

# The World's Youth 2000



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## Overview

There are more young people on Earth than ever before. At the turn of the new century, 1.7 billion people are between the ages of 10 and 24, and the vast majority live in less developed countries. Meeting the needs of youth today is critical for a wide range of policies and programs, because the actions of young people will shape the size, health, and prosperity of the world's future population.

This report and its accompanying data sheet give a profile of today's youth, providing data on population, education, and health, with a special focus on sexual and reproductive health. (The data tables appear in the Appendix, on pages 17–24.)

Young people's needs vary tremendously depending on their stage of life—puberty, adolescence, and early adulthood—and on the context in which they live. While this diversity makes it difficult to make generalizations about young people, the action plans adopted at recent international conferences make it possible to identify critical needs and compare progress in health and education against agreed-upon goals.

Overall, young people's health and educational prospects are improving, and marriage and childbearing are occurring at later, more mature stages of life, compared with previous generations. Nevertheless, some concerns remain. For example:

- Despite increasing attention given worldwide to education, secondary school enrollments are still low in many parts of the world, and girls' school enrollments still lag behind boys'.
- Complications of pregnancy, childbirth, and unsafe abortion are the major causes of death for women ages 15 to 19.
- Young people ages 15 to 24 have the highest infection rates of sexually transmitted infections (STIs), including HIV/AIDS.
- Statistics on rape suggest that between one-third and two-thirds of rape victims worldwide are age 15 or younger.

At both the 1994 International Conference on Population and Development (ICPD) and its five-year review in 1999, participants identified adolescents as a particularly vulnerable group. At these world conferences, governments committed “to meet the needs of adolescents and youth for information, counseling, and high-quality sexual and reproductive health services” as a way to “encourage them to continue their education, maximize their potential, and prevent early marriage and high-risk childbearing.”<sup>1</sup> Recent program experiences shed light on practical ways to provide young people with the information, social support, and services they need to protect themselves from sexual and reproductive health problems.

## Introduction: The World of 1.7 Billion Youth

At the turn of the 21st century, 1.7 billion people—more than one-fourth of the world's six billion people—are between the ages of 10 and 24, making this group the largest ever to enter adulthood (see Box 1). Eighty-six percent of 10-to-24-year-olds live in less developed countries. The proportion of youth in these countries is significantly higher than in more developed countries, as shown in Figure 1.

### Box 1:

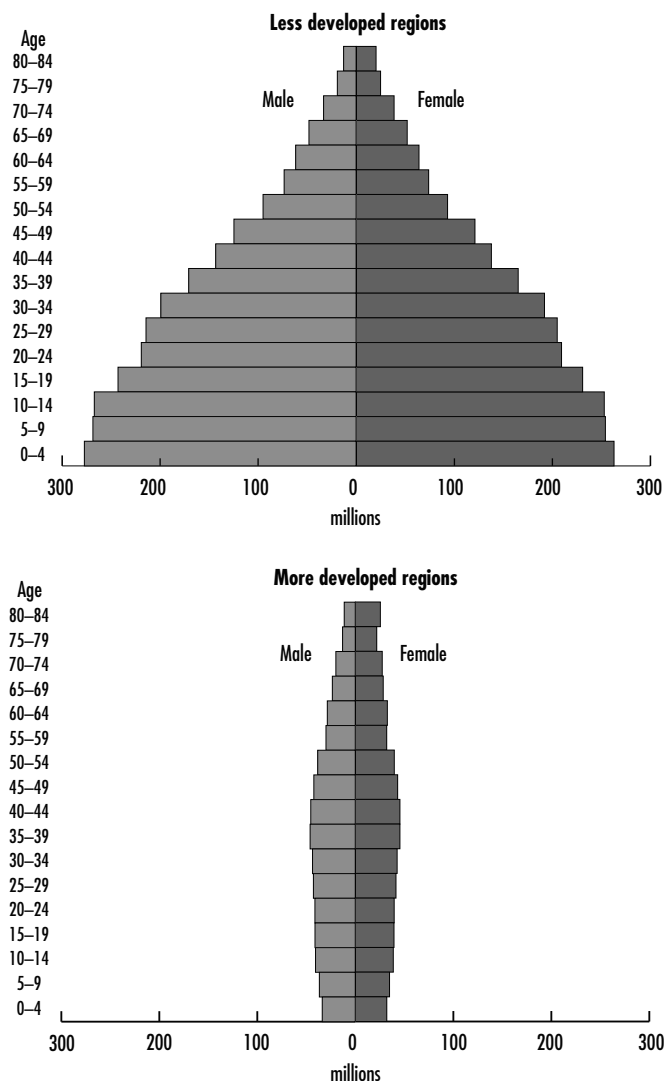
#### Who are "Youth"?

In this report, we define youth or young people as in the 10-to-24 age group, which includes preteens and teenagers (ages 10 to 19) and young adults (ages 20 to 24). We use the terms "adolescents" and "teenagers" interchangeably, though the period of transition known as adolescence may differ from place to place and between boys and girls.

Times are changing for young people around the world, in ways that affect their lives both positively and negatively. The current generation of young people is the healthiest, most educated, and most urbanized in history (see Figure 2 for urbanization trends in less developed countries). While urbanization brings greater access to education and health services, it also carries greater exposure to the risks of drug and alcohol abuse, violence, and sexually transmitted infections (STIs), including HIV/AIDS. Modernization tends to create more employment opportunities, but it may also bring about a loss of traditional cultures and separation from extended families.

The context in which young men and women live greatly influences the course of their lives. Some young people are married and considered adults in their societies; others are still in school and considered dependent children. Many young people are sexually active and have become parents themselves, but may not have achieved the legal adult age as defined by their country or state. "Adolescence" is a modern term meaning

Figure 1:  
**Population by age and sex: Less and more developed regions, 2000**



Note: Data reflect projections for 2000.

Source: United Nations Population Division, 1998.

a period of life that starts at puberty and ends at the culturally determined entrance to adulthood (social maturity and economic independence).

Around the world, the onset of puberty is occurring earlier and the age of marriage is rising. Thus, young people are facing a longer period of time during which they are sexually mature and may be sexually active before marriage. While adolescence is generally a healthy period of life, many young people are exposed to health risks associated with sexual activity, including exposure to STIs, unintended pregnancies, and complications from pregnancy and childbirth. Young people often have inadequate or misleading information on sexuality and reproductive health and lack access to reproductive health care.

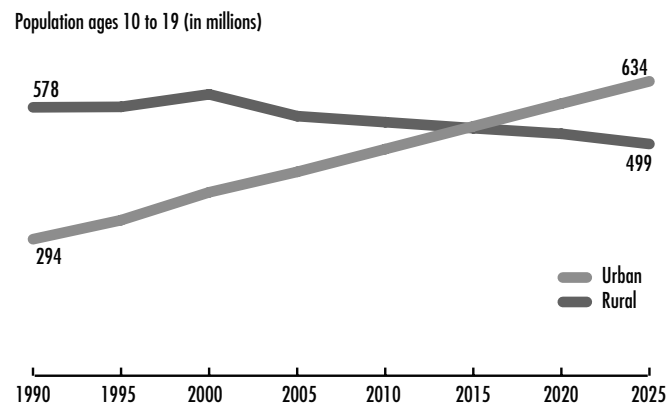
Improving young people's health is a critical goal in and of itself, with long-term benefits to society as a whole. In addition, the extent to which the reproductive health needs of this generation are met will greatly affect global population growth. In particular, the decisions these young people make regarding family size and the timing of births will make today's youth the "critical cohort" in determining the size of world population for years to come.

## Educating Girls and Boys

Recent world conferences have called for universal access to and completion of primary education, and for reducing the "gender gap"—differences in boys' and girls' enrollment—in secondary education. Policymakers increasingly recognize that advancing women through greater educational opportunities is key to economic and social development.

In more developed regions, most girls and boys attend both primary and secondary school. In less developed regions, progress has been made in increasing enrollment levels, but only 57 percent of boys and 48 percent of girls were enrolled in secondary education as of the mid- to late-1990s (see Education columns on pages 18–24 in the Appendix). The gap between boys' and girls' enrollments is most apparent at the

**Figure 2:**  
**Adolescent population in less developed countries by urban and rural areas, 1990–2025**



**Source:** United Nations Population Division, World Population Prospects 1992 and 1996.

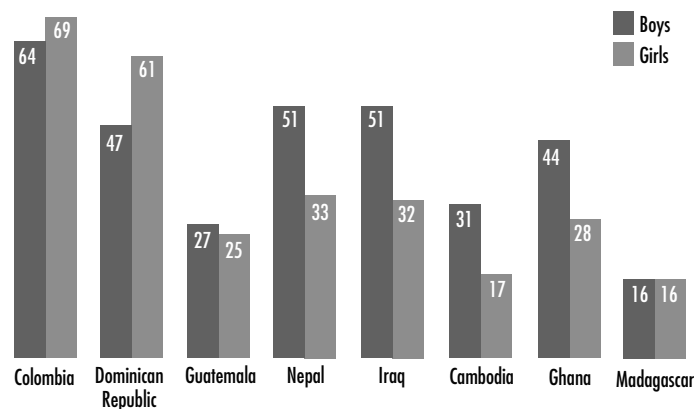
secondary level. However, in some regions where enrollment rates are very low for both girls and boys, merely raising girls' enrollments will not be sufficient. Efforts must be made to increase access to education for all.

Global school enrollment figures mask significant regional and country differences (see Figure 3, next page). In Ghana, for example, 44 percent of boys and only 28 percent of girls are enrolled in secondary school. In Colombia, on the other hand, more girls than boys are enrolled in secondary school: 69 percent of girls and 64 percent of boys. The data also mask important differences among countries and localities in retention rates, attendance, and school quality. For instance, in Côte d'Ivoire, 27 percent of primary school students had to repeat a year of school in 1995, and in Brazil, this figure was 18 percent.<sup>2</sup>

In some of the poorest countries, fewer than half of young women receive a basic education, that is, at least seven years of school.<sup>3</sup> Many young women are becoming wives and mothers or are taking on household responsibilities rather than continuing their education. Several factors explain girls' lower level of

**Figure 3:**  
**Girls' and boys' secondary school enrollment, selected countries**

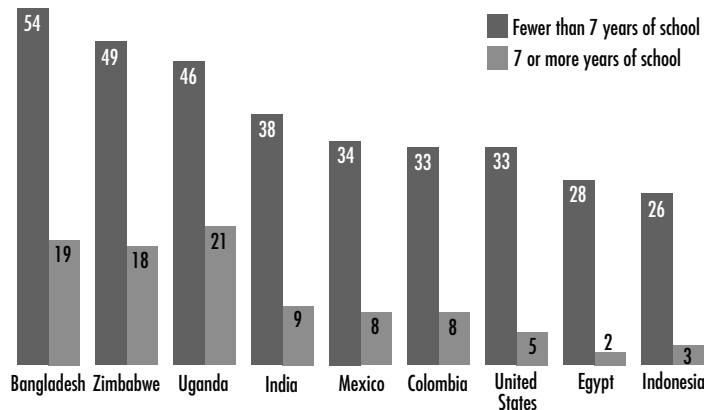
Percent enrolled (gross enrollment ratio)



Source: 1999 UNICEF Statistical Yearbook.

