GUTTMACHER INSTITUTE

IPPF International Planned Parenthood Federation

DEMYSTIFYING DATA:

A Guide to Using Evidence to Improve Young People's Sexual Health and Rights

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Ragnar Anderson
Christine Panchaud
Susheela Singh
Katherine Watson

GUTTMACHER INSTITUTE

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ABBREVIATIONS

CDC: Centers for Disease Control and Prevention

CSE: Comprehensive sexuality education

DHS: Demographic and Health Survey

STI: Sexually transmitted infection

USAID: United States Agency for International Development

UNGASS: United Nations General Assembly Special Session

ITALICIZED GLOSSARY TERMS

Terms defined in the Glossary are italicized the first time they appear in each chapter.

Introduction

Why do we need this guide?

The sexual and reproductive health and rights of *young people* are a pressing concern everywhere in the world. The world's 1.2 billion *adolescents* aged 10–19 account for 18% of the global population.[1] While their situation differs across regions and countries, adolescents share basic rights pertaining to sexual and reproductive health, such as equality, privacy, dignity, freedom from harm and freedom to choose whether or not to marry. They also need information and services to support healthy decision-making related to sexuality and reproduction.

Adolescents' needs vary depending on many factors: their stage of physical and emotional development, whether they are married, whether they have become mothers or fathers, whether they are *sexually active,* and what type of sexual activity and relationship they are engaged in. For example, an estimated one in four women aged 15–19 in the developing world is married or *in union*—that is, living with a partner.[1] Marriage that takes place during adolescence is often not decided by the adolescents themselves, and young women in particular may lack power relative to older partners. Moreover, unmarried adolescents who engage in sexual activity typically face societal disapproval, which can prevent them from receiving the information and services that they need to protect their health.

Many women become mothers during their adolescent years: In 2012, an estimated 15 million babies worldwide were born to mothers aged 15–19.[2] This is important in light of the fact that adolescents aged 15 and younger can have a somewhat higher risk of ill-health from pregnancy, and substantially higher risk of maternal death, compared with women who give birth in their early 20s.[3]

On average, only one-third of adolescents in developing countries who want to avoid pregnancy are using a *modern contraceptive method*; the remaining two-thirds risk having *unintended pregnancies* and, sometimes, unsafe abortions.[4] Unsafe abortion is most prevalent in developing countries and is common among young women; 41% of unsafe abortions occur among women aged 15–24.[5] Also, the risk of *sexually transmitted infections (STIs)*, including HIV, accompanies any *sexual intercourse* including oral and anal sex. Evidence suggests that those who are younger than 25 are more likely to be infected than those aged 25 and older.[6] Although adolescents' sexual activity is difficult to measure, the available data highlight young people's urgent need for sexual and reproductive health information and services beginning from early adolescence.

Many barriers prevent young people from obtaining comprehensive information and quality services. Some key obstacles include poor in-school *curricula,* inadequate training of teachers and inadequate outreach to those who are not attending school. In addition, health care infrastructure is often weak, especially in poor and rural areas, and some providers exhibit judgmental attitudes about sexual activity among unmarried youth.

Sexual activity among young people is highly stigmatized and even criminalized in many countries. *Marriage* is often considered the only context in which it is permissible for young people to be sexually active. As a result, unmarried, sexually active young people are often denied access to sexual health services and information, either because of formal barriers or social taboos. Despite these prohibitions, many young people engage in sexual activity, driven by their curiosity and desire. This reality should be incorporated into any program or policy to improve the sexual well-being of adolescents and young people.

Comprehensive sexuality education is an integral component of such efforts and critical to ensuring that young people are aware of the respect due to them as individuals. Without such education, young people are less likely to be aware of their rights and the ways in which established custom, tradition and law may infringe on those rights.

To this end, scientific evidence on the sexual and reproductive knowledge, attitudes, behaviors and health of young people can strengthen the work of health care providers, educators and advocates as they work toward meeting young people's needs for information, education and services. Reliable statistics based on nationally rep-

resentative samples of youth also provide solid evidence for communicating with policymakers, community leaders and other stakeholders about young people's sexual and reproductive health and rights. Such evidence is an important mechanism for giving legitimacy to the issues and strengthening the case for increasing attention to and resources for improving adolescent *sexual health*.

Existing surveys do not measure all aspects of youth sexual and reproductive health and rights; the existing data on *sexual rights* are especially weak. The limitations of the data are described in each chapter where they appear, and the conclusion addresses some of these limitations by making recommendations for future research.

What are the guide's goals and objectives?

The guide aims to help health care providers, educators and advocates in the field of sexual and reproductive health and rights to better understand and use evidence on adolescents' knowledge and behaviors. The guide provides demographic and socioeconomic information about adolescents, as well as measures of their access to, need for, and use of sexual and reproductive health information and services. It is ultimately designed to provide professionals in the field with information they can use to argue effectively for and design policies and programs to meet young people's needs for sexual and reproductive health, education and services, and information on sexual and reproductive rights.

Presenting the latest available data for 30 countries, the guide explains the practical meaning of the data in clear, nontechnical language. The guide can help those working with young people to bring about much-needed change, including

- provision of comprehensive sexuality education; increased access to sexual and reproductive health services;
- improved policies to protect the sexual and reproductive health and rights of young people; and
- increased understanding of where the need is greatest in order to focus efforts on the most vulnerable young people.

The Guttmacher Institute and the International Planned Parenthood Federation collaborated on this guide to achieve its ultimate goal: to promote and improve the sexual and reproductive health and rights of young people around the world.

Who are the intended audiences?

Data and statistics can seem unapproachable, intimidating and hard to understand, especially to those who are not researchers. This guide seeks to break down the complexity and make data more transparent and easier to use. It is designed for anyone interested in using scientific data to support their work to improve the sexual and reproductive health and rights of adolescents.

The main intended audiences are

- service providers and other stakeholders in the health sector;
- teachers of sexuality and family life education and others working in education; and
- youth advocates and their organizations.

We also anticipate that this guide will be useful to international, regional and national organizations and donor agencies.

The guide is unique in its presentation of 70 *indicators,* covering a wide range of topics related to the sexual and reproductive health and rights of adolescents, in one

DIVISION OF AGE-GROUPS

These definitions are based on those used by the World Health Organization and IPPF.

Young adolescents: 10–14 years old

Adolescents: 10–19 years old

Young people: 10–24 years old

Youth: 15–24 years old

Young adults: 20–24 years old

While the terms used in this guide are consistent with these definitions, we allow some flexibility in the use of these terms when making statements that apply broadly. In such general statements, the terms "adolescents," "youth" and "young people" may be used interchangeably or used to imply either all or part of their defined age ranges. For example, "young people" may be used to refer to 20–24-year-olds or 15–19-year-olds.

place. The information is presented in tables that are easy to read, with explanations and guidance on how to understand and use the data.

What is the geographic coverage?

The 30 countries presented here provide wide-ranging examples of adolescents' situation in several regions of the world, with 27 countries in the developing world and three in Europe. The guide includes 13 countries in Sub-Saharan Africa, one in North Africa, four in South Asia, three in Southeast Asia and six in Latin America and the Caribbean. The countries were selected on the basis of having recent national surveys and representing different world regions; 14 are focus countries of a special project of the International Planned Parenthood Federation that addresses the needs of adolescents and young people worldwide, through working with their Membership Associations. The specific aim is to help the Membership Associations improve their ability to do effective advocacy to increase young people's access to sexual and reproductive health services, provide *comprehensive sexuality education,* and advocate for young people's sexual and reproductive rights.

The printed guide includes national-level data on all indicators for all 30 countries. We also present examples of subnational breakdowns for illustrative countries. The full set of tables for individual countries is available on the CD enclosed with this report and online. The country tables include data for urban and rural areas and for five categories of economic status. This detailed information can help professionals working with youth to tailor their programs to more efficiently and effectively meet the needs of specific subgroups in the population.

How were the data selected?

This guide does not include all measures that pertain to the sexual and reproductive health and rights of adolescents, but it includes measures that are good indicators of essential aspects, available for most or all of the 30 countries, and measured in the same way across countries, permitting comparisons among countries. From the data available, the authors selected 70 indicators that promise to be useful for improving adolescents' access to information and services and for promoting young people's rights.

Using this guide

A workshop would be a useful and efficient way to introduce users to this guide because many of the indicators and data sources may be unfamiliar to those working with youth. A workshop would allow for a walk-through of the document, an overview of the information that the guide offers and an opportunity for users to learn to navigate the sections and begin to apply the information. Please refer to the supplementary documents on the CD and the Guttmacher Web site for ways to conduct such workshops.

To apply the information to practical situations, users might review and discuss the application sections and discussion guides in Chapters 3, 4 and 5. The application section gives ideas on how the information may be used to improve sexual and reproductive health services and information for young people. The discussion guide provides questions to stimulate critical thinking about what the available data mean in a particular country, in terms of specific population subgroups, or related to laws, policies or practices. The advocacy table found on the CD also provides a clear visual reference for which indicators would potentially be most useful in addressing various advocacy issues.

While the definition of the indicators is generally the same across countries, there can be small differences because of data constraints; in these cases, a footnote is added to country tables to explain the difference. The data provided are the most recent available at the time of publication. However, the value for each indicator is expected to change over time, and ideally should be revised as new data become available.

Structure of the guide

Chapter 2 explains the data and the methods used to compile them, including

- the data sources used for the country tables and the selection of indicators;
- geographic coverage, including a list of the 30 focus countries;
- how the data were analyzed and indicators compiled to produce country tables; and
- important gaps in information that result from the way that data are collected. These gaps are essential to bear in mind when working with the data.

Chapters 3–5 present substantive information on sexual and reproductive health, sexual rights, *gender* equality and reaching young people.

- Chapter 3 includes topics such as when young people begin to have sex, when they marry, and whether they use contraceptives and related health services.
- Chapter 4 discusses sexuality education in schools, what young people know about HIV and how to prevent it, and whether women have the autonomy to protect their health and to make decisions about their sexual health, among other topics.
- Chapter 5 presents indicators related to the youth population, school attendance and young people's exposure to various types of media.

These chapters review the 70 indicators in the guide and discuss how they can be applied in numerous settings. Following a brief introduction, each of the three chapters contains the following subsections:

Definitions: This section provides an "everyday" definition of the indicator in clear, comprehensible nontechnical language. Limitations of the indicators are also shown. The CD contains an appendix describing how each indicator is calculated.

Applications: This section gives ideas about how to apply data to

- service delivery and programming;
- sexuality education and information; and
- advocacy.

This information helps the user understand which adolescents are most in need of what information and services, and how to best reach them.

Discussion Guide: This section provides a list of thought-provoking questions related to each main topic discussed in a chapter to facilitate discussions between colleagues. Although the data may not provide answers to all of the questions, these questions are a good starting point for launching into deeper conversations about youth programs and services.

Chapter 6 concludes the guide; it serves several purposes, including:

- Identifying the critical data that are missing from the body of evidence on the sexual and reproductive health and rights of young people
- Recommending actions and strategies to help improve the sexual and reproductive rights of young people around the world
- Suggesting useful future tools and describing how they could be developed and used.

Data and Methods

Data sources

The Guttmacher team reviewed existing data on the sexual and reproductive health and rights of *young people* and selected *indicators* based on

- availability for a large number of countries;
- ability to measure needs regarding reproductive and sexual health and rights;
- ability to identify groups with acute needs; and
- ability to monitor progress over time.

Most of the 70 indicators in the guide are drawn from the *Demographic and Health Surveys* (DHS).* The DHS is a highly respected and widely used source of scientific evidence on a broad range of topics, including those related to sexual and reproductive health in the developing world. With funding primarily from the U.S. Agency for International Development, ICF International works with national organizations to carry out DHS surveys in more than 90 countries. The *surveys* are *nationally representative,* meaning that the *sample* reflects the structure and characteristics of the entire population of women of reproductive age and, in many countries, men. In other words, the data collected correspond statistically to the entire population. Depending on their sample size, some surveys are also statistically representative at regional and lower administrative levels.

DHS surveys are large in scale, with sample sizes that usually range from 5,000 to 30,000 households. They are conducted approximately every five years in a large number of countries. The samples of women (aged 15–49) are generally much larger than the samples of men (typically aged 15–59), and women are usually asked significantly more questions. The surveys consist of three core questionnaires: household, women's and men's. The questionnaires are standardized for the most part, making the survey results comparable across countries.

In this guide, the data for Guatemala were drawn from the most recent national survey conducted by the Centers for Disease Control and Prevention (CDC). CDC surveys are similar to DHS surveys; they are nationally representative and provide comparable scientific data.† The CDC is one of the major operating agencies of the U.S. Department of Health and Human Services.

The data on sexuality education presented in Chapter 4 come from a variety of sources. Most are drawn from the 2010 report of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), which is charged with monitoring HIV policies and programs worldwide. Some additional information was obtained from a 2004 report from the International Bureau of Education of the UN Educational, Scientific and Cultural Organization (UNESCO); a 2007 report from School and Health, a partnership of international NGOs, multilateral donors and four UN organizations working to improve learning through better health, nutrition and education; and reports from the ministries of education of a number of countries. All the data from these various sources have serious limitations. They are included in the guide in the absence of better standardized and comparable measures of *comprehensive sexuality education.*

The demographic information provided in Chapter 5 was generated by applying the proportions of the DHS household samples in the 10-14 and 15-19 age groups to the country's total population which was drawn from the United Nations Population Division estimates.

Coverage

The guide includes data on 30 countries:

Africa: Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda, Zambia and Zimbabwe

Europe: Albania, Moldova and Ukraine

South and Southeast Asia: Bangladesh, Indonesia, India, Nepal, Pakistan, Philippines, and Vietnam

Latin America and the Caribbean: Bolivia, Colombia, Dominican Republic, Guatemala, Honduras and Peru

*DHS data are available at <http://measuredhs.com/> and <http://www.statcompiler.com/>.
†CDC data are available at <http://www.cdc.gov/nchs/surveys.htm>.

From data files to country tables

Guttmacher staff assembled the *quantitative measures* from the DHS surveys and CDC survey (for Guatemala) in a variety of ways. Approximately half of the data in this publication comes from unpublished tabulations by the Guttmacher Institute, using the original data files from the surveys. Tabulations of selected indicators were produced for the 30 countries using SPSS, a statistical software package.

The remaining data were compiled from DHS country reports and from the DHS online data service, *STATcompiler*. These sources provide more limited data and, as a result, subgroup information is occasionally not available. DHS staff tabulated data on male adolescents for this project. The project team crosschecked the data from various sources to verify accuracy.

Important gaps in the data

For each indicator, the team tabulated survey data for young women or compiled such data from existing reports and other sources. In some countries, data for the selected indicators were available for married and unmarried young women and, in some cases, for young men as well. However, the following data limitations should be kept in mind when using this guide.

- **Male data:** Survey data on young men are available for only 23 of the 30 countries. None are available for Bangladesh, Colombia, Egypt, Honduras, Pakistan, Peru and Vietnam. Moreover, very limited data on young men are available for Indonesia and the Philippines. In addition, due to the DHS surveys' focus on the health of women and children, the sample size of men is often much smaller than that of women. As a result, samples of subgroups of young men may be too small to produce statistically valid estimates (see the paragraph below on small sample size); men are also asked fewer questions. These survey characteristics limit the ability to draw comparisons between men and women.

- **Information on sexual activity:** The DHS and other surveys usually obtain information on sexual behavior by asking respondents whether they have had *sexual intercourse* and at what age their first experience took place. The fact that the questions on first sexual intercourse follow questions on *marriage* implies that these questions would have measured only intercourse between a man and a woman. Moreover, these large, national surveys do not provide information on forms of *sexual activity* such as kissing, fondling, or oral and anal sex, nor do they provide information on homosexual or queer identity and same-sex sexual behavior.

- **Exclusion of unmarried women in some countries:** The surveys in five countries (Bangladesh, Egypt, Indonesia, Pakistan, and Vietnam) interviewed only women who had ever been married. As a result, for these countries, no information is available on women who had never married or been *in union*, most of whom are adolescents or women in their early 20s.

- **Exclusion of young adolescents:** Data in Chapters 3 and 4 are not presented for young adolescents aged 10–14 because DHS surveys do not interview this group. Information on primary-school attendance, which includes this age-group, and population numbers of 10–14-year-olds are derived from UN sources (Chapter 5).

- **HIV issues**: Information on HIV knowledge and *gender* attitudes and practices are not collected for all countries. Bangladesh, Pakistan and Vietnam have no data on these topics. Countries with significantly limited data include Bolivia, Colombia, Guatemala, Egypt, Indonesia, Nepal, Peru, Philippines and Ukraine.

- **Sexual rights:** The DHS and other major data sources provide little information on *sexual rights* because this topic is not their focus. This issue is culturally sensitive and challenging to measure: Innovative research methods and study designs are needed to improve measurement in this area.

- **Population subgroups:** For several indicators, the guide does not provide data by urban/rural residence or by wealth category (indicated by "na" in the tables), because the sample size for adolescents in these population subgroups is too small.

- **Comparability of data:** As mentioned above, data for Guatemala come from a CDC survey, rather than a DHS survey. Although the two types of surveys are similar, some of the CDC measures do not correspond exactly to those of the DHS. Differences are noted in Guatemala's data table.

- **Small sample sizes:** When the sample size for a particular indicator is less than 25 respondents, the data are not shown in the tables (they are replaced with an asterisk), because such measures are considered unreliable and not statistically valid. When a sample includes 25–49 respondents, the values are shown in brackets to alert the user, because these values are less accurate than those based on larger samples.

- **Social or response bias:** To conform to cultural ideals and expectations, young women may underreport their sexual behavior in a face-to-face interview (particularly in socially conservative societies), while young men may exaggerate their sexual behavior and experience. This *bias* may lead to lower or higher data values, depending on the nature of the question.

• **Data on sexuality education:** Data are generally not available at the national level on the quality and delivery of skills-based sexuality education, in either developing or developed countries. The best approximation available for a relatively large number of countries is the national policy on the provision of HIV or skills-based health education. When combined with data on school attendance, this information provides an approximation of the coverage of sexuality education. Nationally representative data on young people's knowledge about pregnancy-prevention and HIV-prevention also help to complete the picture about the need for better information to protect young people's sexual health.

3 Sexual and Reproductive Health

This chapter includes data on the extent and timing of sexual activity, *marriage* and childbearing. Information about how many *young people* are *sexually active,* when they initiate sexual activity and when they marry is essential to addressing the *sexual health* of this population. Ideally, young people should receive sexual and reproductive health information and services prior to sexual debut since many of them experience sexual debut long before marriage. It is important to note that throughout the guide we use the term "married" to refer to those who are in a formal, legal union (recognized by the government or a religious institution), as well as those in informal unions, including non-marital cohabitation that is recognized by the community.

Sexually active *adolescents* and young people need comprehensive and age-appropriate information and services to be able to protect their sexual health and rights. The inadequacy of the information and services that young people now receive is seen in the fact that *STI* and HIV infection rates are highest among these age-groups; unsafe abortion levels are also very high among young people. Sexual coercion is also an important issue for young women and men, and they need the knowledge and skills to manage this risk.

Many young people around the world become parents during adolescence and young adulthood and are not provided with enough information about how to prevent an *unintended pregnancy* and how to delay or space pregnancies. To serve them better, health care providers need information about young people's knowledge and use of contraception, including both *modern* and *traditional methods*. Information about how many adolescents and young people are having children, when they are having children and whether the children are planned provides critical knowledge for service providers, educators and advocates working to *empower* young people in their sexual and reproductive lives.

SECTION 1: SEXUAL ACTIVITY AND MARRIAGE

The *indicators* in this section provide a picture of when adolescents and young adults first have sexual relations and when they marry—events that often do not occur at the same time. This information is critical to understanding young people's need for sexuality education and for sexual and reproductive health services.

In most countries, there is a high value placed on *marriage*. In many developing countries, a large proportion of young women are married during adolescence, and sexual activity among young, unmarried women is frowned upon or forbidden. As a result, the stigma associated with premarital sex creates barriers that prevent unmarried, sexually active young women from accessing the services they need.

Among young men, marriage occurs later, typically when they are in their early to late 20s. In addition, there is generally greater social acceptance of young men becoming sexually active before marriage, and higher proportions do so.

Age of marriage has crucial implications for young people's sexual and reproductive health: For some, marriage represents their sexual debut, while for many others it represents the legalization or regularization of their sexual activity. In some parts of the world, marriage is quickly followed by parenthood and in all countries some unmarried young women and men become parents.

Variations in marriage and union practices can occur among population subgroups within countries, according to their social values and norms. These variations need to be taken into consideration when working in a particular country and when comparing countries or regions. While marriage can offer social and emotional support and often corresponds to increased access to sexual and reproductive health services, it does not necessarily offer protection against violence, HIV and other *STIs*, unintended pregnancy, rape, coercion or abuse, nor is it necessarily accompanied by stability, safety, pleasure or comfort. Forced sex under any circumstances, including within

marriage, is against internationally accepted standards of women's rights and sexual rights for all.[7]

Regardless of marital status, all young women and men have a right to express their sexuality and need access to information and services to protect their sexual health, including contraceptive, pregnancy-related and STI and HIV services.

DEFINITIONS

1. % of women aged 15–19 who have ever been sexually active

This indicator measures the extent to which adolescent women are sexually experienced (i.e., have started to be sexually active), regardless of whether they are married* or not.

2. % of men aged 15–19 who have ever been sexually active

This indicator measures the extent to which adolescent men are sexually experienced (i.e., have initiated sexual activity), regardless of whether they are married or not.

3. % of women aged 20–24 who have ever been sexually active

This indicator measures the extent to which young women are sexually experienced (i.e., have initiated sexual activity), regardless of whether they are married or not.

4. % of men aged 20–24 who have ever been sexually active

This indicator measures the extent to which young men are sexually experienced (i.e., have initiated sexual activity), regardless of whether they are married or not.

5. % of women aged 15–24 who had sexual intercourse before age 15

This indicator measures the extent to which young women become sexually active at a young age.

6. % of men aged 15–24 who had sexual intercourse before age 15

This indicator measures the extent to which young men become sexually active at a young age.

7. % of women aged 18–24 who had sexual intercourse before age 18

This indicator measures the extent to which young women become sexually active before age 18, which most countries define as the age of majority or adulthood.

8. % of men aged 18–24 who had sexual intercourse before age 18

This indicator measures the extent to which young men become sexually active before age 18, which most countries define as the age of majority or adulthood.

Limitations pertaining to data on sexual activity:

Definition of sexual activity: The questions in the DHS addressing sexual activity ask about "sexual intercourse." Other sexual activities, such as kissing or fondling, are not addressed. Many, if not most, young people experience sexual activity incrementally and (ideally) in a way that corresponds to their physical and emotional development. Also, some young people engage in sexual activity with same-sex partners, which this question may not capture. Thus, sexual activities other than heterosexual intercourse are not captured in this measure.

Stigma surrounding female sexual activity: In general, and especially in socially conservative communities, many unmarried female adolescents may not report their sexual activity because of social stigma. As a result, sexual activity in these communities and countries is likely to be underestimated.

Social pressure surrounding male sexual activity: Male adolescents and young adults may report having started sexual intercourse while they were very young if there is a prevailing cultural pressure to demonstrate their masculinity in that manner. Thus, indicators about male sexual activity may be overestimated. However, little information is available on the extent to which this type of misreporting actually occurs.

