



Ensuring a Healthier Tomorrow in Central America

**PROTECTING THE SEXUAL AND REPRODUCTIVE
HEALTH OF TODAY'S YOUTH**

Lisa Remez

Elena Prada

Susheela Singh

Luis Rosero Bixby

Akinrinola Bankole

English translation of *Asegurar un mañana más saludable en Centroamérica: proteger la salud sexual y reproductiva de la juventud de hoy*. Online only.

Acknowledgments

Ensuring a Healthier Tomorrow in Central America: Protecting the Sexual and Reproductive Health of Today's Youth was written by Lisa Remez and Elena Prada, independent consultants; Susheela Singh and Akinrinola Bankole, both of the Guttmacher Institute; and Luis Rosero Bixby, Centro Centroamericano de Población. The report was edited by Haley Ball, Guttmacher Institute, and translated by Xavier González-Alonso. Matilde Rosero, independent consultant, was responsible for layout and printing, under the direction of Kathleen Randall of the Guttmacher Institute.

The authors thank the following Guttmacher colleagues: Suzette Audam, for her invaluable assistance with data tabulations; Alison Gemmill for research and administrative support throughout the project; Fatima Juárez for help in devising and implementing the policy component; and Melanie Croce-Galis, Leila Darabi and Patricia Donovan for their assistance in developing the report. They also gratefully acknowledge the contribution of former Guttmacher colleagues Beth Fredrick, Jennifer Nadeau and Joanna Drescher.

Early drafts of the report benefited from the comments and suggestions provided by the following colleagues: Amy Bank, Puntos de Encuentro; Nanette Ecker, Sexuality Information and Education Council of the United States; Matilde Maddaleno and Ewa Nunes Sörensson, Pan American Health Organization; Axel Mundigo, Guttmacher Senior Fellow; Suzanne Petroni, Summit Foundation; Eva Roca and Ricardo Vernon, Population Council; and Paul Stupp, Centers for Disease Control and Prevention. The authors also acknowledge with gratitude the contributions of the following research partners: in Guatemala, Werner Figueroa and Felipe Antonio López; in Honduras, Kenia Bautista-Sabonge; and in Nicaragua, Luis Blandón and Luis Carballo-Palma. The authors also thank the policy partners who conducted the qualitative interviews in their respective countries: in Guatemala, Telma Duarte de Morales; in Honduras, Karla Zepeda; and in Nicaragua, Luis Carballo-Palma.

This report was made possible by funding from the Swedish International Development Cooperation Agency.

Suggested citation: Remez L et al., *Ensuring a Healthier Tomorrow in Central America: Protecting the Sexual and Reproductive Health of Today's Youth*, New York: Guttmacher Institute, 2008.

Guttmacher Institute
125 Maiden Lane
New York, NY 10038 USA
Telephone: 212-248-1111; Fax: 212-248-1951
E-mail: info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036 USA

www.guttmacher.org

©2008 Guttmacher Institute, a not-for-profit corporation advancing sexual and reproductive health worldwide through research, policy analysis and public education. All rights, including translation into other languages, reserved under the Universal Copyright Convention, the Berne Convention for the Protection of Literary and Artistic Works and the Inter- and Pan American Copyright Conventions (Mexico City and Buenos Aires). Rights to translate information contained in this report may be waived.

English translation of *Asegurar un mañana más saludable en Centroamérica: proteger la salud sexual y reproductiva de la juventud de hoy*, ISBN: 978-1-934387-00-9.

Local communications partners:

Asociación Guatemalteca de Mujeres Médicas (AGMM)
6ta. Calle 1-36 Zona 10
Apartamentos Valsari
7mo. Nivel Oficina 702
Ciudad de Guatemala, Guatemala.
Telefax: +502 2362 2437
E-mail: agmmgua@gmail.com

Centro de Derechos de Mujeres
Colonia Lara Norte
Ave. Manuel José Arce
Calle Lara N. 834
Apartado Postal 4562
Tegucigalpa, Honduras
Telefax: +504 221 0459/ 0657
E-mail: cdm@derechosdelamujer.org

Federación Red NicaSalud
Km. 4 ½ Carretera a Masaya
de La cocina de Doña Haydee 1/2 c. abajo. Casa No.29
Managua, Nicaragua
Teléfono: +505 270 0099
Fax: +505 277 0855.
E-mail: nsalud@nicasalud.org.ni

Puntos de Encuentro
Rotonda Plaza España 4 c. abajo 1 c. al lago
Apartado Postal RP-39
Managua, Nicaragua
Teléfono: +505 268 1227
Fax: +505 266 6305
E-mail: puntos@puntos.org.ni

Table of Contents

Executive Summary	2
Chapter 1: Introduction	4
Chapter 2: The Context of Young People’s Lives	10
Chapter 3: Sexual Relationships and Unions	13
Chapter 4: Early Pregnancy and Childbearing	23
Chapter 5: Preventing Unintended Pregnancy	33
Chapter 6: Central American Youth and STIs, Including HIV	40
Chapter 7: Policies and Programs for Youth	47
Chapter 8: Conclusions and Recommendations	51
References	55
Appendix Tables	62

Executive Summary

Protecting the sexual and reproductive health of today's Central American youth is urgent. El Salvador, Guatemala, Honduras and Nicaragua have the highest rates of adolescent childbearing in all of Latin America. Moreover, current HIV prevalence has surpassed the 1% threshold for a generalized epidemic in Honduras and is nearing that magnitude in El Salvador and Guatemala. Preserving young people's health is not only important for youth themselves; it is also a vital development priority. This report, based on recent national surveys, presents key patterns and trends in the sexual and reproductive behavior of 15–24-year-olds in these four countries, and identifies important gaps and needs.

Traditional gender norms undermine young people's sexual and reproductive health

In a cultural climate where sexual activity is frowned on for single women but permitted, or even encouraged, for single men, reported levels of young people's sexual activity differ broadly by gender.

- High proportions of 20–24-year-olds (58–67% of women and 79–92% of men) first have intercourse before they turn 20. The bulk of current sexual activity takes place within union for young women, but outside of union for young men.
- Overall, men engage in riskier sexual behaviors than women: One-quarter to two-fifths of sexually active young men have had at least two sexual partners in the last year, compared with negligible proportions of women.

Early unions before 20 have declined

Early unions remain common for women in the subregion, but young women have begun postponing their first unions in all four countries. No comparable uniform trend has emerged in the postponement of first sex.

- Currently, 45–60% of 20–24-year-old women enter into a union as an adolescent, and this proportion is consistently higher among less educated, poorer and rural women.
- Solid majorities (roughly three-quarters) of unions in three of the four countries are consensual rather than legal. Guatemala, where less than half (47%) of all unions are consensual, is the exception.

The timing of first births has barely changed

Although adolescent fertility rates have fallen recently in all four countries, current levels far exceed the average for Latin America as a whole. The declines that have occurred reflect women having fewer second births during adolescence, rather than women postponing a first birth until age 20 or older. Possible reasons for why the timing of first births has not appreciably changed include the lack of employment opportunities for women with higher levels of education and traditional norms that continue to support early childbearing.

- Two-fifths to one-half of women have their first child as a teenager; these proportions are far higher among rural, poorer and less educated women.
- A substantial proportion of adolescent births are unplanned (from one-third in Guatemala to nearly one-half in Honduras), and those proportions represent increases from just a few years ago in all four countries, with the largest increase having occurred in Nicaragua.
- Most sexually active single women want to avoid pregnancy. In addition, many young women in union want to delay pregnancy, especially once they have already become mothers (i.e., 83–92% of those in union who have already had one child vs. 32–68% of those who have not).

The level of unmet need for modern contraceptives is very high

The high proportions of births that are unplanned demonstrate that young women are not necessarily acting on their stated preference to delay a first birth or space later births.

- The proportion of sexually active women currently using a modern method is highest in Nicaragua (55%) and lowest in Guatemala (25%). Use of the injectable and the pill predominate young women's modern method use in these countries. Reliance on each is roughly equal in Nicaragua and Honduras, but use of the injectable is 3–5 times higher than that of the pill in El Salvador and Guatemala.
- Nonetheless, one-third to one-half of sexually active young women have an unmet need for modern contraception, a level that is appreciably higher among single than married women, and is usually higher among adolescents compared with 20–24-year-olds.

Young people need more information to adequately protect themselves from STIs, including HIV

- Honduras has the highest HIV prevalence among 15–24-year-olds in these countries (1.8%) and Nicaragua, the lowest (0.2%). However, the perception of being at risk was exactly the opposite, at least among men (i.e., lowest in Honduras at 16% and highest in Nicaragua at 56%). About one-quarter of women in each country believe they are at risk.
- In all four countries, low proportions of youth spontaneously mentioned abstinence as a way of avoiding infection (4–22%) and somewhat higher proportions cited limiting the number of sexual partners (17–54%). Some 49–68% of men cited using a condom, but fewer than one-third of women in El Salvador and Guatemala gave this response.
- Relatively low proportions—only 11–26% of single sexually active young women and 43–66% of similar men—used a condom the last time they had sex. Considering the elevated risk for infection linked to multiple sexual partnerships, the finding that just 40–55% of men with two or more sexual partners in the past year had recently used a condom indicates that these youth are inadequately protected.

Evidence suggests several steps toward helping youth safeguard their future

- *Make reproductive health services more accessible, especially to youth who need them most.* Strengthen services overall through broad-based efforts to increase resources, expand infrastructure and promote greater acceptance among adults of young people's need for information and services. Affordable, youth-friendly services can better reach those young people who avoid seeking care because they cannot afford services or fear judgmental treatment. Integrate STI and family planning services to optimize use of limited resources. Provide family planning counseling, and increase access to a wide a range of methods, especially condoms, to help young people successfully prevent unintended pregnancy and infection.
- *Implement comprehensive sex education and promote gender equity.* Both young women and men need information and skills if they are to delay sexual debut, resist pressure to have sex and engage in safer sex. Support teacher training, target adolescents early and help young people stay in school for as long as possible. Develop alternative strategies to provide sex education to young people who are no longer in school.
- *Prioritize youth needs and harmonize conflicting provisions across policies.* Provide resources and political support to ensure the implementation of new and existing laws, regulations and policies that enable young people to safeguard their health. Coordinate the administration of programs and services to avoid inefficient duplication of effort among the responsible ministries and departments.

Chapter 1: Introduction

Central American youth, like young people everywhere, encounter myriad challenges to their sexual and reproductive health as they initiate sexual activity, form unions and start their families. Young people's responses to the risks they face can have lifelong repercussions for them, their families and, ultimately, the well-being of the societies in which they live.¹

Sexual and reproductive health risks and negative outcomes—specifically unintended pregnancy and sexually transmitted infections (STIs), including HIV—can generally be avoided if youth have and are able to act on accurate information and obtain needed services. Helping young people preserve their sexual and reproductive health requires strong societal and governmental commitments to preventive action. Certain risk factors, such as widespread gender inequality and sexual violence, call for highly targeted interventions.

Responding to sexually active young people's needs for health information and services is a formidable task, given the pervasiveness of cultural taboos surrounding sexuality and the resulting resistance to addressing those needs. The task is made even harder by the sheer numbers involved: Although the proportion of the overall Central American^{*A} population that is made up of 15–24-year-olds^{*B} has been relatively stable over the past decade (roughly one-fifth), high fertility in the recent past has caused the number of young people to grow by 2.2 million (from 5.7 million to 7.9 million) between 1990 and 2005.²

The chapters that follow provide an updated profile and analysis of the sexual and reproductive behavior of 15–24-year-olds in four Central American countries with comparable and recent national data: El Salvador, Guatemala, Honduras and Nicaragua. The young people in these countries were born primarily in the troubled decade of the 1980s, when a large part of the region was at war; as such, they embody a special legacy of hope for a less conflicted society. Theirs is also one of the first generations to be born when overall fertility is declining; they thus will have to deal with a relatively larger older population than did previous generations.

The time is especially ripe for action, since governments and other stakeholders are increasingly recognizing the importance of helping young people attain more education, acquire the skills needed for work, and protect their sexual and reproductive health. Young people in the four study countries, which are among the poorest in Latin America, encounter the typical stresses inherent in managing their transition to adulthood, such as the pressure involved in leaving school and looking for work. However, resources are often inadequate to fully support their wide-ranging needs. This report examines young people's sexual and reproductive behaviors and related needs for information and services, many of which are far from being met.

^A The geographic region of Central America consists of the following seven countries: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.

^B Definitions of the age-range of adolescents and young people vary across organizations and studies. In this report, we refer to those aged 15–24 as young people or youth, and to the subgroup of 15–19-year-olds as adolescents.

Young people face two distinct risks

Young people's level of health risk related to their sexual behavior depends on many factors, including when they initiate sexual activity, whether it takes place within a socially recognized union,^c whether sex is wanted, whether they are monogamous or have multiple partners, and whether they use protection to prevent unintended outcomes. These factors put some young men and women at risk for becoming parents before they are ready and for contracting STIs, including HIV.

These four Central American countries have the highest rates of adolescent childbearing in Latin America, and much of the burden of such pregnancies falls on young women. For most young Central American women, becoming pregnant while still in school means an end to their education.

A sizable proportion of first pregnancies among adolescents in this region are unintended.³ Abortion is severely legally restricted and highly stigmatized in these countries, yet some young women will nonetheless risk severe social and legal punishment to resolve an unintended pregnancy through clandestine abortion. In doing so they also put their physical health at risk, given the high rates of complications that are linked to clandestine abortion.⁴

As of 2005, Central American countries also had the highest rates of HIV infection in Latin America.⁵ HIV has now become a generalized epidemic (defined as infecting at least 1% of the population) in Honduras, where the adult prevalence is 1.5%, and it is nearing that threshold in Guatemala and El Salvador (0.9% in each).⁶ There are very scarce data on the prevalence of other STIs among today's Central American youth, not because such infections are not occurring, but because good measurement systems are not in place.