**Figure 4:**  
**Mother's education and childbearing, selected countries**

Percent of women ages 20 to 24 who had a child by age 18



Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

secondary school enrollment: parents' perception that secondary education is more beneficial for their sons than for their daughters; worries about girls' safety outside the village environment; and limited job opportunities for women in sectors that require higher education. Decades of research have shown that educated women have greater control of their reproductive lives, such as decisions about the number and spacing of their children (see Figure 4). Research also shows that women with more education have healthier children.

Recent progress has been promising. Between 1985 and 1995, access to education improved worldwide, particularly for girls and particularly at the secondary level.<sup>4</sup> Young women in less developed regions are now more educated than their mothers. For example, young women ages 15 to 19 in Morocco are four times more likely than their mothers to have completed seven years of schooling. In Sudan, this figure is nine times.<sup>5</sup> Nevertheless, education levels are still low in these countries, as in many others, and governments need to increase them.

## The Sexual and Reproductive Lives of Young Men and Women

### Marriage

Age of marriage is one of many aspects of young people's lives that is currently in transition. Overall, marriage before age 18 is less common than it was a generation ago; however, there is much regional variation. Figure 5 illustrates a range from as low as 3 percent in Germany to 73 percent in Bangladesh. (Data on marriage include formal unions that are legally or religiously sanctioned, as well as informal, cohabiting unions.) Compared with levels 20 years ago, early marriage has declined by one-fourth in India and Bangladesh and by about one-half in Indonesia. However, average age at marriage is still relatively young in these countries, as in Bangladesh, where the average age is 14.2.

In sub-Saharan Africa, the proportion of married adolescents has decreased over the last 20 years. Nonetheless, at least one-fourth of 15-to-19-year-old women are married in many sub-Saharan African countries, and about half of 15-to-19-year-old women in Mali, Mozambique, Niger, Chad, and Uganda are married. In much of Latin America and the Caribbean, early marriage is as common for young women today as it was for their mothers: Between 20 percent and 40 percent of women in this region form their first union before age 18.<sup>6</sup>

Marrying later in life has a number of implications for young people. Young women who marry later are more likely to have a basic education than those who marry early. Subsequently, women with more education tend to be healthier and more prosperous, and have fewer and healthier children. However, later marriage combined with increased premarital sex among adolescents puts young people at greater risk of unintended pregnancies, unsafe abortion, births outside of marriage, and STIs, including HIV/AIDS.

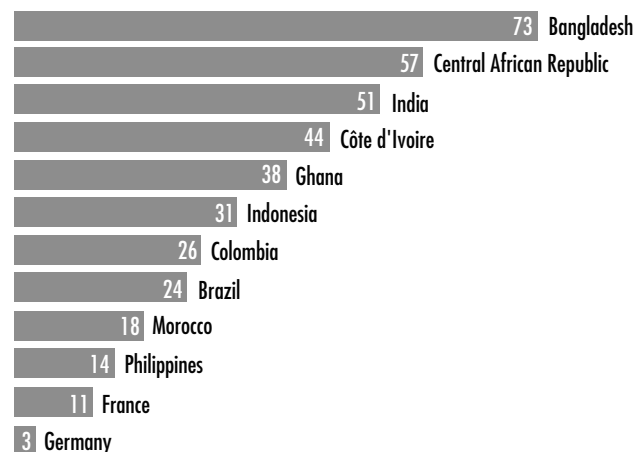
### Adolescent Sexual Activity

Premarital sexual activity is common in many parts of the world and is reported to be on the rise in all regions.<sup>7</sup> In many countries, young women and men are under strong social and peer-group pressure to engage in premarital sex. Moreover, some features of modern life may increase both the desire and opportunity for sexual activity: the mass media, the breakdown of traditional families and mores, and increased migration, urbanization, and materialism. For a substantial minority of young women, early sexual activity is not consensual (see page 9).

As shown in Table 1, in Kenya there is more than a three-year gap between age at first intercourse and age at marriage; in Brazil, it is slightly more than two years. Surveys show that, on average, 43 percent of women in sub-Saharan Africa and 20 percent in Latin America have had premarital sex before age 20. Sexual activity among adolescents is even higher in some developed countries: 68 percent of teenage women in the United States and 72 percent in France have had premarital sex by age

Figure 5:

### Percentage of women married\* by age 18, selected countries



\*Includes formal marriage and cohabiting unions.

Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

Table 1:

### Age at marriage and age at first sexual intercourse among young women,\* selected countries

Country	Median age at marriage**	Median age at first intercourse
Cameroon	18.0	15.9
Kenya	20.2	16.8
Niger	15.3	15.3
Bolivia	20.9	19.0
Brazil	21.0	18.8
Guatemala	19.2	18.6
Haiti	20.5	18.7
Indonesia	19.9	19.8
Philippines	22.7	22.8

\*Among women 25 to 29 years old.

\*\*Includes formal marriage and cohabitation. Median age indicates that half the women surveyed entered their first union before this age and half after this age.

Source: Demographic and Health Surveys (Calverton, MD: Macro International).

20.<sup>8</sup> Sex before marriage is more common among young men than among young women, however. In many societies, sex is viewed as a sign of maturity and status for adolescent boys, while for young girls it is forbidden and shameful.<sup>9</sup> (See Box 2 for more discussion of young men.)

Serious risks and consequences accompany increased premarital sex, particularly when combined with inadequate information and reproductive health services. Increased sexual activity places youth at greater risk of unintended pregnancies and STIs, including HIV/AIDS (see section on HIV/AIDS, page 10). Many unintended pregnancies end in abortion, but com-

plete data on abortion are only beginning to be available (see Figure 6). Unsafe abortions, which are sometimes self-induced, can result in severe illness, infertility, and death. Even in places where safe abortion services exist, access is often restricted for teenage girls. Complications from unsafe abortion are the leading cause of death among teenagers in some countries.<sup>10</sup>

**Adolescent Childbearing**

Of the 15 million young women ages 15 to 19 who give birth every year, 13 million live in less developed countries.<sup>11</sup> Thirty-three percent of women in less developed countries give birth

*Box 2:*  
**Reaching Young Men**

Young men typically report having their first sexual experience earlier than women and also tend to marry later. Therefore, they experience a longer period of time in which they maybe sexually active outside of marriage. Yet, while health specialists increasingly recognize that young people need support and information to take control of their sexual and reproductive lives, the focus on women's health often leaves men out of the picture. In fact, health communications and services are much less likely to target young men than young women.

Cultural standards about what is acceptable sexual behavior for young men and women complicate the issue of adolescent reproductive health. In some societies, young men are encouraged or pressured to take part in sexual behaviors that are risky, such as having multiple partners or having their first sexual experience with a sex worker. Yet services often do not provide youth with the means to protect themselves and their partners from infections and unintended pregnancies. Limited access to condoms and other contraceptives, even where they are affordable, remains a major barrier to use. Other barriers to use include attitudes and

misconceptions. For instance, some young men believe that they should use condoms when having intercourse with sex workers but not with girlfriends.

Program efforts to reach young men are now underway in many countries. Repro-

**Percentage of single, sexually active adolescent men and number of partners they had in one year, selected countries**

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

**Source:** *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

ductive health programs for young men primarily encourage responsible sexual behavior. They can also support other positive behaviors and attitudes, such as staying in school, re-examining their perceptions of gender roles and responsibilities, supporting female partners in their reproductive health needs and decisions, and avoiding violence and drug and alcohol abuse.

Program planners need to distinguish young men's needs from those of young women and differentiate young men by age groups, as developmental and emotional changes occur rapidly during adolescence. Some of the venues for reaching young men include community sites such as discos, pool halls, sports events and marketplaces; the workplace; youth-friendly/male-friendly clinics; and multipurpose youth centers. Information channels for reaching young men include the mass media (radio, television, and popular music), and face-to-face communication through peer education and counseling.

**Source:** C. Green, "Reaching Young Men with Reproductive Health Programs," *In FOCUS* (Washington, DC: Pathfinder International, 1998).

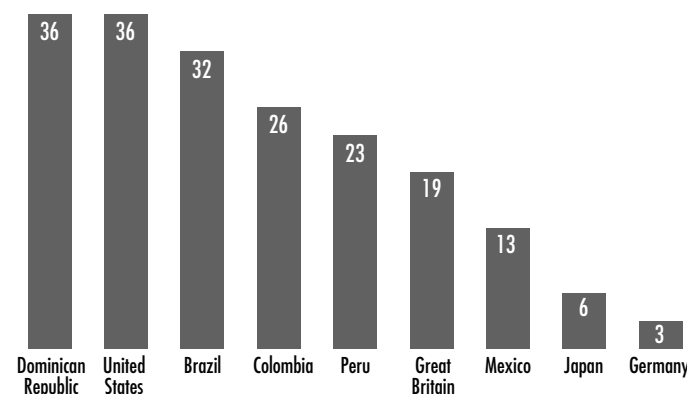


before the age of 20, ranging from a low of 8 percent in East Asia to 55 percent in West Africa. In more developed countries, about 10 percent of women give birth by age 20; however, in the United States, the level of teen childbearing is significantly higher, at 19 percent. Significant differences also exist between countries in the same region (see Figure 7, and Teen Population columns on pages 18–24 in the Appendix). For example, in Senegal, 43 percent of women ages 20 to 24 gave birth by age 20, compared with 70 percent in Mali.

