanted to participate), *Ishraq* has been sufficiently successful in improving girls capabilities and opportunities, leading to plans for expanding the program to 120 villages across three of the most conservative Upper Egyptian governorates.

Prepared by Martha Brady, for more information see <http://www.popcouncil.org/me/ishraq.html>.

The revived interest in childhood immunization provides a potential avenue of effective contact, as **there is an overlap between the oldest ages of many new child health initiatives, picking up those who never received or are lacking final immunizations, and the youngest adolescents (10-14)**. To the extent that such programs are creating new social and health platforms, some of these might be permanentized as a way of serving isolated, poorer, at risk 10-14-year-olds. As the AIDS epidemic penetrates to younger and younger ages, there needs to be more consistent thought given to linking child health initiatives with adolescent policy. This may be particularly urgent when seeking to protect adolescent girls, plausibly triply affected as older siblings involved in care and support in AIDS affected families, as orphans, and as individuals subject to sexual coercion and exchanges of sex for gifts or money.

Maternal and child health/safe motherhood initiatives are well accepted, and these too might be **refocused to reach out more purposely to the newly married, and the youngest and first-time parents**. Combined social and health promotion activities could effectively engage girls leading up to marriage, from marriage to pregnancy, and through the postpartum period; assist them in developing more equal communication with partners; and address the extreme social isolation and often poverty of married girls. Recent activities undertaken in Gujarat and West Bengal, India suggest that married girls – provided gatekeepers and family are included in dialogue – are able (and eager) to form regular meeting groups, and establish momentum in reaching out to successive waves of girls as they are engaged, married, pregnant, or parents for the first time (Box 8).

⁷⁶ Brady, Martha, Abeer Salem, and Nadia Zibani. 2005. "Bringing new opportunities to adolescent girls in socially conservative settings: The Ishraq program in rural Upper Egypt." Transitions to Adulthood Brief No. 12. New York: Population Council. Available online at: http://www.popcouncil.org/pdfs/TABriefs/GFD_Brief-12_ISHRAQ.pdf

Box 8. Connecting young married girls in India⁷⁷

In India the Deepak Charitable Trust (in Vadodara, Gujarat) and the Child In Need Institute (in South 24 Pargana, West Bengal) with research support from the Population Council, have organized groups of married girls as a key component of the First Time Parents Project. Group formation addresses social vulnerabilities and isolation of married adolescent girls/first time mothers. The vast majority of these girls have never met their husband before they were married (69 percent in Vadodara, 80 percent in South 24 Pargana), and few had friends in their new home. Less than 2 percent were members of a group or club. Groups increase married girls' contact with peers and mentors, expose them to new ideas, and help engage them in a participatory learning approach covering subjects such as legal literacy, vocational skills, pregnancy and postpartum care, government schemes that women can access, public amenities, gender dynamics within and outside of the family, relationship issues, and nutrition. The project has been able to mobilize over 750 girls into dynamic groups of roughly 8 to 12 girls per group who work together on development projects, celebrate common festivals, and organize welcome ceremonies for newly married members.

The microfinance movement has provided highly creative and practical solutions for poor women (and men) in some of the most densely populated countries in the world (India and Bangladesh). Yet, most of these successes have been among adult, married women, and although many of them are still young, they have numbers of children, or even completed family size. Much remains to be done to **adopt what has been learned from the microfinance movement** (the social support, peer to peer guarantees, and the slow but steady building of the asset base) to the life conditions of the **most socially isolated and economically disadvantaged adolescents**.