New evidence can guide efforts to lower risk

The four contiguous nations (Figure 1.1) covered in this report account for just over 80% of Central America's population, and the target population of 15–24-year-olds totals roughly 6.6 million.⁷ (Belize, Costa Rica and Panama are omitted from the report for reasons of data unavailability.) To help guide decisions about where resources may be most effectively invested to address young people's needs, this report presents evidence on the current state of their sexual and reproductive health, along with data on the direction and pace of recent change in key measures. Evidence from recent national reproductive health surveys of both men and women allows for comparisons across the four countries and by gender (for more information on data sources, see data box). Important differences exist within countries by where youth live and by their level of education, ethnicity, and union and economic status; given space and data limitations, we address such key variations when relevant and feasible.

Guide to the report

The following chapters provide a portrait of young people's transition to adulthood in El Salvador, Guatemala, Honduras and Nicaragua. Chapter 2 describes the overall context of young people's lives in the four focus countries; Chapter 3 paints a picture of young people's

^c In this report, "union" and "marriage" are used interchangeably to mean both consensual union (i.e., cohabiting) and formal marriage.

sexual activity and unions; and Chapter 4 discusses how they begin their families. Young people's fertility preferences and their use of contraceptives to achieve their reproductive goals are discussed in Chapter 5, while Chapter 6 assesses young people's exposure to the risk of HIV and their understanding of the virus. Chapter 7 focuses on the policy climate that shapes young people's access to sexual and reproductive health information and services. The final chapter discusses the implications of the overall findings and offers recommendations to help policymakers, program managers and other stakeholders improve the sexual and reproductive health of Central American youth.

Figure 1.1 Map of Central America



Data Sources

National Surveys

The main data analyzed in this report come from nationally representative surveys. The data collection efforts in Nicaragua, and in Honduras in 2005–2006, were part of the Demographic and Health Surveys program (with technical assistance from Macro International), whereas the surveys conducted in El Salvador, Guatemala and Honduras in 2001 were carried out as part of the Reproductive Health Surveys program (with technical assistance from the Centers for Disease Control and Prevention). The programs collect similar information on sexual and reproductive behaviors, and the information is broadly comparable across countries and survey types. The report analyzes data from the following surveys.

- El Salvador: 2002–2003 Encuesta Nacional de Salud Familiar (FESAL).¹
- Guatemala: 2002 Encuesta Nacional de Salud Materno Infantil (ENSMI)² and the 2002 Encuesta Nacional de Salud Masculina (ENSM).³
- Honduras: 2001 Encuesta Nacional de Epidemiología y Salud Familiar (ENESF) and the 2001 Encuesta Nacional de Salud Masculina (ENSM).⁴ Although a more recent survey, the Encuesta Nacional de Demografía y Salud (ENDESA)⁵ was conducted in 2005–2006, the women’s data files only became available toward the end of the preparation of this report and, as of this writing, the data for men have yet to be released for public use. Therefore, we present updated data where the indicators apply to women only, and comment in the report on important changes that occurred between the two surveys. However, for

indicators that directly compare men and women, we use the 2001 survey (same year and questionnaire) to assure comparability.

- Nicaragua: Data on women come from the 2001 Encuesta Nicaragüense de Demografía y Salud (ENDESA),⁶ and because no men were interviewed in 2001, data on men come from the next most recent national survey, the 1998 ENDESA.⁷ However, because these surveys used different approaches to gathering data on spontaneous knowledge of HIV prevention, we use data on this measure from the single earlier survey conducted in 1998 for both women and men to ensure that the gender comparisons are valid.

The samples of 15–24-year-olds were 3,753–8,352 for women and 414–1,179 for men, and they were large enough in all surveys to allow comparisons by area of residence, educational attainment, socioeconomic status and, for Guatemala, ethnicity. All data presented in the report are weighted; unweighted numbers of respondents are presented in Appendix Table 2.

Respondents could be single, formally married or in consensual unions. Women in legal and consensual unions have similar fertility preferences and levels of exposure to pregnancy; thus they are grouped together in the analyses.

In-depth Interviews

In addition to survey data, this report draws on qualitative information on youth policies in three of the four focus countries (Guatemala, Honduras and Nicaragua). Research partners in each country conducted in-depth individual interviews and meetings with representatives from government ministries, nongovernmental

organizations and international cooperation agencies in each country. A total of 33 individual interviews and three group meetings were conducted between May and July of 2006.

Limitations

Instances where the questionnaires for the nine individual surveys differed in the wording of specific questions, the flow and skip patterns of the questions, or the inclusion of particular questions constrain data comparability across countries and genders. These instances are mentioned in the text or in notes to the tables wherever applicable. Moreover, since this report draws on an earlier research project, some of the data breakdowns are unavailable for El Salvador, the one country that was not part of that initial undertaking.

Further, because of space and sample-size constraints, we often need to collapse adolescents and young adults into a single age-group of 15–24, although we present important differences between 20–24-year-olds and adolescents whenever possible. To examine trends over time, we compare the behaviors of current 20–24-year-olds with those of 40–44-year-olds; a limitation of this approach is that reports, especially those of older women, may be subject to recall bias. We also do not know how social desirability bias in self-reports of sensitive data on sexual activity—which men tend to exaggerate, and women to underreport—may have changed over time.

In addition, because samples of men were much smaller than those of women in all four countries, some indicators for men are based on relatively small numbers of cases, which may affect the precision of the estimates. We recommend that results based on 26–49 respondents (unweighted numbers;

indicated in appendix tables) be interpreted with caution; when the number of cases is 25 or less, no data are presented.

References

1. Asociación Demográfica Salvadoreña (ADS), *Encuesta Nacional de Salud Familiar, FESAL 2002/03*, San Salvador, El Salvador: ADS; and Atlanta, GA, USA: Centers for Disease Control and Prevention (CDC), 2004.
2. Ministerio de Salud Pública y Asistencia Social (MSPAS) et al., *Encuesta Nacional de Salud Materno Infantil, 2002*, Guatemala City, Guatemala: MSPAS, 2003.
3. MSPAS et al., *Encuesta Nacional de Salud Masculina, 2002*, Guatemala City, Guatemala: MSPAS, 2003.
4. Secretaría de Salud and Asociación Hondureña de Planificación de Familia (ASHONPLAFA), *Encuesta Nacional de Epidemiología y Salud Familiar, ENESF 2001; Encuesta Nacional de Salud Masculina, ENSM 2001*, Tegucigalpa, Honduras: ASHONPLAFA; and Atlanta, GA, USA: CDC, 2002.
5. Secretaría de Salud, Instituto Nacional de Estadística (INE) and Macro International, *Encuesta Nacional de Demografía y Salud, ENDESA 2005–2006*, Tegucigalpa, Honduras: Secretaría de Salud and INE; and Calverton, MD, USA: Macro International, 2006.
6. Instituto Nacional de Estadísticas y Censos (INEC) and Ministerio de Salud, *Encuesta Nicaragüense de Demografía y Salud, 2001*, Managua, Nicaragua: INEC; and Calverton, MD, USA: ORC Macro, 2002.
7. INEC and Ministerio de Salud, *Encuesta Nicaragüense de Demografía y Salud, 1998*, Managua, Nicaragua: INEC; and Calverton, MD, USA: Macro International, 1999.

Chapter 2: The Context of Young Peoples' Lives

The cultural, social and economic context in which youth live shapes every facet of their development, including their sexual and reproductive behavior. Despite the notable diversity across El Salvador, Guatemala, Nicaragua and Honduras in terms of population size and ethnic make-up,^{*D} these countries nonetheless share broad socioeconomic traits. Each of the four is characterized by a struggling economy, a severely inequitable distribution of wealth and, for all but Honduras, a recent and lengthy period of civil unrest and political violence. They also share a legacy of the Catholic Church wielding enormous influence over sexual and reproductive issues, especially among the political and economic elites (although Evangelical Protestants are growing in number and political power in the Guatemalan population, especially among the very poor).

All four countries are deeply impoverished

Poverty, which affects every facet of young people's health and access to services, is endemic throughout these four countries: The percentages of the overall population living in poverty—those who are unable to afford basic food, goods and services—range from 46% in El Salvador and Nicaragua to 56% in Guatemala and 72% in Honduras (see Appendix Table 1).⁸ These data include the proportions living in abject or extreme poverty, which is defined as being too poor to afford food alone; the level of abject poverty reaches 53% in Honduras and ranges from 15% to 20% in the other three countries.⁹(Table 2.2) These national levels obscure the far greater rates of poverty in rural than in urban areas.⁹ In the highly urbanized context of Latin America and the Caribbean, where just 23% of the population lives in rural areas,² these Central American countries stand out for having much higher proportions still living in rural areas (53–54% in Guatemala and Honduras and 40–42% in Nicaragua and El Salvador).⁸

In the four study countries, rates of unemployment are at least two times higher among 15–24-year-olds than among adults aged 25 and older.¹⁰(Table 1) Severe economic difficulties have, in large part, driven the phenomenon of migration, both within countries (i.e., from rural to urban areas) and to other countries. Migrants are typically young men and women (e.g., 42% of male Nicaraguan migrants are aged 15–24¹¹), with women predominating in rural to urban population movements. Migration can facilitate the spread of HIV, as population mobility tends to foster social isolation, which can lead to high-risk sex with sex workers; when migrant men return home, either temporarily or permanently, some serve as a bridge for the virus to expand into the general population.¹²

Other than domestic work and *maquila* assembly jobs, few employment opportunities are available to young women. This is likely due to the combination of weak economies and widespread cultural expectations of early marriage and motherhood at the expense of young women's further education and employment. The recent explosion of tourism in the region has increased poor young women's susceptibility to commercial sexual exploitation.¹³

^D Guatemala's population is roughly twice that of each of the other three and is the only country with a large indigenous (predominantly Mayan) minority, which accounts for 41% of the total population (sources: reference 7 and Instituto Nacional de Estadística [INE], *XI Censo Nacional de Población y VI de Habitación 2002*, Guatemala City, Guatemala, INE, 2003).

Moreover, although almost identical proportions of both 15–24-year-old men and women currently are students, and higher proportions of men work, the proportion who neither study nor work in these four countries is 3–5 times higher among women than men.⁸ These women (33–51% of all women in the four countries, proportions that exceed the regional average of 30%) likely include those who are not in school or the workforce because they have already married and are raising a family.

Educational levels have started to improve but remain low

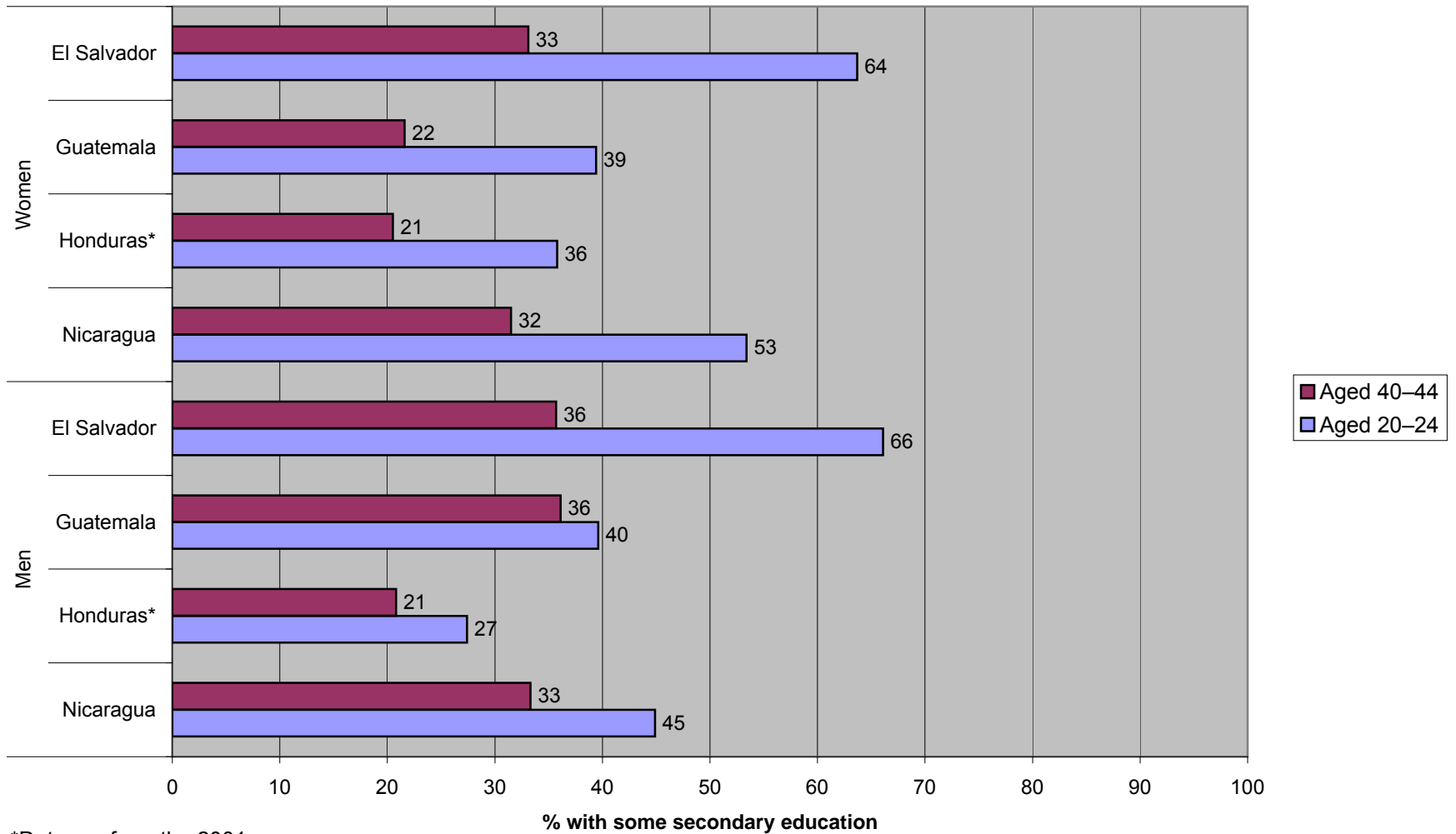
Throughout the developing world, higher levels of education are consistently associated with lower fertility, delayed union formation and higher socioeconomic status. The good news is that the clearest route to improving young women’s preparation for the modern world—education—is undeniably showing progress: Except for El Salvador, where both sexes experienced roughly equal gains in education, levels of women’s educational attainment rose more than those of men over the past two decades (Figure 2.1).⁸ As a result, young women aged 20–24 in Guatemala and El Salvador are now about as well-educated as young men; in Honduras and Nicaragua, they are even better educated than young men. For example, the proportion of women aged 20–24 who have had some secondary schooling now ranges from 39% in Guatemala to 64% in El Salvador, which represents considerable gains compared with levels among women who went to school roughly a generation ago (22–33% among those currently aged 40–44).⁸ Improvements in women’s education over time were greatest in El Salvador (31 percentage points) and smallest in Honduras (15 percentage points).