Early pregnancy and childbearing are typically associated with less education and lower future income for young mothers. For unwed teens in some countries, motherhood can result in social ostracism. In other settings, teens may choose to become pregnant to gain status with their peers, improve their relationship with family members, or because they have few other life opportunities outside of motherhood.<sup>12</sup> These circumstances carry different policy and service implications.

Young women and their children face serious health risks from early pregnancy and childbearing. More adolescent girls die from pregnancy-related causes than from any other cause.<sup>13</sup> In fact, maternal mortality among 15-to-19-year-old women is twice as high as for women in their 20s. Because adolescent women have not completed their growth, in particular height and pelvic size, they are at greater risk of obstructed labor (when the birth canal is blocked), which can lead to permanent injury or death for both the mother and the infant. Infants of young mothers are also more likely to be premature and have low birth weights. In many countries, the risk of death during the first year of life is 1.5 times higher for infants born to mothers under age 20 than for those born to mothers ages 20 to 29.<sup>14</sup> For all women, first births are higher risk than subsequent births, and for teens, the risks are greater still. Because adolescents have less experience, resources, and knowledge about pregnancy and childbirth than older women, they and their children suffer when obstetric emergencies occur.

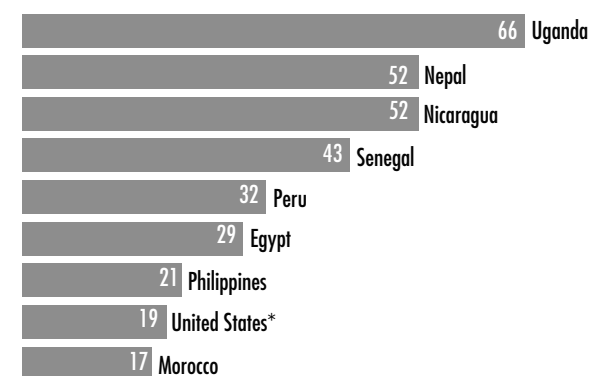
**Figure 6:**  
**Number of abortions per 1,000 adolescent women ages 15 to 19, selected countries**



Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

**Figure 7:**  
**Percentage of women giving birth by age 20, selected countries**

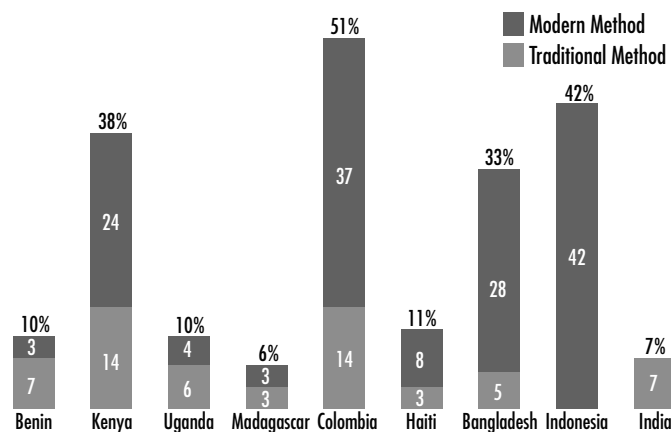
Percent of women ages 20 to 24



\*1995 National Survey of Family Growth (Hyattsville, MD: National Center for Health Statistics).

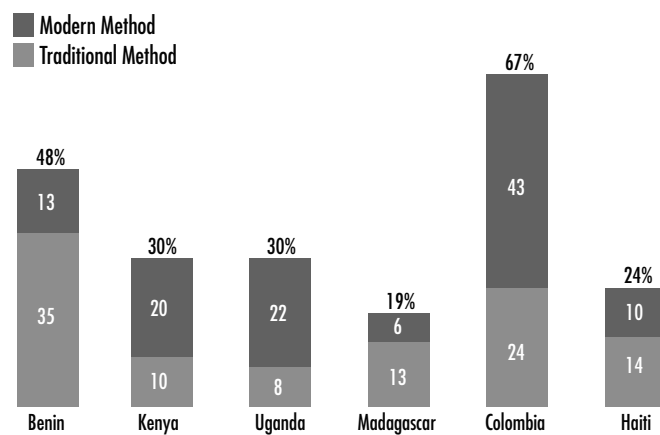
Source: Demographic and Health Surveys, 1995-1998 (Calverton, MD: Macro International).

*Figure 8:*  
**Contraceptive use among married  
 15-to-19-year-old women, selected countries**



Source: Demographic and Health Surveys (Calverton, MD: Macro International).

*Figure 9:*  
**Contraceptive use among single, sexually active  
 15-to-19-year-old women, selected countries**



Source: Demographic and Health Surveys (Calverton, MD: Macro International).

## Impact of Adolescent Childbearing on Future World Population

The reproductive decisions of today's youth will have a dramatic effect on future world population growth. United Nations demographic projections illustrate how small differences in levels of childbearing can result in large differences in population size. For instance, the UN projected in 1998 that if women have on average two children, world population would rise to 9.4 billion by 2050. However, if women average 2.5 children, world population would reach 11 billion by 2050.<sup>15</sup>

Timing of births is also critical. Projections show that if today's young women begin childbearing two and a half years later than the current average age at first birth, population size by 2100 would be 10 percent lower than if no change in timing of birth occurred. Similarly, if they waited five years to have their first births, population size would be 20 percent lower than it would be if current patterns continue.<sup>16</sup>

## Use of Contraception

Generally speaking, adolescent women are less likely than women over age 20 to use contraceptive methods. Reasons for this include lack of information, misinformation, and fear of side effects, along with geographic, social, cultural and economic barriers to access and use of family planning. Typically, family planning services are designed to serve married, adult women. Unmarried teens may find service providers hostile or unhelpful, especially where strong cultural or religious beliefs condemn sexual activity among unmarried adolescents. Teens may be unwilling to disclose their sexual activity to parents or service providers. Also, the sporadic and unplanned nature of adolescent sexual activity can be an obstacle to consistent contraceptive use.

Surveys indicate that between 12 percent and 42 percent of married adolescent women in less developed countries who say they would prefer to space or limit births are not using family planning. If sexually active unmarried teens were included, the

unmet need numbers would certainly be higher.<sup>17</sup> Married adolescent women can benefit from contraceptive use by delaying first births until their bodies are physically mature enough to carry a healthy pregnancy to term, and by delaying subsequent births.

Contraceptive use varies substantially by region and country (see Figure 8, and Teen Population columns on pages 18–24 in the Appendix). Only 13 percent of married adolescents ages 15 to 19 use contraception in sub-Saharan Africa, compared with 55 percent in Latin America and the Caribbean. In Latin America and the Caribbean, 11 percent of married adolescents in Haiti use contraception, compared with 51 percent in Colombia. Turning to Asia, in India 7 percent use contraception, compared with 42 percent in Indonesia.

The breakdown between use of modern and traditional methods also varies from one country to another. Modern methods typically used by youth include condoms, oral contraceptive pills, and hormonal injections. Traditional methods include the calendar or rhythm method, herbal methods, and withdrawal. In India, of the 7 percent who use any method of contraception, none are using a modern method. In Indonesia, by contrast, nearly all of the 42 percent of married adolescent women using contraception are using modern methods (see Figure 8).

Figures 8 and 9 also highlight differences between the contraceptive practices of married and unmarried adolescents. In several countries in Latin America and the Caribbean, unmarried teens are just as likely to use contraception as their married counterparts. In sub-Saharan Africa, unmarried adolescents are more likely to use contraception than married teens. In Benin, for example, 47 percent of single, sexually active 15-to-19-year-old women use a method of contraception (traditional and modern combined), compared with 9 percent of their married peers. While contraceptive use among married adolescents has increased significantly in parts of Asia, less is known about the contraceptive practices of unmarried youth in the region, as they are often excluded from national surveys.

## Sexual Violence Against Young Women

### Sexual Abuse and Coercion

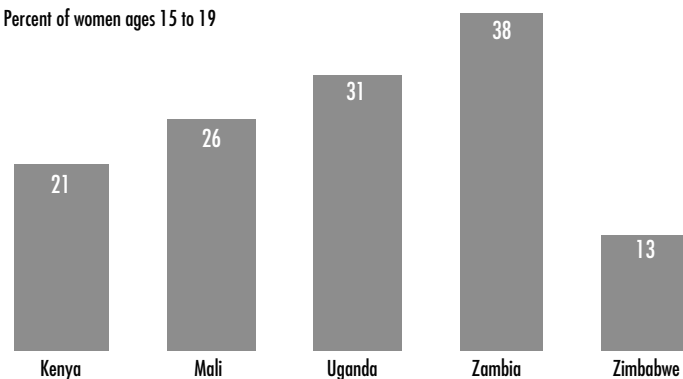
Adolescent sexual activity exists throughout much of the world, yet the extent to which it is nonconsensual is only recently being assessed. Sexual abuse includes rape, sexual assault, sexual molestation, sexual harassment, economic exchange for sex, and incest. Because sexual violence and exploitation are abuse of power, young people are especially at risk, and the violations can have devastating and long-lasting consequences. Also, because most youth reproductive health programs are geared toward young people engaging in consensual sex, the different and urgent needs of those who have been sexually abused are not met.<sup>18</sup>

Women are more vulnerable than men to violence and abuse at all stages of life through infanticide, incest, child prostitution, sex trafficking, rape, partner violence, psychological abuse, sexual harassment, rape as a weapon of war, and harmful traditional practices such as forced early marriage, female genital cutting, and bride burning. Statistics on rape suggest that between one-third and two-thirds of rape victims worldwide are 15 years old or younger.<sup>19</sup> While boys are also victimized, girls are more likely to be subjected to sexual abuse and are at risk of becoming infected with HIV and other STIs at a much younger age than boys. Other risks include unintended pregnancies, physical injury, and psychological trauma. Studies also show that young people who have been victims of sexual abuse are more likely to engage in high-risk sexual behavior than those who have not been abused.<sup>20</sup>

Sexual exploitation of children and adolescents is a multi-billion-dollar illegal industry, according to UNICEF. Some young people become prostitutes in order to make money. In many places, such as Bangladesh, Brazil, Nepal, the Philippines, and Thailand, young people are lured or forced into prostitution.<sup>21</sup> Similarly, economic deprivation leads many young women in sub-Saharan Africa and elsewhere into sexual relationships with older men—sometimes known as “sugar

*Figure 10:***Unmarried adolescent women who have recently\* received money or gifts in exchange for sex, selected sub-Saharan African countries**

Percent of women ages 15 to 19



\*Zimbabwe: within the past 4 weeks; Uganda: last sexual encounter; other countries: within the past 12 months.