9. % of women aged 15–19 who have ever been married

This indicator measures the extent to which female adolescents have ever been married or have lived with a male partner.

10. % of men aged 15–19 who have ever been married

This indicator measures the extent to which male adolescents have ever been married or have lived with a female partner.

*Throughout the guide, the term "married" refers to those who are in a formal, legal union (recognized by the government or a religious institution) and those in informal unions, including nonmarital cohabitation that is recognized by the community.

11. % of women aged 20–24 who have ever been married

This indicator measures the extent to which young women in their early twenties have ever been married or have lived with a male partner.

12. % of men aged 20–24 who have ever been married

This indicator measures the extent to which young men in their early twenties have ever been married or have lived with a female partner.

13. Median age at first sexual intercourse among women aged 20–24

This indicator is the age by which half of young women aged 20–24 have sexual intercourse for the first time, whether they have ever married or not.

14. Median age at first marriage among women aged 20–24

This indicator is the age by which half of young women aged 20–24 get married or start living with an intimate partner.

15. Gap between median ages at first sexual intercourse and first marriage among women aged 20–24

This indicator gives a sense of the possible duration of premarital sex among young women.

16. Median age at first sexual intercourse among men aged 25–29

This indicator is the age by which half of young men aged 25–29 have sexual intercourse for the first time, whether they have ever married or not.

17. Median age at first marriage among men aged 25–29

This indicator is the age by which half of young men get married or start living with an intimate partner.

18. Gap between median ages at first sexual intercourse and first marriage among men aged 25–29

This indicator gives a sense of the possible duration of premarital sex among young men.

Limitations pertaining to data on marriages/unions:
The DHS definition of "in union" excludes those who are in same-sex unions.

APPLICATIONS

Service delivery and programming

Using the data

Data on the timing and pattern of young people's sexual activity and entry into marriage can inform the development of programs that aim to meet their need for sexual health information and services.

Data about subgroups (by urban/rural residence and *wealth quintiles*) allows organizations to provide information and services in a manner that best suits those subgroups. For example, in India, female adolescents living in rural areas marry earlier than those living in urban areas: The *median age* at first marriage is 16.6 and 19.2, respectively for young women 15–19 (indicator 14). In Zambia, 19% of female adolescents in the lowest *wealth quintile* (the poorest one-fifth of households) had sexual intercourse before age 15 (indicator 5) while only 7% of those in highest wealth quintile have had sex by this age. (This sub-group data can be found on the CD.) These data show the greatest need for services is often found among adolescents living in rural areas and in low-income families.

This detailed data can help program managers design approaches that are tailored to different situations. For example, program planners that aim to work with young women from rural areas and poor households should take into consideration that a significant proportion of them are married, while those working with adolescent women from urban and wealthier households should be aware that these women are more likely to be unmarried.

Also, this kind of information may lead a service-providing organization to reallocate its funding to conduct more outreach to rural and disadvantaged communities, set up community-based distribution of contraceptives or train young people as peer educators in rural and disadvantaged communities.

The gap between the median age of first sexual intercourse and the median age at first marriage gives a sense of the prevalence of premarital sexual relations. For example, in Zambia, the median age of first intercourse for women aged 25–29 in urban areas is 17.9 (indicator 13), while the median age at first marriage is 20.1 (indicator 14). This indicates that most young Zambian women in

urban areas initiate sexual relationships approximately two years before marriage. If sexual and reproductive health information and services were only available to young, married women, more than 200,000 sexually active unmarried Zambian women aged 15–19 would be left with little to no access to critical information and services.

Addressing stigma

Young people can be stigmatized and even criminalized for engaging in sexual activity before a certain age or before or outside of marriage. The shame and fear that they experience can make them uncomfortable using sexual health services or seeking information.

Young people often have to confront discrimination and judgmental, negative attitudes from service providers when they seek reproductive and sexual health services. Thus, service-providing organizations should ensure that young people feel comfortable making use of services and can do so confidentially. Clinics should display their confidentiality policy, specifying that it applies to all clients. Also, providers should start every consultation by reassuring young clients that their privacy will be respected.

Positively transforming young people's experience in the clinic setting is an important part of changing cultural norms that stigmatize their sexual activity. Service providers have a special role to play in reducing the stigma, shame, fear and embarrassment that prevent unmarried young people from obtaining services and exercising their *sexual rights*.

Service providers should ensure that special measures are in place to reach out to young people and should be actively involved in reducing the stigma through awareness-raising and education in the community. In light of the stigma that surrounds adolescent sexuality (and, to a lesser extent, that of young adults), service providers need to reach out to young people rather than wait for them to come to a clinic or other service delivery point. Schools, youth clubs and community centers are just a few of the types of sites where service providers can position themselves to serve young people in surroundings where they feel comfortable.

There are several ways to ensure that adolescents and young adults have access to information and services. In general, it is helpful to make the clinic hours convenient for those in school, keeping the clinic open on weekends or during after-school hours. Setting up information stands at sports events, music festivals and other youth-friendly events is another way to reach young people. Eliminating as many logistical barriers as possible is an essential step in improving access.

Marriage and education

Often young people who are married are viewed as adults whereas, in reality, many are still in adolescence and need special support to access sexual and reproductive health services. For example, female adolescents who are married to older spouses may have difficulty exercising their autonomy and negotiating safe sex. They are generally more vulnerable than other women to domestic violence, STIs and unintended pregnancy due to power imbalances that may result from the age difference.[8–10]

Women who are married during adolescence may be forced to drop out of school, thus diminishing their employment and income-earning prospects. Further, they may miss out on school-based sexuality education, which would give them crucial information and skills for making informed decisions. Service providers should consider the special needs of female adolescents who are married and take steps to ensure that they have adequate information and skills to manage their sexual and reproductive health.

Needs of young men

Young men have specific sexual and reproductive health needs. Information provided through counseling or outreach should empower them to feel respected and confident in obtaining support and using condoms. Programs should also seek to increase their life skills and understanding of sexual health, as well as the benefits of equitable relationships. Young men should be encouraged to assume responsibility for their sexual behavior and to protect the health, rights and well-being of their partners and families, as well as their own.

In many countries young men are likely to have sexual intercourse earlier than their female peers. In Guatemala, for example, the median age at first intercourse among men is 16.4 (indicator 16) compared with 18.4 for women (indicator 13). Young men are also likely to enter a marriage or union later than women (age 23.1 versus age 19.4). As a result, young men are typically unmarried and sexually active for longer periods than young women, and they need information and services to protect their sexual health and that of their partners. Another example from Zambia shows that the gap between the median age at first intercourse and first marriage for men (indicator 18) is 5.4 years in rural areas and 7.1 in urban areas. In contrast, the same gap for women (indicator 15) is only 1.1 year in

rural areas and 2.2 years in urban areas.

While these examples provide some information about the sexual and marital practices of young men and women in Guatemala and Zambia, it is important to note that not all sexual activity within marriage is safe or consensual, nor is all sex outside of marriage risky and problematic. To change cultural norms that reinforce such assumptions, advocates and others can use the data to inform audiences about the actual needs and practices of young people.

Program planners can use this information to ensure that services are addressing the sexual health needs of both young men and women and that unmarried young people feel comfortable obtaining sexual health services free of stigma. Service-providing organizations also have a role to play in ensuring that communities are supportive of providing young, unmarried people with sexual and reproductive health services.

Although young men often enjoy more independence outside the home than their female counterparts do, this freedom may also bring greater pressure from peers to be sexually active (as long as their sexual desires are directed toward women). Some young men may wish to delay sexual activity, but they feel significant pressures to "prove their manhood" through early, frequent and sometimes even aggressive sexual experiences. In many settings young men are expected to take risks including:

- engaging in physical violence (against people they know or do not know);
- avoiding seeking health care, or even admitting that they are sick or have been harmed;
- "proving" their heterosexuality, for example, by having heterosexual intercourse or even fathering a child;
- engaging in unsafe sex (thus increasing their risk of acquiring HIV infection); and
- taking physical risks, including with drugs or alcohol, or with a vehicle.[10]

Young men should therefore receive comprehensive information to understand and manage the pressures and risks they face and to safeguard their sexual health and rights—ideally, before they become sexually active.

Sexuality education and information

Using the data—initiation of sexual activity

Informing youth about sexual and reproductive health prior to their sexual initiation increases their ability to protect their health and well-being, increasing the likelihood that they will engage in healthy sexual relationships and decreasing the likelihood of health problems such as the following:[9–11]

- HIV
- Other sexually transmitted infections (STIs)
- Early childbearing and unintended pregnancies
- Unsafe abortion
- Sexual violence

Although some adolescents become sexually active before age 15 (indicators 5, 6), higher proportions begin to have sex in their mid- and late-teenage years. One-third or more of young women had become sexually active before their 18th birthday in 21 of the 26 countries with data for this indicator, and more than half had done so in eight countries. Thus, all adolescents need information about sexual health and rights from their early teen years onwards. Further, it is the right of children and young people to have access to the information they need in order to make informed decisions about their lives, health and well-being.

Young people may also engage in sexual activities such as oral or anal intercourse (activities that are generally not measured in population-based surveys, including the DHS), prior to their so-called sexual debut (usually assumed to be first vaginal intercourse), thus increasing the value of sexual health information at an earlier age. The timing of sexual debut also indicates the latest age by which young people should have begun receiving guidance and support to develop decision-making skills regarding sexual activity, sexual health and sexual rights, all of which can be improved with sexuality education.

These data can be used to accompany the important rights-based arguments for providing such information and education for young people. Policymakers, educators and program managers should use this information to determine when to teach particular topics and skills to adolescents, keeping in mind that activities such as kissing, fondling and oral sex, and experiences of peer pressure, may precede the initiation of sexual intercourse.

Providing sexuality education out of school

Since many young women and men do not attend school, *comprehensive sexuality education* should be provided in additional settings outside the classroom. For example, in Zambia, only 35% of young women and 38% of young men are enrolled in secondary school (indicators 63, 64). This indicates that the majority of young people in Zambia need of out-of-school alternatives, as well as age-

appropriate information while they are in primary school. Community-based programs and radio programs can be effective ways to reach out-of-school youth, including young women who have left school because of marriage or childbirth.

Addressing gender norms

A focus on *gender* equality and the fulfillment of young people's rights are critical for adolescents and young adults to make informed decisions about sex, sexuality and health, and to translate these decisions into action. Gender norms—the values and roles that societies assign to men and women—and gender inequality have a direct influence on so-called sexual risk behaviors; egalitarian gender attitudes are associated with safer behaviors, such as consistent use of contraceptives, and condoms in particular.[11] Sexuality education should address gender issues (including power imbalances between the sexes) and promote equal rights. It should also dispel myths about virginity and various forms of sexual activity by presenting young people with facts rather than opinions.

Advocacy

Dispelling common myths

Data on sexual activity provide scientific evidence that refute the widespread misperception that adolescents are not sexually active. Advocates can use this information to show policymakers that young people do, in fact, have a need for sexual health information and services.

The tables found at the end of this chapter and the more detailed, country-specific versions on the CD and Guttmacher website provide information on the extent to which young people are sexually active and at what age they initiate sexual activity. Advocates can use this information to provide specific recommendations (i.e., the age at which information and services are needed) to improve the sexual and reproductive health of young people.

For example, 14% of young women in Zambia become sexually active before they are 15 years old (indicator 5), and 59% do so before they are 18 (indicator 7), indicating that many initiate sexual activity between the ages of 15 and 18. Similarly, in Guatemala, 20% of men become sexually active before age 15 (indicator 6) and 60% before age 18 (indicator 8). Data on when adolescents become sexually active is critical to make the case for providing sexual health information to all adolescents. The median age at first sexual intercourse provides a useful measure as it shows when half of the adolescent population has had intercourse. Sexual health information and services should be provided well in advance of sexual initiation; this measure gives concrete information about level and timing of the initiation of sexual intercourse, helping advocates make the case for the provision of sexuality education far before this age.

Adolescent marriage—sexual behavior and social effects

In some countries, many adolescents marry during adolescence. Looking specifically at adolescent marriage in rural areas, the data indicate that one quarter of young women aged 15–19 Zambia (26%) have been married, as have one third of young women aged 15–19 in India (33%) (indicator 9). These data can be used to justify the need for contraception and sexuality education programs that enable young people to choose whether and when to have children and to protect their health. These high rates of adolescent marriage also highlight the importance of ensuring that young women have access to education and have the autonomy to decide whether and when to marry.

Marriage usually involves sexual activity but being married does not necessarily correspond to a desire to have children immediately, in quick succession or ever. Advocates can make the case that high levels of adolescent marriage signal a particularly strong need to provide information and services to all young women so that they can better plan their families and prevent unintended pregnancies.

In some contexts, *early marriage* can constrain young women's opportunities to attain higher education and earnings; it may also limit their autonomy and isolate them socially. Advocates can use marriage data to lobby for the enforcement of legal restrictions on early marriage and for policies and incentives that increase school and work opportunities for adolescents.

Additionally, marriage data may demonstrate how practice diverges from the law. In India, for example, the legal age of marriage is 18, but the median age of marriage among women is 17.4 nationally and 16.6 in rural areas (indicator 14), meaning that half of female adolescents were married before this age.[12–13] These data can be used to advocate for public education campaigns and resources to educate parents about the law and to ensure the law is enforced.

Often the gap between the median age at first *sexual intercourse* and at first marriage is greater for young men than young women. For example, in Guatemala, the gap is one year for women (indicator 15) and 6.7 years for men

(indicator 18). This means that young men spend more years sexually active before marriage and are therefore likely to have more sexual partners before marriage than young women. These data can be used to advocate for young men to be given greater access to condoms in school and in the community to prevent HIV, other STIs and unintended pregnancies.

DISCUSSION GUIDE

Sexual activity

- If a significant number of young people are having sexual intercourse before age 15, at what age should they be given information on sexual and reproductive health? Who should provide it to them, how and where?
- What are some of the sexual and reproductive health issues that young male adolescents who have intercourse before age 15 may face? Are these different for girls younger than 15? If so, why?
- Given the sexual and reproductive health issues that young adolescents under 15 may face, what services are required to meet their needs?
- The regret expressed by some young people about their early sexual experiences is often related to coercion and pressure—which is generally exerted by young men on young women but also occurs within peer groups of both sexes. How could this be addressed in your organization's provision of sexuality education and services?
- Given that there will be young adolescents who require information and services on sexual and reproductive health before age 15, what barriers may they face in obtaining them? How does your work currently address those barriers? What more could you do?
- Where and from whom are you going to find support for sexual and reproductive health services for adolescents and young adults?
- What life skills should be taught to young adolescents under age 15 to prepare them for sexual initiation?
- What are the ways girls and boys navigate their sexual lives in socially conservative settings?

Marriage

- In some of the 30 countries included in this tool, DHS surveys interview only ever-married women (Bangladesh, Egypt, Indonesia, Pakistan and Vietnam), so that information on unmarried women is lacking. The surveys do, however, provide information on the timing of marriage. Do you think this limited information is useful? What can you do to get some sense of the situation of unmarried young people's sexual experience?
- What specific risks do young married women face?
- What can be done to raise awareness of young women's right to choose whether and when to have children (even if their preferences are different from those of their spouse)?
- What possible changes to social and health policies in your country could address the particular needs of young women who marry at an early age?
- What policy changes could address the needs of female adolescents who have been married but are no longer?
- How do parents and extended family members influence the decision to have their daughters marry at an early age? How can policies address the issue of forced marriage?
- What are the main barriers (or taboos) that prevent addressing adolescents' needs for sexual and reproductive health services and protection of their sexual rights? (Among other rights, these include the right to information, education and services; to be protected from early and forced marriage; to bodily integrity; and to privacy.)
- How can sexual and reproductive health services address sexual violence and rape in marriage?

Sexual rights and gender equality

- Can you give examples of how you have made your programs more gender- sensitive?
- Investing in young women and girls: What would be your three top priorities?
- What do the differences in the percentages of young men and women who had intercourse before age 15 illustrate about gender norms, gender-based violence and gender equality in your country?
- How do you present a positive approach to sexual diversity and different forms of sexual expression (other than sexual intercourse) in your programs?
- How do you address inequality between young women and men in your programs?
- What are you doing for male adolescents? How do you target them and how successful have you been?

SECTION 2: CONTRACEPTIVE KNOWLEDGE, USE AND NEED

DEFINITIONS

19. % of women aged 15–19 who have not heard of family planning on any of three sources (radio, television or newspaper)

This indicator measures the extent of exposure to family planning messages from the major media sources among adolescent women.

20. % of men aged 15–19 who have not heard of family planning on any of three sources (radio, television or newspaper)

This indicator measures the extent of exposure to family planning messages from the major media sources among adolescent men.

Limitation pertaining to exposure to family planning messages:
While this indicator measures the degree of familiarity with family planning through media messages, it does not provide information on the content of the messages nor does it encompass all ways that adolescents learn about family planning. Family planning information provided through television, radio or newspaper may be inaccurate or ideologically driven, which can promote myths or misconceptions. Also, adolescents may learn about family planning from sources other than those listed in the question, such as school, family, friends and the Internet.

21. Average number of modern methods known among women aged 15–19

This indicator measures the extent to which young women know about modern contraceptive methods, i.e. sterilization, contraceptive pills, the patch, the IUD, injectables, implants, male or female condoms, diaphragms, and spermicides, such as foam or jelly.

Limitation pertaining to "knowledge" of modern contraceptive method:
Respondents may not know methods by the name that the interviewer uses, which could lead to an underestimate of the number of methods known. Another limitation is that there is a difference between having heard of a method, which may mean simply being aware of it, and having sufficient knowledge about where to get it and how to use it. As a result, "knowledge" indicators from the surveys do not measure comprehensive or in-depth knowledge about contraceptive methods. Rather, this indicator measures a general level of awareness, which may be somewhat superficial.

22. % of sexually active, never-married women aged 15–19 currently using any contraception

This indicator measures the extent to which never-married, sexually active, female adolescents are using any method of contraception, modern or traditional, to prevent pregnancy.

23. % of married women aged 15–19 currently using any contraception

This indicator measures the extent to which married female adolescents are using a modern or traditional contraceptive method to prevent pregnancy.

24. % of sexually active men aged 15–24 currently using any contraception

This indicator measures extent to which young men report that they or their partners are a using modern or traditional contraceptive method to prevent pregnancy.

25. % of sexually active, never-married women aged 15–19 currently using modern contraception

This indicator measures the extent to which sexually active, never-married, female adolescents are currently using effective contraceptive methods.

26. % of married women aged 15–19 currently using modern contraception

This indicator measures the extent to which young married women are currently using effective contraceptive methods.

27. % of sexually active men aged 15–24 currently using modern contraception

This indicator measures the extent to which young men are currently using effective contraceptive methods.

28. % of sexually active men aged 15–24 currently using the condom

This indicator measures the extent to which sexually active young men used the condom at last intercourse.

29. % of sexually active, never-married women aged 15–19 currently using traditional contraception

This indicator measures the extent to which never-married, sexually active female adolescents are currently using less effective, traditional methods, which include periodic abstinence, withdrawal, breastfeeding and country-specific methods.

30. % of married women aged 15–19 currently using traditional contraception

This indicator measures the extent to which married female adolescents are currently using less effective, traditional contraceptive methods.

31. % of sexually active men aged 15–24 currently using traditional contraception

This indicator measures the extent to which young men report that they or their partners are currently using less effective, traditional contraceptive methods.

Limitation pertaining to male and female reporting of contraceptive use:
For the questions regarding contraceptive use, it is possible that a female respondent may not mention the male condom or, less commonly, male sterilization because she is not the one using it. Similarly, a male respondent may not be aware of a method his sexual partner is employing, such as the IUD or the pill. Both of these scenarios would lead to an underestimation of contraceptive use. On the other hand, some adolescents may report using contraception because of the social pressure to do so, even though they may not be using a method. This would lead to an overestimate of contraceptive use.

32. % of sexually active, never-married women aged 15–19 who have unmet need for contraception

This indicator measures the magnitude of need for contraception among never-married, sexually active female adolescents. Women with unmet need are those who are able to become pregnant, but would prefer to avoid a pregnancy in the next two years or ever and are not using any contraceptive method.

Limitation pertaining to "sexually active:"
This guide defines "sexually active" as having had intercourse in the past three months. The DHS is somewhat ambiguous in their definition of "sexually active;" the questionnaire poses questions about sexual intercourse, but this is not explicitly defined, leaving the respondent to define what that means for themselves. Please see glossary for a definition of "sexually active." Married women are assumed to be sexually active. Indicators 24, 27, 28 and 31 include both married men and sexually active unmarried men.

33. % of married women aged 15–19 who have unmet need for contraception

This indicator measures the magnitude of need for contraception among married female adolescents. Women with unmet need are those who are able to become pregnant, but would prefer to avoid a pregnancy in the next two years or ever and are not using any contraceptive method.

APPLICATIONS

Service delivery and programming

Assessing contraceptive use and need

Young people have a right to health, including the right to obtain sexual and reproductive health information and services. Against the backdrop of the information on sexual activity in Section 1, service providers and program planners can use data in this section to identify the gaps in contraceptive knowledge and use among young people.

Indicators 22, 25, 29 and 32 show the level of overall contraceptive use and unmet need among never-married, sexually active female adolescents. These data can help service providers and program managers to better understand the level of need for sexual and reproductive health services among this population.

For example, among sexually active, never-married women aged 15–19 in Zambia, only 28% are using a contraceptive method, and 64% have an unmet need for contraception (indicators 22 and 32). Knowing the level of unmet need among female adolescents who live in urban and rural areas, as well as among poor and better-off adolescents can help organizations to target their service outreach and consider adjusting prices for poor adolescents. Also, data on knowledge of contraceptive methods (indicator 21) and exposure to family planning messages (indicators 19 and 20) can also inform interventions to increase adolescents' knowledge.

In addition, to increase contraceptive use and reduce unintended pregnancies, family planning counselors should help young women switch to another method when they are experiencing problems with a particular method.

Young married people also have the right to decide whether and when to have children; thus, improving their knowledge of and access to contraceptives is important

as it is for unmarried young people. Data on the prevalence of marriage among adolescents (indicators 9 and 10), contraceptive use and unmet need among married adolescent women (indicators 23, 26, 30 and 33) can help providers and program planners focus their efforts to give young married adolescents the information and services they need to manage the timing of their pregnancies. For example, in India, use of any contraceptive method among married female adolescents aged 15–19 is 13%, while unmet need for contraception among this group of women is much greater, at 27%. This latter figure indicates that there is a significant desire among married adolescents to avoid a pregnancy. Providing contraceptive services to married adolescents is therefore important, especially in countries where pregnancy often follows quickly after marriage.

Sexuality education and information

Gaining access to contraceptive knowledge

Knowledge is an important part of obtaining and effectively using contraception. Given that many youth become sexually active during adolescence, it is critical that they have comprehensive information about sexuality, relationships and contraception before age 15, and that they receive help building skills, like communicating with partners and making decisions independently. Young people need to find the contraceptive method that best suits their individual needs and be supported to make autonomous, informed decisions about their health, well-being and relationships. Young people are better equipped to make such autonomous, conscientious choices when they are made aware of, and challenge, constraining social norms and gender roles that may promote inequitable dynamics in relationships.