Despite this progress, however, overall educational levels are still distressingly low: Setting aside El Salvador (where two-thirds of 20–24-year-old men and women have had some secondary schooling), just one-quarter of young men in Honduras to one-half of young women in Nicaragua have attained some secondary education. And while the all-important educational attainment of young people is improving in the aggregate, national averages mask far poorer progress among disadvantaged subgroups.

Youth in rural areas and indigenous youth fare much worse than their urban and nonindigenous counterparts. For these young people, myriad cultural, socioeconomic and structural barriers prevent them from getting the schooling they need. For example, despite *de jure* guarantees of free primary schooling, the reality is that one or more of a variety of fees and expenses—for tuition, registration, transportation, uniforms, textbooks and supplies, school meals and school construction¹⁴—have resulted in “*de facto* poverty-based exclusion from school” in all four countries.¹⁵

Furthermore, scarcity of schools and teachers in rural areas, lack of transportation infrastructure, high rates of grade repetition (which lead to high dropout rates), poor quality of instruction, and students’ need to join the workforce or help out at home all contribute to preventing these countries from meeting the Millennium Development Goal of universal primary education. Indeed, of the total of 18 Latin American countries examined in a 2005 study, El Salvador, Guatemala, Honduras and Nicaragua have the lowest projected primary-school completion rates for 2015: An estimated one-fifth to one-third of 15–19-year-olds will likely not finish primary school that year.¹⁶

Figure 2.1 Women have experienced larger recent gains in education than men in Guatemala, Honduras and Nicaragua.



Note *Data are from the 2001 survey.

Source Reference 8.

Chapter 3: Sexual Relationships and Unions

The timing of sexual initiation and entry into union helps determine young people's needs for information and services, and data on such topics are integral to designing effective programs and policies. For example, age at first sex directly affects young people's length of exposure to the risk of unintended pregnancy and STIs, including HIV. Moreover, for young women, the length of time separating when they first become sexually active and when they marry is closely related to their risks of unintended pregnancy and all its potential social and health consequences, including the possibility of unsafe abortion.

Stigma and social taboos play a large role in determining young people's level of risk. Given prevailing cultural expectations and norms that proscribe nonmarital sexual activity, especially among women, and that reproductive health services are largely unavailable or inhospitable to single young people, whether early sexual activity occurs within or outside of union is important. Furthermore, prevailing gender norms that promote vastly different behaviors for men and women mean that the specific risks they face also differ. Throughout Latin America—and Central America is no exception—early sexual activity outside of marriage is accepted, or even encouraged, for men, but such activity is condemned for women.¹⁷

Indeed, many young men are pressured or encouraged by their peers and male relatives to have sex at an early age to demonstrate their masculinity and heterosexuality.^{18,19} Other risky behaviors, such as having multiple partners, are also seen as proof of masculinity.^{18,20,21} Young women, on the other hand, are encouraged to marry at a young age and stay chaste until then, even as they are often pressured by their partners to have sex. These conflicting pressures can trap young women into forgoing contraception when they do have sex to avoid having to admit—both to themselves and to others—that they are sexually active.

Many Central Americans initiate sex at a young age

The initiation of sexual activity, an intrinsic part of human development, begins in adolescence for most people and is almost universal by the time youth reach their early twenties. Throughout Central America, men are considerably younger than women when they begin sexual activity, according to young people's own reports. The median age at first sex for men aged 20–24 in the four study countries ranges from 15.8 years in Nicaragua to 16.9 years in Guatemala (for all survey data presented in this chapter, see Appendix Table 2).²² Women tend to initiate sex about two or three years later: Their median age at first sex falls between 18.1 in Nicaragua and 19.0 in Guatemala.

Among 20–24-year-olds, the proportion who first had sex before age 15 is 11–14% among women and 27–35% among men.²² Roughly the same gender differential characterizes first sex before age 18 (41–49% of women vs. 63–80% of men) and before age 20 (58–67% vs. 79–92%). Nicaraguan youth of both sexes—but males especially—generally initiate sex sooner than youth in the other three countries, and the gender differential in age at first sex is also largest in this country.

Interesting gender differences emerge in the timing of sexual initiation within subgroups. Because rural women marry earlier than urban women, far higher proportions of rural than urban women in all countries but El Salvador have initiated sex as an adolescent (a differential of 13–19 percentage points).^{23–26} The opposite is usually true among young men: Those in rural areas tend to start having sex later than those in urban areas (a differential of 10–14 percentage points). The exception is Nicaragua, where men uniformly begin sexual activity early, regardless of where they live.²⁶ Moreover, in Guatemala, the gender differences in early sex disappear among indigenous (predominantly Mayan) youth, since, compared with their nonindigenous counterparts, indigenous males are less likely, and indigenous females more likely, to initiate sex at an early age.²⁴

One should note that the prevailing cultural climate of machismo and *marianismo* (feminine chastity ideals) likely reinforces expected reporting bias whereby males tend to overreport, and females underreport, their sexual experience.²⁷ Moreover, the extent to which this bias may vary between countries, or over time for the trends examined here, is unknown.

Contrary to the widespread opinion that young people are becoming sexually active sooner than they did in the past, slightly *lower* proportions of current 20–24-year-olds than 40–44-year-olds first had sex when they were adolescents in most study countries (Figure 3.1).²² This pattern is most consistent in El Salvador, where decreases over time of at least five percentage points among both men and women in the proportions who first had sex before each age (15, 18 and 20) suggest that a trend toward later sexual debut may be starting to take hold in that country. Although we cannot say for sure, these declines in early sexual debut are likely related to the especially large gains in education in that country.

Not all early sex occurs within union, especially among young men

Youth who are currently sexually active (those who are in union plus those who are single and have had intercourse in the past three months) are the population most clearly in need of information and services.^{*E} Among men, the proportion who are sexually active is consistently higher in Nicaragua than in the other three countries—44% vs. 23–30% among 15–19-year-olds and 86% vs. 64–70% among 20–24-year-olds.²² In Honduras and El Salvador, the proportions of women and men who are sexually active are roughly the same, but in Nicaragua, the proportion who are sexually active as adolescents and young adults is higher among men than among women.

Among those aged 15–24 in all four countries, higher proportions of young women than young men are currently married (34–40% vs. 17–25%, Figure 3.2).²² The opposite pattern holds true for 15–24-year-olds who are sexually active and single: Far higher proportions of men (22–37%) than of women (2–10%) are single and have had sex in the past three months. Thus, most current sexual activity occurs within union among women, but the opposite is true among men (Figure 3.3). To take Guatemala as an example, although similar proportions of all males and females are currently sexually active (roughly two-fifths), among sexually active

^E The need for information and services is likely acute among the youngest sexually active adolescents, but available survey data used a minimum eligibility age of 15, so we are unable to present any information on current sexual activity among those aged 14 and younger.

women, the vast majority—95%—are in a union and just 5% are single, whereas among sexually active men, just 46% are in a union and 54% are single.

Adolescent premarital sex—the proportion of 20–24-year-olds who had had sex before marriage during adolescence—is far more common among men than women, and it is highest among Nicaraguan men (83% vs. 74–76% among men in the other countries) and among Salvadoran women (30% vs. 18–21%).²² Comparing the adolescent experiences of older adults (currently aged 40–44) with those of 20–24-year-olds shows some change over time, though in opposite directions according to gender: Moderate declines in early premarital sex appear to have occurred among young men in three of the four focus countries (El Salvador, Honduras and Nicaragua). Among young women, however, small increases occurred over time in the proportion who had had premarital adolescent sex (from 13–25% to 18–30%). Today's young women might be more willing than those who were adolescents a few decades ago to report this behavior, and the positive trend toward later marriage, discussed later in this chapter, might also play a role by lengthening the period in which young women are exposed to the possibility of premarital sex.

In accordance with prevailing norms that expect women, but not men, to be chaste until marriage, far higher proportions of sexually experienced women (from 27% in El Salvador to 64% in Guatemala) than of similar men (2–9%) first had sex with their spouse.²² Instead, men are more likely to report that their first sexual partner was a girlfriend (52–54% in Guatemala and Honduras) or a friend or acquaintance (48% in El Salvador; comparable data were not collected in Nicaragua). Very few Central American young men (1–9%) said their first sexual experience was with a sex worker.

Gender inequities pose challenges to young women's health and well-being

For a high proportion of young women—ranging from one-third in Guatemala to one-half in Honduras—their first sexual partner was at least five years older than they were.²² Such age discrepancies often reinforce gendered power imbalances that make it difficult for young women to refuse unwanted sex and negotiate condom or contraceptive use. In fact, a World Health Organization study that included two Latin American countries (Brazil and Peru) found that the younger a woman was at first sex, the more likely that her first experience was forced.²⁸ The situation is likely similar in the Central American subregion.

Although we lack data on the extent to which young women's first sexual experiences were forced and by whom, 6–13% of all 15–24-year-old women in the three countries with data report having ever been sexually abused.²² Given the shame and fear associated with sexual abuse, and that face-to-face interviews in general surveys not specifically designed to address this topic are poor vehicles for collecting such sensitive information, the data most probably underestimate the true occurrence of nonconsensual acts.

About half of all women enter a union during adolescence

Worldwide, early entry into marriage is closely associated with unequal gender roles, lower educational attainment and lower socioeconomic status for women.^{29–33} Further, women who enter into very early marriages (defined in the source cited here as occurring before age 18) are likely to be substantially younger than their husbands, and such large age differences are

known to severely limit wives' autonomy.³¹ Conversely, better-educated and urban women tend to marry later; they also have smaller families. The situation in El Salvador, Guatemala, Honduras and Nicaragua is no different.

The proportion of women aged 20–24 who entered into union before their 20th birthday ranges from 45% in El Salvador to 60% in Nicaragua (Figure 3.4²²; for a discussion of each type of marriage and its implications, see union box). The proportion in Nicaragua is especially high for a Latin American country. Indeed, that country has the highest proportion of young women in union before age 18 in all of Latin America (i.e., 43%; for context, the world's highest rate, 77%, is in Niger).³⁴

The national proportions of women who form a union before age 20, however, mask especially wide variations by level of educational attainment and rural or urban residence. In the four study countries, proportions are consistently higher among those with fewer than seven years of schooling than among those with at least some secondary education (65–79% vs. 26–43%) and among those in rural areas compared with urban areas (51–73% vs. 40–53%).²² Men enter into union during adolescence at roughly half the rate of women (i.e., just 21–39% were in union before age 20). Even so, adolescent unions among men are more common in Central America than in other parts of Latin America and in Africa.²⁹

Encouragingly, consistently lower proportions of today's 20–24-year-old women entered into union during adolescence than did women who are currently 40–44 years old, a finding that likely reflects today's higher secondary school attendance rates. The decline in early marriage over time was greatest in Guatemala (15 percentage points) and smallest in Honduras (six percentage points; Figure 3.4).²²

No consistent pattern over time emerges among men, however; only in El Salvador was there a decline (from 27% to 21%). There was no change among Guatemalan and Honduran men, and the rate of male adolescent unions in Nicaragua, which is the highest of all four countries, unexpectedly increased over time (from 29% to 39%).

In theory, the encouraging trend toward delayed marriage among women should be associated with their attaining more schooling and being better educated when they do marry, all of which should better equip them to realize their reproductive aspirations.²⁹ However, if the services young single people need continue to be highly unavailable or inaccessible, any lengthening of the period between first sex and first union could actually increase the likelihood that adolescents will engage in unprotected sex, thereby increasing their risk of STIs, unintended pregnancies and unsafe abortion. Although all sexually active young people, in union or single, need to protect their sexual and reproductive health, organized reproductive health services are geared mainly toward adult married women, and the fear and shame many single adolescents feel can keep them from obtaining needed care, if they even know where to go for care. Moreover, many young people tend to view health facilities as irrelevant to their needs³⁵ and may require education before they consider them as sources of support, counseling and preventive care.