Source: Demographic and Health Surveys (Calverton, MD: Macro International).

daddies”—who provide money and other necessities, such as clothing and school supplies and fees, in exchange for sex (see Figure 10).

**Female Genital Cutting**

Between 100 million and 180 million women around the world have undergone female genital cutting (FGC), also known as female circumcision and female genital mutilation, in which parts of the female genitalia are cut away. Some 600 girls are at risk every day. FGC is a serious health issue, with effects including hemorrhage, shock, pain, and various infections and other complications that can significantly damage a girl's health over her lifetime. Because FGC violates a woman's right to good health and bodily integrity, it is also a human rights issue. FGC occurs primarily in Africa, but is also practiced by minority groups and African immigrants in other regions.

In recent years, communities and countries have begun to make progress toward the internationally agreed-upon goal of eradicating FGC. Local efforts in diverse settings are starting to

build a body of knowledge about how best to address FGC. These efforts include developing alternative rites of passage for adolescent girls; public declarations against FGC by families and community members; and empowerment and advocacy programs for women and girls. Systematic evaluation of these efforts will be needed to determine the most promising approaches for ending the practice.

**Youth and the HIV/AIDS Crisis**

About half of all people infected with HIV are under age 25, according to World Health Organization estimates, and in less developed countries, up to 60 percent of all new infections are among 15-to-24-year-olds.<sup>22</sup> In this age group of newly infected people, there are twice as many young women as young men.

Adolescents are at high risk of contracting HIV and other STIs because, among other reasons, they often have multiple short-term sexual relationships and do not consistently use condoms. They also tend to lack sufficient information and understanding of HIV/AIDS: their vulnerability to it, how to prevent it, and the self-confidence necessary to protect themselves. STIs other than HIV (such as chlamydia and gonorrhea) are also a serious threat to adolescents. Worldwide, the highest reported rates of STIs are found among young people ages 15 to 24. In more developed countries, two-thirds of all reported STI infections occur among men and women under age 25, and in less developed countries, the proportion of infected young people is even higher.<sup>23</sup>

Young people face special obstacles in obtaining diagnosis and treatment of HIV/AIDS and other STIs, even where services are available. They usually lack information about STIs, their symptoms, the need for treatment, and where to obtain services. They are also reluctant to seek care, and providers may be hesitant to treat them. Because females with chlamydia and gonorrhea, the most common STIs, often do not show symptoms, and because having another STI increases an individual's susceptibility to HIV, young people are at high risk of contract-

ing and spreading these infections.<sup>24</sup> They may also face legal and/or institutional obstacles to using services, such as negative provider attitudes or requirements for parental, spousal, or partner consent before testing or treatment. Additionally, young people often believe (incorrectly) that STIs will simply go away if untreated or that they will not recur if treated.

Young women are particularly vulnerable to STIs for both biological and cultural reasons. Adolescent women have fewer protective antibodies than do older women, and the immaturity of their cervixes increases the likelihood that exposure to infection will result in the transmission of the disease.<sup>25</sup> Sexual violence and exploitation, lack of formal education (including sex education), inability to negotiate with partners about sexual decisions, and lack of access to contraception and reproductive health services work together to put young women at especially high risk. Additionally, women in many societies are not accustomed to discussing issues of reproductive health and sexuality with others, which further increases their vulnerability.

### **A Call for HIV/AIDS Education**

Policymakers are giving greater attention today to the need for AIDS education, prevention, and treatment. It is estimated that over 30 million adults and children worldwide are living with HIV or AIDS, but most do not know they are infected. An overwhelming majority, 95 percent of HIV-infected people, live in less developed countries.<sup>26</sup> In 1999, at the five-year review of the ICPD, governments established the goal of giving at least 90 percent of young men and women ages 15 to 24 access to preventive methods by 2005 in order to reduce vulnerability to HIV infection.<sup>27</sup> These methods include female and male condoms, voluntary testing and counseling, and follow-up. The Health column on pages 18–24 in the Appendix shows, as of 1993, whether or not countries had HIV/AIDS education included in their school curriculum. More current data are needed to determine the extent of policy responses to the HIV/AIDS crisis.

Despite the urgent need for raising public awareness, cultural and institutional barriers stand in the way of educating people about the risks of HIV and ways to prevent it from spreading. Many parents and educators have long been concerned that sex education may increase sexual activity among young people. However, a recent assessment by the Joint United Nations Programme on HIV/AIDS (UNAIDS) reveals that HIV and sexual health education promotes safer sexual practices and does not increase sexual activity.<sup>28</sup> According to the report, effective programs help delay first intercourse and protect sexually active youth from STIs, including HIV, and from unintended pregnancy. UNAIDS also reports that sexual health education is most effective when started before the onset of sexual activity.

## **Socially Marginalized Youth**

There is increasing concern for young people who are disconnected from their families and social institutions, such as schools, religious institutions, youth clubs, or the workplace. These “socially marginalized” youth are vulnerable to sexual exploitation and are at a disproportionately high risk of unintended pregnancies and STIs, including HIV/AIDS. They often lack access to health information, counseling, legal protection, and health and other services. Living or spending most of their time on the streets, the only social support they receive is typically from peers living under similar circumstances. Counting these young people is as difficult as reaching them with assistance. Nevertheless, statistics show that significant numbers of youth need information and services beyond what is provided by traditional and school-based programs.

- The UN estimates that 404 million youth under the ages of 18—or 38 percent of youth in less developed countries—do not attend school.
- UNICEF estimates that approximately 100 million young people work on the streets in activities such as picking up garbage, hawking small goods, parking and washing cars,

shining shoes, and begging. Approximately 10 percent of these youths actually live on the streets, with no connection to their families or a permanent home.

- A homeless teenage girl in the United States is 14 times more likely to become pregnant than a girl with a home.<sup>29</sup>
- A study of 143 Guatemalan street youth showed that all had been sexually abused: the majority by family members, often stepparents, or other people they knew. These youths frequently cited physical, emotional, and sexual abuse as their reasons for leaving home.<sup>30</sup>

A new group of socially marginalized youth, AIDS orphans, is often shunned by their communities and neglected. Like other orphans in general they have higher rates of malnutrition, stunting, and illiteracy. Socially isolated because of the stigma of the disease, AIDS orphans are more vulnerable to

abuse and exploitation and may be left to fend for themselves on the streets. These youth are often left with care-taking responsibilities for younger siblings and may have a harder time staying in school. The UN predicts that HIV/AIDS will orphan 13 million children—that is, leave them without a mother or both parents—by the end of 2000. At the latest count, 90 percent of the 8.2 million children who have already been orphaned due to AIDS live in sub-Saharan Africa.<sup>31</sup>

In many places, children over age five are no longer a main target of health services, as their survival is relatively assured. The health needs of many youth are neglected until, as is too often the case, adolescent girls seek health services when they are pregnant. Likewise, boys, who are at high risk of accidents, violence, and substance abuse, often only seek services when they become victims of these social ills (see Box 3).

#### *Box 3:*

### **Keys to Reaching Socially Marginalized Youth**

- Since many socially marginalized youth live in situations characterized by violence and distrust, programs need to establish an environment of respect, acceptance, and stability.
- To make initial contact, outreach programs find youth in places where they spend most of their time, such as on the streets. For example, programs in Guatemala, Honduras, and Mexico have outreach teams providing street youth with emergency medical care, HIV education, informal education, and counseling.
- Drop-in centers and shelters offer young people a place to rest and be safe. Transitional homes and group homes prepare youth for independent living or help reunite them with their families.
- Programs can work with the members of the community who have already earned young people's trust, such as market or street vendors, shopkeepers, or health care providers.

**Source:** C. Stevens, "Reaching Socially Marginalized Youth," *In FOCUS* (Washington, DC: Pathfinder International, 1999).

## **Policy and Program Approaches**

Meeting adolescents' needs for sexual and reproductive health information and services is vital to young people's future. At several international conferences and conventions in the 1980s and 1990s, governments repeated their commitment to a universal agenda for action to improve the health of adolescents, as follows<sup>32</sup>:

- Provide health education to adolescents, both men and women, including information on sexuality, responsible sexual behavior, reproduction, voluntary abstinence, family planning, unsafe abortion, STIs including HIV/AIDS, and gender roles.
- Encourage parental involvement and promote adult communication and interaction with adolescents.
- Use peer educators to reach out to young people.
- Provide integrated health services to adolescents that include family planning information and services for sexually active adolescents.
- Make health services adolescent-friendly by ensuring confidentiality, privacy, respect, and the high-quality informa-

tion necessary for informed consent and by including youth in program design.

- Increase opportunities for women's education and employment.
- Take measures to eliminate all forms of violence against women and end trafficking in women.
- Eradicate female genital cutting.

Research and program experience suggest that policy-makers and health providers need to remove the legal and institutional barriers that keep young people from using existing family planning and reproductive health services. In addition, information and services need to be designed to accommodate the unique needs of adolescents and young adults.

### **Informing Youth through Sexuality Education**

Sexuality education for youth has long been hampered by adult concerns that knowledge will promote promiscuity among unmarried teens. However, worldwide reviews of studies by WHO and UNAIDS<sup>33</sup> conclude that sexuality education does not encourage early initiation of intercourse, but instead can delay first intercourse and lead to more consistent contraceptive use and safer sex practices (see also section on HIV/AIDS education, page 11).

It is vital to reach adolescents early with information, before the onset of sexual activity. Schools are a key location for reaching large numbers of young people; however, as many youth are not in school, community-based approaches are also needed in many areas. Specialists in adolescent reproductive health suggest the following elements for a successful sex and HIV education program<sup>34</sup>:

- Give a clear message on risky sexual behaviors. Focus on reducing a few key behaviors that lead to unintended pregnancy or HIV/STI infection.
- Use a behavior change framework to define and evaluate activities.

- Provide basic, accurate information about the risks of unprotected intercourse and ways to avoid unprotected intercourse.
- Include activities that address social pressures on sexual behavior. Provide modeling and practice of communication, negotiation, and refusal skills.
- Employ a variety of teaching methods designed to involve the participants and have them personalize the information. Use teachers and peers who believe in the program they are implementing, and provide training for them.
- Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.