Box 9. Adapting microfinance to reach girls at risk in Kenya

The K-Rep Development Agency and the Population Council have collaborated on the development of a livelihood program for adolescents including savings, credit, financial education and social support activities. The program design incorporates social mobilization and group lending strategies and adapts them to address the needs of socially and economically vulnerable girls aged 16-22. This program provides more intensive social support than what is offered in mainstream group lending programs, creating a cohesive group process and a reliable safe space. Another adaptation has been to include an option of voluntary savings for less experienced girls, who may or may not subsequently join the mainstream credit program. In the context of an HIV crisis in Kenya that increasingly is selective of young women, and in an atmosphere where forced sex, exchanges of sex for gifts and money are not uncommon, the project partners have been mindful to incorporate support within the program to assist girls in preventing, mitigating the effects of, or leaving unsafe sexual relationships.

Finally, societies must make specific operational plans to build young people's stake in their societies and acknowledge their rights and citizenship. Many societies – particularly the poorest – make little official contact with the neediest young people between the completion of

⁷⁷ Santhya, K.G., F. Ram, Nicole Haberland, S.K. Mohanty, Elizabeth McGrory, R.K. Sinha, Arup Das, and Anupa Mehta. 2003. "The gendered experience of married adolescent girls in India: Baseline findings from the First Time Parents Project," paper presented at the Second Asia and Pacific Conference on Reproductive and Sexual Health Bangkok, 6-10 October. Also, Haberland, Nicole and K.G. Santhya. 2004. "Addressing the social context of married adolescent girls: experiences from the first time parents project." Paper presented at Adolescent Girls' Livelihoods: Building Assets for Safe, Productive Lives. Population Council, New York, April 7-8.

their immunizations (usually under the age of five) and the commencement of their military service (circa age 18 and applicable often only to boys). It would make strategic sense for governments to define a **sequence of check-ins** where nations reaffirm a direct relationship between society and the young individual – the issuing of a birth certificate, receipt of immunizations and the immunization record, formal registration for school at around age six, and, proposed here, **citizenship-oriented programs around the time of puberty**. Initiating such programs around age 12 would be an acknowledgement of young people’s evolving capacity and its timing strategic, allowing for implementation before young people’s mobility makes the administration of a massive program less feasible. Puberty is a moment that brings elevated risk to girls and boys alike of school-leaving, as well as moving out of the parental home for often unsafe and exploitative work, and in the case of girls, premature marriage.

Early adolescence may be the last and best moment at which to celebrate and consolidate adolescents’ right to a safe and continuing childhood while acknowledging impending adult roles. Citizenship “retreats,” or “camps,” conducted annually, could be a positive and happy rite of passage where young people meet and share experiences (possibly in single-sex groups), receive identification cards (vital to future work, travel, and the exercise of voting rights), health certificates, and other vital documents, and orientation to their rights and responsibilities as citizens. Systematic health checks at this time could allow for catch up on immunizations, be used to establish appropriate health-seeking behaviors, address harmful traditional practices, and remind parents of their responsibility to allow their adolescents to complete their childhood before entering marriages or starting families themselves.

The Millennium Development Goals will help frame global efforts over the next ten years, and concentrate our minds and energies. None of these goals can be achieved without substantial, focused, thoughtful investment in the social, financial, and personal assets of those 10-19 – those in the second decade of life, in the poorest parts of the globe.

ANNEX 1. Population Council Tabulations of Data on Adolescents

Facts About Adolescents from the Demographic and Health Survey: Statistical Tables for Program Planning

The Population Council began its work on adolescents in the mid-1990s, and has emphasized the need to look beyond the health sector in addressing adolescents' needs, focusing on early marriage, livelihoods, schooling, and social structure. The Council has especially concerned itself with the adolescent girl, whose world contracts at this stage in her life, as limitations on her autonomy, mobility, opportunity, and power increase.

One challenge to moving beyond the health sector has been that comprehensive data on adolescents in developing countries have not been easily accessible, nor compiled with this multi-sectoral view in mind. In the absence of data descriptive of the diversity of the adolescent experience, Western notions of adolescence and intervention models often served as the basis for programs in developing countries. Yet depending on their age, gender, area of residence, school enrollment, work status, marital status, and childbearing status, adolescents have vastly different realities and needs - both within and across nations.