Comprehensive sexuality education should include much more than information about contraception. However, the data presented here illustrate how informed young people are about contraception in particular. Data on exposure to family planning messages (indicators 19 and 20), the average number of methods known (indicator 21) and contraceptive use (indicators 22–31) can help sexuality educators to identify the most urgent gaps in knowledge and protective behaviors. *It's All One Curriculum*[14] is one source for activities and guidelines for educators on this topic. Data on unmet need (indicators 32 and 33) reveal gaps in access to quality contraceptive services among young women, both married and unmarried.

Improving knowledge about sexual health services

A lack of knowledge about contraceptive methods and inability to access services are common reasons why young people do not use contraceptives. For example, in Zambia, 64% of young women aged 15–19 have not heard of family planning on the radio, on television or in the newspaper (indicator19). Contraceptive knowledge is relatively high in Zambia, with respondents knowing of an average of 3.5 methods (indicator 21) and 76% of women aged 15–24 reporting knowing a source for condoms (indicator 43). This level of knowledge however does not necessarily correspond to access to or use of contraception. Looking specifically at those women aged 15–19 who have never been married and who are sexually active, this critical knowledge gap is evident in that only 28% use any form of contraception (indicator 22) and 64% have an unmet need for contraception (indicator 32).

Young men are generally well-informed about condoms and know where to get them, but they need to be better informed about HIV and about other contraceptive methods, so that they can discuss method choice with their partners and use them. In Zambia, 88% of young men know a source for condoms (indicator 44), but only 37% have comprehensive knowledge of HIV (indicator 48) and 58% have not heard about family planning from the radio, television or newspaper (indicator 20). This lack of knowledge is higher in rural areas, where only 29% of young men have a comprehensive knowledge of HIV and 69% have not heard about family planning from the radio, television or newspaper.

Advocacy

Communicating the gaps in knowledge, use and need

The information in this section shows the extent to which young people need and use contraception. Advocates can use this information to lobby policymakers and ministries of education to make contraceptive information and services available to youth.

Indicators 32 and 33 on unmet need for contraception among female adolescents can be used to advocate to ministries of finance and health for an increase in funding for purchasing contraceptive commodities and providing youth-friendly services. For example, among women aged 15–19 in Guatemala, 26% of those who are married and 55% of those who are not have an unmet need for contraception. The level of *unplanned births* is also high; 35%

of births among Guatemalan adolescents aged 15–19 are unplanned. This proportion is even higher in Zambia, at 44% (indicator 37). Often, policymakers and others in positions in power are unaware of how a lack of access to contraception impacts the lives and circumstances of the general public; they may be particularly unaware of how this lack of access affects young people.

Data on adolescents' use of traditional contraceptive methods can be used to advocate for sexuality education curricula to include information on the inefficacy of these methods compared with modern methods in preventing unintended pregnancy. Traditional methods, such as the rhythm method, are much less effective than modern methods, but myths about the side effects from hormonal methods of contraception sometimes prevent young people from using these and other modern methods. The data on types of contraceptive methods used, for example, could be highlighted to persuade the government to fund a campaign promoting modern contraceptives and dispelling myths about hormonal methods. Access to modern methods of contraception is also important for female adolescents and young adult women in union. For example, in Zambia 11% of married women aged 15–19 were using traditional methods (indicator 30).

The limited variety of methods offered to young people can lead to lower rates of contraceptive use if the methods provided do not fit young people's needs. For example, a young woman who does not have sex often may prefer female or male condoms over ongoing hormonal methods; if her preferred method is not offered, she may not use contraception at all. Data on unmet need for contraception among young women can be used to advocate for providing a variety of methods to correspond to young people's situations.

DISCUSSION GUIDE

Contraceptive use

- What are some gender-related barriers to contraceptive use, and how does your organization try to address them?
- How have you been supporting and developing young people's capacity to make informed decisions about contraception in your programs?
- How does your organization promote choice in terms of choosing a contraceptive method among the young people you serve?
- How does your organization's sexuality education curriculum deal with issues such as respect for others, negotiation in sexual relationships and freedom of expression?
- What are some myths or misconceptions about condom use among young people? How can your organization help to dispel those myths?

Contraceptive knowledge

- How does your organization make sexual and reproductive health information and services available and approachable for young people, especially for young, unmarried women and girls?
- Does your organization provide information to young men on abortion, contraception, and HIV and other STIs? Do you think that it's important to have separate information for young men and young women? Why or why not?
- How could your organization work with the media to help ensure that messages targeted to young people about sex, sexuality and contraception are accurate?
- What are some of the myths or misconceptions that young people have about modern contraceptive methods? How can your organization help to dispel those myths?

Contraceptive need

- What types of contraceptive methods does your organization offer to young people? Do you think that there are other options that some young people may want? If so, how easy would it be to offer those methods or to refer young people elsewhere?
- Can young men and women obtain condoms easily? What can your organization do to improve their access? Are adolescents and young adults taught how to use condoms correctly and safely?

Sexual rights and gender equality

- How does your organization teach young men and boys about the harmful effects of some traditional gender norms? How do you promote equitable relationships?

- How important are male role models in empowering young men to understand and promote gender equality? Can you identify some of these role models? Has your organization made use of them?
- Are there ways in which your organization may unintentionally promote negative stereotypes of young men's or young women's sexual behavior and gender roles? If so, how could this be improved?

SECTION 3: CHILDBEARING

DEFINITIONS

34. % of women aged 15–19 who have ever had a child

This indicator measures the percentage of female adolescents who have had at least one live birth.

Limitations:
This measure provides information on live births; data are not available on pregnancies that end in miscarriage or abortion.

35. Median age at first birth among all women aged 20–24

This indicator provides the age at which half of young adult women have had their first child.

36. % of mothers younger than 20 whose most recent birth was delivered at a health facility

This indicator measures the extent to which adolescent mothers give birth at a health facility (such as a hospital or health clinic), as opposed to at home or in another environment.

37. % of recent births among women aged 15–19 that were unplanned

This indicator measures the extent to which female adolescents, whether married or not, gave birth to a child that they did not plan to have at that time or ever.

Limitations pertaining to bias in reporting unplanned births:
Measures on the planning status of recent births are usually based on live births during the five years prior to the interview. However, in some countries, the measure is based on births in the three years prior to the interview. In this case, proportions of unplanned births (indicator 37) may be slightly higher than those reported on births in the past five years because the more time that has elapsed since the birth, the more likely a pregnancy that was unintended at the time of conception would be reclassified by women as intended.

Reporting of unwanted or mistimed pregnancies is prone to reporting bias because young women who were not planning a pregnancy may either not wish to admit that a given pregnancy was unwanted or mistimed, or they may genuinely now feel that they want a pregnancy which was initially unintended. This translates to underreporting of unwanted and mistimed pregnancies and results in an underestimation of this indicator.

In addition, this indicator does not take into account unintended pregnancies that end in miscarriage and abortion, for which data are lacking in most countries. This indicator therefore captures only a portion of unintended pregnancies experienced by young women.

APPLICATIONS

Evidence demonstrating the high level of unplanned births among adolescents in developing countries indicates that young people are urgently in need of contraception. In addition, these data show adolescent women's need for routine reproductive health services, such as antenatal and delivery care, including emergency obstetric services. Motherhood at a young age can endanger women's health, their future economic possibilities, and the health and well-being of their families when young women do not receive the support that they need. Comprehensive sexuality education, contraceptive counseling and services oriented toward young women are vital for them to make informed decisions about whether and when to have children.

Service delivery and programming

Some evidence indicates that young women who give birth before the age of 16 are at a greater risk of negative health outcomes than women who have their first child at an older age.[11,15] These data support the critical need for sexual and reproductive health services for young women; it is also critical to prevent unintended pregnancies. For example, in Zambia, 22% of female adolescents aged 15–19 had already given birth at least once, and 44% of recent births among these adolescents were unplanned. Contraceptive information, counseling and services can help young women better achieve their reproductive goals, prevent *unintended pregnancies* and reduce the risks of unsafe abortion since legal and safe pregnancy termination is unavailable in many countries. Provision of such services can also help young women to delay their first birth so that it occurs at a time when they are prepared to take on the demands of motherhood. The ability to avoid unintended pregnancy is a key factor in keeping young women in school longer and enabling them to have greater autonomy.

The data demonstrates existing gaps in the provision of obstetric health services to pregnant adolescents. The services are critical and even lifesaving, given the risk of complications that may occur unexpectedly during pregnancy and childbirth. Postpartum contraceptive services to encourage young mothers to plan their next birth and prevent future unintended pregnancies are also needed, as are health services for the baby and information on breast-feeding and healthy child care practices. Program managers can use these indicators to justify the need for this range of services for pregnant young women and those who are already mothers.

Delivery at a health facility (indicator 36) with trained health personnel contributes to the survival of both women and children. The proportion of births that take place in an institutional setting is an important indicator of maternal health that helps to identify the size of the group with unmet need for adequate delivery care. For example, in Zambia, 60% of recent births among women younger than 20 were delivered at a health facility, meaning that 40% of young mothers did not receive what is considered basic, necessary care. Data show that the need for information and services is even greater in rural areas and disadvantaged communities. In rural areas of Zambia, where births to adolescent women are more common than in the country as a whole, only 44% of recent births among women younger than 20 were delivered at a health facility. Young women from poor households are also less likely than better-off women to give birth in a health facility, with 36% in the poorest quintile delivering in a health facility, compared with 91% in the wealthiest quintile.

Sexuality education and information

Evidence that many births among adolescent mothers are reported as either mistimed (they were wanted but came too soon) or unwanted demonstrates young women's need for contraceptive information and services to delay their first birth or postpone a subsequent one, and their need for access to safe abortion.

If a young mother does not use contraception, she may face adverse health consequences if she becomes pregnant again too soon. Closely spaced births (those occurring less than two years apart) put babies and their siblings at increased risk of illness and death, and can harm women's health.[16-17]

Sexuality education and other education and information programs should seek to counter stigma, where it exists, around adolescent pregnancies and respect the rights and dignity of pregnant girls and young mothers. Too often, messages about adolescent pregnancy are overly negative, alienating the young women and discouraging them from seeking health services. In addition, sexuality education and information programs need to adequately cover what are the recommended standards of health care during pregnancy and at delivery, as well as the benefits of such care for mothers and their newborns.

Advocacy

Adolescent childbearing is more prevalent among poor women than among those who are better-off, and unplanned childbearing is prevalent among all groups (poor, better-off, urban and rural). This means that disadvantaged women have a particularly great need for services during pregnancy and delivery, and all groups need information and services to protect themselves against early and unintended pregnancies. In Guatemala, for example 21% of young women aged 15–19 in the lowest wealth quintile had ever had a child, compared with only 8% of those in the highest wealth quintile. Similarly, in India, 18% of those in the lowest wealth quintile had had a child versus only 3% in the highest wealth quintile. Advocates can use this information to lobby governments to give priority to poor women.

These indicators can also be used to raise awareness of the adverse health consequences of early childbearing, such as birth complications, low birth weight and reduced chances of survival.[11,15] Advocates can use this piece of information to argue for giving young people the right to information and services that prevent poor health outcomes for both mother and child.

These data can be used to advocate for providing sexual and reproductive health information to all women in this age-group, whether or not they already have children. The data can also be used to advocate for increased services and support for young parents, including policies and programs to help young women resume studies or work after childbirth.

DISCUSSION GUIDE

Childbearing

- How should services and support for young pregnant women differ from those provided to adult pregnant women? What characteristics are crucial for services to be youth-friendly?
- In many countries, young, unmarried pregnant women are seen as a problem and, as a result, may not be supported by their families and communities. Discuss how young pregnant women experience stigma and discrimination in your country. How can your organization better support them in their choice to continue their pregnancy?
- In some countries, young married women are expected to bear a child within the first year or two after marriage. How can your organization help ensure that all young women are able to decide the timing of their first birth?
- A rights-based approach where young, pregnant adolescents are supported to make their own informed choices about their pregnancy can conflict with the view that parents and the community should be involved. How can or should parents be involved in the decision-making of young people? Should parental involvement be mandatory? Why or why not?
- How can the family and community be involved in supporting young pregnant women?
- How can young mothers be supported to complete their schooling?
- Supporting young women through pregnancy, childbirth and motherhood requires a collaborative effort across multiple sectors. What is the role of the educational sector? The health sector? What other sectors should be involved?

Sexual rights and gender equality

- Young pregnant women should be supported in their decisions about whether or not to continue their pregnancies. Does your sexuality education curriculum address young women's rights and choices related to pregnancy?
- Ensuring that young women and men have access to clear, accurate information about what it means to be pregnant and have a baby is crucial for supporting informed decision-making. However, the use of scare tactics is contrary to a positive and rights-based approach. How does your organization approach providing information on pregnancy and childbearing to young people?
- How can organizations like yours promote equitable parenting?
- How can your organization support young men's involvement in pregnancy, birth and childrearing? Discussion of pregnancy with young men is uncommon and therefore challenging. The role of young men as fathers needs to be considered in information, education and services.
- What does your organization do to make service delivery more comfortable for young men?
- How does your organization address the anxieties and challenges that young fathers experience?
- How does your organization communicate with young men about the societal expectations of fatherhood? Does your organization provide safe spaces for them to discuss their emotions, feelings and concerns during pregnancy?
- How does your organization address questions and doubts around paternity?

INDICATOR NUMBER	1	2	3	4	5	6
	% who have ever been sexually active				% who had sexual intercourse before age 15	
Region and country	Women 15–19	Men 15–19	Women 20–24	Men 20–24	Women 15–24	Men 15–24
AFRICA						
Dem. Rep. of Congo (2007)	52	51	91	91	18	18
Egypt (2008)[1,2]	nc	nc	nc	nc	nc	nc
Ethiopia (2011)	25	8	73	44	11	1
Ghana (2008)	37	22	88	74	8	4
Kenya (2008–09)	37	44	86	88	11	22
Malawi (2010)	44	54	94	87	14	22
Mozambique (2003)	73	69	98	97	28	26
Nigeria (2008)	46	22	86	62	16	6
Rwanda (2010)	14	22	58	61	4	11
Senegal (2010–11)	30	19	69	45	11	5
Tanzania (2010)	46	37	91	84	13	7
Uganda (2006)	43	35	92	86	16	12
Zambia (2007)	48	45	93	86	14	16
Zimbabwe (2010–11)	34	25	85	85	4	4
EUROPE						
Albania (2008–09)	12	19	53	68	1	1
Moldova (2005)	21	44	77	93	1	9
Ukraine (2007)	18	33	78	92	1	2
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	nc	nc	nc	nc	nc	nc
India (2005–06)	28	11	76	44	10	2
Indonesia (2007)[1,3]	nc	nc	nc	nc	8	0
Nepal (2011)	29	21	78	68	7	3
Pakistan (2007)[1,2]	nc	nc	nc	nc	nc	nc
Philippines (2008)[3]	14	nc	56	nc	2	nc
Vietnam (2002)[1,2]	nc	nc	nc	nc	nc	nc
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	30	38	76	90	7	13
Colombia (2010)[2]	50	nc	91	nc	14	nc
Dominican Republic (2007)	39	50	82	92	15	24
Guatemala (2008)[4]	28	40	36	89	8	20
Honduras (2005–06)[2]	32	nc	75	nc	11	nc
Peru (2007–08)[2]	26	nc	74	nc	6	nc

Full name of indicators above
1. % of women aged 15–19 who have ever been sexually active
2. % of men aged 15–19 who have ever been sexually active
3. % of women aged 20–24 who have ever been sexually active
4. % of men aged 20–24 who have ever been sexually active
5. % of women aged 15–24 who had sexual intercourse before age 15
6. % of men aged 15–24 who had sexual intercourse before age 15

INDICATOR NUMBER	7	8	9	10	11	12
	% who had sexual intercourse before age 18		% who have ever been married			
Region and country	Women 18–24	Men 18–24	Women 15–19	Men 15–19	Women 20–24	Men 20–24
AFRICA						
Dem. Rep. of Congo (2007)	61	56	25	6	73	33
Egypt (2008)[1,2]	nc	nc	13	nc	54	nc
Ethiopia (2011)	39	13	23	2	68	28
Ghana (2008)	44	28	9	1	51	17
Kenya (2008–09)	47	58	13	1	62	17
Malawi (2010)	60	53	26	3	86	41
Mozambique (2003)	81	72	43	6	84	52
Nigeria (2008)	49	26	29	1	62	16
Rwanda (2010)	17	27	4	0	41	20
Senegal (2010–11)	34	21	25	1	62	6
Tanzania (2010)	58	44	20	5	72	28
Uganda (2006)	62	48	22	2	78	44
Zambia (2007)	59	51	19	1	74	29
Zimbabwe (2010–11)	38	25	26	1	75	29
EUROPE						
Albania (2008–09)	15	23	8	1	38	8
Moldova (2005)	24	56	11	2	61	24
Ukraine (2007)	28	44	7	3	53	26
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	nc	nc	47	nc	86	nc
India (2005–06)	40	12	28	3	75	33
Indonesia (2007)[1,3]	38	12	13	nc	61	nc
Nepal (2011)	39	24	29	7	77	46
Pakistan (2007)[1,2]	nc	nc	16	nc	48	nc
Philippines (2008)[3]	17	nc	11	nc	49	nc
Vietnam (2002)[1,2]	nc	nc	4	nc	48	nc
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	39	60	15	4	52	35
Colombia (2010)[2]	61	nc	17	nc	52	nc
Dominican Republic (2007)	51	70	27	5	66	35
Guatemala (2008)[4]	38	60	22	6	60	44
Honduras (2005–06)[2]	44	nc	25	nc	66	nc
Peru (2007–08)[2]	36	nc	13	nc	46	nc

Full name of indicators above
7. % of women aged 18–24 who had sexual intercourse before age 18
8. % of men aged 18–24 who had sexual intercourse before age 18
9. % of women aged 15–19 who have ever been married
10. % of men aged 15–19 who have ever been married
11. % of women aged 20–24 who have ever been married
12. % of men aged 20–24 who have ever been married

INDICATOR NUMBER	13	14	15	16	17	18
	Median age at first sexual intercourse	Median age at first marriage	Gap between first sexual intercourse and first marriage	Median age at first sexual intercourse	Median age at first marriage	Gap between first sexual intercourse and first marriage
Region and country	Women 20–24[5]	Women 20–24[5]	Women 20–24[5,6]	Men 25–29[7]	Men 25–29[7]	Men 25–29[7]
AFRICA						
Dem. Rep. of Congo (2007)	17.0	19.1	2.1	18.0	24.8	6.8
Egypt (2008)[1,2]	nc	21.2	na	nc	nc	na
Ethiopia (2011)	17.4	17.4	0.0	21.8	23.9	2.1
Ghana (2008)	18.6	21.0	2.4	19.9	25.7	5.8
Kenya (2008–09)	18.3	20.2	1.9	17.4	24.8	7.4
Malawi (2010)	17.4	18.0	0.6	18.5	22.3	3.8
Mozambique (2003)	16.0	17.5	1.5	16.8	21.2	4.4
Nigeria (2008)	18.1	19.3	1.2	20.6	26.9	6.3
Rwanda (2010)	21.3	22.3	1.0	22.0	25.3	3.3
Senegal (2010–11)	19.8	20.4	0.6	22.7	28.9	6.2
Tanzania (2010)	17.4	18.9	1.5	18.8	23.9	5.1
Uganda (2006)	16.7	18.0	1.3	17.9	21.9	4.0
Zambia (2007)	17.4	18.7	1.3	17.9	23.5	5.6
Zimbabwe (2010–11)	19.3	19.9	0.6	20.6	24.6	4.0
EUROPE						
Albania (2008–09)	20.8	22.3	1.5	20.8	26.7	5.9
Moldova (2005)	19.4	20.3	0.9	18.5	23.1	4.6
Ukraine (2007)	19.3	21.2	1.9	18.6	23.7	5.1
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	nc	16.4	na	24.1	24.5	0.4
India (2005–06)	18.0	17.4	-0.6	22.7	23.1	0.4
Indonesia (2007)[1,3]	20.0	20.8	0.8	24.5	25.1	0.6
Nepal (2011)	19.0	18.9	-0.1	20.6	22.1	1.5
Pakistan (2007)[1,2]	nc	20.3	na	nc	nc	na
Philippines (2008)[3]	21.3	22.1	0.8	21.1	25.2	4.1
Vietnam (2002)[1,2]	nc	21.1	na	nc	nc	na
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	18.8	21.1	2.3	17.1	23.3	6.2
Colombia (2010)[2]	17.6	21.4	3.8	nc	nc	na
Dominican Republic (2007)	17.8	18.5	0.7	16.3	23.9	7.6
Guatemala (2008)[4]	18.4	19.4	1.0	16.4	23.1	6.7
Honduras (2005–06)[2]	18.2	18.9	0.7	nc	nc	na
Peru (2007–08)[2]	18.9	22.0	3.1	nc	nc	na

Full name of indicators above
13. Median age at first sexual intercourse among women aged 20–24
14. Median age at first marriage among women aged 20–24
15. Gap between median ages at first sexual intercourse and first marriage among women aged 20–24 (years)
16. Median age at first sexual intercourse among men aged 25–29
17. Median age at first marriage among men aged 25–29
18. Gap between median ages at first sexual intercourse and first marriage among men aged 25–29 (years)

INDICATOR NUMBER	19	20	21	22	23	24
Region and country	% who have not heard of family planning on radio, TV or newspaper		Average number of modern contraceptive methods known	% who are currently using any contraception		
	Women 15–19	Men 15–19	Women 15–19	Sexually active, never-married women 15–19	Married women 15–19	Sexually active men 15–24
AFRICA						
Dem. Rep. of Congo (2007)	83	85	1.7	45	15	nc
Egypt (2008)[1,2]	41	nc	4.4	na	23	nc
Ethiopia (2011)	57	51	4.2	51	24	43
Ghana (2008)	44	39	4.7	42	14	50
Kenya (2008–09)	44	36	3.7	22	23	65
Malawi (2010)	48	26	5.1	25	29	44
Mozambique (2003)	55	62	3.1	44	20	30
Nigeria (2008)	69	56	1.6	48	3	46
Rwanda (2010)	40	25	5.4	17	33	51
Senegal (2010–11)	69	66	2.9	16	6	57
Tanzania (2010)	50	51	5.2	40	15	42
Uganda (2006)	46	38	4.3	36	11	42
Zambia (2007)	64	58	3.5	28	28	43
Zimbabwe (2010–11)	75	74	4.1	25	36	64
EUROPE						
Albania (2008–09)	46	81	2.9	63	55	47
Moldova (2005)	48	70	4.3	66	58	nc
Ukraine (2007)	42	79	3.8	84	48	77
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	58	nc	5.8	nc	42	nc
India (2005–06)	39	20	3.9	[31]	13	25
Indonesia (2007)[1,3]	75	67	4.5	nc	47	nc
Nepal (2011)	32	24	6.2	*	18	45
Pakistan (2007)[1,2]	67	nc	3.7	nc	7	nc
Philippines (2008)[3]	24	nc	4.2	[31]	26	nc
Vietnam (2002)[1,2]	30	nc	1.9	nc	23	nc
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	56	46	4.5	47	41	77
Colombia (2010)[2]	25	nc	6.5	65	61	nc
Dominican Republic (2007)	nc	nc	6.1	42	46	71
Guatemala (2008)[4]	52	42	4.8	39	33	39
Honduras (2005–06)[2]	37	nc	5.0	43	46	nc
Peru (2007–08)[2]	44	nc	5.6	54	60	nc