### **Building Links with Services**

Increasing knowledge is only the first step in the prevention of unintended pregnancies and STIs, including HIV. To be effective, educational programs (in or out of school) need to inform youth about what kinds of services they may need and where to get them. While school-based clinics may be an effective way to provide services to students, community-based clinics are needed to reach the large numbers of out-of-school youth. Community outreach may also be needed to reach young men, street children, prostituted teens, and other marginalized groups, who may not feel comfortable using services designed for mothers and their children.

A number of program models incorporate youth-friendly components in existing health services.<sup>35</sup> Multiservice centers for youth are only one approach to meeting these needs; linking social services through referral systems may be a more realistic option in many settings. Some programs try to bring services to locations where young people study, work, or socialize. Regardless of the venue, the basic components of a youth-friendly service include specially trained providers, privacy, confidentiality, and accessibility.<sup>36</sup>

*Box 4:***Case in Point—MEXFAM's Adolescent Program in Mexico**

In 1986, MEXFAM, Mexico's largest private family planning provider, began an adolescent program in urban areas called *Gente Joven* or "Young People." The program's decentralized, community-based approach, which uses youth promoters for outreach activities, is flexible and adaptable to local circumstances. Designed to reach out to adolescents on their own turf, such as schools, clubs, recreation centers, gang hangouts, and sports facilities, the program has reached over 4 million young people since its inception. *Gente Joven* is built around youth-to-youth activities, allowing adolescents to take a more dynamic role in providing information and services to their peers. The program's integrated approach includes three main elements:

- reproductive health and sex education;
- collaboration between adult coordinators and youth volunteers; and
- integrated participation and action—young people, parents, and teachers are all involved.

*Gente Joven* recognizes that young people will explore their sexuality regardless of societal constraints; therefore, it promotes safe, healthy, and responsible sex. The program confronts the strong negative attitudes many adults have toward adolescent sexuality by working to sensitize parents, teachers, and local politicians through films, discussions, pamphlets, and radio programs. Overall, key approaches to the success of this program include:

- **Youth-centered approach.** Youth-to-youth promotion ensures that the program does not diverge from the needs and expressed desires of the youth themselves.
- **Intensive training.** Staff and volunteers are trained in counseling, communication, and sex education.
- **Dedicated staff and volunteers.** *Gente Joven* has been instrumental in motivating and developing leadership potential in young volunteers.
- **High-impact educational materials.** *Gente Joven's* award-winning videos, guides to

using them, and other materials go to the heart of youth's concerns.

- **Flexibility with accountability.** The program gives its coordinators the flexibility to build on their own talents but maintains consistency with overall program goals through monitoring and evaluation.

Overall, *Gente Joven* has been credited with greatly improving intergenerational communication on sexuality. Five years after the program's inception, MEXFAM reported that in schools where the number of pregnancies was very high, teen pregnancies dropped dramatically after the introduction of *Gente Joven's* 10-hour course. The program addresses issues that are important to youth in a frank and open manner, encouraging reflection and discussion on the major decisions that they confront.

**Source:** "Mexico: *Gente Joven*, MEXFAM's Adolescent Program" in *Family Planning Programs: Diverse Solutions to a Global Challenge* (Washington, DC: Population Reference Bureau, 1994); latest data from MEXFAM's website at [www.mexfam.org.mx/](http://www.mexfam.org.mx/).

## Other Promising Approaches

Programs targeting youth can use a variety of communication approaches to provide sexual and reproductive health information, encourage dialogue on sensitive topics, and help youth develop the knowledge and confidence needed to safeguard their health. Box 4 describes an innovative example. Peer counseling—where young people are trained to talk to their peers—can take place in schools, the workplace, or other public places frequented by youth. Messages can also be delivered via the mass media and entertainment, such as popular songs, soap operas, videos, television spots, billboards, sporting events, and theater performances. Combining entertainment with educa-

tion has proven appealing and successful in reaching youth in many settings. In addition, telephone hotlines and radio call-in shows give youth an opportunity to discuss their concerns anonymously with trained counselors. Pharmacies and social marketing programs are also beginning to target young adults as consumers of health products, especially condoms.

Young people have a variety of special needs that differ from one setting to another. A key aspect of the design of youth programs is the involvement of young people in helping to determine the program approaches and components that best respond to their concerns. In doing so, young people gain new skills and self-confidence as they make decisions that



impact their future and that of future generations.

Ideally, countries will develop a comprehensive, multifaceted strategy for reaching youth. Providing young people with reproductive health information, counseling, and services can be both challenging and controversial, because of cultural sensi-

tivities about adolescent sexuality. Nevertheless, recent trends in adolescent health and sexual activity, and particularly the HIV/AIDS pandemic, call for urgent attention, public discussion, and policy action. ■

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## Definitions of selected terms in report and data tables

- The **percent enrolled in secondary school** is the ratio of the total number enrolled in secondary school to the applicable age group, or the gross enrollment ratio.
- The **total fertility rate (TFR)** is the average number of children that would be born to a woman during her lifetime assuming the age-specific birth rates of a given year.
- **Births attended by trained personnel** are births attended by a physician, nurse, or trained midwife; definitions of medical personnel vary from country to country and some data may include traditional birth attendants.
- **Percent of adult population infected with HIV** are provisional estimates supplied by the World Health Organization (WHO) and based on official country estimates when available. When not available, WHO figures are based on HIV sero-prevalence studies, reported AIDS cases, population size and structure, and the predominant modes of transmission.
- **Percent using contraception** is the percent of married women ages 15 – 19/sexually active, single women 15 – 19 who are currently practicing a form of family planning. Single, sexually active teens are those who reported intercourse within four weeks prior to the survey.
- **Modern methods of contraception** include clinic and supply methods such as the pill, IUD, condom, and sterilization. **Any method of contraception** includes modern methods as well as traditional methods.

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# **APPENDIX**

The World's Youth 2000 Data Tables

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)			% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)			
	2000	2025	2000	Males	Females	Males	Females	All Women	TFR	Ages 15-19	Personnel	Ages 15-49, 1997	Curriculum, 1993	2000	Males	Females	(females)	(females)	Age 20 <sup>c</sup>	Personnel	Any/Modern Method	Married* Any/Modern Method	
WORLD	1,663	1,796	27	54	44	63	56	22	2.9	12	71	—	—	554	17	27	19	—	31	—	—/—	20/—	
More Developed	241	198	20	88	89	99	102	25	1.5	10	99	—	—	81	—	—	6	—	—	—	—/—	—/—	
Less Developed	1,423	1,597	29	43	30	57	48	21	3.2	12	63	—	—	474	18	29	21	—	33	—	—/—	19/—	
Less Developed (Excl. China)	1,105	1,321	31	38	27	52	42	20	3.7	13	53	—	—	373	23	36	26	—	42	47	—/—	22/—	
AFRICA	256	401	33	26	15	38	33	20	5.3	12	48	—	—	86	—	—	26	—	47	50	—/—	14/13	
Sub-Saharan Africa	210	352	33	19	10	29	23	19	5.8	—	46	—	—	70	—	—	29	—	52	50	—/—	13/11	
NORTHERN AFRICA	56	63	33	47	29	63	57	21	3.6	7	49	—	—	19	21	40	12	—	24	51	—/—	19/—	
Algeria	10.3	12.0	33	40	26	65	62	24	3.8	3	77	0.1	Y	3.5	11	31	9	—	—	—	—/—	—/—	
Egypt	22.1	22.8	32	66	41	83	73	19	3.3	10	39	z	N	7.6	26	44	14	—	29	41	—/—	21/18	
Libya	2.0	2.3	35	88	63	95	95	—	4.1	7	81	0.1	Y	0.7	2	14	—	—	—	—	—/—	—/—	
Morocco	9.1	9.1	32	32	20	44	34	20	3.1	8	45	z	Y	3.0	28	52	10	—	17	47	—/—	32/30	
Sudan	9.8	13.6	33	20	12	23	20	24	4.6	6	31	1.0	Y	3.5	22	38	15	—	26	68	—/—	4/—	
Tunisia	3.0	2.9	32	34	20	66	63	25	2.8	3	79	z	Y	1.0	5	22	4	—	13	81	—/—	11/—	
WESTERN AFRICA	73	122	33	24	12	31	22	18	5.9	12	38	—	—	25	—	—	37	—	55	39	41/14	5/2	
Benin	2.1	3.6	34	24	8	26	11	19	6.3	10	80	2.1	N	0.7	46	71	29	9	50	82	47/13	9/3	
Burkina Faso	3.9	7.7	33	4	2	11	6	18	6.8	12	42	7.2	Y	1.3	—	—	44	4	62	31	31/14	1/z	
Côte d'Ivoire	5.2	7.5	35	26	11	34	16	18	5.2	13	45	10.1	N	1.8	34	56	—	19	—	51	47/16	11/4	
Gambia	0.4	0.6	29	16	7	30	19	—	5.6	15	44	2.2	Y	0.1	—	—	53	—	—	—	—/—	—/—	
Ghana	6.6	11.3	33	50	31	44	28	19	4.5	11	41	2.4	Y	2.2	—	—	20	8	49	63	45/23	20/13	
Guinea	2.5	3.9	34	24	10	20	7	—	5.5	18	31	2.1	—	0.8	—	—	—	—	39	—/—	3/2		
Guinea-Bissau	0.4	0.6	30	10	2	—	—	18	5.8	17	27 <sup>a</sup>	2.3	N	0.1	34	77	—	—	—	—	—/—	—/—	
Liberia	1.2	2.3	38	31	12	—	—	20	6.2	17	58 <sup>a</sup>	3.7	—	0.4	39	62	32	41	64	62	—/12	2/—	
Mali	3.8	6.8	34	12	5	17	8	16	6.7	14	47	1.7	—	1.3	—	—	49	6.9	70	50	29/16	5/2	
Mauritania	0.9	1.5	32	17	4	21	11	23	5.5	12	47	0.5	—	0.3	41	58	14	—	84	45	—/—	—/—	
Niger	3.4	7.1	32	7	3	9	5	15	7.5	15	39	1.5	N	1.1	72	88	60	10**	70	37	—/8	6/2	
Nigeria	36.7	57.6	33	25	13	36	30	17	6.0	12	31	4.1	N	12.4	—	—	37	10.2	54	29	40/13	1/1	
Senegal	3.1	5.3	33	15	7	20	12	18	5.7	11	47	1.8	Y	1.0	48	70	28	9**	43	44	—/16	6/2	
Sierra Leone	1.5	2.6	31	20	8	22	13	18	6.3	17	25 <sup>a</sup>	3.2	Y	0.5	—	—	58	—	—	—	—/—	—/—	
Togo	1.5	2.8	33	50	16	40	14	19	6.1	10	82	8.5	Y	0.5	23	56	19	16.5	38	85	56/25	15/4	