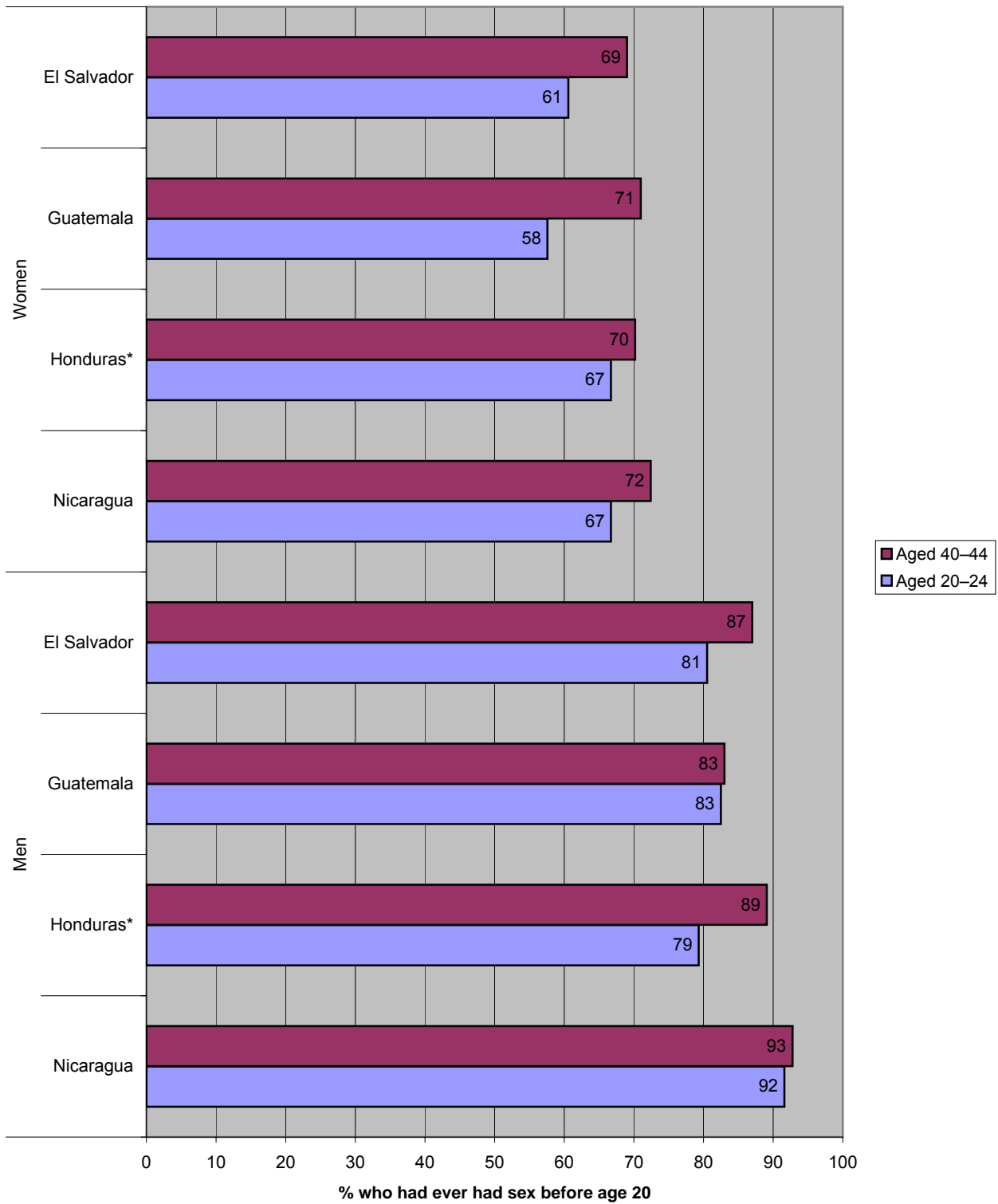
Young men engage in riskier sexual behaviors than do young women

In Central America, many young people are sexually active for several years before they enter into union. For women, the period between first intercourse and first union is fairly short, so

they are at risk of a nonmarital pregnancy for about six months in Nicaragua to two years in El Salvador.²² The story is quite different for men, who, compared with women, not only become sexually active at a younger age, but also enter into union at a later age. The gap between men's first sexual experience and their entry into union stretches from five years (in Nicaragua) to seven years (in El Salvador).

Men are also more likely than women to have multiple partners, a behavior that can further increase the risk to their sexual health. For the three countries with available data (these data were not collected in Nicaragua), one-quarter of sexually active young men in Guatemala, one-third in El Salvador and two-fifths in Honduras have had two or more sexual partners in the past 12 months. The proportions among women—available for Nicaragua and Honduras only—are a negligible 1%. Although a social reporting bias is likely operating here (in which men exaggerate, and women hide, their sexual activity),²⁷ the size and cross-country similarity of the gender gap suggest that there are real gender differences, even if they may be somewhat narrower than reported.

Figure 3.1 Large majorities of men and women have sex during adolescence, but the proportion who do so has started to decline.



Note *Data are from the 2001 survey.
Source Reference 22.

Figure 3.2 Far larger proportions of young women than of young men are currently in union.

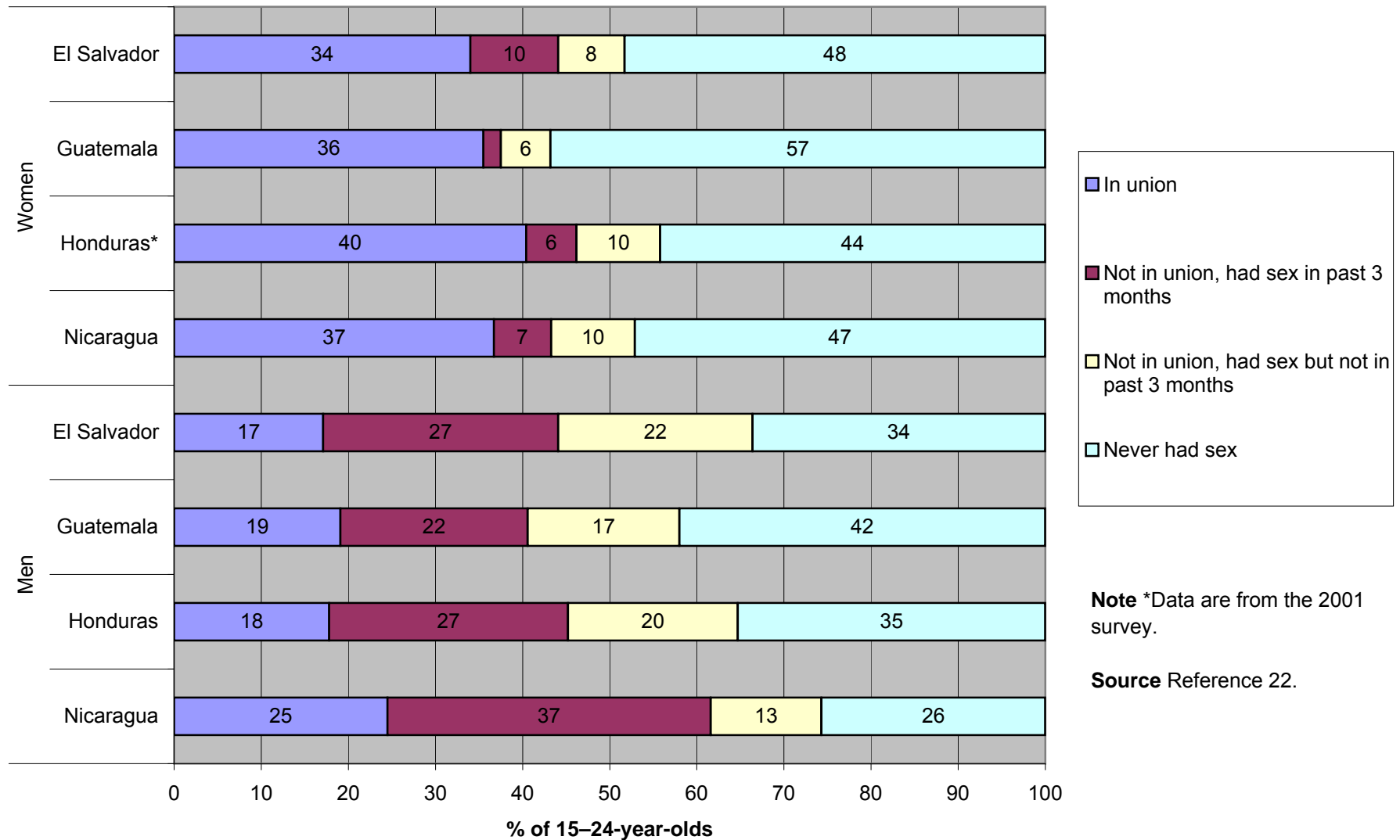
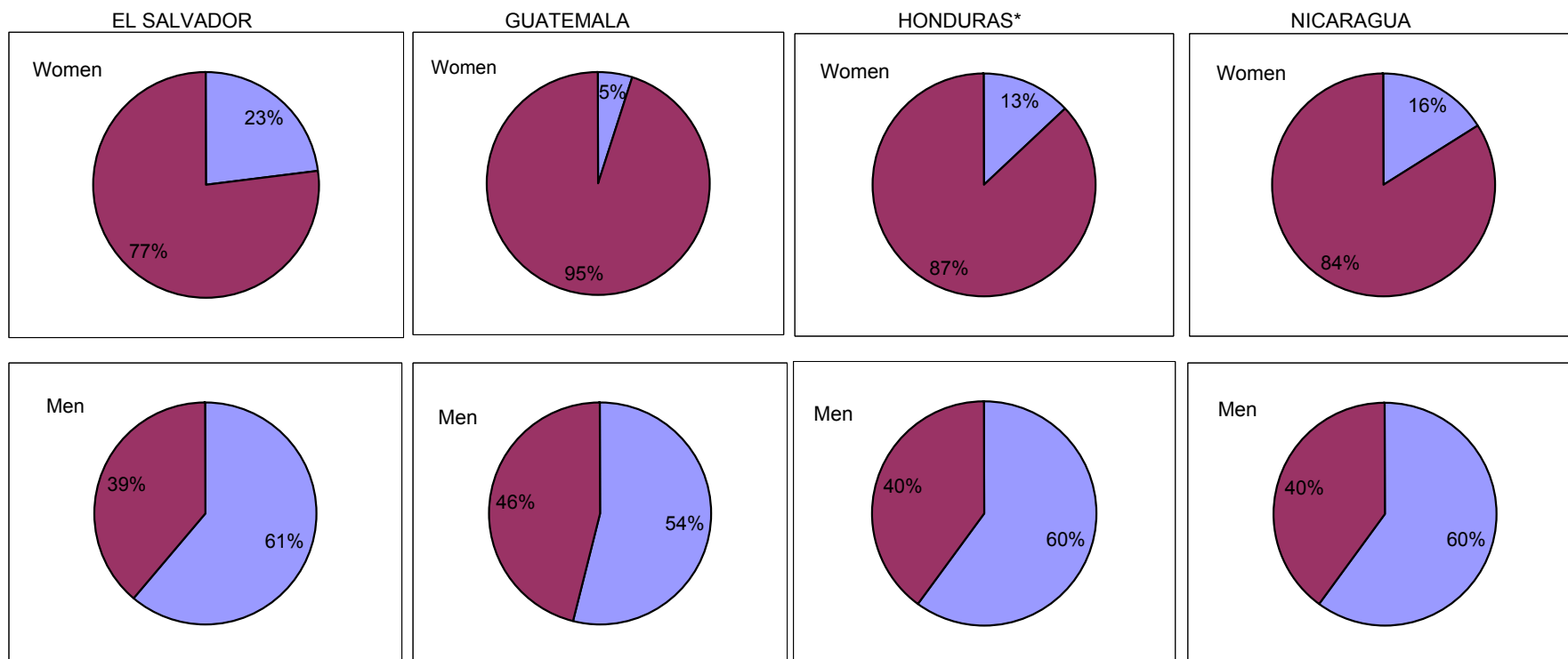


Figure 3.3 The overwhelming majority of sexually active young women are in union, whereas the majority of sexually active young men are single.

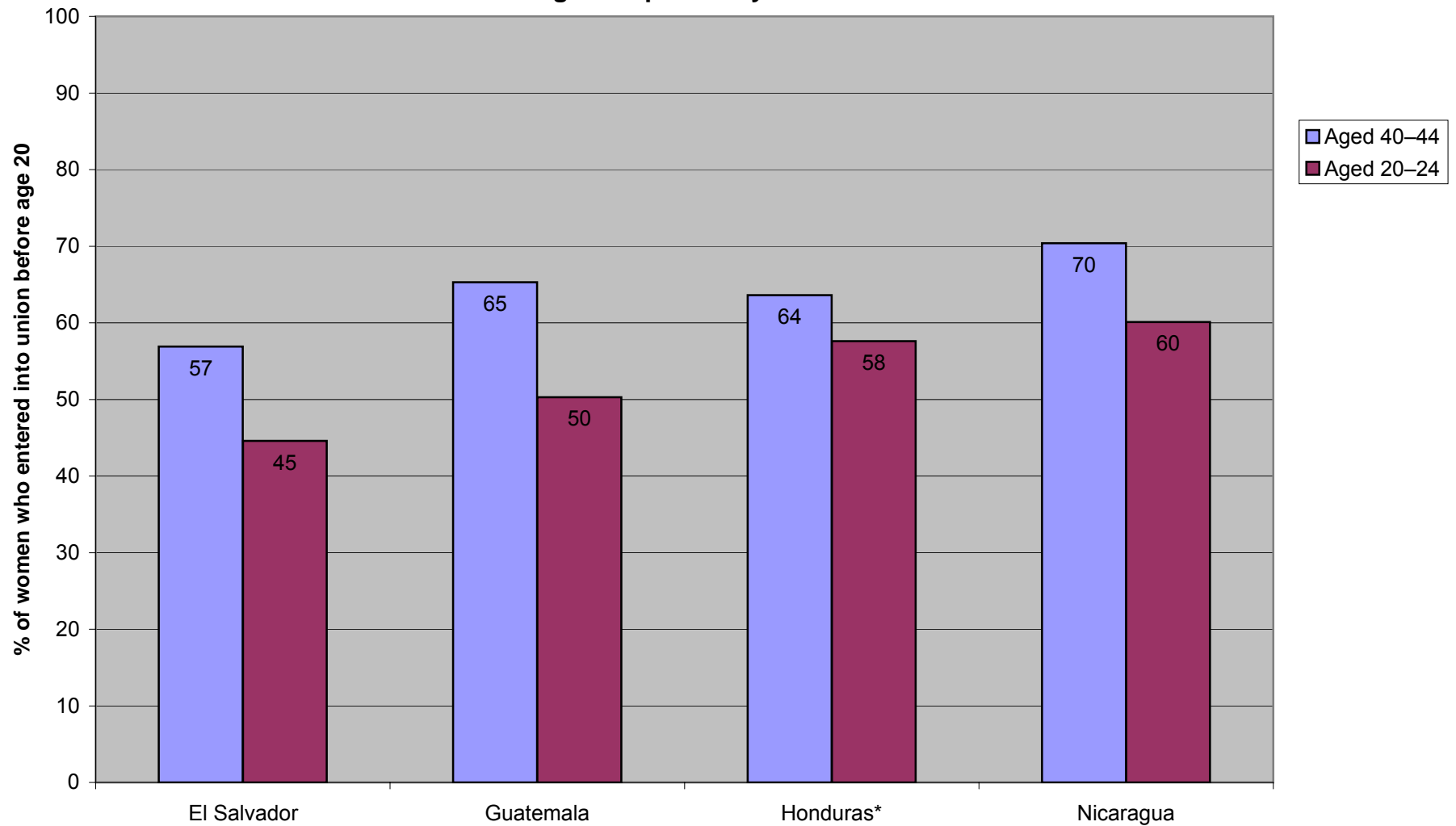


■ Single
■ In union

Note *Data are from the 2001 survey.

Source Reference 22.

Figure 3.4 Marriage during adolescence has declined among women in all four countries, although comparatively less in Honduras.



Note *Data are from the 2001 survey.

Source Reference 22.