To fill this void, the Population Council began analyzing Demographic and Health Survey (DHS) data in a way that could clearly illustrate the diversity of adolescents' lives. It is the Council's goal that these analyses will be used to improve understanding about the adolescent experience, and to build interventions based on fact rather than assumption.

These analyses, "Facts About Adolescents from the Demographic and Health Survey: Statistical Tables for Program Planning," are presented in individual country reports (available reports listed below); each report consists of fourteen data tables and commentary highlighting some of the more noteworthy information.

List of Table Titles:

- Table 1 Urban-Rural Residence and Population Distribution
- Table 2 Parental Survival Status and Residence in Household
- Table 3 Characteristics of Head of Household
- Table 4 Educational Enrollment and Attainment
- Table 5 Educational Enrollment and Attainment in Urban Areas
- Table 6 Educational Enrollment and Attainment in Rural Areas
- Table 7 Educational Enrollment in Urban and Rural Areas: Comparison Summary
- Table 8 Marital Status
- Table 9 Sexuality and Childbearing
- Table 10 Educational Enrollment and Work Status
- Table 11 Awareness and Use of Modern Contraceptive Methods
- Table 12 Awareness of HIV/AIDS
- Table 13 Experience with Sexually Transmitted Diseases
- Table 14 Female Genital Circumcision

Selected DHS Data on 10-14-Year-Olds: Annex to "Facts About Adolescents from the Demographic and Health Survey Statistical Tables for Program Planning"

The period of early adolescence (10–14 years old) is one of both extreme vulnerability and enormous opportunity in the developing world. While early adolescence is often marked by energy, creativity, and resilience, it may also be the stage at which young adolescents are pulled out of school, start working, begin substance abuse (primarily alcohol and tobacco use), initiate sexual activity, and, in some regions, get married and start having children. It is vital to reach this age group when health behaviors and gender norms are still malleable. Programs and services

targeting young adolescents are still in a nascent stage, and several challenges exist in trying to reach this group. Not the least of these challenges is a dearth of data, as adolescents ages 10–19 are often grouped together in statistical reporting, or 10–14-year-olds are excluded altogether from reproductive health surveys, which are relatively common.

In order to fill in some of the gaps in our knowledge, the Population Council undertook a “mapping” exercise to analyze existing data on 10-14-year-olds. To identify vulnerable subgroups and better tailor programs to meet young adolescents’ needs, Council researchers analyzed and interpreted Demographic and Health Survey data from 49 countries on schooling, living arrangements, media access, and marital status. Special effort has been expended to explore the presence of 10-14-year-olds in potentially protective structures – families and schools – by cross-tabulating the presence of young adolescents in different kinds of living arrangements with school enrollment. The reports are intended to complement the Council’s other country report series, “Facts About Adolescents From the Demographic and Health Survey,” and are best viewed in conjunction with those reports to view young adolescents’ experiences in context.

Country Reports (Year of Survey)