Full name of indicators above
19. % of women aged 15–19 who have not heard of family planning on any of three sources (radio, TV or newspaper)
20. % of men aged 15–19 who have not heard of family planning on any of three sources (radio, TV or newspaper)
21. Average number of modern contraceptive methods known among women aged 15–19
22. % of sexually active, never-married women aged 15–19 currently using any contraception
23. % of married women aged 15–19 currently using any contraception
24. % of sexually active men aged 15–24 currently using any contraception

INDICATOR NUMBER	25	26	27	28
Region and country	% who are currently using modern contraception			% currently using the condom
	Sexually active, never-married women 15–19	Married women 15–19	Sexually active men 15–24	Sexually active men 15–24
AFRICA				
Dem. Rep. of Congo (2007)	19	4	nc	nc
Egypt (2008)[1,2]	nc	20	nc	nc
Ethiopia (2011)	51	23	41	15
Ghana (2008)	28	8	43	39
Kenya (2008–09)	18	19	59	54
Malawi (2010)	24	26	42	33
Mozambique (2003)	41	7	30	26
Nigeria (2008)	31	2	42	40
Rwanda (2010)	17	29	47	28
Senegal (2010–11)	15	5	56	56
Tanzania (2010)	36	12	42	38
Uganda (2006)	31	8	38	31
Zambia (2007)	26	17	41	35
Zimbabwe (2010–11)	25	35	63	42
EUROPE				
Albania (2008–09)	23	12	47	46
Moldova (2005)	46	29	nc	nc
Ukraine (2007)	81	43	68	64
SOUTH AND SOUTHEAST ASIA				
Bangladesh (2007)[1,2]	nc	38	nc	nc
India (2005–06)	[18]	7	18	12
Indonesia (2007)[1,3]	nc	46	nc	nc
Nepal (2011)	*	14	41	29
Pakistan (2007)[1,2]	nc	4	nc	nc
Philippines (2008)[3]	[4]	14	nc	nc
Vietnam (2002)[1,2]	nc	14	nc	nc
LATIN AMERICA & CARIBBEAN				
Bolivia (2008)	31	25	47	31
Colombia (2010)[2]	59	55	nc	nc
Dominican Republic (2007)	37	43	70	45
Guatemala (2008)[4]	32	28	32	34
Honduras (2005–06)[2]	34	40	nc	nc
Peru (2007–08)[2]	39	40	nc	nc

Full name of indicators above
25. % of sexually active, never-married women aged 15–19 currently using modern contraception
26. % of married women aged 15–19 currently using modern contraception
27. % of sexually active men aged 15–24 currently using modern contraception
28. % of sexually active men aged 15–24 currently using the condom

INDICATOR NUMBER	29	30	31	32	33
	% currently using traditional contraception			% who have unmet need for contraception	
Region and country	Sexually active, never-married women 15–19	Married women 15–19	Sexually active men 15–24	Sexually active, never-married women 15–19	Married women 15–19
AFRICA					
Dem. Rep. of Congo (2007)	26	10	nc	5	26
Egypt (2008)[1,2]	nc	4	nc	nc	8
Ethiopia (2011)	0	1	2	37	33
Ghana (2008)	14	6	8	52	62
Kenya (2008–09)	4	3	6	75	30
Malawi (2010)	1	2	2	67	25
Mozambique (2003)	3	13	1	37	17
Nigeria (2008)	16	1	4	50	19
Rwanda (2010)	0	3	5	73	6
Senegal (2010–11)	2	1	0	77	31
Tanzania (2010)	5	3	1	50	16
Uganda (2006)	5	3	5	55	34
Zambia (2007)	2	11	2	64	22
Zimbabwe (2010–11)	0	2	1	59	17
EUROPE					
Albania (2008–09)	40	42	0	29	17
Moldova (2005)	20	29	nc	32	13
Ukraine (2007)	3	6	9	16	30
SOUTH AND SOUTHEAST ASIA					
Bangladesh (2007)[1,2]	nc	4	nc	nc	20
India (2005–06)	[14]	6	7	[20]	27
Indonesia (2007)[1,3]	nc	1	nc	nc	10
Nepal (2011)	*	3	4	*	41
Pakistan (2007)[1,2]	nc	3	nc	nc	20
Philippines (2008)[3]	[27]	12	nc	[57]	36
Vietnam (2002)[1,2]	nc	9	nc	nc	13
LATIN AMERICA & CARIBBEAN					
Bolivia (2008)	17	16	30	49	38
Colombia (2010)[2]	6	6	nc	32	20
Dominican Republic (2007)	5	3	1	48	28
Guatemala (2008)[4]	7	5	7	55	26
Honduras (2005–06)[2]	9	6	nc	47	26
Peru (2007–08)[2]	15	20	nc	36	18

Full name of indicators above
29. % of sexually active, never-married women aged 15–19 currently using traditional contraception
30. % married women aged 15–19 currently using traditional contraception
31. % of sexually active men aged 15–24 currently using traditional contraception
32. % of sexually active, never-married women aged 15–19 who have unmet need for contraception
33. % of married women aged 15–19 who have unmet need for contraception

INDICATOR NUMBER	34	35	36	37
	% who have ever had a child	Median age at first birth[8]	% whose most recent birth was delivered at a health facility[9]	% of recent births to women 15–19 that were unplanned
Region and country	Women 15–19	Women 20–24	Mothers under 20	Women 15–19
AFRICA				
Dem. Rep. of Congo (2007)	19	20.2	73	31
Egypt (2008)[1,2]	6	22.9	73	4
Ethiopia (2011)	10	21.4	12	28
Ghana (2008)	10	21.1	57	56
Kenya (2008–09)	15	19.8	53	46
Malawi (2010)	20	18.9	81	35
Mozambique (2003)	34	18.6	57	23
Nigeria (2008)	18	20.9	23	12
Rwanda (2010)	5	22.9	87	40
Senegal (2010–11)	16	21.4	75	20
Tanzania (2010)	17	19.6	58	27
Uganda (2006)	19	18.8	54	41
Zambia (2007)	22	19.2	60	44
Zimbabwe (2010–11)	19	20.2	65	33
EUROPE				
Albania (2008–09)	2	23.9	95	9
Moldova (2005)	5	22.0	100	22
Ukraine (2007)	3	23.1	99	23
SOUTH AND SOUTHEAST ASIA				
Bangladesh (2007)[1,2]	27	19.0	16	21
India (2005–06)	12	19.9	41	14
Indonesia (2007)[1,3]	7	22.5	38	10
Nepal (2011)	12	20.1	47	24
Pakistan (2007)[1,2]	7	22.3	36	10
Philippines (2008)[3]	7	23.1	38	30
Vietnam (2002)[1,2]	2	22.6	48	12
LATIN AMERICA & CARIBBEAN				
Bolivia (2008)	14	21.1	76	62
Colombia (2010)[2]	16	21.4	96	62
Dominican Republic (2007)	16	20.3	99	47
Guatemala (2008)[4]	17	20.3	60	35
Honduras (2005–06)[2]	17	20.0	76	47
Peru (2007–08)[2]	11	22.3	81	61

Full name of indicators above
34. % of women 15–19 who have ever had a child
35. Median age at first birth among all women aged 20–24
36. % of mothers younger than 20 whose most recent birth was delivered at a health facility
37. % of recent births to women aged 15–19 that were unplanned

NOTES TO TABLES, indicators 1–37

1. These countries' female DHS samples consist only of women who had ever been married. Indicators on unmarried women were not collected, and indicators for "all women" will only reflect women who are currently married, widowed or divorced/separated. Exceptions are indicators 9, 11 and 14, in which household survey data are used to provide a basis for measuring the timing of marriage for all women in the respective age-group.

2. No men were interviewed for the DHS in these countries; therefore we are unable to provide any male data.

3. Men who participated in the DHS for these countries were given a brief version of the interview, so only limited male data are available.

4. Indicators 2, 4, 6, 8, 10, 12, 16, 17, 19, 20, 24, 27, 28 and 31 were unavailable or incomplete in the 2008 CDC report for Guatemala; the data provided are from the 2002 CDC report for Guatemala.

5. For Bolivia, Colombia, Dominican Republic, Ethiopia, Ghana, Guatemala, Honduras, Kenya, Moldova, Nigeria, Pakistan, Peru, Philippines, Rwanda, Tanzania, Uganda, Ukraine, Zambia and Zimbabwe indicators 13, 14 and 15 give the medians (and differences between them) that were calculated among women aged 25–29, because fewer than 50% of women in these countries had married or had intercourse by age 24. Thus, the medians could not be calculated using the 20–24 age-range, as was done in the other 11 countries.

6. The negative value of indicator 15 for India and Nepal (the median age at first intercourse is higher than the median age at first marriage) is a result of a widespread traditional cultural practice of postponing cohabitation/sexual intercourse by a few months after marriage. For these two countries, this indicator measures these behaviors essentially only among ever-married women: In the case of Nepal, only ever-married women were interviewed, so the median age at intercourse does not capture the behaviors of unmarried women. The case of India, where the 2005–06 DHS does include unmarried women, this indicator principally captures age at first sex among ever-married women, because in this socially conservative context, unmarried women are highly unlikely to report sexual activity.

7. For Bolivia, Democratic Republic of Congo, Dominican Republic, Ghana, India, Indonesia, Kenya, Moldova, Mozambique, Nigeria, Philippines, Senegal, Tanzania, Uganda and Zambia, indicators 16, 17 and 18 give the medians (and differences between them) that were calculated among men aged 30–34, because fewer than 50% of men in these countries had married or had intercourse by age 29. Thus, the medians could not be calculated using the 25–29 age-range, as was done in the other 15 countries.

8. For Democratic Republic of Congo, Ghana, Indonesia, Kenya, Moldova, Nepal, Nigeria, Pakistan, Peru, Philippines, Rwanda, Senegal, Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe, indicator 35 gives the median age at first birth among women aged 25–29. We calculated the median using this age-group because fewer than 50% of women in these countries had experienced a birth by age 24. Thus, the indicator could not be calculated using the 20–24 age-range as was done in the other 12 countries.

9. For Ukraine, comparable data were unavailable, so indicator 36 gives the percentage of mothers younger than 20 for whom all births in the preceding three years (rather than the most recent birth) were delivered at a health facility.

nc=not collected

na=not available

* = When DHS data is available for fewer than 25 respondents, no value is given (the data is suppressed) because there is too little information to accurately represent the group.

[ ] = When DHS data is available for 25–49 respondents, the value is bracketed to indicate that, since the sample size is small, the value will be less accurate than values based on more than 50 respondents.

4 Sexual Rights and Gender Equality

This chapter presents measures related to knowledge about sexual health issues and sexuality education in schools, both of which are necessary for *adolescents* to make informed decisions. It also provides information on adults' attitudes toward teaching adolescents about condoms and sexual health, and adolescents' knowledge about *sexual health* issues. Women's autonomy to make health decisions and attitudes about women's rights within a relationship are also addressed. The *indicators* were selected because they are the only reliable measures available on these topics for a wide range of countries, and they shed light on young people's experience of *sexual rights* and *gender* equality. The sexual rights of young people include the right to equality, the right to life and to be free from harm, the right to health, and the right to know and learn.[18]

To document sexual rights and gender equality adequately, a much broader range of information on sexuality education, sexual rights and attitudes, and behaviors related to gender equality and sexual rights is needed. Because such broad-based information is lacking, this chapter presents the measures that are available for a large number of countries, to provide some degree of insight, however limited, into the issues addressed in this chapter. More specific data limitations are also discussed after each group of indicators.

SECTION 1. SEXUALITY EDUCATION IN SCHOOLS

As governments and health professionals increasingly recognize young people's sexual and reproductive rights, international guidelines and standards for sexuality education have progressively incorporated a stronger focus on human rights into the content of sexuality education. There is a trend toward a more holistic approach to sexuality education that seeks to support and empower young people to "handle sexuality in responsible, safe and satisfactory ways, instead of focusing primarily on individual issues or threats."[19] Shifting the teaching approach from a narrow HIV/AIDS focus towards a more integrated, comprehensive approach will also encourage *young people* to think critically about social and cultural pressures surrounding sexuality and gender.

Teaching sexuality education in schools is a way to reach a large number of adolescents and equip them with skills to make informed decisions to protect their health. However, standardized and reliable data are not available on the actual delivery of sexuality education in classrooms or on the quality of such education. The only approximation that can be found and is comparable for a large number of countries is the exposure of adolescents to skills-based HIV education and health education (indicators 38 and 39). Such education provides information on the risk of infection with *STIs,* including HIV, ways to protect one's health and myths and misconceptions about HIV. It includes decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach adolescents how to cope with their emotions and causes of stress. *Skills-based health education* also usually provides some information about human reproduction, including contraception.

Researchers have made several recent attempts to document the provision of skills-based HIV education in schools, as shown in the table for indicator 38 and 39. The two indicators presented below provide information about the number of schools in the country that were teaching the topic at the time of the survey (indicator 38) and about the attention governments give to skills-based HIV or health education (indicator 39). When combined with other data on school attendance (indicators 60, 61, 63 and 64), these data provide an idea of the proportion of adolescents who may receive skilled-based HIV or health education in schools.

These indicators are insufficient to assess the comprehensiveness and the quality of sexuality information and education provided to children and adolescents in schools. Also, the measures exclude information and education provided outside of school and through the media. However, they are the only ones available for a large number of countries and, despite their serious limitations, provide some information about sexuality education in schools.

DEFINITIONS

38. % of schools that provided skills-based HIV education in the last academic year

This indicator shows the percentage of schools surveyed (both private and public) that said that they provided "within the last academic year at least 30 hours of skills training, including on HIV, to each grade." This indicator is far from sufficient to show how closely the HIV education approximates *comprehensive sexuality education* in terms of the specific content, teaching approach used and quality of instruction. However, it can be used as a *proxy* measure of sexuality education because it includes some of the same topics.

39. Inclusion in the national school curriculum of skills-based HIV education or health education, including HIV prevention

This indicator measures the government's and education ministry's awareness of and commitment to skills-based health education, including HIV prevention. It describes the status of HIV education in the *national curriculum.* If such education is included, teachers have to deliver a fixed number of lessons on the topic, using a skills-based approach.

Limitations:

Indicators 38 and 39 are derived from desk reviews by Guttmacher staff members of published reports and therefore capture only what exists on paper, not what is actually implemented. Also, the measures exclude information and education provided by programs outside of school and through the media.

These indicators do not provide specific information on the content of the skilled-based HIV or health education, the number of hours spent on these topics and in what grades this information is provided. Indeed, many studies show that some topics that are included in the national curriculum are not systematically taught, especially when topics are difficult to teach and/or the students are not tested or graded on the subject.

The variety of programs and approaches to skills-based HIV education and health education makes it more difficult to compare across countries. Substantial variations in the levels of school attendance must be taken into account when interpreting these indicators or making cross-country comparisons: programs will reach relatively fewer adolescents in countries with low school attendance.

Moreover, most data are self-reported and governments may overstate their achievements to conform to international standards or to obtain international financial support.

APPLICATIONS

Despite the serious limitations mentioned above, these two indicators on skills-based HIV education and health education in schools give some indication of the openness and readiness of education ministries and schools to address sensitive topics. Even where school attendance is low, schools remain a good way to reach large numbers of young people.

Service delivery and programming

In countries where school attendance is low (see indicators 60, 61, 63 and 64) and where school-based sexual and reproductive health education is weak, significant knowledge gaps on sexual and reproductive health are very likely. For example in Zambia, primary school attendance is around 80% for both sexes, and secondary school attendance is 35% for female adolescents and 38% for male adolescents. These data mean that even if comprehensive sexuality education is provided in schools, many adolescents will not receive it because they are not in school. With these data, organizations and service providers can justify the need to develop their own education programs and materials and train staff to provide comprehensive sexuality education in out-of-school forums, such as youth or sport clubs.

In advocating for including sexuality education in national school curricula, cooperation between the health and education ministries is vital. Ministries of health can provide the situational analyses that are necessary to make the case for sexuality education to be integrated into mainstream education. The health ministry can also ensure that sexuality education is linked to health services that are accessible to young people.

Sexuality education and information

The indicators in this section show that most countries have included some kind of sexuality education in their national *curriculum.* However, information about the quality of such programs and their actual implementation is scarce. Other available research on sexuality education in school reveals that implementation is often incomplete and that many programs are far from being comprehensive.[20]

Moreover, not all adolescents and young people attend school (see indicators 60, 61, 63 and 64). In conjunction with indicators on knowledge and self-efficacy (indicators

42–46), service providers can evaluate the gaps in the sexual health knowledge of the adolescent population they serve. For example, in India, only 20% of young women aged 15–24 and 36% of young men have a comprehensive knowledge of HIV/AIDS (indicators 47 and 48).

The data demonstrate that to reach more young people, programs need to provide sexuality education both in and out of schools. The programs can be community-based, delivered at health facilities or through the media. Health professionals may also consider contributing to sexual and reproductive health education in schools, for example, by supporting the school system to develop teaching material, training teachers or working with teachers inside or outside the classroom. To do so, health professionals should work in close cooperation with the Ministry of Education.

As mentioned above, these indicators do not reveal the quality or comprehensiveness of sexuality education. Further, the indicators focus specifically on modules for HIV prevention education. Organizations can use the available information as an impetus to conduct more research on the quality, comprehensiveness and coverage of sexuality education.

Advocacy

These indicators demonstrate that it is still necessary in most countries to advocate for sexuality education that is comprehensive, skills-based and age-appropriate. The data in Chapter 3 on young people's knowledge and use of contraception (indicators 19–33) and age of sexual initiation (indicators 5–8) could be extremely useful in conjunction with data on the coverage of sexuality education (indicators 38–39).

A skills-based approach to sexuality and reproductive health helps young people understand and assess the factors that increase the risk of *unintended pregnancy,* HIV and other STIs, and sexual violence and abuse. A skills-based approach, when correctly implemented, can have a positive effect on communication, *self-efficacy*, negotiation, and ultimately on behaviors, such as contraceptive use and safer sex practices.

Advocating for an early start of sexuality education, i.e., before the onset of *sexual activity,* is very important. All adolescents and young adults have the right to know about sexuality and sexual and reproductive health so that they can make the best decisions to protect their health and that of their partners. In places where secondary school attendance is low, advocating for sexuality education in primary schools and in other venues outside of school is also important.

Data on HIV education could be used to lobby ministries of education to improve the implementation of existing curricula on sexual health and to improve the approach if necessary, toward skills-based, comprehensive sexuality education. While most governments declare that skills-based HIV education is included in the curriculum, most are not able to provide information about coverage and quality. When data have been collected through surveys of schools, they often show that not all schools are providing such education. For example, 31% of schools in India provide such education, but the data do not specify whether this number refers to primary schools, secondary schools or both.

To improve the quality of education, advocacy is also needed for effective training of teachers, the use of good (often already existing) teaching materials and the integration of sexuality education into the national curriculum. In particular, sexuality education must be provided in several grades according to the needs of students, and enough lesson time must be provided.

The lack of standard and reliable information on whether official school curricula include HIV or skills-based information should provide an impetus to advocate for more data collection on the status and quality of sexuality education in schools.

DISCUSSION GUIDE

School-based sexuality education

- Do you have a copy of your national curriculum? Is sexuality education included in the topics that must be taught in schools? If so, look at what specific topics are mentioned and compare them with *IPPF's Framework for Comprehensive Sexuality Education* to determine whether all essential elements are included.
- What are the greatest obstacles to implementing comprehensive sexuality education in your country? What opportunities currently exist?
- If sexuality education is already included in the national curriculum in your country or region, do you see opportunities for improving implementation? What can your organization do to achieve this?
- Are teachers trained to teach sexuality education? What kind of support do they receive?

RESOURCES FOR DEVELOPING QUALITY SEXUALITY EDUCATION

The IPPF Framework for Comprehensive Sexuality Education (CSE) [21] reflects a rights-based approach to adolescent sexuality. It provides a checklist for determining whether all of the essential elements of comprehensive sexuality education are present, a basic planning framework for implementing such education, in-depth resources and sample curricula.

In **Lessons Learned in Life Skills-Based Education for HIV/AIDS,**[22] UNICEF presents lessons from a wide range of research and experiences with HIV/AIDS-prevention education in both developing and developed countries, with the aim of maximizing the quality of programs and, ultimately, improving program outcomes. The lessons it contains are also relevant to comprehensive sexuality education.

Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics,[23] by Douglas Kirby and colleagues, summarizes 83 evaluations of sexuality and HIV education programs for youth based on written curricula and implemented in schools, clinics or other community settings in developing and developed countries. These programs typically focus on pregnancy or the prevention of HIV and other STIs, not on broader issues of sexuality such as developmental stages, gender roles or romantic relationships. This review and the related guide have some limitations, as they do not include the elements of a rights-based approach to sexuality education.

Tool to Assess the Characteristics of Effective Sex and STI/HIV Education Programs,[24] by Douglas Kirby and colleagues, is an organized set of questions designed to help practitioners assess whether *curriculum*-based programs have incorporated characteristics common to effective programs identified through the research study listed above.

It's All One Curriculum,[14] produced by the Population Council, IPPF and others, provides a holistic, comprehensive sexuality education *curriculum* that emphasizes gender equality and human rights. It presents important topic areas to cover, lesson plans and advice on how to tackle sensitive issues in a positive, proactive manner.

- If young people do not receive sexuality education in school, what other sources are they using to get information? Are there good sources, providing reasonably comprehensive and accurate sexuality education?
- What myths or misinformation do some of these sources promote? How could you work with these other sources to correct inaccuracies and promote healthy, rights-based messages?

SECTION 2: ADULTS' ATTITUDES ABOUT SEXUAL HEALTH INFORMATION

This section presents data on the general attitudes of adults toward one aspect of HIV prevention programs. Adults' attitudes toward teaching young adolescents aged 12–14 about condoms, (which are effective in preventing HIV when used correctly), is the only reliable measure that is available for a large number of countries.

To adequately measure this topic, a much broader range of measures of adults' attitudes on a number of aspects of provision of sexual health information to adolescents, beyond HIV/AIDS prevention, is needed. However, lacking such broad-based information, we present this single measure linked to condom and HIV/AIDS-prevention education to provide at least a limited insight into the views of adults in regard to providing sexual health information to adolescents.

DEFINITIONS

40. % of women aged 18–49 who agree that adolescents aged 12–14 should be taught about using a condom to prevent HIV

This indicator measures the opinion of adult women regarding the need to teach young adolescents about using a condom to prevent HIV.

41. % of men aged 18–49 who agree that adolescents aged 12–14 should be taught about using a condom to prevent HIV

This indicator measures the opinion of adult men regarding the need to teach young adolescents about using a condom to prevent HIV.

Limitations pertaining to availability: These indicators are not available for many countries, which makes comparisons across countries difficult.

Limitations pertaining to proxy measure:
Although this indicator is used here to approximate support for sexuality education, it is possible that support for education to prevent HIV is stronger than support for more comprehensive sexuality education. In most countries, HIV has become an important public health issue, whereas sexuality in general and adolescent sexuality in particular may be still regarded as taboo. Thus, sexuality education may be regarded as unsuitable for young adolescents (aged 12–14), even where there is support for teaching them how to prevent HIV.