Types of Unions

Consensual unions predominate over legal unions in much of the region

Among young people in union in three of the four countries examined here, solid majorities are in consensual unions (69–79%), rather than in formal marriages (22–31%).¹ The exception is Guatemala, where slight majorities of 15–24-year-old men and women are formally married. Because consensual unions lack formal starting points in terms of ceremonies or legal marriage contracts, survey data connected to the date of first unions should be interpreted with caution.

Although there are no major differences between them in terms of whether the relationship, and the resulting children, are recognized as legitimate, the two union types nonetheless have important differences. Research has documented that consensual unions tend to carry less prestige than formal marriages and are more prevalent among less educated and poorer women.^{2,3} They are commonly characterized by less male responsibility in providing for the children and household, and informal unions are often associated with low levels of female autonomy.

In addition, consensual unions are known to be less stable than formal unions, and thus they are more likely to lead to female-headed and impoverished households. On the other hand, given the high rates of male migration, consensual unions can mean that women have the freedom to form new cohabiting relationships when male partners are absent for long periods.

Consensual unions' greater instability, at least in Nicaragua and Honduras, is apparent in the nationally representative

survey samples used in this report: Even at this relatively young age (15–24), the proportion who are *currently* in union is roughly one-fifth lower than the proportion who have *ever* been in union in those two countries.¹ By contrast, there seems to be much less union dissolution in Guatemala, where formal marriages predominate over informal ones among 15–24-year-olds (the proportion of those who are currently in union is just 8% lower than the proportion who have even been in union).

References

1. Appendix Table 2.
2. Parrado EA and Tienda M, Women's roles and family formation in Venezuela: new forms of consensual unions? *Social Biology*, 1997, 44(1–2):1–24.
3. Castro Martín T, Matrimonios sin papeles en Centroamérica: persistencia de un sistema dual de nupcialidad, 2007, <<http://www.ccp.ucr.ac.cr/~icamacho/probl emas/castro.doc>>, accessed Dec. 4, 2007.

Chapter 4: Early Pregnancy and Childbearing

Early childbearing can be accompanied by a number of potentially adverse consequences. In Guatemala, for example, giving birth during adolescence is significantly associated with prolonged and entrenched poverty among women who are already poor and with higher completed fertility.³⁶ Giving birth during adolescence is also linked with lower educational attainment, as young women are often unable to finish school once they become pregnant or have a child. Furthermore, the health consequences of giving birth can be substantial for the very youngest adolescents, whose bodies have not yet matured physically.³⁷

In spite of these consequences, having a child soon after marriage and during adolescence is a commonly accepted societal norm in the four study countries. For many women, especially the poorest, the decision to have a baby during adolescence comes after they are already out of school and partly results from cultural expectations and pressures, along with the absence of educational and employment opportunities. Many adolescents know no other option and long to have a child to please a partner, gain status by fulfilling the coveted role of motherhood or escape an untenable situation in their childhood home.³⁸

Yet despite the general acceptance and support for early motherhood, many young women become pregnant before they want to be. For married adolescent women, it is usually the second birth that is reported as unplanned (i.e., either mistimed or unwanted). For single adolescent women, unintended pregnancy is especially problematic, given the uncertainty of support from the father, and young women's limited opportunities to continue school and find work once they become mothers.

Central America has the highest adolescent fertility rates in Latin America

We focus here on childbearing among adolescents, as opposed to 20–24-year-olds, because the repercussions of early motherhood are concentrated among this younger group.³² However, it is notable that 59–64% of all women aged 20–24 have had a child in these four countries.^{39–42} Births to 15–19-year-olds account for one-fifth of all births in Guatemala and Honduras, and for roughly one-fourth in Nicaragua and El Salvador (for all survey data presented in this chapter, see Appendix Table 3).⁴³ According to national data, each year there are 102–119 births for every 1,000 women aged 15–19 in these four countries (Table 4.1).^{39–42} These adolescent fertility rates far exceed the Latin American regional average for 2000–2005 of 80 per 1,000, and instead approach the average for Africa (116 per 1,000).²

An important, positive trend is that adolescent fertility rates have been declining over the past 15 years. The annual declines, which average 1–1.5%, started in the late 1980s and continued midway into the first decade of the 2000s (Table 4.1). However, because of high fertility in the recent past, there are simply more adolescent women in the population now, so the annual numbers of births to adolescents have either not changed (e.g., a constant of 34,000–35,000 in Nicaragua⁴⁴) or have even increased (e.g., from 57,000 to 72,000 in Guatemala⁴⁵).

However, despite the declines in the number of children born to adolescents, the timing of first births—i.e., the proportion of women who have their first birth during adolescence—has not changed much over the past few decades. For example, in El Salvador, Guatemala and

Honduras, roughly the same proportion of women now aged 20–24 as those aged 40–44 had had their first child before their 18th birthday (one-quarter), and there was also little change in the proportion doing so before they turned 20 in El Salvador and Honduras (nearly one-half in both cohorts; Figure 4.1).^{23,46–48} The timing of first births changed somewhat more in Nicaragua (where the proportion who first gave birth during adolescence fell by eight percentage points over the past two decades) and in Guatemala (where the proportion fell by five percentage points).

The fact that adolescent fertility has declined while the proportion of women who have their first birth during adolescence has stagnated is largely explained by a decline in the proportion of women having *second* births during their adolescent years. Comparing data on the distribution of 15–19-year-olds by their number of children shows how the proportion with two children has fallen over time. In the case of El Salvador, for example, whereas 21% of married 15–19-year-olds in 1985 had had two children,⁴⁹ the comparable proportion in 2002–2003 was 12%.⁴⁰ Similarly, in Honduras, 17% of married 15–19-year-olds interviewed in 1996 had had two children,⁵⁰ compared with 9% of those interviewed in 2005–2006.⁴² (Although it would be better to cite data from an even earlier survey, comparable Honduran data are unavailable for the mid-1980s.)

Why are early first births still so prevalent in Central America, especially considering the important trends toward greater urbanization and educational attainment? Part of the answer lies in persistent, even deepening, poverty and the still strong traditional norms that endorse early unions and expect childbearing to follow soon after. Young women may be marrying somewhat later, but they are likely having their first birth very closely afterward. Additional possible explanations include the absence of viable alternatives to motherhood such as employment and higher education, and that our measure of schooling captures a relatively low educational level (just any secondary schooling). The explanation for why the timing of adolescents' first birth has changed so little definitely warrants further study.

The proportion of women who are adolescent mothers is invariably higher in rural than urban areas, as the former generally have more entrenched traditional gender roles that lower the opportunity costs of being an adolescent mother. Whereas 49–62% of rural women gave birth before age 20 in these four countries, the comparable proportions among urban women are 35–40%.⁴³ Similarly, the proportion giving birth as an adolescent falls as the young woman's socioeconomic status rises (i.e., 60–68% of young women in the lowest socioeconomic bracket give birth before age 20, compared with 25–32% in the highest bracket; Figure 4.2).

Educational attainment creates an equally wide gulf in the proportions of women giving birth as adolescents: Among young women who have had some secondary schooling, just 22–29% had their first birth before age 20, compared with 58–70% of those who had less schooling.⁴³ As has been demonstrated in other parts of the developing world,²⁹ as women make further strides in their schooling and the number of better-educated women in the overall population grows, these Central American countries will also likely see increases at the national level in the proportion of women who delay both marriage and childbearing. It is intriguing, however, that recent improvements in education seem to have had such little impact on the timing of first births. In Guatemala and El Salvador, for example, nearly

identical proportions of better educated women (i.e., those with at least seven years of schooling) give birth before age 20 today as did so two decades ago (i.e., 28–29% of better educated women aged 20–24 and 40–44 in El Salvador²³ had an adolescent first birth, as did 22–23% of similar women in Guatemala⁴⁶).

Use of maternal and infant health services is uneven

Whatever the mother's age, adequate birthspacing and prenatal care are crucial to ensuring healthy mothers and babies. Currently, the intervals separating first and second births in each of the study countries fall short of the World Health Organization (WHO) recommendation that women wait at least 24 months before attempting another pregnancy (which translates into intervals of about 36 months between live births).⁵¹ Second births follow first births by intervals that range from national averages of 26 months in Guatemala to 31 months in Honduras and El Salvador,⁴³ and are likely to be even shorter among women who are disadvantaged by their ethnicity, educational attainment or socioeconomic status.

Although prenatal and delivery coverage have undoubtedly improved as a result of efforts to address unacceptable maternal mortality ratios in the recent past, both maternal and infant mortality are still stubbornly high, especially among disadvantaged subgroups of women who live far from services or whose cultural background makes them more likely to want to give birth at home with traditional birth attendants. For example, the maternal mortality ratio among Guatemalan indigenous women is three times higher than that among nonindigenous Guatemalan women.⁵²

For all four focus countries, rates of receipt of any professional prenatal care for 15–24-year-olds now stand at 68–87%.⁴³ (We lack a more meaningful measure of whether these women made the recommended number of *professional* prenatal care visits, which is usually a minimum of four or five, as specified by the ministries of health in these countries.³) However, prenatal care coverage is disturbingly lower among some subgroups of young women, such as indigenous women in Guatemala (54%).⁴⁵ Moreover, young Guatemalan women are even less likely to have a medically assisted delivery than to receive professional prenatal care: Just 52% of all young Guatemalan mothers have a medical professional deliver their baby, even though 71% receive some professional prenatal care. The rate of professionally attended deliveries reaches three-quarters in the remaining three countries.⁴³

Many births to adolescents and young women are unplanned

From one-third (Guatemala) to one-half (Honduras) of adolescent births in the past five years were characterized by the mother as either mistimed (meaning they were wanted but had come too soon) or as unwanted.⁴³ Rates of unplanned births were only slightly lower among young women in the combined age-group of 15–24.

Such unplanned early childbearing appears to have increased sharply over the past few years, especially in Nicaragua. As recently as 1998 in that country, for example, 26% of live births to adolescents in the five years preceding the survey were unplanned;⁴⁴ by 2001, that proportion reached 45%.⁴³ Smaller upward trends emerged in El Salvador (increase of one-quarter, from 34% in 1998⁵³ to 43% in 2003),⁴³ in Guatemala (increase of one-fifth, from 24% in

1995 to 29% in 2002–2003⁴⁵) and in Honduras (increase of one-fifth, from 40% in 2001 to 47% in 2005–2006⁴³).

The rate of unplanned adolescent childbearing, a measure that relates the proportion of births that were unplanned to age-specific fertility rates, offers another perspective. The rate of unplanned adolescent births increased most in Nicaragua (from 34 per 1,000 15–19-year-old women in 1998⁵⁴ to 54 in 2001⁴⁷); it rose moderately in El Salvador^{23,55} and slightly in Guatemala;^{46,56} but that rate actually dropped in Honduras (because the decline in the adolescent fertility rate overtook the decline in the proportion of adolescent births that were unplanned).^{48,57} In sum, current rates indicate that the numbers of unplanned births each year to adolescents in these countries—from 33 per 1,000 in Guatemala to 54 in Nicaragua—continue to be unacceptably high.

The high proportions and rates of unplanned births suggest that young women are not succeeding in delaying a first birth or postponing a second one. Indeed, when 15–24-year-olds, both in union and single, are asked about their current desires to have a child, substantial majorities of women in every country (78–89%) say they do not want to have a child for at least two years.⁴³ In keeping with a climate of machismo—in which men are encouraged to prove their virility by fathering children and women bear the brunt of the opportunity costs of childbearing—the proportion of men who want to postpone births is much lower (i.e., 50% in Honduras and 69–83% in the other three countries).

As suggested by the overall finding that second births to young women have started to change but not so much the timing of first births (except in Nicaragua), the desire to postpone a second child is generally much stronger than the desire to delay a first child.⁴³ This is especially true in El Salvador, where just 32% of Salvadoran women in union want to postpone a first birth, but 83% of those who have already had one child do not want another one soon; in the other three countries, 62–68% want to postpone a first birth and 88–92% want to delay a second one (Figure 4.3). These findings are consistent with overall cultural patterns of early unions and social pressure to conceive soon afterward.

Relatively few adolescents have a child outside of union

Although giving birth as an adolescent outside of union remains rare in the region, in at least one country—El Salvador—nearly one-tenth of young women aged 20–24 had a child as an adolescent before entering a union. In the remaining three countries, just 4–5% of 20–24-year-old women have done so.⁴³ Evidence suggests that premarital conceptions often precipitate unions: Roughly one-tenth of first births to 15–24-year-old women in all four countries occur fewer than seven months after forming a union.

However, when marriage is not an option, the occurrence of such unintended pregnancies can be problematic, given the legal climate of severe, if not total, restrictions on abortion in these countries. The law in Honduras, Nicaragua and El Salvador prohibits all induced abortions, even those to save the life of the pregnant woman;⁵⁸ in theory, Guatemala's penal code allows therapeutic abortions when the woman's life is in danger,⁵⁹ but in practice very few legal abortions are performed there.

Although we lack region-specific data on the incidence and safety of young women's abortions, we do know that, overall, young women are more likely than older women to have

procedures that result in complications,⁶⁰ both because younger women are less able to afford a trained provider and because they tend to delay the procedure until later in the pregnancy.^{37,61,62} Moreover, the fear of disclosure leads greater proportions of younger than older women to forgo treatment for complications, which further jeopardizes their health.⁶³

Despite the dangers, many single young women likely obtain an unsafe abortion as a last resort. (Married women also resort to clandestine abortions in this setting, although at far lower rates.⁶⁰) WHO estimates for the Latin American and Caribbean region as a whole suggest that 43% of all abortions in the region are obtained by women aged 15–24.⁶⁴ The estimated rate among 20–24-year-olds, 43 abortions per 1,000 women, is higher than the rate among all other age-groups, including that among adolescents (20 per 1,000). These rates are far higher than those in many countries that have legalized the procedure⁶⁵ and point to the need for high-quality postabortion care to limit the harm to young women caused by unsafe clandestine abortions.