Armenia 2000 (Annex only)	Madagascar 1997 (+Annex)
Bangladesh 1996-97 (+Annex)	Malawi 1992 (+Annex)
Benin 1996* (+Annex)	Mali 1995-96* (+Annex)
Bolivia 1998 (+Annex)	Morocco 1992* (+Annex)
Brazil 1996 (+Annex)	Mozambique 1997 (+Annex)
Burkina Faso 1999* (+Annex)	Namibia 1992 (+Annex)
Cameroon 1998* (+Annex)	Nepal 1996 (+Annex)
Central African Republic 1994* (+Annex)	Nicaragua 1998 (+Annex)
Chad 1996-97* (+Annex)	Niger 1998* (+Annex)
Colombia 1995 (+Annex)	Nigeria 1999 (+Annex)
Comoros 1996 (+Annex)	Pakistan 1990-91 (+Annex)
Côte d’Ivoire 1994* (+Annex)	Paraguay 1990 (+Annex)
Dominican Republic 1996 (+Annex)	Peru 1996 (+Annex)
Egypt 1995 (+Annex)	Philippines 1998 (+Annex)
Ethiopia 2000 (+Annex)	Rwanda 1992 (+Annex)
Ghana 1998 (+Annex)	Senegal 1992-93 and 1997* (+Annex)
Guatemala 1995 (+Annex)	South Africa 1998 (Annex only)
Guinea 1999 (Annex only)	Tanzania 1999 (+Annex)
Haiti 1994-95 (+Annex)	Togo 1998* (+Annex)
India 1992-93 (+Annex)	Turkey 1993 (+Annex)
Indonesia 1997 (+Annex)	Uganda 1995 (+Annex)
Jordan 1997 (+Annex)	Uzbekistan 1996 (+Annex)
Kazakstan 1995 (+Annex)	Zambia 1996 (+Annex)
Kenya 1998 (+Annex)	Zimbabwe 1999 (+Annex)
Kyrgystan 1997 (+Annex)	

*Indicates French translation also available

Reports available online at
www.popcouncil.org/gfd/gfdcountries.html

Annex 2. A Summary of Selected DHS Data on Very Young Adolescents

Country	Year of DHS	% of population 10-14 years old	% in rural areas	% with one or both parents deceased	% with neither parent in household (girls/boys)	% not in school (girls/boys)	% living with neither parent & not in school (girls/boys)	% of 15-19-year-old girls who reported ^a :		
								Had sex before age 15	Married before age 15	Gave birth before age 15
West and Central Africa										
Bénin	1996	14	60	12	32 / 18	68 / 41	26 / 8	14	5	1
Burkina Faso	1998/99	15	86	13 ^b	21 / 15 ^b	79 / 70	16 / 10 ^b	12	6	2
Cameroon	1998	14	67	16	24 / 21	24 / 19	6 / 4	26	11	4
Central African Republic	1994/95	13	55	18	28 / 25	50 / 28	17 / 8	25	16	5
Chad	1996/97	13	77	13	19 / 19	71 / 50	13 / 9	22	19	4
Côte d'Ivoire	1998-99	14	65	11 ^b	34 / 24 ^b	53 / 35	23 / 11 ^b	22	8	6
Ghana	1998	14	69	9	29 / 21	20 / 18	7 / 4	7	4	0
Guinea	1999	14	68	13	26 / 20	75 / 62	19 / 13	28	20	7
Mali	2001	14	73	9	19 / 14	68 / 54	14 / 7	26	19	5
Niger	1998	13	78	11	22 / 17	78 / 68	18 / 12	N/A	27	4
Nigeria	1999	12	70	10	21 / 17	30 / 26	7 / 5	17	14	7
Rwanda	2000	17	87	41	26 / 22	59 / 59	17 / 15	3	0	0
Senegal	1997	14	63	11 ^b	22 / 21 ^b	69 / 58 ^b	16 / 12 ^b	10	8	2
Togo	1998	15	70	16	29 / 23	34 / 16	12 / 4	21	4	2
East and Southern Africa										
Comoros	1996	14	74	8	29 / 23	40 / 29	13 / 7	6	5	2
Ethiopia	2000	13	86	19	18 / 18	64 / 55	13 / 12	14	14	1
Kenya	1998	16	88	14	20 / 14	9 / 7	4 / 2	15	2	1
Madagascar	1997	12	76	16	20 / 19	43 / 41	11 / 9	20	12	6
Malawi	2000	13	87	21	31 / 25	16 / 16	7 / 5	17	6	1
Mozambique	1997	14	77	22	28 / 22	42 / 29	16 / 9	30	14	4
Namibia	1992	12	75	13	41 / 35	7 / 9	3 / 4	8	1	1
South Africa	1998	14	54	15	34 / 34	3 / 4	1 / 2	9	0	1
Tanzania	1999	13	80	16	23 / 24	31 / 31	9 / 9	15	4	1
Uganda	2000/01	15	88	23	30 / 25	10 / 9	4 / 3	14	7	2
Zambia	1996	14	61	20	28 / 25	25 / 24	9 / 7	22	4	2
Zimbabwe	1999	15	77	22	30 / 28	8 / 7	4 / 4	3	2	1