APPLICATIONS

Parental resistance to sexuality education programs can be an obstacle to their implementation. Involving parents and explaining to them the benefits of adolescents receiving comprehensive education on sex, sexuality and sexual health is therefore important. Parents, teachers and other adults' understanding of the importance of sexuality education may help influence decision makers and schools to provide it.

Service delivery and programming

These indicators can be used to demonstrate the need for more or better communication with parents and other adults to increase their awareness of the need to educate adolescents about condoms and other sexual health and rights issues before they become sexually active.

For example, in Zambia, 48% of female adolescents aged 15–19, and 45% of their male counterparts, have had sexual intercourse. Many births—44% of those among adolescents aged 15–19—are unplanned. Unmet need for contraception is high among married female adolescents aged 15–19 (22%), and even higher among sexually active adolescents who are not married (64%). These data demonstrate that many adolescents are sexually active and need a way to protect themselves from STIs and avoid unintended pregnancies.

Although most young people in Zambia (76% of young women and 88% of young men, indicators 43 and 44) know a source for condoms, obtaining them may still be difficult, as only 40% of young women aged 15–24 report that they could get condoms on their own (indicator 42). Condom use is not very common: Only 35% of sexually active young men aged 15–24 report using them the last time they had sex. Service providers, educators and advocates can use these data to raise awareness among adults and parents about the importance of providing knowledge and access to services, including condoms, to all adolescents.

Health professionals can play an important role in facilitating communication between young clients and their parents or other adult caregivers. Given their ability to draw on their experiences, they are also well positioned to help advocate for sexuality education for adolescents.

Sexuality education and information

Where support for teaching younger adolescents about condom use is low, it is likely that most adolescents do not receive this information—or information on other topics relating to sexual health and rights—at home, in schools or through the media. Indicators on sexual activity from Chapter 3 can be used to explain to parents and other adults why it is so important to provide this information to young people during early adolescence.

For example, in Guatemala, 22% of female adolescents aged 15–19 have ever been married, 38% have had intercourse before age 18, and 35% of recent births to adolescent women were unplanned. But only 22% of Guatemalan young women have a comprehensive level of knowledge of HIV (indicator 47). Young men in Guatemala also need access to information and services: Sixty percent have had intercourse before age 18 (indicator 8), and only 34% of those who are currently sexually active are using condoms (indicator 28).

Advocacy

Indicators 1–18 show that sexual activity is part of the lives of many adolescents, regardless of whether they are married or not. In places where the support among adults for education on condom use for younger adolescents is low, advocacy is needed to explain the importance of comprehensive sexuality education (not only on condom use). The level of support for teaching adolescents about condoms varies widely across countries. In India, for example, only 28% of adult women (aged 18–49) and 35% of adult men agree that girls aged 12–14 should be taught about using a condom to prevent HIV, whereas, in Zambia 56% of adult women and 68% of adult men support the provision of such information to young adolescents (indicators 40 and 41).

These data and evidence from other countries show that advocacy work is needed to gain adults' acceptance about providing sexuality education, including on condom use, to adolescents of all ages, including younger adolescents. Where the level of adult support for teaching about condoms is sufficient, these data can be used to advocate with the education ministry, schools, teacher associations, health service providers and community-based organiza-

tions for providing more comprehensive sexuality education, including for young adolescents.

For instance, in the Dominican Republic, adult support for teaching young adolescents (aged 12–14) about using condoms to prevent HIV is over 90% (indicators 40 and 41), but only 6% of surveyed schools were delivering skills-based HIV education (indicators 38 and 39). This is clearly a context in which evidence can be used to do more advocacy in order to increase HIV skills-based education in schools.

DISCUSSION GUIDE

Teaching adolescents about condom use

- How does your organization reach out and talk to parents about the importance of sexuality education for young people?
- Without looking at your country's indicators, do you believe that there is a high level or low level of support for teaching young adolescents about condom use? Brainstorm about what contributes to low levels of support for HIV prevention education, then consider ways to address this using the DHS data from other sections of this guide (e.g., Chapter 3).
- Do you think that teaching young people about HIV prevention can open the door to talking about other issues? If so, how? What other issues could you link to a lesson on HIV prevention?
- Consider the elements of your organization's comprehensive sexuality education curriculum and compare it with the essential elements in IPPF's Comprehensive Sexuality Education Framework.[21] What is missing? What could be improved?

SECTION 3: ADOLESCENTS' SELF-EFFICACY RELATED TO SEXUAL HEALTH

The indicators in this section also relate mainly to HIV prevention. They were chosen because they are the only ones available for a wide range of countries and are considered reliable. To adequately measure *self-efficacy*—one's judgment or belief about being able to adopt a specific behavior or perform a particular activity—a much broader range of measures on adolescents' knowledge and access to sexual health and rights information and services is needed. However, access to condoms and knowledge about risks and ways to protect one's health provide a first insight into adolescents' self-efficacy.

Knowledge and access do not translate automatically into behavior change, but if young women are able to obtain a male condom on their own, then they are more likely to be able to use the method consistently. Similarly, if young women and young men are knowledgeable about HIV other STI facts, myths and prevention methods, they are more likely to make decisions to protect their health.

DEFINITIONS

42. % of women aged 15–24 who report that they could get condoms on their own

This indicator measures the level of young women's independent access to condoms without the assistance of a sexual partner, friend or family member.

Limitations:
While a woman may report that she is able to obtain a condom on her own, she may not necessarily obtain one or use one once she has it. In some cultures, it is considered unacceptable for a woman to carry a condom or insist on its use during a sexual encounter. It may be perceived as a sign that she is promiscuous or infected with an STI, particularly HIV, or that she believes that her partner is infected. Such perceptions may put her at risk for sexual violence or social discrimination.

43. % of women aged 15–24 who know a source for the condom

This indicator measures the extent to which young women know where to obtain condoms.

44. % of men aged 15–24 who know a source for the condom

This indicator measures the extent to which young men know where to obtain condoms.

45. % of women aged 15–49 who know that HIV risk is reduced by condom use

This indicator measures the level of knowledge among adult women about using a condom as one effective way to prevent HIV transmission.

46. % of women aged 15–49 who know that HIV risk is reduced by having one uninfected partner

This indicator measures the proportion of adult women who know that having only one HIV-negative sexual partner decreases risk of contracting HIV.

47. % of women aged 15–24 with comprehensive knowledge of HIV/AIDS

This *composite indicator* combines the answers to several questions to measure the proportion of young women who know the main facts about how to prevent HIV. Respondents must correctly report that consistent use of condoms during sexual intercourse and having just one partner who is HIV-negative and has no other partners can reduce the risk of getting HIV, and reject the two most common local misconceptions about HIV transmission and prevention.

48. % of men aged 15–24 with comprehensive knowledge of HIV/AIDS

This composite indicator combines the answers to several questions to measure the proportion of young men who know the main facts about how to prevent HIV. Respondents must correctly report that consistent use of condoms during sexual intercourse and having just one partner who is HIV-negative and has no other partners can reduce the risk of getting HIV, and reject the two most common local misconceptions about HIV transmission and prevention.

Limitations pertaining to HIV/AIDS data:
These measures about knowledge (indicators 45–48) are related to HIV/AIDS prevention and do not capture all the dimensions of sexual activity and rights which would be useful to measure the sexual health self-efficacy of adolescents. No other standardized measures are available. Despite their serious limitations, these indicators provide some information about the likely level of knowledge about this aspect of sexual health.

Limitations pertaining to larger age-groups:
Indicators 45 and 46 are provided for women aged 15–49. It is important when using data for all women to be careful not to interpret these measures as necessarily valid for young women and to consider whether they also apply to younger women.

Limitations pertaining to social pressure:
This measure does not capture the pressure that women may experience from sexual partners to have unprotected sex. Given the social sensitivity around HIV/AIDS, it is possible that those interviewed were affected by social response bias—that is, they reported certain beliefs or refuted certain myths because they knew that these were the socially acceptable responses. For instance, some people may know that they are supposed to say that condoms prevent HIV, but they may still believe that they are ineffective.

Limitations pertaining to measuring actual behaviors
None of these indicators measure actual behaviors, such as buying, carrying and using condoms or practicing safer sex. They measure the ability to get condoms and knowledge about where to get them, different ways to prevent HIV, and the some misconceptions about HIV transmission and prevention. Knowledge does not necessarily translate into behaviors such as condom use. It is therefore important to distinguish data that pertain to knowledge of an effective risk-reduction method versus the use of that method. For instance, a woman who knows that having one uninfected sexual partner decreases risk (indicator 46) may not necessarily be able to choose to only have one partner.

The results could be misleading because it is difficult to know whether the survey questions about common misconceptions (indicators 47 and 48) successfully capture the most common or widely disseminated myths.

APPLICATIONS

The indicators demonstrate that many women may know facts about HIV prevention but still believe popular myths about HIV, which can both increase transmission risks and perpetuate social stigma against those who are HIV-positive. They also show that HIV knowledge varies widely across and within countries, as does the ability to access condoms.

Service delivery and programming

The information about access to condoms (indicators 42–44) is useful in highlighting gaps in access to services more generally and suggests the need to make services more accessible and welcoming to young people, especially in the population groups that have lower than average access to condoms. For example, in Kenya, 25% of young women aged 15–24 in the lowest *wealth quintile* and 50% in the highest quintile report that they can purchase or obtain condoms on their own; 49% in urban areas and 37% in rural areas report this. Clinics and other facilities (such as schools, bars or other places frequented by young people) should place both male and female condoms in discreet places, such as bathrooms, where young men and women can take them without being publically observed.

Data on knowledge about specific methods to prevent HIV (indicators 45 and 46) enable service providers to target education and services to those who are least informed. For example, in India, 4% of young women in the lowest wealth quintile and 45% in the highest quintile have a comprehensive knowledge of HIV/AIDS. The women in the lowest quintile also have less knowledge about specific ways to reduce risk of HIV (indicators 45 and 46) and are less aware of their right to exercise control over their own bodies (indicators 49, 50, 52 and 54) than women in the highest quintile.

Service providers can also use this information to conduct training for providers that emphasizes the benefits of condom use, communicating that it prevents *unintended pregnancy*, HIV and other STIs. Health professionals can also explain to young clients how to use a condom and how to negotiate condom use with a sexual partner.

Where the population has a low level of knowledge about HIV transmission and risks related to multiple sexual partners, service providers can start by providing such information. If few women have comprehensive knowledge of HIV (indicator 47), service providers can increase efforts to educate them about HIV, sexual health and *sexual rights* when they make gynecological or other medical visits.

Condoms must be used correctly to prevent HIV and other STIs and unintended pregnancies. Health professionals should consider how they can help young people obtain condoms and use them correctly and consistently. For example, health professionals may point out youth-friendly pharmacies or youth centers where young clients can access condoms easily, without fear of stigma or embarrassment. Health professionals should educate young people about correct use of condoms, through demonstrations with artificial models or through description and discussion. To increase use and decrease stigma, normalization and familiarization with condoms and other contraceptive methods is critical.

Although some data are available on whether women believe that a wife would be justified in asking her husband to use a condom if he has an STI (indicator 52), none of the indicators fully measures women's ability to negotiate with their partners about using condoms. Service providers should therefore discuss with their clients the pressure that women may experience from sexual partners to have unprotected sex, and how to negotiate condom use, particularly if a partner is known to be HIV-positive. Service providers should give clients ideas about language and arguments that can be used to persuade their partners to use a condom. Providers can also offer women the option of coming in for an additional visit with their sexual partners to discuss the issue. Where data show that women's *self-efficacy* is low (indicators 49–55), service providers and program managers could consider offering training to improve women's negotiating skills and workshops for both men and women that promote open, equitable communication in sexual relationships.

Sexuality education and information

The indicators in this section demonstrate the need for more education about condoms in schools and other settings and possibly in the media. Sexuality education should include clear messages about the benefits of condom use, including the fact that condoms and abstinence are the only methods that prevent both unintended pregnancy and STIs.

Moreover, the data on comprehensive knowledge of HIV show that many women know some facts about prevention, but far fewer have comprehensive knowledge. They may therefore also believe in myths that can increase risk and perpetuate stigma against those who are living with HIV. For example, in the Dominican Republic, 83% of women know that condom use reduces HIV risk (indicator 45), and 88% know that having only one uninfected partner reduces HIV risk (indicator 46), but only 41% have a comprehensive knowledge of HIV/AIDS (indicator 47).

Comprehensive education on HIV, including skills and sexual rights, should be provided as a standard component of sexuality education curricula for young people. Young people should be given scientifically sound facts about HIV transmission, prevention and treatment, as well as information on where to obtain youth-friendly, voluntary HIV testing and counseling. If possible, condoms should be provided to young people in sexuality education lessons or be available in a discreet location identified in the lesson (for instance, in a school bathroom).

HIV education is important but far from sufficient to meet the information needs of adolescents regarding sexual and reproductive health and rights. Nevertheless, advocates, educators and other stakeholders can use the data on HIV-related knowledge to gauge provision of sexuality education in general, and build on this information to identify groups with the least knowledge and to develop sexuality education programs that are comprehensive and not limited to HIV prevention.

Advocacy

Advocates can use data on access to condoms (indicators 42–44) to argue for programs that address the reasons why young people have trouble obtaining condoms and to address inequalities in access within a country, where they exist.

Where there is a relatively low level of knowledge about condom use and HIV prevention (indicators 45–48), advocates can argue for the importance of providing comprehensive sexuality education programs and make sure that such programs include HIV prevention and knowledge as well as addressing myths and stigma around condoms. All sexual health programs should also include information on healthy relationships, particularly with respect to communication and equality within relationships as these attributes may directly affect sexual health outcomes.

DISCUSSION GUIDE

Access to condoms

- How can your organization use the indicators on access to condoms (indicators 42–44) to improve the ability of young people to obtain other sexual health services? What other measures do you think are needed for your work?
- Where are condoms available in your clinics or other service outlets? Does your organization provide a condom to each and every young client who comes for sexual or reproductive health services? If not, why not? How can your organization facilitate better access for young people?
- Where in your community can young people get condoms without fear, shame or embarrassment? What can your organization do to diminish stigma around obtaining condoms?
- How might your organization work with pharmacies in your area to ensure that condoms are available for young people? Could you train pharmacists to be youth-friendly so that young people feel more comfortable buying condoms from them?
- What might young people in your area consider to be their main barriers to condom use?

  How can your organization address the belief that condom use reduces sexual pleasure?
- Are female condoms also available? Should they be more easily available? Would it improve the situation for women?

Knowledge and self-efficacy regarding sexual health issues

- How can better linkages be made in your community between sexuality education and sexual health services? What are the barriers to linking education and services and providing them at the same time and place?
- What are the most common myths surrounding HIV and people living with HIV in your community? What information or outreach do you think needs to be provided to dispel these myths?
- Do laws or policies in your country discriminate against those living with HIV? If so, how? What can your organization do to address this?
- How can you use the indicators on knowledge about HIV prevention and myths to estimate how much adolescents know about other topics related to their sexual health and rights? What other measures do you think are needed for your work?

SECTION 4: WOMEN'S AUTONOMY, SOCIETAL NORMS AND GENDER EQUALITY

There are no systematic, comparable data showing the extent to which youth are aware of their sexual rights and able to exercise them. The indicators presented below do not measure these rights directly. Similarly, to measure gender equality adequately, a much broader range of measures is needed. However, the indicators in this section provide useful proxies by measuring the extent to which women have a say regarding their own health care and the attitudes of women and men about women's control over their own sexuality and their right to physical integrity. Although attitudes do not translate automatically into behaviors, they shed light on the social acceptability of certain behaviors and rights. They also provide information about self-efficacy. Because these indicators measure broad and fundamental societal values and attitudes, they provide valuable information about young people's situation, even though they do not reflect the views of all women (or men) of reproductive age. Similarly, although these measures are about husbands' behaviors and wives' rights, they likely apply to all men and women, married and unmarried.

When women are able to make decisions regarding their own health care, and when they are aware of their right to make decisions regarding sexual intercourse and to be free from physical harm from their husbands, they are more likely to succeed in protecting their health, navigating their sexual lives and expressing their sexuality in a healthy and satisfying manner. Knowing men's opinions about women's rights is also important because increasing men's support for women's rights may represent an important opportunity for positive change.

DEFINITIONS

49. % of married women aged 15–49 who have the final say in their own health care

The indicator measures the level of control a woman has over her own body by assessing her degree of autonomy in her own health care. In some contexts, a woman may be subject to the decisions made by her husband, parents or extended family with respect to her health care. This indicator provides a measure of women's bodily autonomy.

50. % of women aged 15–49 who agree with all three reasons why a wife is justified in refusing to have intercourse with her husband

This indicator measures the extent to which women reject gender norms that imply husbands have the right to control their wives' sexual behaviors and bodies. In most surveys, the three reasons are: the wife knows that her husband has had sex with another woman, she knows that he has an STI, and she is tired or not in the mood. The indicator also provides a measure of the level of control that women have over their own lives and bodies.

51. % of men aged 15–59 who agree with all three reasons why a wife is justified in refusing to have intercourse with her husband

This indicator measures the extent to which men reject gender norms that imply that husbands have the right to control their wives' sexual behaviors and bodies (see the reasons listed for indicator 50). It also provides a measure of the level of control that women have over their own lives and bodies.

52. % of women aged 15–49 who believe that if the husband has an STI, his wife is justified in asking him to use condom

This indicator shows the degree to which women believe they have the right to protect themselves in situations of known risk by requesting condom use. It is also a measure of women's attitudes toward their right to protect their own sexual health.

53. % of men aged 15–49 who believe that if the husband has an STI, his wife is justified in asking him to use condom

This indicator shows the extent to which men agree that women have the right to protect themselves in situations of known risk and relates to men's acceptance of condom use by married couples.

54. % of women aged 15–49 who agree with at least one reason why a husband is justified in hitting or beating his wife

This indicator measures the level of women's acceptance of a lower social status for women compared with men and of gender norms that allow men to beat their wives. DHS surveys ask questions about violence for the following items: the wife burns the food, she argues with her husband, she goes out without telling him, she neglects the children or she refuses sexual intercourse with him.

55. % of men aged 15–59 who agree with at least one reason why a husband is justified in hitting or beating his wife

This indicator measures the level of men's belief in women's lower social status and acceptance of gender norms that allow husbands to beat their wives (see the reasons listed for indicator 54).

Limitations pertaining to larger age-group:
The indicators in this section pertain to women and men of reproductive age because the goal is to measure broad societal values and norms in a country, and these data reflect the conditions that influence young people. The responses of women aged 15–49 and men aged 15–59 may be considered as a valid approximate for younger women or men. Nevertheless, in some cases, this limitation should be considered when planning services or for advocacy:

- For instance, a comparative analysis of DHS data shows that in many countries there are no significant differences between age groups. However, in some countries, older women have somewhat more say over their own health care than younger women do.[8] This means that age is an important variable in decision-making processes.
- These measures do not take into account additional barriers that younger women may face in making decisions regarding their own health care and sexuality.

Limitations pertaining to gender norms and dynamics:
These indicators are designed to measure the self-efficacy and sexual rights of women. More specifically, they measure the power and the rights of women in making their own decisions regarding health care and sexual behavior. Asking men's opinion about women's rights is important because in many societies, men frequently make decisions for their wives and daughters; women's decisions are often strongly influenced by men's attitudes.

Limitations pertaining to attitudes versus behaviors:
Indicators 50–55 measure attitudes, but actual behaviors of respondents might differ from their attitudes, for instance:

- Women may find it generally acceptable for a wife to refuse sex with her husband or to ask her husband to use a condom, but may not feel empowered to exercise these behaviors in their own life or intimate relationship.
- Men may be open to the idea of women refusing sex with their husbands or requesting condom use, but they may not apply these attitudes to their own relationships.
- In addition, reported attitudes may reflect some amount of response bias when respondents believe that certain answers (for instance, opposition to spousal abuse or support of women's sexual autonomy) are expected of them or will show them in a better light, despite being different from what they actually believe or practice. Because of potential bias, indicators 54 and 55 cannot be assumed to reflect the actual occurrence or severity of hitting and beating of wives by husbands.

Limitations pertaining to data availability:
Some of these indicators are available only for a small number of countries, or are available only for women, and thus do not allow comparisons across countries or between men and women.

APPLICATIONS

These indicators provide information about the level of women's and men's acceptance of social norms that reinforce unequal gender roles and power imbalances between men and women. Gender does not relate only to biological sex but also to roles, rights and social norms that are assigned to men and women. The data reveal that the level of control that men exert over women is often high. In many cases, these data demonstrate that women still have limited control over their own bodies and sexuality, and social norms often make it difficult for them to make the necessary decisions to protect their health.

Information about gender norms and dynamics pertaining to sexual activity and female autonomy within marriage can be critical when developing programs, delivering services and formulating the most effective advocacy strategies. Ultimately, to gain control over her own body and sexuality and make decisions for herself, a woman may have to reject social norms such as those that would permit domestic violence.

Health professionals should provide information and education to empower women to make their own decisions. Evidence shows that autonomous women have better health outcomes, as do their children.[8,11] For all these indicators, differences between men and women, between rural and urban areas and between different socioeconomic groups can be important. These differences must be taken into account to tailor services, education and advocacy according to the needs and situations of those different groups.

Service delivery and programming

Women's autonomy

These indicators can also be used to demonstrate the need for contraceptive and STI prevention methods which allow women greater control over their reproductive and sexual health outcomes. For instance, greater access to female condoms might allow women to gain more control in protecting their health. These indicators can help health professionals and program managers to identify groups of women with less say about their own health care and to make specific efforts to improve accessibility for these women.

In Zambia, for example, 72% of women in urban areas have the final say in their own health care, compared with only 61% in rural areas. These data show that women in rural areas tend to have less decision-making power over their own health than women living in urban areas. This information can help service providers target subgroups of women most in need of services that are easy to access and use discreetly.

Visits to health centers and other points of service represent opportunities to educate and empower women and help them to make their own decisions. Programs promoting women's *empowerment* could be set up and provided in health facilities, possibly in partnership with other organizations concerned with women's rights.

Health professionals and facility managers can use the indicators in this section to design and organize services (in terms of schedule, location, confidentiality and pricing) that will facilitate access for all women. In places where women have little decision-making power regarding their own sexuality and health care, it might be necessary to design services that allow women to use them without the knowledge or permission of their husband or other members of their family or community.

Intimate partner violence

Violence against women and gender inequality are rooted in social, cultural and policy issues that cannot be solved by the provision of sexual and reproductive health services alone. Health care providers, educators and other service providers are, however, uniquely positioned to recognize the signs of intimate partner violence and connect those who experience such violence to services and provide resources. Service providers should be attuned to these issues and the ways in which they affect women's well-being and their reproductive and sexual health. Whenever possible, counseling and referrals should be set up to protect and care for the victims of abuse. Health professionals should be trained to screen for gender-based violence as a normal part of each medical visit.

Barriers related to gender inequality are often compounded by other barriers to good health, such as lack of access to contraception. Health professionals have a role to play in building young women's (and men's) capacities to make informed, autonomous decisions about their sexual and reproductive health. For example, health professionals can explain the different types of contraception available, and methods and strategies to successfully negotiate safer sex.