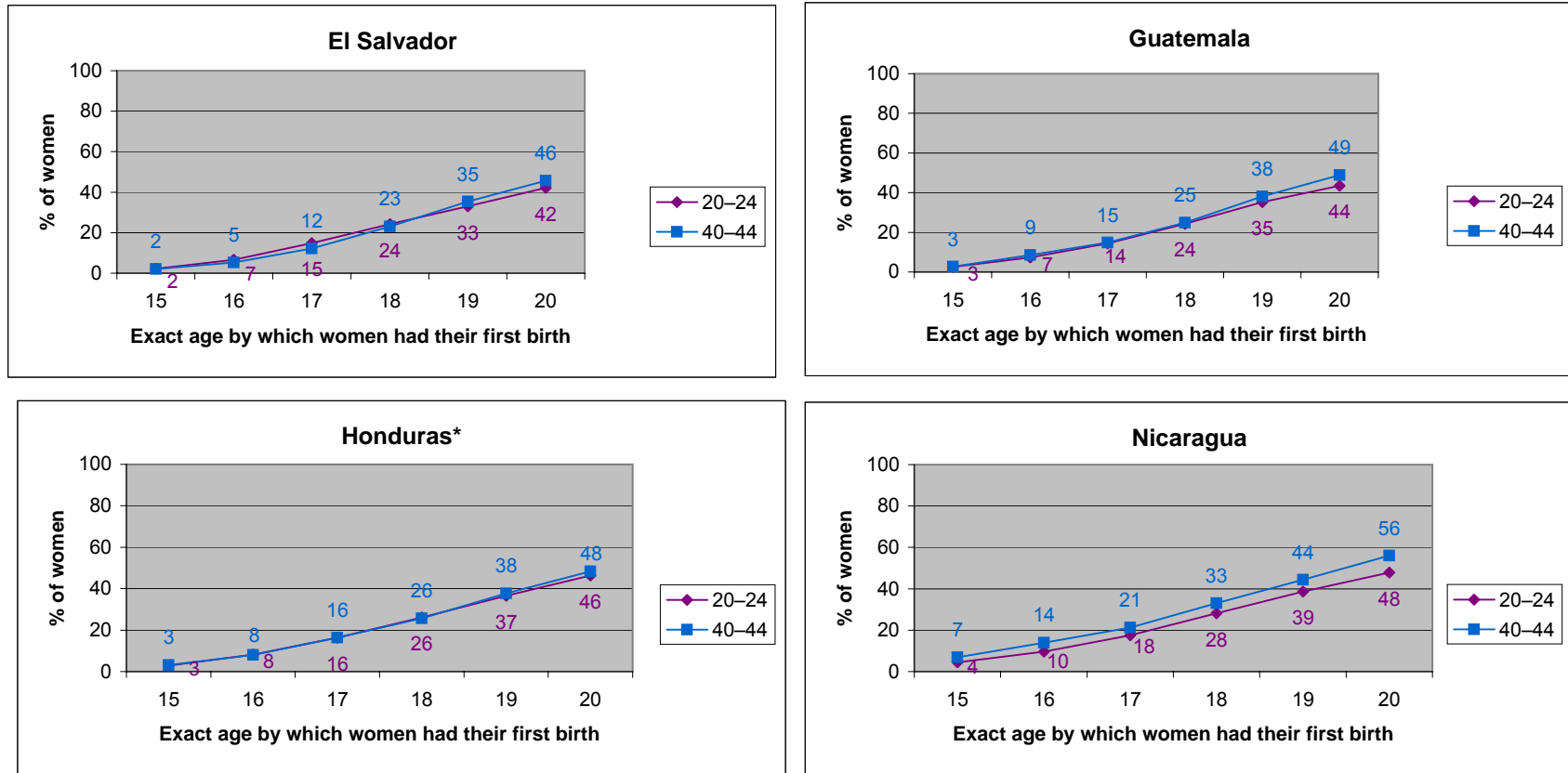
According to a recent study that used indirect estimation techniques to assess the incidence of abortion in Guatemala, abortions appear to be especially unsafe in that country: Nearly three-fifths (59%) of the estimated 65,000 induced abortions in 2003 are thought to have led to complications serious enough to warrant hospitalization.⁶⁶ Guatemala's 2003 abortion rate, which was partially estimated on the basis of that complication rate, was 24 per 1,000 women of reproductive age (15–49 years).⁶⁷

Table 4.1 Annual number of births per 1,000 women aged 15–19, and annual percentage decline, by country, according to time period

Country	Late 1980s	Mid-1990s	Late 1990s	Early 2000s	Average annual % decline, late 1980s–early 2000s	Average annual % decline, mid-1990s–early 2000s
El Salvador	125	124	116	104	1.12	1.70
Guatemala	139	126	117	114	1.20	1.36
Honduras	132	136	137	102	1.52	2.63
Nicaragua	149	158	130	119	1.34	2.90

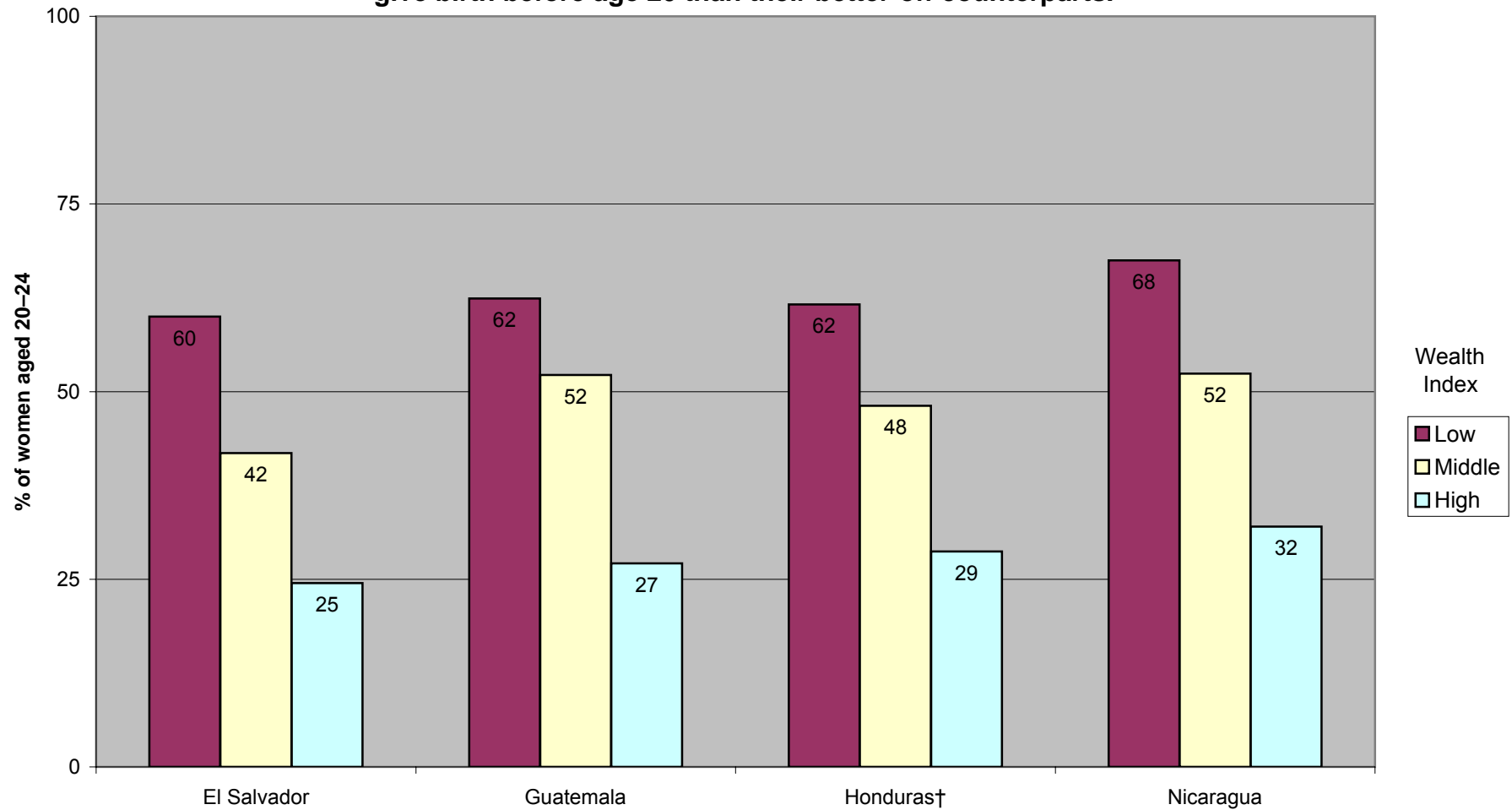
Sources **El Salvador**—2002–2003 FESAL (Table 4.1); **Guatemala**—1987 ENSMI, 1995 ENSMI, 1998/99 ENSMI and 2002 ENSMI; **Honduras**—1991/92 ENESF, 1996 ENESF, 2001 ENESF and 2005–2006 ENDESA; and **Nicaragua**—1992/93 ESF, 1998 ENDESA and 2001 ENDESA.

Figure 4.1 In three of the four countries, the proportion of women who become mothers at each successive age during adolescence has barely changed over the past few decades.



Note *Data are from the 2005–2006 survey.
Sources References 23, 46-48.

Figure 4.2 Women in the low socioeconomic status bracket* are more than twice as likely to give birth before age 20 than their better-off counterparts.

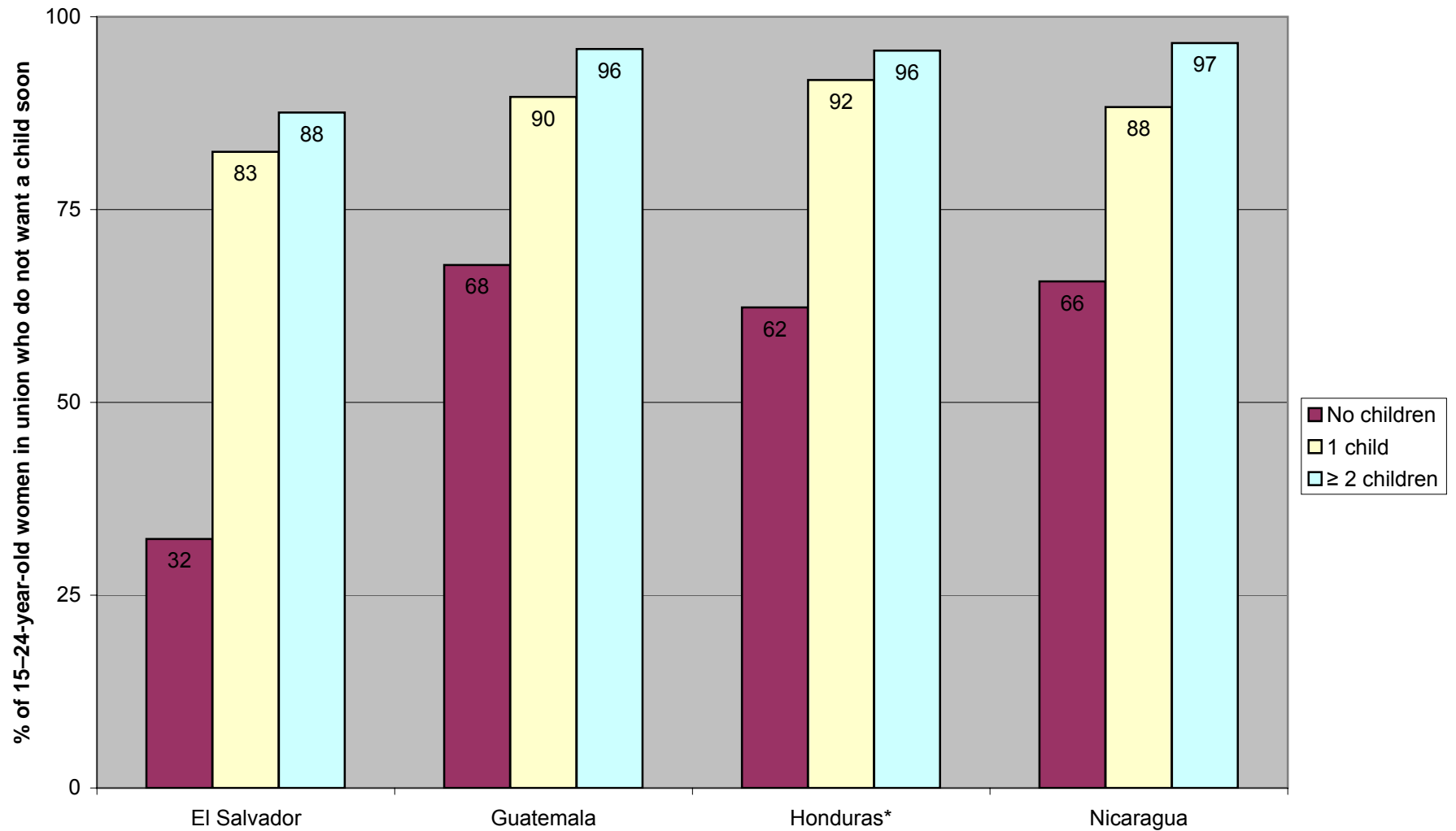


Note *Socioeconomic status is based on an index of goods, services and household characteristics.

†Data are from the 2005–2006 survey.

Source Reference 43.

Figure 4.3 At least 80% of married young women want to delay their next birth once they have a child.



Note *Data are from the 2005–2006 survey.

Source Reference 43.

Updated Data from Honduras

Young Honduran women have made recent strides

Some important positive changes, especially in adolescent sexual activity, contraceptive behavior and childbearing, occurred over the short period separating the two most recent reproductive health surveys conducted in Honduras—the 2001 Encuesta Nacional de Epidemiología y Salud Familiar¹ and the 2005–2006 Encuesta Nacional de Demografía y Salud.² Because of the yet unresolved initial concern about the quality of the latest fertility data, we are unable to say whether all of the change in fertility is real, but the changes in other measures are likely reliable. We comment here on some changes that are robust—i.e., they are relatively large for the short period between surveys and are not likely to result from differences in the questionnaires or reporting quality.

First, the proportion of 15–19-year-old women who had ever had sex fell nearly seven percentage points from 2001 to 2005–2006. Moreover, because there was no change in the proportion of single adolescents who were sexually active, the drop in the proportion currently in a legal or consensual union was entirely responsible for the fall in the total currently sexually active.

Modern method use rose by nearly one-third among sexually active single 15–24-year-old women (from 30% to 39%). Gains in use among married women and among all sexually active women were somewhat smaller in magnitude (roughly six percentage-point differences for each, an increase of 16% over the period between the surveys).