**Notes**

- a: Data prior to 1990
- b: Among 18-24-year-olds
- c: % ever married women ages 15–19 who are mothers
- d: Among women ages 15–24
- e: Among women currently ages 20–24
- f: Delivery in public facilities

\*: May include formal and/or informal unions  
 \*\*: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.  
 z: number rounds to zero  
*7.1*: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total) 2000	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)		
	2000	2025		Males	Females	Males	Females								Males	Females					Single Any/Modern Method	Married* Any/Modern Method	
EASTERN AFRICA	82	140	33	12	7	18	13	19	6.0	11	43	—	—	27	29	41	30	—	53	60	—/15	13/ —	
Burundi	2.2	3.7	33	4	2	8	5	22	6.5	4	19 <sup>a</sup>	8.3	Y	0.7	38	46	6	3**	27	37	—/10	4/ —	
Comoros	0.2	0.4	35	30	15	24	19	19	5.1	9	85	0.1	N	0.1	26	40	10	—	29	88	—/—	11/5	
Djibouti	0.2	0.3	32	16	9	17	12	19	5.8	3	79 <sup>a</sup>	10.3	N	0.1	—	—	7	—	—	—	—/—	—/—	
Eritrea	1.2	2.1	32	—	—	24	17	17	6.1	10	21	3.2	—	0.4	—	—	33	—	47	23	—/—	3/1	
Ethiopia	20.1	38.2	32	12	6	14	10	18	6.7	12	14 <sup>a</sup>	9.3	N	6.5	47	62	42	—	—	—	—/—	—/—	
Kenya	11.1	13.1	37	23	16	26	22	20	4.7	11	92	11.6	Y	3.7	8	11	15	8	46	91	30/20	37/24	
Madagascar	4.7	8.9	30	—	—	16	16	19	6.0	13	77	0.1	Y	1.5	—	—	28	11.1	57	75	18/6	6/3	
Malawi	3.6	6.6	33	7	3	21	12	—	5.9	12	55	14.9	Y	1.2	31	48	36	—	63	53	11/7	11/6	
Mauritius	0.3	0.3	27	51	49	63	66	23	2.0	10	97	0.5	N	0.1	9	8	11	—	—	—	—/—	46/—	
Mozambique	6.2	10.4	32	8	3	9	5	17	5.6	10	44	14.2	N	2.1	33	67	45	11	65	47	7/5	1/1	
Reunion	0.2	0.2	27	—	—	—	—	28	2.2	5	—	z	—	0.1	5	2	3	—	—	—	—/—	—/—	
Rwanda	2.7	4.1	35	4	3	12	9	23	6.5	5	26	12.8	N	0.9	—	—	8	7**	25	37	—8/	11/—	
Somalia	3.2	7.2	32	11	4	—	—	20	7.0	15	2 <sup>a</sup>	0.3	—	1.1	—	—	—	—	—	—	—/—	—/—	
Tanzania	11.2	19.0	33	4	2	6	5	18	5.6	11	47	9.4	N	3.7	—	—	23	11.9	52	54	14/12	7/4	
Uganda	7.3	15.5	34	7	3	15	9	18	6.9	13	38	9.5	Y	2.4	24	34	47	3.6	66	44	29/22	10/4	
Zambia	3.3	5.3	36	22	11	34	21	18	6.1	12	47	19.1	Y	1.1	22	27	25	9.5	63	49	16/13	17/9	
Zimbabwe	4.2	4.5	36	17	12	52	45	19	4.0	12	69	25.8	Y	1.4	3 <sup>b</sup>	3 <sup>b</sup>	19	14**	47	71	37/34	—/—	
MIDDLE AFRICA	30	61	32	—	—	31	19	19	6.6	16	64	—	—	10	—	—	28	—	—	—	—/—	6/—	
Angola	4.1	8.2	32	20	9	—	—	—	6.8	16	15 <sup>a</sup>	2.1	N	1.3	—	—	—	—	—	—	—/—	—/—	
Cameroon	4.9	8.6	32	24	13	32	22	18	5.2	13	64	4.9	Y	1.6	—	—	34	13.5	54	58	73/20	15/3	
Central African Republic	1.2	1.8	33	21	7	15	6	17	5.1	15	67	10.8	Y	0.4	—	—	39	11.2	61	70	25/10	13/2	
Chad	2.4	4.5	32	—	—	15	4	16	6.6	15	32	2.7	N	0.8	—	—	47	3.7	71	37	14/10	3/1	
Congo, Dem. Rep. of (Zaire)	16.4	1.9	32	—	—	32	19	20	7.2	16	80 <sup>a</sup>	4.3	Y	5.4	—	—	24	—	—	—	—/—	3/—	
Congo, Rep. Of	0.9	34.6	32	89	60	62	45	22	5.3	12	—	7.8	Y	0.3	6	13	16	—	—	—	—/—	—/—	
Gabon	0.3	0.6	28	35	13	32	19	—	5.4	17	—	4.4	Y	0.1	—	—	—	—	—	—	—/—	—/—	
SOUTHERN AFRICA	15	16	31	—	—	82	96	26	3.1	10	80	—	—	5	15	14	6	—	—	—	—/—	63/63	
Botswana	0.6	0.7	35	17	20	61	68	25	4.1	9	78 <sup>a</sup>	25.1	Y	0.2	11	5	6	26	55	86	—/35	17/—	
Lesotho	0.7	1.1	32	14	21	25	36	—	4.4	9	50	8.4	Y	0.2	—	—	17	—	—	—	—/—	—/—	
Namibia	0.6	0.8	32	—	—	58	67	—	5.1	11	67	19.9	N	0.2	14	8	7	16.4	42	76	29/27	21/17	
South Africa	12.4	13.1	31	—	—	88	103	26	2.9	10	82	12.9	—	4.1	15 <sup>b</sup>	15 <sup>b</sup>	5	—	—	—	—/—	66/64	
Swaziland	0.3	0.5	33	39	37	55	54	29	5.9	10	56	18.5	Y	0.1	15	13	—	—	—	—	—/—	—/—	

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)	% Illiterate		Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)		
	2000	2025	2000	Males	Females	Males	Females	All Women						2000	Males	Females					Single Any/Modern Method	Married* Any/Modern Method	
ASIA	1,031	1,048	28	48	34	62	51	21	2.8	11	65	—	—	342	19	31	20	—	29	—	—/—	16/—	
ASIA (Excl. China)	714	772	29	45	31	57	44	21	3.3	—	51	—	—	242	26	41	27	—	40	38	—/—	18/—	
WESTERN ASIA	57	78	31	49	31	63	48	22	4.0	8	74	—	—	19	6	20	15	—	—	—	—/—	—/—	
Armenia	1.0	0.8	28	—	—	100	79	—	1.3	12	96	0.1	—	0.3	—	—	15	—	—	—	—/—	—/—	
Azerbaijan	2.2	1.9	29	—	—	73	81	24	1.9	4	99	z	Y	0.7	—	—	9	—	—	—	—/—	—/—	
Bahrain	0.2	0.2	25	70	58	91	98	25	2.8	4	98	0.2	—	0.1	1	1	6	—	49 <sup>c</sup>	100	—/—	30/—	
Cyprus	0.2	0.2	24	90	90	96	99	25	1.9	4	100 <sup>a</sup>	0.3	Y	0.1	z	z	—	—	—	—	—/—	—/—	
Georgia	1.1	1.0	23	—	—	78	76	24	1.2	12	—	z	—	0.4	—	—	17	—	—	—	—/—	—/—	
Iraq	7.6	12.5	33	76	38	51	32	22	5.7	4	54 <sup>a</sup>	z	Y	2.5	—	—	18	—	—	—	—/—	4/—	
Israel	1.6	1.8	26	67	77	89	87	23	2.9	4	99 <sup>a</sup>	0.1	Y	0.5	1 <sup>b</sup>	2 <sup>b</sup>	6	—	—	—	—/—	—/—	
Jordan	2.2	3.6	33	79	63	—	—	22	4.4	4	97	z	N	0.7	2	3	8	—	17	98	—/—	33/19	
Kuwait	0.7	0.7	33	84	76	64	66	23	3.2	6	99 <sup>a</sup>	0.1	Y	0.2	4	11	11	—	54 <sup>c</sup>	98 <sup>f</sup>	—/—	8/—	
Lebanon	0.9	1.0	29	59	61	78	84	—	2.4	5	85	0.1	N	0.3	—	—	—	—	—	—	—/—	—/—	
Oman	0.8	1.7	33	17	6	68	66	19	7.1	7	93	0.1	—	0.3	—	—	36	—	61 <sup>c</sup>	88 <sup>f</sup>	—/—	3/—	
Qatar	0.1	0.2	23	64	68	80	79	23	4.2	9	98	0.1	—	0.04	5	6	10	—	48 <sup>c</sup>	92 <sup>f</sup>	—/—	16/—	
Saudi Arabia	6.7	12.0	31	36	23	65	57	22	6.4	10	90	z	N	2.2	4	16	15	—	—	—	—/—	—/—	
Syria	5.9	7.5	36	57	35	45	40	22	4.7	6	54	z	Y	2.0	10	35	—	—	—	—	—/—	—/—	
Turkey	19.6	19.2	29	44	24	68	48	24	2.5	9	76	z	N	6.8	3	10	13	—	25	81	—/—	34/16	
United Arab Emirates	0.6	0.7	26	55	49	77	82	23	4.9	11	99	0.2	—	0.2	8	11	17	—	—	—	—/—	—/—	
Yemen	5.8	12.9	32	7	4	53	14	17	6.5	7	43	z	N	1.8	15	60	26	—	45	50	—/—	9/3	

**Notes**

- a: Data prior to 1990
- b: Among 18-24-year-olds
- c: % ever married women ages 15–19 who are mothers
- d: Among women ages 15–24
- e: Among women currently ages 20–24
- f: Delivery in public facilities