Sexuality education and information

The data in this section provide evidence that sexuality education needs to address gender norms and women's rights from a young age to empower young women and to foster more balanced relationships between men and women.

Indicators 49, 50, 52 and 54 illustrate women's understanding of their own rights. For instance, in Zambia, 62% of women agree with at least one reason why a husband is justified in hitting or beating his wife, and only 39% agree with all the reasons why a wife is justified in refusing to have intercourse with her husband. These data indicate the need for skills-based education that could equip young women with negotiating and critical thinking skills to increase self-efficacy. With enhanced self-efficacy, a young woman has greater control over her sexual life and health.

These indicators can also help make the case that sexuality education should do more than provide information. It should build a set of competencies that young people can apply to all areas of their lives, including sexual and reproductive health. For example, interpersonal skills can help a young person just as much in securing employment as in choosing a sexual partner.

Advocacy

These indicators show that there is a need in many countries to advocate for women's right to decide about their own health and sexuality. As data on HIV show, women often have difficulty negotiating safe sex practices with their husbands and partners, because many men would view condom use as an admission of extramarital sex or a sign of lack of trust.[25]

Also, the data on attitudes regarding whether women are justified in asking their husbands to use a condom (indicators 52 and 53) can be used to show the need to advocate for greater acceptance of condom use within marriage. One way to promote this would be to emphasize the dual protection that condoms provide—against pregnancy and STIs. If few women say they have the final say over their own health care (indicator 49), advocates could use this information to promote and defend the right of women to have full access to health services on their own. For example, the indicator could be used to remove spousal consent requirements for health care.

Data related to spousal violence (indicators 54 and 55) provide the basis for promoting women's right to protection from physical and psychological harm under all circumstances. They also show the need for enacting and enforcing laws and policies that protect women from violence, within and outside of marriage.

In many countries, a higher percentage of men than women support a woman's right to say no to sex with her husband or to request that her husband (indicators 50 and 51) use a condom when he has an STI (indicators 52 and 53). For example, in Zambia, 58% of men and 39% of women agree with all three reasons why a wife is justified in refusing to have sexual intercourse with her husband. Similarly, 87% of men and 74% of women believe that if the husband has an STI, the wife is justified in asking him to use a condom. One interpretation is that these data show men's readiness to accept and even support changes in unequal and rigid gender roles and power imbalances between the sexes. To the extent that this is the case, men are valuable allies in advocating for women's right to make decisions about their own health care and sexuality. Another interpretation is that men are aware that they should report socially acceptable views and therefore report that they think women should have more autonomy. However, in reality, they may not respect this autonomy in their own relationships.

Regardless of the reasons, advocates can use to their advantage the findings about men's support for women's increased autonomy. The data can also be used to demonstrate the need for better information and education programs aimed at raising awareness of women's right to make their own decisions regarding sexuality and health care. Ultimately, the more men and women who recognize the right of women to have control over their own bodies, the more likely social norms are going to evolve, creating more equitable families, communities and societies.

DISCUSSION GUIDE

Building skills

- How do health professionals in your organization help to build the decision-making capacities of young women during clinic visits? You may be doing this without even knowing it.
- List the skills that you think young women should possess to make their own decisions regarding their sexual and reproductive health. Discuss how young women develop these skills and who has the responsibility to help them.

Involving men

- Why is it harmful to see men only as perpetrators of violence rather than partners in finding a solution for an equitable society?
- How does your organization involve male partners in advocating and promoting the rights of women, including young women? Name some specific examples or case studies from your own experience.

Sexual rights and gender equity

- Think about your own family. Were there any differences in the way that your parents or guardians raised their sons as opposed to their daughters? Give examples and discuss why this was the case. What would you do differently with your own children?
- What role do teachers and sex educators play in achieving gender equity? How can your organization support them?
- Discuss whether you believe that a woman's ability to control her own body is a prerequisite to exercising other rights. Which other rights might be contingent upon the realization of her sexual rights?
- What are the laws in your country related to violence (including sexual violence) within marriage? What local and national resources are available to women and men who experience intimate partner violence?
- How can teachers and educators be supported in efforts to raise awareness that both boys and girls can benefit from less rigid gender norms and social expectations?
- What are some ways that teachers and educators can address the topic of gender roles without generating defensiveness or hostility?

	38				39	
Region and country	% schools providing skills-based HIV education, last academic year [1]			Comments for indicator 38 [1]	HIV education in national curriculum	
	Provided in primary school	Provided in secondary school	School level is not specified		Skill-based HIV education [1,2]	Skill-based health education, including HIV [3]
AFRICA						
Dem. Rep. of Congo	na	na	na		Secondary	Primary, secondary
Egypt	na	na	na	HIV education is not included in the national curriculum because "it is not relevant to county epidemic status."[1]	Not included	Secondary
Ethiopia	na	na	38.4		Primary, secondary	na
Ghana	79.1		na	The Ministry of Education Statistics provided data on the proportion of schools with Family Life Education in 2009: Some 79.1% of all schools offered this curriculum, as did 84.0% of public schools and 59.9% of private schools.[1]	Secondary	Primary, secondary
Kenya	na	na	na	The country has a policy to promote HIV-related sexuality education for young people, and it is part of the curriculum for primary and secondary schools and for teacher training. But it is not subject to exams and may not be taken seriously.[1]	Primary, secondary	na
Malawi	na	na	na	Data on the percentage of schools that pro-vided life skills-based HIV education within the last academic year is not available because life skills was compulsory but not subject to exams. It is subject to exams as of 2010–2011.[1]	Primary, secondary	Primary, secondary
Mozambique	na	na	na	The Ministry of Education developed curricula covering sexual and reproductive health and HIV and promoted extracurricular life-skills–based activities supported by peer education. Comprehensive programs were developed to provide life-skills–based education in primary, secondary and technical education.[1]	Primary, secondary	Secondary
Nigeria	na	22.8	na	Ministry of Education routine data (not a survey), available only for secondary schools.	Primary, secondary	Primary, secondary
Rwanda	na	98.0	na	Ministry of Education routine data for secondary schools only. In Rwandan secondary schools, life skills related to HIV are taught to students through anti-AIDS clubs.[1]	Secondary	Secondary
Senegal	na	na	na		Primary, secondary	Primary, secondary
Tanzania (excluding Zanizbar)	62.5	80.2	na		Primary, secondary	Primary, secondary
Uganda	na	na	na	As of 2005,15% of primary and secondary schools had trained teachers in life skills only in schools that had the President's Initiative on AIDS Strategy for Communication to Youth (PIASCY) program. A number of information, education and communication programs have been implemented in schools at all levels.[1]	Primary, secondary	Primary, secondary

	38				39	
Region and country	% schools providing skills-based HIV education, last academic year [1]			Comments for indicator 38 [1]	HIV education in national curriculum	
	Provided in primary school	Provided in secondary school	School level is not specified		Skill-based HIV education [1,2]	Skill-based health education, including HIV [3]
AFRICA						
Zambia	na	na	na	Ministry of Health aims to reach at least 60% of schools with life-skills–based HIV/AIDS education.[1]	Primary, secondary	Primary, secondary
Zimbabwe	na	na	na	The Ministry of Education aims for all teachers to give lectures on life skills, HIV and AIDS education for about two hours per week. Data are not available on whether this is happening, and at what level of quality, must be ascertained by survey.[1]	Primary, secondary	na
EUROPE						
Albania	na	na	na	Literature and manuals have been prepared for HIV and sex education programs, and teachers have been trained, but there are considerable gaps in implementation of the curricula.[1]	In progress; level not specified	na
Moldova	0		na	In 2008–2009, an optional life skills course was taught for a limited number of hours. The National Health Policy promotes HIV prevention in schools by calling for a mandatory life skills curriculum and teacher training. [1]	Level not specified	na
Ukraine	58.7		na	Data are drawn from a survey. Life-skills–based HIV education should cover 100% of primary school students who study "health fundamentals" (35 hours per year). At last report, senior school students receive teaching on HIV prevention and healthy lifestyles through optional classes.[1]	Primary, secondary	na
SOUTH AND SOUTHEAST ASIA						
Bangladesh	na	0.1	na	More than 6,000 institutions have trained teachers and are ready to introduce life-skills–based education.	In progress; level not specified	na
India	na	na	30.9	Under the Adolescence Education Programme (AEP), 47,000 schools were scheduled to teach life-skills–based sexuality education in 2009–2010, including 16 hours of sessions in classes IX and XI.[1]	Primary, secondary	na
Indonesia	na	na	na	Curriculum and teacher training are in the initial stages of development. In primary schools, the focus of sexuality education has been only the biology of reproduction. In secondary schools, students learn about family planning, HIV and other sexually transmitted infections.	Primary, secondary	na
Nepal	7.5	4.1	7.6	Primary and secondary school data were reported for 2007, but data for 2009 only showed totals.	Primary, secondary	na
Pakistan	na	na	na	Subject matter not relevant. No HIV-related sexuality education for young people.	Not included	na

	38				39	
Region and country	% schools providing skills-based HIV education, last academic year [1]			Comments for indicator 38 [1]	HIV education in national curriculum	
	Provided in primary school	Provided in secondary school	School level is not specified		Skill-based HIV education [1,2]	Skill-based health education, including HIV [3]
SOUTH AND SOUTHEAST ASIA						
Philippines	na	na	na	The United Nations Population Fund (UNFPA) provided some HIV related education through its 6th country program in 24,851 primary school students and 39,742 secondary students in 2008–2009 and 2009–2010. As the national program has yet to fully take off, a higher number of schools should benefit form the program in the future.	Primary, secondary	na
Vietnam	na	34.3	na	Data from a survey by Ministry of Education and Training (MOET) 2009. Following a review of existing curricula and global best practices in 2009, the Ministry of Education and Training developed a new curriculum integrating reproductive health and HIV prevention and is piloting it with encouraging results.	Primary, secondary	na
LATIN AMERICA & CARIBBEAN						
Bolivia	na	na	na	The Ministry of Education and Culture reports that it is in the process of incorporating sexuality education with an HIV-prevention component.[1]	Level not specified	na
Colombia	na	na	na	In 2010, the Ministry of Education, in collaboration with UNFPA, worked to strengthen schools in the area of sexuality education; 2,390 institutions have a teaching program under the Programa de Educacion para la Sexualidad y Construccion de Ciudadania (PESCC).[4]	Primary, secondary	na
Dominican Republic	na	na	6.2		Primary, secondary	na
Guatemala	0.9	5.8	2.4		Primary, secondary	na
Honduras	na	na	18.0		Primary, secondary	na
Peru	na	na	4.5		Primary, secondary	na

Full name of indicators above

38. % of schools that provided skill-based HIV education in the last academic year

39. Inclusion in the national school curriculum of skill-based HIV education or health education, including HIV prevention

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INDICATOR NUMBER	40	41	42	43	44	45
	% who agree that adolescents aged 12–14 should be taught about using a condom to prevent HIV[5]		% who report that they could get condoms	% who know a source for the condom		% who know HIV risk is reduced by condom use
Region and country	Women 18–49	Men 18–49	Women 15–24	Women 15–24	Men 15–24	Women 15–49
AFRICA						
Dem. Rep. of Congo (2007)	45	58	14	37	61	54
Egypt (2008)[1,2]	nc	nc	nc	nc	nc	18
Ethiopia (2011)	54	76	33	43	74	56
Ghana (2008)	53	56	30	74	87	76
Kenya (2008–09)	61	72	40	65	84	75
Malawi (2010)	58	64	51	79	89	72
Mozambique (2003)	62	66	nc	57	83	53
Nigeria (2008)	32	47	12	37	68	53
Rwanda (2010)	89	91	59	86	91	91
Senegal (2010–11)	42	43	19	44	75	70
Tanzania (2010)	65	72	70	81	88	76
Uganda (2006)	nc	nc	34	70	90	70
Zambia (2007)	56	68	40	76	88	73
Zimbabwe (2010–11)	37	48	42	64	82	81
EUROPE						
Albania (2008–09)	61	57	38	79	88	74
Moldova (2005)	73	85	nc	90	95	78
Ukraine (2007)	93	83	58	96	98	92
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	nc	nc	nc	nc	nc	32
India (2005–06)	28	35	12	46	85	36
Indonesia (2007)[1,3]	nc	nc	24	39	na	36
Nepal (2011)	nc	nc	37	85	97	74
Pakistan (2006–07)[1,2]	nc	nc	nc	nc	nc	20
Philippines (2008)[3]	nc	nc	36	65	nc	59
Vietnam (2002)[1,2]	29	nc	nc	76	nc	82
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	nc	79	36	70	83	60
Colombia (2010)[2]	92	nc	81	95	nc	82
Dominican Republic (2007)	91	91	72	90	nc	83
Guatemala (2008)[4]	79	87	nc	nc	73	74
Honduras (2005–06)[2]	nc	nc	44	76	nc	70
Peru (2007–08)[2]	nc	nc	48	90	nc	53

Full name of indicators above
40. % of women aged 18–49 who agree that adolescents aged 12–14 should be taught about using a condom to prevent HIV
41. % of men aged 18–49 who agree that adolescents aged 12–14 should be taught about using a condom to prevent HIV
42. % of women aged 15–24 who report that they could get condoms on their own
43. % of women aged 15–24 who know a source for the condom
44. % of men aged 15–24 who know a source for the condom
45. % of women aged 15–49 who know that HIV risk is reduced by condom use

Adolescents' Self-Efficacy Related to Sexual Health/ Women's Autonomy, Societal Norms and Gender Equality

SECTION 3/4

INDICATOR NUMBER	46	47	48	49	50	51
	% who know HIV risk is reduced by having one uninfected partner	% with comprehensive knowledge of HIV/AIDS[6]		% who have the final say in their own health care[7]	% who agree with all three reasons why a wife is justified in refusing to have intercourse with her husband[8,9,10]	
Region and country	Women 15–49	Women 15–24	Men 15–24	Married women 15–49	Women 15–49	Men 15–59
AFRICA						
Dem. Rep. of Congo (2007)	76	15	21	41	25	nc
Egypt (2008)[1,2]	59	5	18	87	nc	nc
Ethiopia (2011)	65	24	34	74	62	72
Ghana (2008)	85	28	34	69	63	64
Kenya (2008–09)	92	48	55	73	52	nc
Malawi (2010)	87	42	45	55	52	54
Mozambique (2003)	53	20	38	61	45	40
Nigeria (2008)	68	22	33	44	47	52
Rwanda (2010)	85	52	47	74	61	nc
Senegal (2010–11)	87	29	33	31	27	nc
Tanzania (2010)	87	48	43	60	63	nc
Uganda (2006)	89	32	38	61	61	64
Zambia (2007)	90	34	37	65	39	58
Zimbabwe (2010–11)	90	52	47	84	54	51
EUROPE						
Albania (2008–09)	78	36	22	85	63	49
Moldova (2005)	81	42	54	97	71	68
Ukraine (2007)	89	45	43	97	83	68
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1,2]	33	8	18	56	nc	nc
India (2005–06)	45	20	36	62	68	70
Indonesia (2007)[1,3]	42	10	15	85	57	57
Nepal (2011)	79	26	34	65	83	80
Pakistan (2006–07)[1,2]	31	3	nc	nc	nc	nc
Philippines (2008)[3]	77	21	nc	94	nc	nc
Vietnam (2002)[1,2]	85	42	nc	nc	nc	nc
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	62	24	28	89	79	nc
Colombia (2010)[2]	80	24	nc	81	72	nc
Dominican Republic (2007)	88	41	34	87	88	83
Guatemala (2008)[4]	85	22	19	43	nc	nc
Honduras (2005–06)[2]	89	30	nc	81	84	nc
Peru (2007–08)[2]	27	10	nc	72	81	nc

Full name of indicators above
46. % of women aged 15–49 who know that HIV risk is reduced by having one uninfected partner
47. % of women aged 15–24 with comprehensive knowledge of HIV/AIDS
48. % of men aged 15–24 with comprehensive knowledge of HIV/AIDS
49. % of married women aged 15–49 who have the final say in their own health care
50. % of women aged 15–49 who agree with all three reasons why a wife is justified in refusing to have intercourse with her husband
51. % of men aged 15–59 who agree with all three reasons why a wife is justified in refusing to have intercourse with her husband

INDICATOR NUMBER	52	53	54	55
	% who believe that if the husband has STI, his wife is justified in asking him to use a condom[11,12]		% who agree with at least one reason why a husband is justified in hitting/beating his wife[13,14,15]	
Region and country	Women 15–49	Men 15–49	Women 15–49	Men 15–59
AFRICA				
Dem. Rep. of Congo (2007)	54	nc	76	nc
Egypt (2008)[1,2]	nc	nc	39	nc
Ethiopia (2011)	69	88	68	45
Ghana (2008)	87	93	37	21
Kenya (2008–09)	87	96	53	44
Malawi (2010)	85	91	13	13
Mozambique (2003)	71	80	54	42
Nigeria (2008)	70	84	43	30
Rwanda (2010)	96	96	56	25
Senegal (2010–11)	79	78	60	24
Tanzania (2010)	80	87	54	38
Uganda (2006)	nc	nc	70	59
Zambia (2007)	74	87	62	48
Zimbabwe (2010–11)	80	83	40	33
EUROPE				
Albania (2008–09)	82	86	30	36
Moldova (2005)	91	94	21	22
Ukraine (2007)	97	95	4	11
SOUTH AND SOUTHEAST ASIA				
Bangladesh (2007)[1,2]	86	90	36	36
India (2005–06)	78	83	54	42
Indonesia (2007)[1,3]	83	nc	31	16
Nepal (2011)	93	96	23	3
Pakistan (2006–07)[1,2]	nc	nc	nc	nc
Philippines (2008)[3]	nc	nc	14	nc
Vietnam (2002)[1,2]	83	nc	nc	nc
LATIN AMERICA & CARIBBEAN				
Bolivia (2008)	87	nc	16	nc
Colombia (2010)[2]	79	nc	2	nc
Dominican Republic (2007)	98	97	4	7
Guatemala (2008)[4]	nc	nc	7	nc
Honduras (2005–06)[2]	48	nc	16	nc
Peru (2007–08)[2]	nc	nc	nc	nc

Full name of indicators above
52. % of women aged 15–49 who believe that if the husband has an STI, his wife is justified in asking him to use condom
53. % of men aged 15–49 who believe that if the husband has an STI, his wife is justified in asking him to use condom
54. % of women aged 15–49 who agree with at least one reason why a husband is justified in hitting/beating his wife
55. % of men aged 15–59 who agree with at least one reason why a husband is justified in hitting/beating his wife

NOTES TO TABLES, indicators 40–55

1. These countries' female DHS samples consist only of women who had ever been married. Indicators on unmarried women are unavailable, and indicators for "all women" will only reflect those who are currently married, widowed or divorced/separated.

2. No men were interviewed for the DHS in these countries; therefore we are unable to provide any male data.

3. Men who participated in the DHS in these countries were given a brief version of the interview, so only limited male data are available.

4. Indicators 40, 41, 44 and 48 were unavailable or incomplete in the 2008 CDC report for Guatemala; the data provided are from the 2002 CDC report for Guatemala.

5. Indicators 40 and 41 were unavailable or incomplete in the 2010 DHS for Tanzania; the data provided are from the 2004 DHS for Tanzania.

6. Comprehensive knowledge is a three-part measure. It combines respondents' ability to correctly report ways of reducing the risk of getting HIV (by consistently using condoms and by having just one partner who is HIV-negative who has no other partners) and to correctly reject the two most common local misconceptions about HIV transmission and prevention.

7. Indicator 49 was unavailable or incomplete in the 2002 DHS for Vietnam; the data provided for Vietnam were drawn from the 2005 AIDS Indicator Survey (AIS).

8. The three reasons are: the wife knows that her husband has had sex with another woman, she knows that he has an STI, and she is tired or not in the mood.

9. Rwanda's 2010 DHS proposed only two reasons why a wife might be justified in refusing to have intercourse with her husband (he sleeps with other women or he has an STI); the data provided for indicators 50 and 51 for Rwanda reflect the percentage of respondents who agreed with both reasons.

10. Indicators 50 and 51 were unavailable or incomplete in the 2011 DHS for Zimbabwe; the data were instead drawn from the 2006 DHS for Zimbabwe.

11. For Bangladesh, Bolivia, India, Indonesia and Kenya, the data provided reflect the percentage of women or men aged 15–49 who believe that if the husband has an STI, his wife is justified in refusing to have intercourse with him, as opposed to asking him to use a condom.

12. Indicators 52 and 53 were unavailable or incomplete in the 2009 DHS for Kenya; the data provided were drawn from the 2003 DHS for Kenya.

13. DHS surveys ask questions about violence for the following items: the wife burns the food, she argues with her husband, she goes out without telling him, she neglects the children or she refuses sexual intercourse with him.

14. Indicators 54 and 55 were unavailable or incomplete in the 2011 DHS for Nepal; the data provided were drawn from the 2006 DHS for Nepal.

15. For Dominican Republic and Ethiopia, indicator 55 displays the percentage of men aged 15–49 (not 15–59) who agree with at least one reason why a husband is justified in hitting/beating his wife.

nc=not collected

na=not available

5 Reaching Young People

This chapter presents demographic data on male and female *adolescents* aged 10–14 and 15–19, school attendance among these age-groups and exposure to the media among those aged 15–19. The information is useful for considering the most efficient and effective ways to reach adolescents.

SECTION 1: DEMOGRAPHIC INFORMATION

DEFINITIONS

56. Number of girls aged 10–14 in 2011

This indicator provides information about the size of the population of young adolescent females.

57. Number of boys aged 10–14 in 2011

This indicator provides information about the size of the population of young adolescent males.

58. Number of women aged 15–19 in 2011

This indicator provides information about the size of the population of older adolescent females.

59. Number of men aged 15–19 in 2011

This indicator provides information about the size of the population of older adolescent males.

APPLICATIONS

These *indicators* provide data on the total size of the adolescent population in a country and in some regions. These data are important because they allow program planners to calculate the actual numbers of adolescents who have certain characteristics or behaviors documented by the DHS surveys (or any other survey). Both percentages and numbers are useful for tailoring the program response to the population in need.

Service delivery and programming

By using the number of adolescents living in a country in conjunction with the indicators on the proportion of adolescents who are engaging in particular activities or having various experiences, planners can determine the size of the groups of adolescents that need attention. The data can be used to set priorities, calculate service or program costs, or justify the need for sexual and reproductive health services for adolescents nationally or in certain areas (i.e., rural or urban). For example, 48% of the estimated 718,800 female adolescents aged 15–19 living in Zambia report that they have ever been *sexually active* (indicators 1 and 58). This means that at least 345,000 female adolescents need information and possibly sexual and reproductive health services.

The indicators can also be used to identify where needs are greatest and to define priorities. In Zambia, over 344,000 15–19-year-olds are living in urban areas, and 40% have ever been sexually active (indicator 1; subgroup data can be found on the CD). This translates to approximately 137,600 young women who have had sex and are therefore in need of information and services designed specifically for sexually active *young people* (for example, an emphasis on abstinence may be inappropriate for this group). These figures demonstrate that information and sexual and reproductive health services should be provided to even larger numbers of rural women aged 15–19 than to those of the same age living in urban areas.