Most of the promising uptake in use is due to increased reliance on the injectable. For

example, injectable use nearly doubled among married 15–19-year-olds, from 13% to 22%, and it also rose among married 20–24-year-olds, from 17% to 22%. The rise in the use of effective modern methods seems to have had tangible effects on adolescent childbearing: The proportion of 15–19-year-olds who had ever had a child dropped six percentage points in the handful of years between the surveys, and the proportion with two or more children also fell.

Nonetheless, more needs to be done to help adolescents avoid becoming pregnant before they want to be. Although unmet need for a modern method decreased among married adolescents, it barely budged among single adolescents. This stagnation suggests that single adolescent women's desires to prevent pregnancy are outpacing their ability to obtain modern methods and calls out for more sustained efforts to help single adolescents overcome daunting social and logistical barriers to services.

References

1. Secretaría de Salud and Asociación Hondureña de Planificación de Familia (ASHONPLAFA), *Encuesta Nacional de Epidemiología y Salud Familiar, ENESF 2001; Encuesta Nacional de Salud Masculina, ENSM 2001*, Tegucigalpa, Honduras: ASHONPLAFA; and Atlanta, GA, USA: CDC, 2002.
2. Secretaría de Salud, Instituto Nacional de Estadística (INE) and Macro International, *Encuesta Nacional de Demografía y Salud, ENDESA 2005–2006*, Tegucigalpa, Honduras: Secretaría de Salud and INE; and Calverton, MD, USA: Macro International, 2006.

Chapter 5: Preventing Unintended Pregnancy

Given that so many young people say they want to postpone having a child, how many act on their stated preferences by practicing contraception? If they fail to do so, what are their primary reasons for exposing themselves to the risk of unintended pregnancy? Does education play a role by affecting motivation to prevent a pregnancy or birth and mediating access to and use of contraceptives? How much of a constraint is lack of availability and accessibility of contraceptive services and supplies in rural areas, and how important are other factors?

High levels of awareness do not mean high levels of use

It is encouraging that levels of awareness of modern contraceptive methods are extremely high among adolescents (the age-group for whom educational interventions are most feasible, given that they are likely still in school). Nearly all adolescents in Nicaragua and Honduras, and female adolescents in El Salvador,^{*F} know at least one modern contraceptive method^{G*} (for all survey data presented in this chapter, see Appendix Table 4).⁶⁸ The proportion who are familiar with a modern method, while still very high, is somewhat lower among Guatemalan adolescent men and women (90% and 85%, respectively).

Having heard of a modern method, however, does not necessarily mean that young people fully understand how methods work or how unprotected sexual activity can lead to pregnancy. Indeed, nearly one-third of ever-pregnant 15–24-year-olds in El Salvador (29%), Guatemala (33%) and Honduras (28%) did not believe they could become pregnant the first time they did so.³

The picture of actual use is quite different from that of knowledge. Among young adults in union, there is little difference in modern method use by gender, which suggests that both men and women accurately report behavior at the couple level. With the exception of Guatemala, use of a modern method by married young people generally ranges from 36–41% in Honduras to 55–58% in Nicaragua.⁶⁸ In Guatemala, however, fewer than one-quarter of young adults in union use a modern method. This finding is partially explained by the exceptionally low prevalence among the country's large indigenous population (just 8–10% of indigenous 15–24-year-olds in union use a method).²⁴

Use varies widely by parity, since young women in these four countries are more likely to use a method to postpone a second birth (43–68%) than to delay a first one (9–33%).⁶⁸ Among the four study countries, contraceptive use among married young women who have not yet

^F Although Salvadoran males are probably at least as likely, if not more likely, than Salvadoran females to know of a modern method, the item assessing knowledge in the male questionnaire is so different as to render it noncomparable with the female questionnaire.

^G Modern methods refer to the pill, IUD, injectable, implant, male and female sterilization, vaginal methods (diaphragm, and spermicides in the form of vaginal tablets, foam or gel), the male condom and, in some surveys, the female condom and emergency contraceptive pills. Some surveys first asked for spontaneous knowledge and then prompted respondents' recognized knowledge; others asked only about recognized knowledge. Not all methods were specifically mentioned in each survey questionnaire. For example, of the nine individual questionnaires, only three (the 2001 Nicaraguan ENDESA and the Guatemalan 2002 female ENSMI and male ENSM) mentioned the female condom.

had a child is currently highest in Nicaragua, a fact that is consistent with that country's distinction of being the only one in which childbearing before age 20 decreased appreciably over time.⁴³

Possibly reflecting the social barriers unmarried women face in obtaining specialized family planning services, sexually active single women's use of an effective method is notably lower than that among married women (i.e., 30–38% vs. 41–58%, excluding Guatemala, which lacks a sample large enough for analysis). The situation for men is quite different and varies by country.

Although sexually active young men are more likely than similar women to be single, in general, almost the same proportions of single men as single women currently use a modern method. Only in El Salvador are single men much more likely than single women to be practicing modern contraception (50% vs. 32%).⁶⁸ Use of the condom specifically is another story, however, as single young men are more likely than single young women to have used that particular method the last time they had sex. (See Chapter 6 for detailed data on condom use at last sex, a different measure than current use.)

These national averages among both married and single youth obscure wide variations in prevalence by subgroup, as levels of modern method use are markedly lower among women who are disadvantaged by their lower socioeconomic status, lower educational attainment, indigenous ethnicity and residence in less developed, underserved rural areas. In Guatemala, for example, modern method prevalence among married young women is 38% in urban areas but only 19% in rural areas, while in Honduras, the 2001 rates were 50% and 35%, respectively.²⁵ The rural-urban differential in use in the overall higher-prevalence country of Nicaragua is smaller (just seven percentage points).²⁶

The method mix is often narrowly defined

The mix of modern methods used by young people varies according to country, and has implications for the continuity and efficacy of contraceptive use—important factors in preventing unintended pregnancy. The extent to which individual methods are used reflects a range of issues, among them the availability of specific methods in the national program, patterns of supply, funding specifications, providers' preferences, prevailing cultural beliefs (e.g., a tradition of trust in injectable medicines), and specific methods' qualities, such as being easy to conceal, which can be important in a social climate that often links women's contraceptive use to suspicions of infidelity or illicit behavior.

The injectable predominates in Guatemala, where the overall prevalence of modern methods is lower than in the other countries (Figure 5.1).^{23,46,47,57} Less effective traditional methods, primarily rhythm and withdrawal, are also commonly used in that country. Young women rely disproportionately on the injectable in El Salvador too, albeit at double the rate than in Guatemala (30% vs. 14%). By contrast, the method mix in Nicaragua and Honduras is more varied: Substantial and nearly equal proportions use the injectable and the pill, and a sizable minority use the IUD. In Honduras, use of the injectable rose considerably between 2001 and 2005–2006 (from 15%⁵⁷ to 20%;⁴⁸ see box on recent changes in contraceptive use in Honduras).

The methods young people use are also inextricably linked to the ease with which they can obtain them. In these countries, where the pill and the injectable are both available without a

doctor's prescription, and where youth often prefer the convenience and anonymity of pharmacies,⁶⁹ a large proportion of those currently practicing contraception get their methods from retail drugstores. The proportion of young people obtaining methods from such sources ranges from a consistent one-fifth of young women using a modern method to 35–62% of comparable men.*^{H68}

Unmet need for modern contraceptives is high, especially among single women

Given the relatively high levels of unplanned births in the subregion—from 27% of births to 15–24-year-old women in Guatemala to 49% in Honduras⁴³—current contraceptive practice is clearly not widespread enough to enable women to avoid pregnancies they do not want to have. The concept of unmet need*^I is a useful tool to gauge young peoples' need for contraceptive services to achieve their reproductive goals. As might be expected in countries where unmarried women are discouraged from using contraceptive services,⁷⁰ unmet need is invariably higher among single than married 15–24-year-old women (Figure 5.2).⁶⁸ Overall, among all sexually active young women, unmet need is highest in Guatemala (53%) and lowest in Nicaragua (31%).

The level of unmet need for a modern method is usually higher among adolescents than 20–24-year-olds, and it is especially elevated among single adolescent women in the three countries with available information (55% in Honduras and 64–66% in Nicaragua and El Salvador).⁶⁸ Although the levels of unmet need are lower among married adolescents (from 30–41% in these three countries to 50% in Guatemala), they are still relatively high and suggest that many married adolescents are at risk of becoming pregnant when they do not want to be.

Moreover, need is usually greatest among women whose low socioeconomic status makes reaching and obtaining services especially arduous. In Guatemala, for example, unmet need for a modern method among married 15–24-year-olds is as high as 64% among those in the lowest socioeconomic status, compared with 37% in the highest status group. In the other three countries, the differential by socioeconomic status is not as large.

Women face a wide range of barriers to use

Several cultural and personal barriers prevent young women from practicing contraception. In the three countries with comparable data, roughly three-quarters (67–83%) of sexually active young women who fail to practice contraception report primary reasons for doing so that suggest the need for better information and easier access (Figure 5.3).^{23,46,57} These include the reasons linked to low perceived risk of pregnancy (i.e., because they have sex too infrequently or are breast-feeding—even though exclusive breast-feeding, which is what confers contraceptive protection, is rarely practiced). They also encompass method-related reasons

^H The male survey items are not strictly comparable in that the questionnaires used in Nicaragua and El Salvador asked where men obtained just a single method—the condom—whereas the ones administered in Guatemala and Honduras asked about the source of any modern method.

^I Unmet need for effective contraception is defined here as the proportion of sexually active, fecund women who do not want a child for at least two years but who are not using a modern method of contraception.

that are amenable to intervention (i.e., lack of awareness about methods, unavailability, high cost, poor service, health concerns about side effects and inconvenience of use).

In terms of individual reasons (not shown in figure), the most commonly cited in two of the three countries (the exception is Guatemala⁴⁶) is having sex too infrequently to be at risk (given by 32–42% of 15–24-year-old women who had had sex in the past three months).^{*J23,57} This finding is unsurprising given young women’s reluctance to admit to sexual activity and their common, though mistaken, belief that sporadic sexual activity carries little risk of pregnancy.⁷¹

The frequency with which women gave inaccurate reasons in terms of their true risk for unintended pregnancy points to a need for better sex education to inform young women about the risk posed by each unprotected sexual encounter and about the limited protection conferred by nonexclusive breast-feeding. That so many women said they were not using a method because they had sex infrequently also suggests that emergency contraception, which is rarely used in the region,^{72,73} could reduce early unplanned pregnancy in these countries. Indeed, a study on attitudes toward emergency contraception conducted in Honduras found that young age (15–19) was significantly associated with willingness to use the method.⁷²

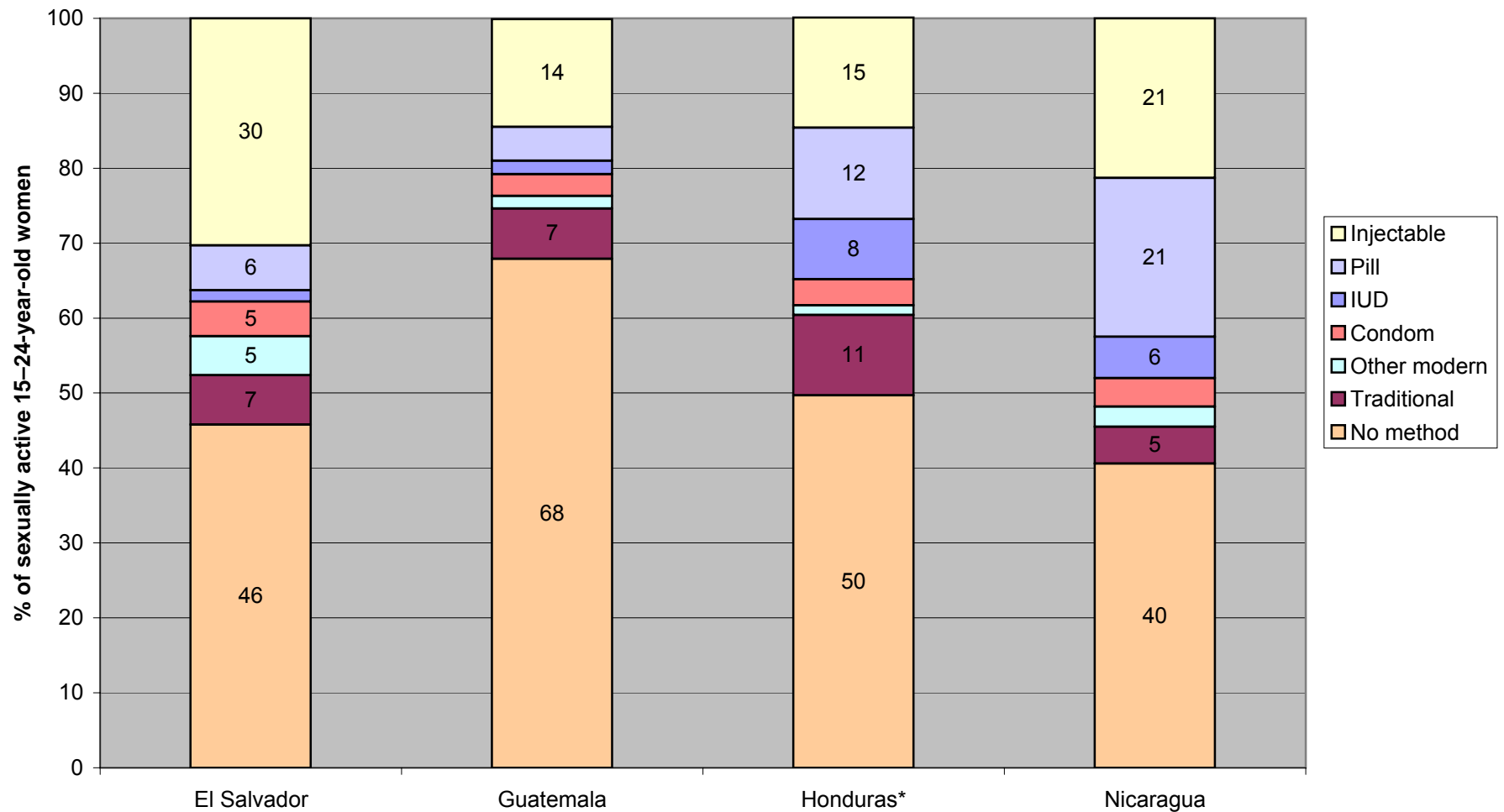
Roughly one-fifth of nonusers in all three countries cited as their primary reason for forgoing protection concerns that a method would harm their health.^{*K23,46,57} It is essential to provide young women with as wide a range of methods as possible, along with up-to-date factual information on each method’s potential side effects and follow-up counseling and services, so they can make informed decisions about protecting their health.