- \*: May include formal and/or informal unions
- \*\*<sup>c</sup>: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.
- z: number rounds to zero
- 7.1: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total) 2000	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)		
	2000	2025		Males	Females	Males	Females								Males	Females					Single Any/Modern Method	Married* Any/Modern Method	
<b>SOUTH-CENTRAL ASIA</b>	<b>458</b>	<b>503</b>	<b>31</b>	<b>38</b>	<b>20</b>	<b>55</b>	<b>37</b>	<b>20</b>	<b>3.6</b>	<b>15</b>	<b>36</b>	<b>—</b>	<b>—</b>	<b>156</b>	<b>36</b>	<b>57</b>	<b>36</b>	<b>—</b>	<b>47</b>	<b>33</b>	<b>—/—</b>	<b>12/—</b>	
Afghanistan	6.3	14.4	28	16	4	32	12	—	6.1	11	9 <sup>a</sup>	z	—	2.0	52	87	53	—	—	—	—/—	—/—	
Bangladesh	46.5	46.2	36	26	9	25	13	14	3.3	18	8	z	N	16.6	58	71	48	—	63	14	—/—	33/28	
Bhutan	0.7	1.2	31	3	1	—	—	—	5.6	6	15	z	N	0.2	—	—	—	—	—	—	—/—	—/—	
India	300.2	307.3	30	39	20	59	39	20	3.3	18	34	0.8	N	102.0	20	44	38	—	49	34	—/—	7/—	
Iran	24.8	22.1	37	52	32	81	73	22	2.9	5	86	z	N	8.4	6	15	22	—	—	—	—/—	34/—	
Kazakhstan	4.6	3.9	28	—	—	82	91	21	1.7	12	100	z	—	1.5	z	z	12	—	29	99	—/—	39/24	
Kyrgyzstan	1.4	1.5	31	112	108	75	83	20	2.8	6	98	z	—	0.5	—	—	12	—	37	97	—/—	29/21	
Nepal	7.8	11.2	33	33	9	51	33	16	4.6	13	10	0.2	N	2.6	26	51	43	—	52	14	—/—	7/4	
Pakistan	49.1	77.5	31	20	8	33	17	22	5.6	9	18	0.1	N	15.9	56	74	24	—	31	17	—/—	3/—	
Sri Lanka	5.5	5.0	29	52	57	72	78	24	2.1	5	94	0.1	Y	2.0	9	10	7	—	16	82	—/—	20/—	
Tajikistan	2.0	2.4	33	—	—	83	74	22	2.7	4	79	z	—	0.7	z	z	14	—	—	—	—/—	—/—	
Turkmenistan	1.4	1.6	32	—	—	—	—	24	2.5	3	96	z	—	0.5	—	—	6	—	—	—	—/—	—/—	
Uzbekistan	7.8	8.5	32	117	94	100	88	20	2.8	5	98	z	—	2.6	—	—	13	—	25	100	—/—	16/15	
<b>SOUTHEAST ASIA</b>	<b>157</b>	<b>155</b>	<b>30</b>	<b>40</b>	<b>35</b>	<b>53</b>	<b>49</b>	<b>21</b>	<b>3.0</b>	<b>9</b>	<b>64</b>	<b>—</b>	<b>—</b>	<b>53</b>	<b>4</b>	<b>5</b>	<b>14</b>	<b>—</b>	<b>26</b>	<b>48</b>	<b>—/—</b>	<b>34/30</b>	
Cambodia	3.3	4.7	29	—	—	31	17	23	5.3	2	31	2.4	N	1.2	3	8	5	—	—	—	—/—	—/—	
Indonesia	63.6	61.1	30	35	23	55	48	19	2.8	11	54	0.1	N	21.3	2	3	17	—	31	32	—/—	42/42	
Laos	1.7	3.0	31	25	16	34	23	—	5.6	9	—	z	N	0.5	—	—	—	—	—	—	—/—	—/—	
Malaysia	6.5	7.0	29	50	46	59	69	24	3.2	4	99	0.6	Y	2.3	3	4	8	—	—	—	—/—	—/—	
Myanmar	14.0	12.7	31	—	—	29	30	22	3.8	5	56	1.8	N	5.0	12	18	16	—	—	—	—/—	—/—	
Philippines	24.0	27.6	32	60	69	77	78	22	3.7	6	64	0.1	N	7.9	4	1	8	z	21	51	—/—	18/11	
Singapore	0.7	0.7	19	60	60	74	70	27	1.5	2	100 <sup>a</sup>	0.2	Y	0.2	1	1	1	—	—	—	—/—	—/—	
Thailand	17.3	14.2	29	30	28	38	37	23	1.9	20	71 <sup>a</sup>	2.2	Y	5.6	1	2	17	—	24	61	—/—	43/—	
Viet Nam	25.3	23.7	32	44	40	48	46	21	2.5	5	85	0.2	Y	8.6	7	7	8	—	19	76	—/—	18/15	
<b>EAST ASIA</b>	<b>359</b>	<b>312</b>	<b>24</b>	<b>59</b>	<b>45</b>	<b>77</b>	<b>70</b>	<b>23</b>	<b>1.8</b>	<b>1</b>	<b>91</b>	<b>—</b>	<b>—</b>	<b>115</b>	<b>3</b>	<b>8</b>	<b>4</b>	<b>—</b>	<b>8</b>	<b>—</b>	<b>—/—</b>	<b>14/—</b>	
China	317.1	276.2	25	54	37	74	67	22	1.8	1	89	0.1	Y	100.9	3	8	4	—	8	—	—/—	11/—	
Hong Kong	1.5	1.1	22	63	65	71	76	27	1.0	3	—	0.1	Y	0.5	—	—	2	—	—	—	—/—	—/—	
Japan	22.6	18.3	18	92	94	103	104	27	1.3	1	100 <sup>a</sup>	z	Y	7.5	—	—	1	—	2	—	—/—	39/—	
Korea, North	5.5	5.5	23	—	—	—	—	—	2.3	z	100 <sup>a</sup>	z	—	1.7	—	—	—	—	—	—	—/—	—/—	
Korea, South	11.0	9.5	23	82	74	102	102	25	1.5	1	98	z	—	3.8	—	—	1	—	—	—	—/—	—/—	
Mongolia	0.9	0.8	34	85	95	48	65	24	2.7	9	100	z	—	0.3	—	—	3	—	22	—	—/—	—/—	
Taiwan	5.5	—	25	81	80	—	—	—	1.5	—	—	—	—	1.9	—	—	1	—	—	—	—/—	—/—	

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)		% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)	
																						Single Any/Modern Method	Married* Any/Modern Method
		2000	2025	2000	Males	Females	Males	Females	All Women						2000	Males	Females	(females)	(females)				
NORTH AMERICA	64	65	21	91	92	99	98	25	2.0	14	99	—	—	22	—	—	4	—	19	—	—/—	—/—	
Canada	6.2	6.3	20	87	89	105	105	26	1.5	8	99 <sup>a</sup>	0.3	Y	2.1	—	—	2	—	—	—	—/—	—/—	
United States	57.7	59.1	21	91	92	98	97	25	2.1	15	99 <sup>a</sup>	0.8	Y	19.4	—	—	5	—	19	—	—/—	—/—	
LATIN AMERICA	155	163	30	41	43	—	—	21	2.8	14	85	0.5	—	52	9	7	15	—	35	—	—	55/—	
CENTRAL AMERICA	42	46	31	46	42	56	57	20	3.1	13	84	—	—	14	6	7	19	—	38	—	—/—	29/—	
Costa Rica	1.2	1.4	30	44	51	47	52	22	3.2	15	98	0.6	N	0.4	3	2	15	—	—	95	—/38	53/30	
El Salvador	2.0	2.3	32	26	23	35	39	19	3.6	15	87	0.6	Y	0.7	14	13	22	11**	46	88	—/—	23/19	
Guatemala	3.8	6.1	34	20	17	27	25	19	5.0	12	35	0.5	Y	1.3	18	27	24	1	45	91	—/—	15/12	
Honduras	2.2	3.0	33	29	31	29	37	19	4.4	13	61	1.5	Y	0.7	—	—	23	—	49	—	—/—	28/17	
Mexico	30.6	30.1	31	51	46	64	64	21	2.7	13	91	0.4	—	10.1	4	4	18	5**	35	—	—/—	30/—	
Nicaragua	1.7	2.5	33	40	45	52	62	18	4.4	17	61	0.2	—	0.6	3	2	26	—	52	91	—/—	40/38	
Panama	0.8	0.8	29	58	65	60	65	22	2.6	16	86	0.6	Y	0.3	5	5	19	—	—	—	—/—	24/—	
CARIBBEAN	11	11	28	—	—	49	55	20	2.6	15	79	1.8	—	4	26	21	20	—	—	—	—/—	—/—	
Cuba	2.4	1.9	21	79	83	76	85	20	1.6	21	99	z	—	0.8	—	—	27	—	—	—	—/—	—/—	
Dominican Republic	2.5	2.6	30	—	—	47	61	19	3.1	16	96	1.9	N	0.8	18	14	23	2.9	39	99	58/42	35/29	
Haiti	2.9	3.5	35	14	13	21	20	21	4.7	8	21	5.2	—	1.0	47	43	15	5.4	32	71	23/10	11/8	
Jamaica	0.7	0.7	29	63	71	63	67	20	2.6	18	91	1.0	Y	0.3	18	6	7	—	—	—	—/—	68/65	
Puerto Rico	1.0	0.9	25	—	—	—	—	22	2.1	17	—	—	—	0.3	10	8	15	—	—	—	—/—	—/—	
Trinidad and Tobago	0.4	0.3	31	73	75	72	75	22	1.7	12	98 <sup>a</sup>	0.9	Y	0.1	1	1	20	7**	30	—	—/18	42/—	
SOUTH AMERICA	102	106	30	38	42	—	—	21	2.7	14	86	—	—	35	9	6	13	—	34	93	63/54	50/41	
Argentina	10.0	10.6	27	53	62	73	81	23	2.6	12	97	0.7	Y	3.3	2	1	10	—	—	—	—/—	—/—	
Bolivia	2.6	3.7	31	42	32	40	34	21	4.2	9	47	0.1	N	0.9	3	7	11	10**	36	67	—/—	31/10	
Brazil	50.9	48.5	30	31	36	—	—	21	2.4	16	92	0.6	N	17.4	15	9	14	8.8	32	97	66/61	54/47	
Chile	3.9	4.2	26	49	56	72	78	23	2.4	10	100	0.2	N	1.3	2	1	10	—	—	—	—/—	—/—	
Colombia	12.4	14.3	29	40	41	64	69	21	3.0	16	85	0.4	Y	4.1	5 <sup>b</sup>	4 <sup>b</sup>	14	4.9	36	95	67/43	51/37	
Ecuador	4.0	4.3	31	53	53	50	50	20	3.3	12	64	0.3	N	1.3	3	3	17	6**	53	61	—/—	27/19	
Guyana	0.2	0.2	29	76	80	71	76	24	2.7	12	71	2.1	—	0.1	—	—	12	—	—	—	—/—	—/—	
Paraguay	1.8	2.6	32	29	29	46	48	21	4.3	9	61	0.1	N	0.6	4	4	16	5.6	37	95	23/13	37/30	
Peru	8.1	8.4	31	63	54	72	67	21	3.4	10	56	0.6	—	2.7	3	5	12	2.2	32	81	70/33	46/31	
Uruguay	0.8	0.8	24	61	62	75	90	23	2.3	15	96 <sup>a</sup>	0.3	N	0.3	2	1	11	—	—	—	—/—	—/—	
Venezuela	7.4	8.5	31	18	25	33	46	21	2.9	16	69 <sup>a</sup>	0.7	Y	2.3	5	3	18	—	—	—	—/—	—/—	