Demographic data can also be used to examine the magnitude of unmet need for contraception. In India, for example, the percentage of married women with unmet need for contraception is roughly the same in rural and urban areas, 26% and 27%, respectively. However, as indicator 58 shows, the population of female adolescents in rural areas is more than double that in urban areas (40

million vs. 18 million). This means that although the need for services is proportionately similar in rural and urban areas, the actual magnitude of need is much larger in rural areas.

Demographic data allow service providers to answer questions such as: how many young people do we need to reach in rural areas? How many in urban areas? How many are sexually active? How many are lacking access to condoms? Knowing the size of the population to be served helps programs plan how many resources (such as facilities, trained staff, supplies, and hours to be open for service) are necessary in a given areas and how much serving a given population will cost.

Sexuality education and information

Schools and the media are key channels for *sexual health* information and education for *young people*. Demographic data help identify the scope of young people's need for educational interventions. Also, data on how many young people are or are not attending school or are exposed to different forms of media can help to plan and organize programs using alternative channels, such as community-based outreach programs.

Advocacy

In developing countries, adolescents represent a large population group. Transforming percentages into numbers is important to show the scope of needs and to advocate for greater funding to respond to these needs. The data can also show the size of the most vulnerable groups, such as those adolescents who have the lowest levels of school attendance, the least knowledge of sexual issues, who live in rural areas, who are poorest and who have the least access to health services.

DISCUSSION GUIDE

- What are some ways that population estimates could be useful in your work as a service provider, a sexuality educator or an advocate?
- What are some simple calculations you can make with the population estimates to determine the number of young women and men who are sexually active?
- Would it be useful to include these calculations in your literature or advocacy briefs?

SECTION 2: SCHOOL ATTENDANCE

DEFINITIONS

60. % of girls attending primary school

This indicator provides the percentage of primary school–age girls who attend primary school. The primary-school age-group is country-specific, but usually includes some young adolescents (aged 10–14), though likely not this full age-range, since most 13–14-year-olds would be in secondary school; it will also most likely include some or all children aged 5–9, depending on the country.

61. % of boys attending primary school

This indicator provides the percentage of primary school–age boys who attend primary school. The primary-school age-group is country-specific, but usually includes some young adolescents (aged 10–14), though likely not this full age-range, since most 13–14-year-olds would be in secondary school; it will also most likely include some or all children aged 5–9, depending on the country.

62. Number of girls per 100 boys attending primary school

This indicator is the ratio of the number of girls in primary school for every 100 boys in primary school.

63. % of women attending secondary school

This indicator provides the percentage of young women of secondary-school age who attend secondary school. The secondary-school age-group is country-specific, but usually includes older adolescents (aged 15–19), though likely not this full age-range, since those aged 18–19 may be outside the age-range expected to be attending secondary school. It will also most likely include some younger adolescents aged 10–14, depending on the country.

64. % of men attending secondary school

This indicator provides the percentage of young men of secondary-school age who attend secondary school. The

secondary-school age-group is country-specific but usually includes older adolescents (aged 15–19), though likely not this full age-range, since those aged 18–19 may be outside the age-range expected to be attending secondary school. It will also most likely include some younger adolescents aged 10–14, depending on the country.

65. Number of women per 100 men attending secondary school

This indicator is the ratio of the number of young women in secondary school for every 100 young men in secondary school.

Limitations pertaining to accuracy and duration of school attendance:

The data on schooling do not reveal how regularly boys and girls actually go to school. These indicators also lack detail about how many years of education (primary or secondary) are completed.

Women and men aged 15 and older are not necessarily in secondary school; sometimes they are still attending primary school because they did not attend school for a year (or several years), or because they started school late or repeated a year (or two). Additionally, countries have different guidelines about the age-groups attending primary and secondary schools, making it difficult to make comparisons across countries.

APPLICATIONS

The indicators on school attendance provide a sense of the level of educational achievement among adolescents and information about when and where to provide *comprehensive sexuality education*. For example, countries with high percentages of school attendance among young people should focus sexuality education interventions in school settings to ensure the highest coverage. On the other hand, countries with low levels of school attendance among adolescents should prioritize out-of-school sexuality education.

Around the world, women's higher levels of education are consistently associated with higher contraceptive use, lower fertility, and higher ages at first sex and first marriage.[26-27] Women who attend school longer are also more able to enact healthy sexual and reproductive behaviors and better childcare practices, contributing to lower rates of maternal mortality and morbidity and higher rates of child survival.[28] It is therefore critical to develop policies and programs that ensure that adolescents attend school regularly and complete at least primary and secondary school wherever possible.

Service delivery and programming

These indicators can be used to demonstrate the need for services that are accessible to all adolescents. Where school-based services are not available, services must be provided outside of the school schedule (for instance, at clinics open at night and on weekends) and through outreach (such as mobile clinics).

Sexuality education and information

These indicators provide information about where to reach adolescents, and about which groups are less likely to attend school and receive school-based sexuality education.

In most developing countries, a large majority of boys and girls aged 10–14 attend primary school. For example, in Zambia, 80% of girls attend primary school (indicator 60), but only 35% of young women attend secondary school (indicator 63). In the Dominican Republic, 90% of girls attend primary school, but only 53% of young women attend secondary school. Figures in these two countries are similar for males. Therefore, school-based sexuality education should be provided during primary school to reach as many adolescents as possible.

Although fewer older adolescents attend school than younger adolescents, sexuality education should also be provided at the secondary school level because secondary school students are at an age at which large numbers of young people first become sexually active. Schools, however, are not always the easiest way to reach young people, especially in countries with low levels of school attendance and where ministries of education are socially conservative.

Indicators 60-65 also provide information on the number of adolescents who are not attending school. Many developing countries have significant numbers of out-of-school adolescents, who need to receive sexual health education from nonschool sources. For instance, in India, 29% of girls are not in primary school and 54% of women are not in secondary school. The venues where out-of-school youth can be reached will likely differ across countries; often, sports clubs and youth-oriented recreational spaces are possible places to reach these groups.

Finally, these indicators show that girls overall are less likely to attend primary and secondary school than boys, and that adolescents in poorer families are less likely to attend school than those in better-off families. In many countries, adolescents in the lower *wealth quintiles* are more likely to not attend school. For instance, in India, 21% of young women in the lowest wealth quintile attend

secondary school, compared with 74% in the highest quintile (indicator 63). In Zambia, 14% of young men in the lowest quintile attend school, compared with 69% in the highest quintile (indicator 64). These data help to identify the groups most in need of sexuality education outside of school settings.

Examining several indicators in combination allows for a more complete picture of the situation among specific subgroups of adolescents. For example, in Zambia, only 21% of young women in rural areas attend secondary school (indicator 63); only 10% are exposed to television (indicator 67); and 77% have not heard about family planning on radio, television or in the newspapers (indicator 19). These data indicate the need to develop education and information programs that can reach rural adolescents through channels other than television and schools; such programs need to make their messages accessible to young people at all education and literacy levels.

Advocacy

In cases where sexuality education is taught in schools, programs are often delivered too late, after many young people have dropped out of formal education or have already become sexually active. Similarly, children and young people may only be exposed to a one-off program that does not include enough coverage of key concepts, such as rights, equality, health and relationships from a young age. Therefore, even those who do receive some sexuality education are likely to be getting too little too late. Data on school attendance can be used to advocate for the need for sexual health education as early as primary school, when most adolescents are still in school.

For adolescents aged 15–19, the data for many countries strongly support the need for sexuality education outside of schools. Finally, the data also provide crucial information about out-of-schools adolescents. They can be used to advocate for providing sexuality education and sexual and reproductive health services to vulnerable groups.

DISCUSSION GUIDE

- How can the ministries of health and education work together more closely to ensure that sexuality education and youth-friendly health services are consistent and accessible to all young people?
- What strategies are most effective to deliver comprehensive sexuality education to out-of-school young people?
- What are the best teaching approaches to deliver comprehensive sexuality education in and outside of schools?
- Are there ways that your organization can ensure that schools are safe and supportive places for girls, young women, young people living with HIV and young lesbian, gay, bisexual, transgender and queer young people?
- Are teachers adequately trained to deliver sexuality education curricula? Besides training, what are some effective ways to support teachers?
- How can we improve linkages between health services and education?
- How can your organization work with the media to ensure that messages targeted toward young people relating to sex, sexuality and contraception are accurate?

SECTION 3: EXPOSURE TO MEDIA

DEFINITIONS

66. % of women aged 15–19 who are exposed to radio

This indicator is the proportion of female adolescents aged 15–19 who listen to the radio at least once a week or almost every day.

67. % of women aged 15–19 who are exposed to television

This indicator is the proportion of female adolescents aged 15–19 who watch television at least once a week or almost every day.

68. % of women aged 15–19 who are exposed to newspapers

This indicator is the proportion of female adolescents aged 15–19 who read a newspaper or a magazine at least once a week or almost every day.

69. % of women aged 15–19 who are exposed to all sources of media (radio, television or newspapers)

This indicator is the proportion of female adolescents aged 15–19 who have access to all three sources of media (radio, television and newspapers or magazines) at least once a week or almost every day.

70. % of women aged 15–19 who are exposed to no source of media

This indicator is the proportion of female adolescents aged 15–19 who have no access at all to any kind of media or have access less than once a week.

Limitations pertaining to content and quality of media:
Mass media communication can have a positive effect on contraceptive use and safer sex behaviors. The indicators provide information about whether adolescents aged 15–19 have access to the media and what kinds of media they use. The data are limited in that they do not provide information about the type, quality or content of the programs that young people are exposed to. These indicators provide only a measure of the size of the group of young people who have access to these media.

It is also important to note that many young people now receive and seek out information through quickly growing media channels such text messaging (SMS), the internet and social networking sites. In many developing countries, these relatively new media channels are becoming the primary sources of information for young people. The DHS does not yet gather information about these media sources and there is not another data set that provides comparable data.

Another limitation regarding mass media communication is that it is difficult to isolate the impact that one particular media source or program may have on sexual and contraceptive behaviors. Media messages may contribute to informing and educating the public, but not necessarily cause changes in behaviors directly.

APPLICATIONS

Mass media is a powerful tool and a cost-efficient way to reach large numbers of people, including hard-to-reach groups such as out-of-school youth and those living in remote areas. Knowing which medium (television, radio, or newspapers) is most accessible or popular among adolescents is therefore critical to the success of these programs that aim to improve young people's sexual health.

Service delivery and programming

The data presented here can help service providers decide which media channels are best for informing adolescents about what services are available and where and when they can access them. This can be particularly helpful for designing cost-effective campaigns and media programs. For example, in Zambia, among young women aged 15–19 in the poorest wealth quintile, 2% have access to television, 17% have access to newspapers and 41% have access to radio. This information indicates that radio would be one of the most effective medium to reach this portion of the population.

Small, printed media such as posters, pamphlets and flyers can be distributed locally and enjoy a long shelf life. However, they may not be effective among adolescents with a low level of education or literacy: if they are used, they can be more effective when accompanied by community-based interventions. Those using print media, radio and television must be sure to communicate messages in all local languages.

Mass media programs have a stronger impact when they combine several media channels and formats. Messages delivering specific information on a particular product or brand or about specific service locations are more likely to have an impact on the public than general messages.

Sexuality education and information

These indicators can help improve the design of media programs because they show which forms of media are best suited to reach particular groups. The use of media allows for adjustments to serve adolescents' needs and speak to their tastes: dramas, serials and all "edutainment" programs that combine education and entertainment. These programs are well-suited to present positive role models and positive approaches to sexuality and *gender* equality. Using media in this way can serve to increase knowledge, improve the accurate perception of risks, increase awareness of *sexual rights*, promote the use of sexual and reproductive health services and contraception, inform youth about safer sexual behaviors, and help youth to question potentially harmful myths or social norms.

There are sometimes large differences in access to media within a country, according to residence and level of wealth. For instance, in India, the vast majority of young people living in urban areas, and 80–93% in the two highest wealth quintiles are exposed to television (indicator 67), making it a suitable medium for broadcasting information and educational programs to young people who fall into these categories. Using mass media will be more problematic for reaching young women in the poorest wealth quintile; 66% of this group have no access or extremely limited access to radio, television or news-

papers (indicator 70). This means that a large number of these young people will have to be reached through other means.

Advocacy

Data on media exposure, combined with school enrollment data, can be used to argue for the need to use the media to reach out-of-school adolescents. For example, in Zambia, 79% of young women aged 15–19 who live in rural areas are not attending school (indicator 63), but 49% of rural women this age have access to radio (indicator 66). Radio programs combined with community outreach or mobile education programs and clinics could help reach adolescents who do not attend school.

Moreover, mass media programs are critical for advocacy. By increasing overall awareness in communities, media campaigns have the potential to engender community dialogue and shape social norms, in addition to influencing individual behavior.

DISCUSSION GUIDE

- How can we ensure that messages about sexuality promoted through mass media are positive and rights-based, rather than fear-based and negative?
- What are the most effective ways to use new forms of social media (for instance, social networking sites, text messaging) to increase access to accurate, rights-based information on sexual and reproductive health?
- What are some ways to develop a better understanding of how social media influence sexual behaviors and attitudes among young people?

INDICATOR NUMBER	56	57	58	59
Region and country	Number aged 10–14 in 2011[2]		Number aged 15–19 in 2011[2]	
	Girls	Boys	Women	Men
AFRICA				
Dem. Rep. of Congo (2007)	4,399,594	4,422,963	3,738,620	3,761,728
Egypt (2008)[1]	3,984,540	4,160,212	3,838,912	3,980,775
Ethiopia (2011)	5,497,408	5,538,506	4,947,828	4,964,409
Ghana (2008)	1,373,236	1,441,274	1,267,679	1,329,661
Kenya (2008–09)	2,468,937	2,490,903	2,174,400	2,187,975
Malawi (2010)	969,934	986,547	852,585	863,421
Mozambique (2003)	1,510,456	1,514,065	1,278,054	1,274,631
Nigeria (2008)	9,532,099	9,935,902	8,206,597	8,530,776
Rwanda (2010)	643,408	636,698	541,248	534,304
Senegal (2010–11)	789,640	805,695	699,063	710,090
Tanzania (2010)	2,801,555	2,834,339	2,412,629	2,426,252
Uganda (2006)	2,265,917	2,274,891	1,902,165	1,882,942
Zambia (2007)	863,766	870,388	718,823	722,876
Zimbabwe (2010–11)	788,897	789,673	811,550	806,186
EUROPE				
Albania (2008–09)	129,565	140,916	136,487	144,310
Moldova (2005)	93,851	96,324	133,092	135,334
Ukraine (2007)	983,873	1,036,007	1,279,304	1,338,524
SOUTH AND SOUTHEAST ASIA				
Bangladesh (2007)[1]	7,788,190	8,210,895	7,594,853	8,007,237
India (2005–06)	58,631,724	64,032,368	57,671,444	63,157,008
Indonesia (2007)[1]	10,454,011	10,833,231	10,574,067	10,909,357
Nepal (2011)	1,781,822	1,881,056	1,645,323	1,734,981
Pakistan (2006–07)[1]	9,929,830	10,344,520	9,615,782	10,003,359
Philippines (2008)	5,213,348	5,457,033	4,812,144	5,025,100
Vietnam (2002)[1]	3,233,587	3,389,917	4,223,782	4,404,002
LATIN AMERICA & CARIBBEAN				
Bolivia (2008)	561,977	584,396	532,803	552,511
Colombia (2010)	2,151,734	2,237,169	2,148,794	2,221,164
Dominican Republic (2007)	489,229	503,865	482,325	491,563
Guatemala (2008)	920,000	938,100	821,900	823,100
Honduras (2005–06)	444,407	461,615	429,279	441,883
Peru (2007–08)	1,423,399	1,473,338	1,414,619	1,457,682

Full name of indicators above
56. Number of girls aged 10–14 in 2011
57. Number of boys aged 10–14 in 2011
58. Number of women aged 15–19 in 2011
59. Number of men aged 15–19 in 2011

School Attendance

INDICATOR NUMBER	60	61	62	63	64	65
Region and country	% attending primary school[3]		Number of girls per 100 boys attending primary school[3]	% attending secondary school[3]		Number of women per 100 men attending secondary school[3]
	Primary school aged girls	Primary school aged boys		Secondary school aged women	Secondary school aged men	
AFRICA						
Dem. Rep. of Congo (2007)	59	63	95	25	32	77
Egypt (2008)[1]	88	89	98	64	67	95
Ethiopia (2011)	65	64	102	13	14	96
Ghana (2008)	74	73	101	42	42	101
Kenya (2008–09)	80	78	103	18	17	108
Malawi (2010)	92	90	102	13	12	108
Mozambique (2003)	57	63	90	7	8	80
Nigeria (2008)	59	65	91	46	52	90
Rwanda (2010)	88	86	102	16	15	107
Senegal (2010–11)	56	52	107	27	29	93
Tanzania (2010)	81	78	104	25	26	95
Uganda (2006)	81	82	99	16	16	101
Zambia (2007)	80	80	100	35	38	93
Zimbabwe (2010–11)	87	87	101	48	47	102
EUROPE						
Albania (2008–09)	95	95	99	55	57	96
Moldova (2005)	84	84	100	79	80	99
Ukraine (2007)	nc	nc	na	nc	nc	na
SOUTH AND SOUTHEAST ASIA						
Bangladesh (2007)[1]	nc	nc	nc	nc	nc	nc
India (2005–06)	71	73	96	46	57	80
Indonesia (2007)[1]	84	86	98	59	57	103
Nepal (2011)	86	92	94	58	59	98
Pakistan (2006–07)[1]	62	70	89	25	29	87
Philippines (2008)	85	81	105	64	50	129
Vietnam (2002)[1]	nc	nc	na	41	nc	na
LATIN AMERICA & CARIBBEAN						
Bolivia (2008)	94	95	99	62	66	95
Colombia (2010)	75	78	97	70	69	101
Dominican Republic (2007)	90	88	102	53	38	140
Guatemala (2008)	86	90	96	39	41	95
Honduras (2005–06)	89	86	103	42	34	124
Peru (2007–08)	87	85	102	63	64	99

Full name of indicators above
60. % of girls attending primary school
61. % of boys attending primary school
62. Number of girls per 100 boys attending primary school
63. % of women attending secondary school
64. % of men attending secondary school
65. Number of women per 100 men attending secondary school

INDICATOR NUMBER	66	67	68	69	70
	% who are exposed to radio	% who are exposed to television	% who are exposed to newspapers	% who are exposed to all 3 sources of media	% who are exposed to no source of media
Region and country	Women 15–19	Women 15–19	Women 15–19	Women 15–19	Women 15–19
AFRICA					
Dem. Rep. of Congo (2007)	32	25	10	4	57
Egypt (2008)[1]	44	96	3	2	3
Ethiopia (2011)	26	18	9	2	62
Ghana (2008)	74	62	26	19	15
Kenya (2008–09)	77	32	26	14	20
Malawi (2010)	58	21	17	7	35
Mozambique (2003)	53	24	6	4	42
Nigeria (2008)	54	44	12	9	36
Rwanda (2010)	71	12	4	1	27
Senegal (2010–11)	62	66	16	11	19
Tanzania (2010)	60	32	26	12	30
Uganda (2006)	75	14	23	8	22
Zambia (2007)	58	36	29	15	29
Zimbabwe (2010–11)	34	38	18	9	47
EUROPE					
Albania (2008–09)	47	99	44	31	1
Moldova (2005)	84	93	60	52	2
Ukraine (2007)	69	98	69	51	1
SOUTH AND SOUTHEAST ASIA					
Bangladesh (2007)[1]	28	51	5	2	37
India (2005–06)	34	59	29	13	29
Indonesia (2007)[1]	32	72	6	2	21
Nepal (2011)	55	52	18	11	24
Pakistan (2006–07)[1]	nc	nc	nc	nc	nc
Philippines (2008)	70	88	34	26	6
Vietnam (2002)[1]	52	78	31	24	16
LATIN AMERICA & CARIBBEAN					
Bolivia (2008)	91	81	42	36	3
Colombia (2010)	nc	nc	nc	nc	nc
Dominican Republic (2007)	86	93	55	49	2
Guatemala (2008)	76	75	74	50	5
Honduras (2005–06)	91	72	45	37	2
Peru (2007–08)	74	65	31	19	10

Full name of indicators above
66. % of women aged 15–19 who are exposed to radio
67. % of women aged 15–19 who are exposed to television
68. % of women aged 15–19 who are exposed to newspapers
69. % of women aged 15–19 who are exposed to all sources of media (radio, television and newspapers)
70. % of women aged 15–19 who are exposed to no source of media

NOTES TO TABLES, indicators 56–70

1. These countries' female DHS samples consist only of women who had ever been married. Indicators on unmarried women are unavailable, and indicators for "all women" will only reflect those who are currently married, widowed or divorced/separated.

2. The values were generated by applying the proportions of the DHS household sample in the 10–14 and 15–19 age-groups to the country's total population in 2011, which was obtained from the United Nations Population Division. The numbers shown are the precise result of this calculation and are useful as the basis for any further estimates that the user wishes to make. However, using these data for advocacy or general audiences, it is usual practice, and we advise, rounding to the nearest thousand.

3. Indicators 60–65 on school attendance were unavailable in the 2007 Bangladesh DHS, the 2007 Ukraine DHS, and the 2008 Guatemala CDC surveys, Thus, the data for these countries were drawn from the World Bank Development Indicators and represent the percentage enrolled in (as opposed to percentage attending) primary/secondary school in 2007 for Bangladesh and Ukraine and in 2008 for Guatemala.

nc=not collected

na=not available

Conclusion

How far is the guide able to go?

The goal of this guide is to make data and statistics more approachable and easier to understand and work with. The data included demonstrate the reality of what is happening in the sexual and reproductive lives of *young people* in the 30 focus countries. To demystify the data, this guide provides practical definitions of all *indicators* and of important terms, explains the limitations of the data and gives concrete examples to illustrate how these indicators can be used in work to improve the lives of young people.

However, largely due to a lack of data, the guide is not able to tell the full story of *adolescents*' and young people's sexual and reproductive health and rights. Users should therefore combine their hands-on knowledge and experience in their own countries with the principles, approaches and data provided here to inform and guide their work in service provision, information and education, and advocacy.

This guide goes as far as existing data allow. Some data are missing because they have never been collected, while other data are missing for some subgroups because of small *sample* sizes. Data for younger adolescents (aged 10–14) are not available in the DHS because this age-group is not surveyed. Published sources of DHS data may not give breakdowns for the age-groups needed (15–19- or 15–24-year-olds, for example). The guide presents data for all women of reproductive age (15–49) to describe overall societal attitudes and norms. These data are appropriate to reflect the conditions that affect and influence young people. Data are particularly scarce on the provision of sexuality education and its quality and content, as well as on *sexual rights* and *gender* equality.

Despite these limitations, the guide explains how to use available data in a relevant manner. Users should rely on their knowledge of the local context and other evidence available in their countries to interpret and apply the survey-based data, including deciding, for example, whether indicators for all women provide reasonable information for the social context and environment in which adolescents live.