Country	Year of DHS	% of population 10-14 years old	% in rural areas	% with one or both parents deceased	% with neither parent in household (girls/boys)	% not in school (girls/boys)	% living with neither parent & not in school (girls/boys)	% of 15-19-year-old girls who reported ^a :		
								Had sex before age 15	Married before age 15	Gave birth before age 15
Latin America and Caribbean										
Bolivia	1998	13	39	8	11 / 10	10 / 6	2 / 1	5	3	1
Brazil	1996	12	24	8	12 / 9	10 / 13	2 / 2	12	4	1
Colombia	2000	10	33	9	14 / 11	12 / 14	2 / 3	10	4	1
Dominican Republic	1996	11	42	7	25 / 20	9 / 12	3 / 3	12	10	2
Guatemala	1998/99	13	62	9	11 / 9	26 / 17	4 / 2	8	7	2
Haiti	1994/95	14	64	18	34 / 26	22 / 21	10 / 8	8	3	1
Nicaragua	1997/98	14	43	8	14 / 13	20 / 25	3 / 3	12	13	3
Paraguay	1990	12	55	N/A	15 / 12	17 / 11	3 / 1	6	3	1
Peru	2000	12	43	8	11 / 9	8 / 5	2 / 1	5	2	1
South and Southeast Asia										
Bangladesh ^c	1999/00	13	82	N/A	N/A	24 / 28	N/A	N/A	27	7
India ^c	1998/99	12	75	N/A	N/A	31 / 18	N/A	N/A	17 ^b	3 ^b
Indonesia ^c	1997	12	74	8	7 / 7	12 / 12	1 / 1	3	3	1
Nepal ^c	2001	13	90	N/A	N/A	35 / 18	N/A	N/A	14 ^b	1 ^b
Pakistan ^c	1990/91	13	68	N/A	4 / 3	55 / 31	2 / 1	N/A	7	2
Philippines	1998	12	55	N/A	N/A	8 / 12	N/A	1	1	0
Middle East and North Africa										
Egypt ^c	2000	13	61	9	2 / 1	18 / 12	1 / 0	N/A	1	0
Jordan ^c	1997	13	19	5	3 / 2	3 / 3	0 / 0	N/A	1	0
Morocco	1992	13	59	8	10 / 7	59 / 40	7 / 3	N/A	2	0
Turkey ^c	1998	11	41	6	5 / 3	39 / 18	2 / 0	N/A	2	0
Europe and Central Asian Republics										
Armenia	2000	10	45	6	1 / 1	1 / 3	0 / 0	1	1	0
Kazakhstan	1999	12	59	9	5 / 6	1 / 1	0 / 0	1	0	0
Kyrgyzstan	1997	13	75	6	6 / 5	3 / 3	0 / 0	0	0	0
Uzbekistan	1996	12	65	5	1 / 1	1 / 2	0 / 0	1	1	0

All data analyzed from Demographic and Health Surveys. N/A denotes that data for that indicator was not collected.

^aData abstracted from the household survey, except for the retrospective reporting of 15-19-year-olds from the individual survey.

^bData for these indicators taken from earlier DHS (years noted as follows), as the respective information was not captured in the DHS listed: Burkina Faso/1992-93, Côte d'Ivoire/1994, Senegal/1992-93, India/1992-93, Nepal/1996.

^cThese countries surveyed ever-married women. Retrospective data presented in the final reports were mathematically adjusted so that they are representative of all women. Never-married women are presumed not to have given birth.