	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)	% Iliterate		% Currently Married*	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025		Males	Females	Males	Females								Males	Females					Single Any/Modern Method	Married* Any/Modern Method
	2000	2025	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000
<b>EUROPE</b>	<b>149</b>	<b>109</b>	<b>21</b>	<b>86</b>	<b>88</b>	<b>97</b>	<b>102</b>	<b>24</b>	<b>1.4</b>	<b>9</b>	<b>99</b>	—	—	<b>50</b>	—	—	<b>7</b>	—	—	—	—/—	—/—
<b>NORTHERN EUROPE</b>	<b>18</b>	<b>16</b>	<b>19</b>	<b>86</b>	<b>90</b>	<b>117</b>	<b>132</b>	<b>26</b>	<b>1.7</b>	<b>7</b>	<b>100</b>	—	—	<b>6</b>	—	—	<b>2</b>	—	—	—	—/—	—/—
Denmark	0.9	0.9	17	105	104	120	122	28	1.7	3	100 <sup>a</sup>	0.1	Y	0.3	—	—	1	—	—	—	—/—	—/—
Estonia	0.3	0.2	23	126	127	100	108	23	1.2	15	—	z	—	0.1	z	z	7	—	—	—	—/—	—/—
Finland	1.0	0.8	19	94	105	110	125	27	1.7	3	100	z	—	0.3	—	—	1	—	—	—	—/—	—/—
Ireland	0.9	0.9	25	85	95	113	122	26	1.9	5	—	0.1	—	0.3	—	—	1	—	—	—	—/—	—/—
Latvia	0.5	0.3	22	—	—	82	85	23	1.2	11	—	z	Y	0.2	z	z	8	—	—	—	—/—	—/—
Lithuania	0.8	0.5	23	—	—	85	88	22	1.3	13	—	z	N	0.3	z	z	—	—	—	—	—/—	—/—
Norway	0.8	0.8	18	92	96	121	116	26	1.8	4	100 <sup>a</sup>	0.1	Y	0.3	—	—	1	—	—	—	—/—	—/—
Sweden	1.6	1.4	18	83	93	128	153	28	1.5	2	100 <sup>a</sup>	0.1	Y	0.5	—	—	1	—	—	—	—/—	—/—
United Kingdom	11.1	9.8	19	82	85	120	139	26	1.7	8	100 <sup>a</sup>	0.1	Y	3.7	—	—	3	—	—	—	—/50	—/—
<b>WESTERN EUROPE</b>	<b>33</b>	<b>28</b>	<b>18</b>	<b>88</b>	<b>90</b>	<b>112</b>	<b>111</b>	<b>26</b>	<b>1.5</b>	<b>3</b>	<b>99</b>	—	—	<b>11</b>	—	—	<b>2</b>	—	—	—	—/—	—/—
Austria	1.5	1.2	18	98	87	105	102	26	1.3	6	100	0.2	Y	0.5	—	—	4	—	—	—	—/—	—/—
Belgium	1.8	1.5	18	90	92	142	151	25	1.6	4	100 <sup>a</sup>	0.1	Y	0.6	—	—	5	—	—	—	—/—	—/—
France	11.6	10.5	20	77	92	112	111	26	1.8	3	99	0.4	Y	3.9	—	—	1	—	7	—	—/—	50/—
Germany	13.9	11.1	17	93	89	105	103	26	1.3	4	99	0.1	Y	4.6	—	—	2	—	—	—	—/—	—/—
Netherlands	2.8	2.3	18	95	90	134	129	27	1.6	1	100 <sup>a</sup>	0.2	Y	0.9	3	3	1	—	—	—	—/—	—/—
Switzerland	1.3	1.1	17	—	—	—	—	28	1.5	1	99 <sup>a</sup>	0.3	—	0.4	—	—	1	—	—	—	—/—	—/—
<b>EASTERN EUROPE</b>	<b>71</b>	<b>47</b>	<b>23</b>	<b>92</b>	<b>92</b>	<b>87</b>	<b>92</b>	<b>22</b>	<b>1.2</b>	<b>14</b>	<b>99</b>	—	—	<b>24</b>	<b>z</b>	<b>z</b>	<b>12</b>	—	—	—	—/—	—/—
Belarus	2.4	1.6	23	—	—	91	95	23	1.3	13	100 <sup>a</sup>	0.2	—	0.8	z	z	10	—	—	—	—/—	—/—
Bulgaria	1.7	1.0	21	85	84	77	76	22	1.1	20	100 <sup>a</sup>	z	—	0.6	1	1	16	—	—	—	—/—	—/—
Czech Republic	2.2	1.3	22	113	116	97	100	22	1.1	10	—	z	Y	0.7	—	—	7	—	24 <sup>d</sup>	—	—/—	51/27
Hungary	2.1	1.3	21	72	67	96	99	22	1.3	10	100 <sup>a</sup>	z	N	0.6	1	1	8	—	—	—	—/—	—/—
Moldova	1.2	0.9	27	78	79	79	82	22	1.5	9	—	0.1	—	0.4	z	z	14	—	—	—	66/40	78/48
Poland	9.5	6.5	25	75	80	98	97	22	1.4	7	99 <sup>a</sup>	0.1	—	3.4	—	—	5	—	—	—	—/—	—/—
Romania	5.3	2.8	24	102	86	79	78	22	1.3	16	100 <sup>a</sup>	z	N	1.6	1	1	11	—	20	—	—/—	43/9
Russia	34.6	23.3	24	95	97	83	91	23	1.2	17	99	0.1	Y	11.9	z	z	13	—	—	—	—/—	—/—
Slovakia	1.3	0.9	25	—	—	92	96	21	1.4	12	—	z	N	0.4	z	z	—	—	—	—	—/—	—/—
Ukraine	11.1	7.2	22	—	—	88	94	—	1.3	13	100	0.4	—	3.8	—	—	15	—	—	—	—/—	—/—

## Notes

a: Data prior to 1990

b: Among 18-24-year-olds

c: % ever married women ages 15–19 who are mothers

d: Among women ages 15–24

e: Among women currently ages 20–24

f: Delivery in public facilities

\*: May include formal and/or informal unions

\*\*: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.

z: number rounds to zero

7.1: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total) 2000	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate		Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20 <sup>c</sup>	% Births Attended by Trained Personnel	% Using Contraception (females)		
	2000	2025		Males	Females	Males	Females								Males	Females					% Single, Sexually Active (females)	% Using Contraception (females)	
																					Single Any/Modern Method	Married* Any/Modern Method	
SOUTHERN EUROPE	27	19	19	74	73	95	99	25	1.3	5	—	—	—	9	z	z	6	—	—	—	—/—	—/—	
Albania	0.9	0.8	28	70	63	37	38	22	2.2	7	99 <sup>a</sup>	z	N	0.3	—	—	—	—	—	—	—/—	—/—	
Bosnia-Herzegovina	0.9	0.7	23	—	—	—	—	23	1.6	10	97	z	—	0.3	—	—	—	—	—	—	—/—	—/—	
Croatia	0.9	0.7	21	—	—	81	83	24	1.5	6	—	z	Y	0.3	z	z	9	—	—	—	—/—	—/—	
Greece	2.0	1.3	19	85	77	95	96	25	1.3	5	97 <sup>a</sup>	0.1	—	0.7	1	z	14	—	—	—	—/—	—/—	
Italy	9.2	6.6	16	73	70	94	95	26	1.2	3	—	0.3	Y	2.9	z	z	5	—	—	—	—/—	—/—	
Macedonia	0.5	0.5	24	—	—	64	62	23	1.9	10	95	z	—	0.2	—	—	—	—	—	—	—/—	—/—	
Portugal	2.0	1.4	20	34	40	106	116	25	1.5	7	90 <sup>a</sup>	0.7	—	0.6	1	1	9	—	—	—	—/—	—/—	
Slovenia	0.4	0.3	21	38	39	90	93	24	1.2	7	—	z	Y	0.1	z	z	2	—	—	—	—/—	—/—	
Spain	7.6	4.9	19	85	89	116	123	26	1.2	3	96 <sup>a</sup>	0.6	Y	2.5	z	z	4	—	—	—	—/—	—/—	
Yugoslavia	2.4	2.0	23	—	—	60	64	24	1.6	10	93	0.1	—	0.8	1	1	—	—	—	—	—/—	—/—	
OCEANIA	7	8	24	63	64	111	113	25	2.4	6	93	—	—	2	—	—	6	—	—	—	—/—	—/—	
Australia	3.9	4.1	21	70	72	150	155	26	1.7	6	100	0.1	Y	1.3	—	—	1	—	—	—	—/—	—/—	
Fiji	0.3	0.3	32	53	57	64	65	23	3.3	9	96 <sup>a</sup>	0.1	—	0.1	2	2	13	—	—	—	—/—	—/—	
New Zealand	0.8	0.9	22	82	84	110	116	27	2.0	8	99 <sup>a</sup>	0.1	Y	0.3	—	—	2	—	—	—	—/—	—/—	
Papua-New Guinea	1.5	2.2	32	15	8	17	11	21	4.8	3	53	0.2	Y	0.5	—	—	19	—	—	—	—/—	—/—	

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