Remaining evidence gaps and research needs

Access to services, information and education

There is a need for more information on adolescents' and young people's preferences, experiences and access to *sexual health* information and services. Information is especially needed on:

- Communities' and providers' attitudes toward adolescent sexuality and toward providing sexual and reproductive health services and information to adolescents
- Adolescents' knowledge and preferences regarding particular sources of information and services
- Barriers, including logistical, personal, family, community and national (i.e., policy and program) barriers, to obtaining services and information
- Effectiveness of different models of adolescent-friendly services, such as having separate facilities for adolescents versus serving all age-groups but providing some confidential services for adolescents through special hours or designated clinic areas; and
- Adolescents' and young people's access to safe abortion services

Data on these issues are important because they influence the choices that providers and advocates might make to improve adolescents' access to information and services to improve their sexual health and rights.

Young people's receipt of information, education and services

Information is also lacking on adolescents' and young people's actual receipt of information and use of services related to sexual and reproductive health and rights. Moreover, data do not exist on the provision of school-based sexuality education. As a result, we do not know whether sexuality education is actually taught in schools (even where the *national curriculum* requires it), and if so, in what proportion of schools. We also do not know what topics are covered by the existing *curricula* or whether teachers are trained to teach it. Even less information is available regarding the availability and quality of sexual health information and education from sources outside

of school, such as health providers, community-based organizations (including faith-based organizations), parents and peers.

Gender equality and sexual rights

Some indicators illustrate adolescents' situation with regard to gender equality and sexual rights. For instance:

- Gender equality can be examined by looking at the ratio of female adolescents to male adolescents attending secondary school
- Sexual rights can be examined by reviewing laws related to intimate partner violence and abuse, sexual identity, health care access and rights within marriage.

For the second group of indicators, data are readily available for a few countries and they are not standardized, making comparisons difficult. In most countries, data are not available on these issues at all.

For others issues, national data are even harder to find. Although studies may have been conducted for particular

COUNTRY EXAMPLE: UGANDA: Gender Differences In Sexual Behavior And Knowledge

The data in this guide show that young women in Uganda are at greater risk for adverse consequences of sexual activity than young men. They become sexually active earlier than young men and have less knowledge about sexual health risks and ways to protect themselves. The data also show that action is needed to increase gender equality.

The data reveal that on average, young women in Uganda experience sexual debut at a younger age than young men. Sixteen percent of young women aged 15–24 report having had sexual intercourse before age 15; 62% of those 18–24 have initiated sex before age 18. In comparison, 12% of young men report having had sexual intercourse before age 15, and 48% before age 18. Women also marry younger than men: Twenty-two percent of 15–19-year-olds have ever been married versus only 2% of male 15–19-year-olds. This gender gap is even more pronounced among 20–24-year-olds: 78% among women versus 44% among men. Furthermore, the gap between median age at first intercourse and median age at marriage is much shorter for young women (1.3 years) than for young men (4.0 years).

Young men in Uganda generally have more knowledge about sexual health risks than young women. For example, more female adolescents (46%) than male adolescents (38%) have not heard about family planning in the media. Comprehensive knowledge about HIV/AIDS also tends to be higher among young men (38%) than among young women (32%). Ninety percent of young men know a source for condoms, while only 70% of young women do; and only 34% of young women report that they can get condoms on their own.

Lack of access to contraceptives likely contributes to the high level of unmet need among 15–19-year-old women in Uganda. Fifty-five percent of sexually active, unmarried 15–19-year-old women have an unmet need for contraception, as do 34% of married women in the same group.

Taking into account population size provides a more comprehensive perspective on the scale of young women's and men's needs. Uganda has more than 4.5 million young adolescents aged 10–14 and more than 3.7 million adolescents aged 15–19. Only 16% of young people attend secondary school, while a much higher proportion (81-82%) attend primary school. It is therefore critical to deliver sexuality education programs that include age-appropriate sexual and reproductive health and rights information in primary school so that girls and boys learn how to avoid unintended pregnancy and STIs, and how to cultivate healthy intimate relationships.

Advocates can use these data to raise awareness among educators, planners and policymakers that comprehensive sexuality education and access to basic services are critically important for young people and especially for young women, both married and unmarried, in school and out of school. Service planners and providers can use data on the predominant behavioral patterns to increase their sensitivity to the specific needs of different groups of young people.

areas or groups in a few countries, they may be so context-specific that the results cannot be used in the framework of this guide. These issues include the following:

- Socioeconomic and ethnic discrimination;
- Violence and abuse; and
- Forced marriage

Data on these topics are important in order to identify and reach the more vulnerable adolescents and to advocate for more awareness of these rights and for better laws, or better implementation of existing laws to protect adolescents.

Adolescents' knowledge of sexuality and sexual rights

Data on knowledge of sexuality and *sexual rights* have been collected mainly in the context of HIV prevention and skills-based health education. These data are useful because they cover some aspects of *comprehensive sexuality education*. But they also omit some important topics, for example, regarding contraception and sexual rights. Adolescents' awareness of bodily changes in adolescence and their implications for sexual and reproductive behavior are critical issues, as well. Data on these topics are important for designing sexuality education programs and for providing sexual and reproductive health information and services to adolescents who need them.

Positive sexuality and pleasure

There is a growing body of evidence on the importance of pleasure and positive experiences in the sexual lives of individuals and couples. Research shows that incorporating positive aspects of sexuality and intimate relationships in sexuality education can improve health outcomes, such as increased use of condoms and other contraceptives.[29–31]

COUNTRY EXAMPLE: DOMINICAN REPUBLIC: Sexual Health of Young Men

Data on the sexual behavior, knowledge, education and contraceptive use of young men are necessary for understanding their health risks and needs. Young men in the Dominican Republic generally become sexually active much sooner than young women. This trend corresponds to the much greater gap between age at first intercourse and age of marriage among men, compared with women. Additionally, fewer than half of sexually active young men report using condoms.

In the Dominican Republic, half of young men become sexually active during adolescence (50% of male adolescents aged 15–19 and 92% of young men 20–24 have had sexual intercourse). These data, along with data on school attendance, indicate the importance of providing young men with sexual health information at a young age, ideally in primary school. Eighty-eight percent of boys attend primary school, while only 38% attend secondary school.

The median age of sexual debut is 16.3 among young Domincan men, while their median age of marriage is 23.9—a gap of 7.6 years. Young women, on the other hand, have a gap of less than one year, on average, between first sex and first marriage. This considerable gap for young men may translate to their having several sexual partners and therefore having a greater risk of contracting HIV and other STIs. Furthermore, only 34% of young men aged 15–24 have comprehensive knowledge of HIV, thus highlighting young men's need for sexual health information and services.

Young men may also face cultural pressure to demonstrate their masculinity through sexual activity. This pressure can harm their sexual health, especially when they respond to social pressure to "prove" their heterosexuality by having sex with sex workers or with multiple partners. While young men in the Dominican Republic report a relatively high level of modern contraceptive use (70%), only 45% use condoms.

In the field, there is a generally greater focus on providing sexuality education and services for young women; the disproportionate attention to women is likely motivated by the fact that they are at risk of unintended pregnancy and often subject to cultural norms that limit their ability to control their sexual and reproductive lives. These are critical concerns. Young men, however, are also an essential part of improving the sexual health and lives of all young people. Program planners and educators can use data on young men to make the case for programs that address their specific needs and challenges.

Sexual health researchers, service providers and educators are increasingly recognizing the value of this relatively new approach, which not only acknowledges but respects the fact that the reasons people want to engage in sexual activity include sexual pleasure, sexual satisfaction and intimacy. Research has also shown that developing a positive relationship to one's own sexuality can increase sexual self-esteem and sexual *self-efficacy*.[32,33] By cultivating these aspects of "positive sexuality," young men and women can make informed choices about how to conduct themselves sexually, free from the shame that can lead to impulsive or risky behaviors.

Younger adolescents

The lack of data on younger adolescents (aged 10–14) is particularly problematic given the often heated debates over the provision of sexuality education and services to this younger age-group. The data presented in this guide show that there are often significant proportions of young people who begin sexual activity before age 15. This information demonstrates the need for sexual and reproductive health information, education and services for younger adolescents. More data on 10–14-year-olds would be useful to demonstrate the specific needs of this group and to advocate for programs that address them.

Disadvantaged adolescents

This guide uses two measures of social and economic status: rural versus urban place of residence and the relative wealth of the household (using the DHS wealth index). It presents differences in knowledge, attitudes, behaviors and needs between less advantaged (rural, poor) and more advantaged (urban, better-off) groups of adolescents, as far as the data permit. School attendance also provides a measure of vulnerability, because people with less education have less access to information and services. However, no systematic information is available for other disadvantaged subgroups, such orphans and homeless youth. Data should be collected on these vulnerable groups of adolescents.

Young men

Data in the field of sexual and reproductive health, including DHS data, typically focus on women because of the surveys' longstanding emphasis on *fertility* and maternal and child health. Data for men is often considered secondary. The DHS conducts male surveys in a large number of countries, but sample sizes are usually smaller and the questionnaires are shorter. As a result, DHS data on men are generally less comprehensive than the data available for women, and are lacking entirely in some countries.

Reliable data on young men is important because their needs may be different from those of young women. Also, men are an essential part of the equation to improve the situation of women. More data on men could improve our understanding of how they behave, what they know about sexual health and what they think about issues related to gender equity. The evidence can help information and service providers to address the specific needs of young men and include them in their programs.

Looking to the future

This guide is designed to provide comprehensive information and clear guidance on ways to use data effectively to improve the sexual and reproductive health of youth worldwide. We hope that it will energize and enable those working towards this objective to be more effective and empowered in their work.

There are many ways that the information presented here can be used. Below are some ideas for materials that could be developed to strengthen the use and reach of this guide:

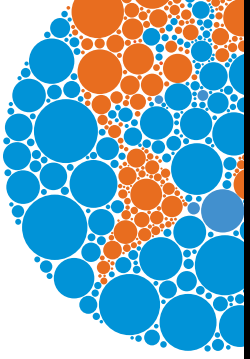
Activity Guides:
Using this publication as a foundation, activity guides and workbooks could be developed that provide concrete, structured ideas on how to best utilize this information in a particular context. They may focus on ways to address a particular issue, such as advocating for the provision of sexuality education to younger adolescents or for sexual health services to married adolescents.

Country Fact Sheets:
Brief, concise reports that summarize the findings for a specific country could be helpful for all of the 30 countries featured in the guide. We plan to produce country factsheets for some of the focus countries, but we encourage the production of tailored factsheets with the data presented in the data tables. For example, indicators that are of interest in a particular country could be presented in conjunction with details on relevant policies and cultural issues.

Trend Data:
The DHS and similar surveys, carried out in more than 90 countries over the past 30 years, are periodically updated. By using the latest data and comparing them to previous data from earlier surveys, users have the opportunity to

examine trends over time and infer possible reasons why those changes have taken place. To monitor trends, it is essential for the indicators to be measured in the same way over time. DHS data can be useful for this purpose, whereas data from multiple sources may not be comparable.

Data for Other Countries:
The analysis and approach presented in this guide can be applied to countries other than the 30 featured here. For example, it would be possible to gather most of the indicators included here for other countries that have a DHS survey using the online guide, *STATcompiler*, and using the definitions, applications and discussion questions in this guide to develop a greater understanding of the data. This guide provides an overall structure that can be applied to any country to enhance comprehension and use of existing data on the sexual and reproductive health of youth.



Glossary

The following list of terms includes those that are frequently used in this guide and not likely to be known by nonspecialists. The definitions are drawn from several sources:

- http://www.ippf.org/resources/glossary
- http://stattrek.com/statistics/dictionary.aspx
- http://www.unfpa.org/swp/2005/presskit/factsheets/facts_child_marriage.htm
- http://www.stats.gla.ac.uk/steps/glossary/basic_definitions.html#samp

Adolescents: People aged 10–19. Demographic Health Survey (DHS) data are usually available for 15–19-year-olds, which this report refers to as adolescents.

Bias: The tendency to systematically under- or overestimate the value of a measure. There are many types of bias, including selection, measurement and response. *Response bias* is the most relevant for the survey data in this guide. It occurs when those who are interviewed adjust their answers to what they believe is socially desirable, give answers that they think are expected of them or intentionally fail to provide answers.

Case study: A collection and presentation of detailed information about a particular individual or small group; the case study draws conclusions only about that individual or group and only in that context. This type of research emphasizes exploration and description.

Census: A survey that collects data from every member of a population. Censuses are considered problematic due to issues of accuracy and high expense.

Composite indicator: A measure that combines responses to several questions.

Comprehensive sexuality education (CSE): Education about all matters related to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes toward sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills.

Curriculum: An educational course or program.

Demographic and Health Surveys (DHS): An international source of data and analysis and the primary source of information on sexual and reproductive health and rights in the developing world.

Early marriage: Defined differently in different cultures and depends to some extent on the legal age of marriage. The minimum age is usually 14 or 16, but in some countries it is 12. Many negative consequences of early marriage have been documented and, as a result, advocates of children's rights argue that young people should not marry before age 18, and that no one of any age should be forced to marry.

Empowerment: Can be defined as the "access to power to achieve goals or ends." It involves not only gaining access to resources, but also understanding one's rights and entitlements.

Fecundity: The physiological capacity of a woman to become pregnant and have a child or of a man to make a woman pregnant.

Fertility: The number of children that are produced by an individual, a group or a population.

Gender: The roles, rights and social norms defined for men and women. It does not refer only to biological sex.

Indicator: A measure that allows for meaningful comparisons across groups, regions or countries. If the values are standardized (for example, the *percentage* of women married before age 18), the result meets the criteria for an indicator. Other examples include average per capita

income and the percentage of women aged 15–49 using modern contraceptives. All indicators in this guide are standardized values and comparable except population values, indicators 56–59.

In union: "In union" and "married" are used interchangeably and may refer to: women and men who are in a marriage recognized by the state and/or a religious institution; those who are living in a consensual union; and those in informal unions that are recognized by the community and referred to by other names, including "free union" or "visiting union."

Life skills-based education: see **Skills-based education**

Marriage: see **In union**

Median age: The age that divides a group or population into two halves. If 16 is the median age at first intercourse for young women, it means that 50% of the girls have had intercourse before age 16 and 50% have done so after turning 16.

Modern contraceptive methods: These include sterilization, hormonal and barrier methods to prevent pregnancy and STIs. Some examples include contraceptive pills, patches, IUDs, injections, implants, male or female condoms, diaphragms, and spermicides, such as foam or jelly.

National (school) curriculum: The official educational program that schools must teach according to the national law. The program may include required topics, the grade at which students must receive information, the number of hours a particular subject must be taught, whether a topic is mandatory and whether students must be tested on it.

Nationally representative study or survey: One for which the **sample** (see below) reflects the structure and characteristics of the entire population under study, which means the data collected from the sample correspond statistically to the data for the entire population.

Proxy: A measure that approximates another or serves as a substitute when a direct measure for the data of interest is not available.

Qualitative measure: A characteristic that cannot be expressed by a number. For example, the quality of sexuality education taught in schools cannot be expressed in numbers, so it would need to be described using a descriptive, non-numerical measure.

Quantitative measure: A quantity that can be measured with numbers. For example, the population of a city is the number of people who live in that city. Therefore, population is a quantitative variable.

Sample: A group of units (such as people in a population survey) selected from a larger group (such as the entire population). A sample is used to draw conclusions about the entire population. A representative sample "looks like" the population and permits appropriate estimation of data for subgroups, such as urban and rural populations. Research often relies on samples because it is impractical to study the whole population. For example, if we wanted to know the average height of 12-year-old boys in a given country, we could not feasibly measure all of the 12-year-old boys in that country, but we could measure a sample of boys.

Self-efficacy: One's judgment or belief about being able to adopt a specific behavior or perform a particular activity.

Sexual health: Pertains to all physical, behavioral, mental, emotional and social aspects of sexual well-being. This includes a positive approach toward sexuality, and the experience of healthy personal relationships, healthy pregnancy and childbearing, all of which contribute to overall well-being.

Sexual intercourse: Can be vaginal (penetration of the vagina by the penis), anal (penetration of the anus by the penis) or oral (oral contact with a partner's genitals). The standard Demographic and Health Survey does not include questions specifically referring to anal or oral intercourse. The questions on sexual intercourse in this survey are considered to pertain to vaginal intercourse, but the questions do not specify any form (or forms) of intercourse.

Sexually active: This is generally understood to refer to **sexual intercourse** (see below; the Demographic and Health Survey questions pertaining to sexual activity ask respondents only about sexual intercourse). It should be noted that sexual activity can also include a wide range of other activities other than sexual intercourse, including kissing, hugging and fondling, but generally when someone has engaged in sexual intercourse they are considered to be sexually active.

Sexually experienced: An adjective used to describe an individual who has had sexual intercourse.

Sexual rights: A subset of human rights that is constituted by a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people. Sexual rights include the right to equality, participation, life, liberty, privacy, autonomy, recognition before the law, freedom of thought and expression, health, education and accountability, regardless of sex, sexuality or gender. It also includes the right to choose whether or not to marry.[18]

Sexually transmitted infection (STI): An infection that is usually acquired through sexual contact but may also be spread through blood transfusions, intravenous drug use and from mother to child. The infections may arise from bacteria or viruses. Some examples include chlamydia, gonorrhea, syphilis and HIV.

Skills-based education: A teaching method that uses participatory exercises to help young people develop skills and critical thinking to deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress.

Survey: A study that obtains data from a **sample** of people in order to estimate population attributes. A survey is often much less expensive than a census. A well-designed survey can provide precise estimates of population characteristics more quickly and cheaply, and with less manpower, than can a census.

Traditional contraceptive methods: These include contraceptive methods that do not involve hormones, surgery or synthetic barrier methods. Some examples include periodic abstinence, withdrawal, breast-feeding and country-specific methods.

Unintended pregnancy: A pregnancy that is either mistimed or unwanted, including pregnancies ending in births, abortions and miscarriages. If a woman does not want to become pregnant at the time of conception, but wants to become pregnant in the future, the pregnancy is considered mistimed. In this guide, we use the DHS definition of mistimed which is when the desired timing of the pregnancy was more than two years after the time of conception. If a woman does not want to become pregnant at conception or at any time in the future, the pregnancy is considered unwanted.

Unplanned birth: A birth that occurs at least two years sooner than desired or that is not wanted at all.

Unwanted pregnancy: see **Unintended pregnancy**

Wealth quintile: The Demographic and Health Survey gives all households a score or ranking based on their assets and then divides the population into five equal parts, or wealth quintiles, according to their score. The five quintiles are poorest, poorer, middle, richer and richest.

Young people: People aged 10–24.

Youth: People aged 15–24.

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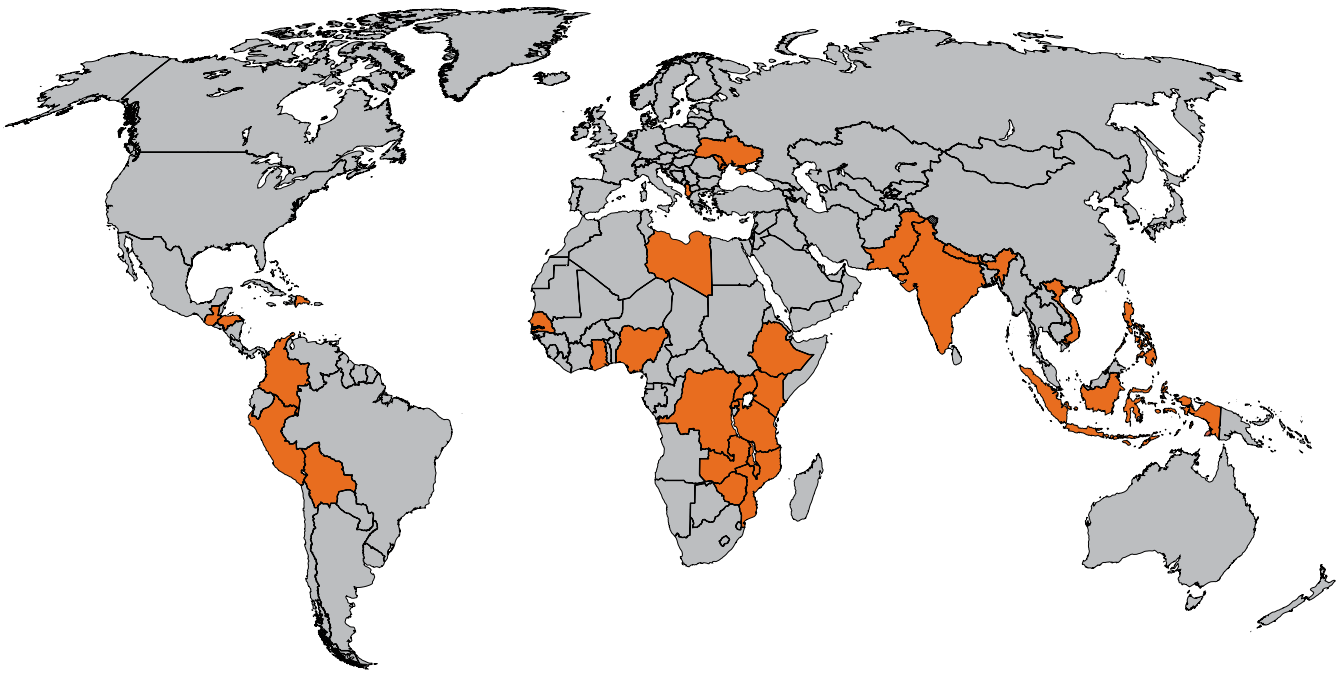
Data for the following 30 countries are provided in this guide

- Albania
- Bangladesh
- Bolivia
- Colombia
- Democratic Republic of Congo
- Dominican Republic
- Egypt
- Ethiopia
- Ghana
- Guatemala
- Honduras
- India
- Indonesia
- Kenya
- Malawi
- Moldova
- Mozambique
- Nigeria
- Nepal
- Pakistan
- Philippines
- Peru
- Rwanda
- Senegal
- Tanzania
- Uganda
- Ukraine
- Vietnam
- Zambia
- Zimbabwe



Selected key data sources for information on the sexual health of young people around the world:

Demographic Health Surveys (DHS): http://www.measuredhs.com/

Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/

Guttmacher Institute: www.guttmacher.org

International Planned Parenthood Federation: www.ippf.org

United Nations Educational, Scientific and Cultural Organization (UNESCO): http://www.unesco.org/new/en/

UNICEF: http://www.unicef.org/

UNAIDS: http://www.unaids.org/en/

United Nations Population Division: http://www.un.org/esa/population/unpop.htm

Contents of CD (inside back cover)

The enclosed CD, found on the back cover, includes the following additional resources:

- **Country-specific data tables for all 30 featured countries** including the 70 selected indicators detailed in the guide. The tables include the national-level data as well as subgroups by residence (urban and rural) and economic status (five wealth quintiles).
- An **advocacy table** which provides suggestions on the best indicators to use for a range of specified advocacy efforts.
- An **indicators appendix** with detailed explanations of how the 70 indicators are calculated.

These additional materials can also be found on the Guttmacher website: www.guttmacher.org

Advancing sexual and reproductive health worldwide through research, policy analysis and public education

125 Maiden Lane
New York, NY 10038
(212) 248-1111; fax (212) 248-1951
info@guttmacher.org

www.guttmacher.org

4 Newhams Row
London, United Kingdom SE1 3UZ
+44 (0)20 7939 8200
fax: +44 (0)20 7939 8300
info@ippf.org

www.ippf.org