Being unaware of contraception itself was an important reason for not using a method only in Guatemala (one-fifth gave this primary reason).⁴⁶ This suggests that a basic information campaign to inform Guatemalan women about the range of methods available to them could substantially reduce unmet need, especially now that Guatemala has adopted a landmark law that guarantees universal, affordable access to family planning.⁷⁴

^J We present only data from the three Reproductive Health Surveys (RHS) whose questionnaires assessed women’s primary reason for nonuse (instead of all reasons, which allowed for multiple responses) to enable a percentage distribution of women by their stated primary reason. Nonetheless, the data from the two noncomparable Demographic and Health Surveys in the analysis (i.e., Nicaragua’s and Honduras’s 2005–2006 survey) confirm the broad results of the RHS surveys in which women most commonly cited having sex too infrequently as a reason for not using contraceptives.

^K Although this category also includes the method-related reason “inconvenient to use,” just a handful of women in any country cited inconvenience as their primary reason for nonuse.

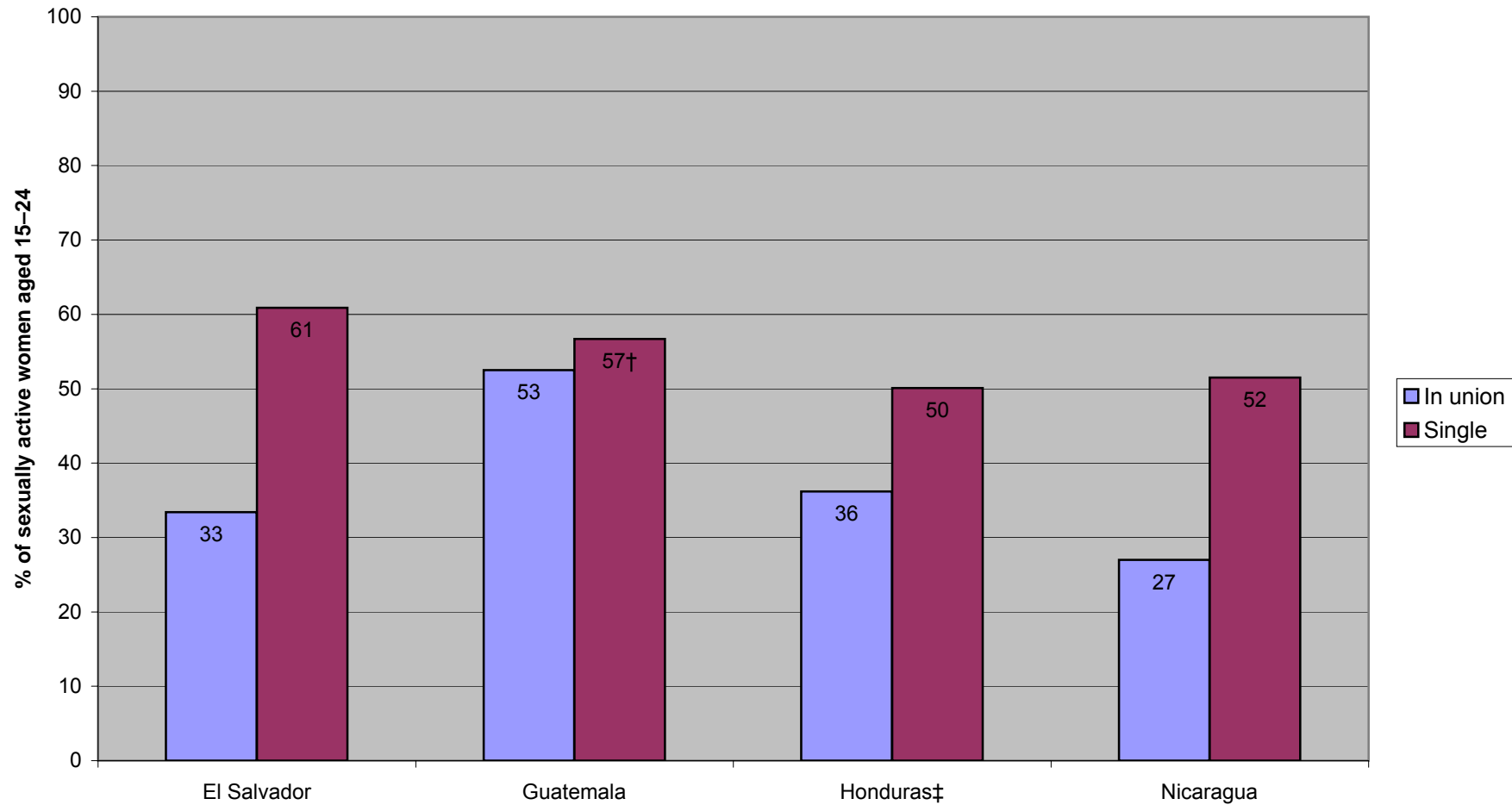
Figure 5.1 One-quarter to one-half of sexually active 15–24-year-old women use modern contraceptives, and the injectable is usually the most widely used method.



Note *Data are from the 2001 survey.

Sources References 23, 46, 47 and 57.

Figure 5.2 Single, sexually active young women are more likely than their married counterparts to have an unmet need* for modern contraception.

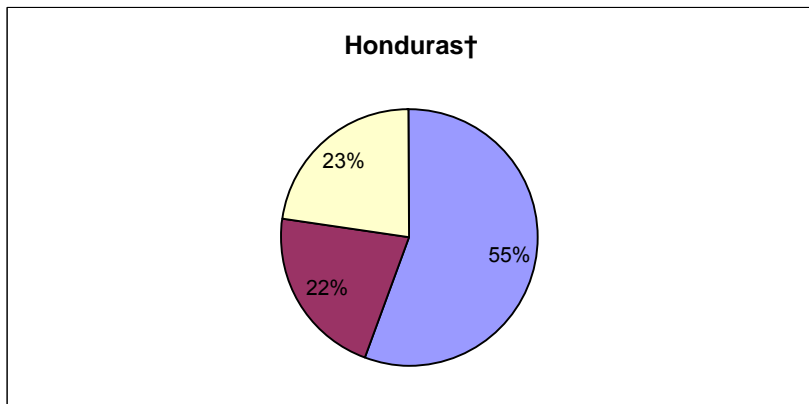
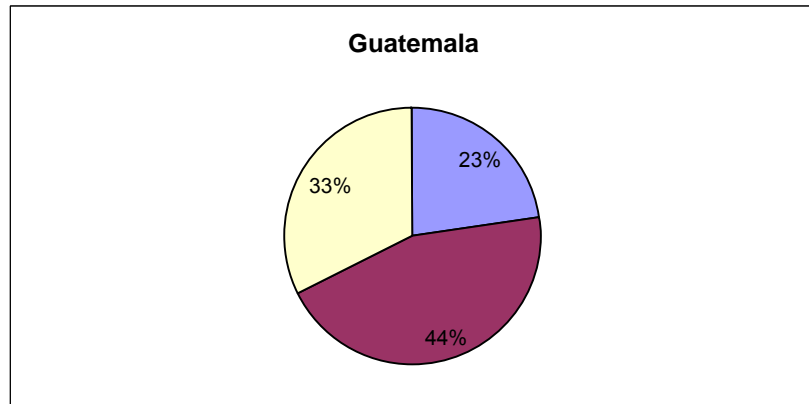
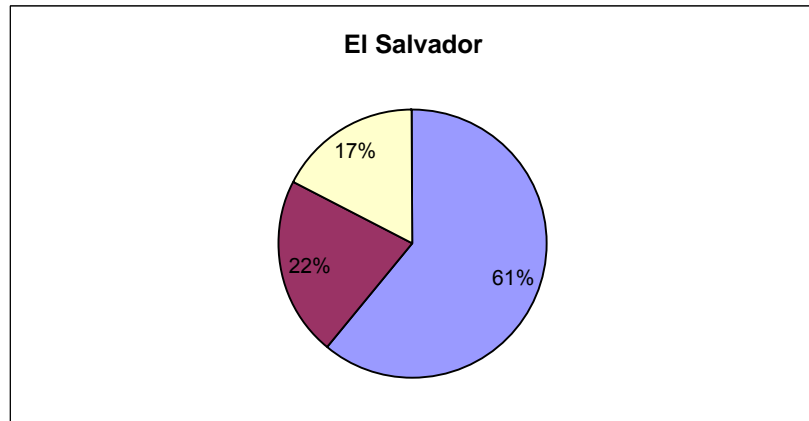


Notes *Women have an unmet need if they are able to conceive and do not want to have a child soon or at all and are not using any modern contraceptive method. †Unweighed N is 46, so results should be interpreted with caution.

‡Data are from the 2005–2006 survey.

Source Reference 68.

Figure 5.3 Many of women's reported reasons for nonuse suggest a need for better information and easier access to services.



- Low perceived risk: includes has sex infrequently and assumes breast-feeding provides protection (even though only exclusive breast-feeding does, and women rarely breast-feed exclusively).
- Method related: includes being unaware of methods; access barriers such as lack of source, cost and poor service; health concerns about side effects; and inconvenient to use.
- Opposition: includes religious and personal opposition; the partner's opposition; and other reasons.

†Data are from the 2001 survey.

Sources References 23, 46 and 47

Chapter 6: Central American Youth and STIs, Including HIV

The World Health Organization estimates that, worldwide, roughly one-half of people living with an STI are aged 15–24.⁷⁵ Of new infections each year, 60% occur among this age-group, with 20–24-year-olds having the highest, and 15–19-year-olds the second highest, rate of newly diagnosed STIs. Although many methods protect sexually active young people from unintended pregnancy, just one—the condom—can effectively prevent STIs, including HIV.

We lack reliable data on STI prevalence among youth in the focus countries, but the prevalence of all STIs combined—many of which are often asymptomatic in women⁷⁶—no doubt far exceeds that of HIV, the single STI for which we do have country-specific data. According to 2004 estimates, the prevalence of HIV infection among 15–24-year-olds is highest in Honduras (1.8%), followed by Guatemala and El Salvador (1.1% and 0.7%, respectively); it is still very low in Nicaragua (0.2%).¹⁶

According to the prevalence data cited above and United Nations (UN) population estimates, an estimated 65,000 individuals aged 15–24 were living with HIV in these four countries in 2004.⁷⁷ Even though Honduras's population is only half that of Guatemala's,⁷ the two countries have roughly the same number of infected individuals because of the much higher prevalence of HIV infection in Honduras. That higher prevalence in part reflects widespread infection among the Garífuna population in Northern Honduras, whose HIV prevalence is more than six times the national average (i.e., 8.4% in 1998⁷⁸).

In all four study countries, the HIV epidemic has become increasingly feminized and is predominantly transmitted via heterosexual sex. Male-to-female ratios have decreased over time as the epidemic has grown less concentrated in small distinct populations (such as among men who have sex with men and sex workers) and has started to spread throughout the population.¹⁷ For example, in Honduras, the country currently most affected by HIV in Hispanic Central America (the rate in English-speaking Belize is even higher⁵), the male-to-female ratio of cases now stands at one to one, and heterosexual sex accounts for the majority—60%—of transmissions.⁷⁹

The age at which infection actually occurs is difficult to determine, given the often lengthy and variable period between infection and development of the syndrome. In Guatemala at least, a slight majority of AIDS cases are among persons aged 20–34,⁸⁰ so a large number of infections are likely occurring early in people's sexual lives.

Given that infection clearly occurs among young people, it is imperative that youth have access to services related to HIV and other STIs. From qualitative interviews with key informants in Guatemala, Honduras and Nicaragua, we know that there are few confidential, youth-friendly sources for STI diagnosis and treatment. According to the professionals interviewed, rather than face staff at STI clinics, many youth with symptoms prefer to self-medicate, seek help from a pharmacist or friends, or avoid treatment altogether.⁸¹

Most young people are aware of HIV and AIDS, but their knowledge is limited

The first step to halting the spread of the virus is educating people about how to prevent infection. Solid majorities of young people, ranging from 84% to 99%, have heard about HIV (for all survey data present in this chapter, see Appendix Table 5).⁸² However, far lower

proportions of youth in these countries have heard of any other STI—43–78% in Guatemala, Honduras and Nicaragua, and 83–93% in El Salvador. Given the importance of recognizing symptoms for early diagnosis and treatment and that being infected with an STI increases both susceptibility to HIV infection and the infectiousness of those who are HIV-positive,⁸³ Central American youth clearly need to be better informed about all STIs.

Consistently lower proportions of young women (59–81%) than of young men (70–90%) in these countries know that an HIV-infected person can appear healthy.⁸² In addition, young people’s attitudes appear to confirm that stigma against HIV is still widespread: Just one-third of Honduran young men and about half of the other young people surveyed believe that HIV-infected persons should be allowed to work or that an HIV-infected teacher should continue to teach.

Central American youth are not as well informed as they need to be about what to do to avoid infection. The proportion who can spontaneously cite each of three established means of preventing infection is low (Table 6.1).⁸² Awareness of prevention methods varies inconsistently by gender; for example, where there is a difference by gender in knowing about abstinence, young men are far less likely than young women to spontaneously cite abstaining from sex as a way of avoiding HIV (4–7% among men and 22% among women, respectively, in Guatemala and Honduras).

By comparison, roughly two-thirds of young men in all countries but Guatemala (where the proportion was one-half) spontaneously identified condom use as a way to prevent it. Women were less likely than men to be informed about the condom.^{*L} We know that school-based HIV education tends to target messages about condom use to young men,⁸¹ given prevailing expectations that women remain chaste until marriage. This situation leaves women underinformed and thus in need of increased attention.

The gender differential in knowing a third way to avoid HIV, limiting one’s number of sexual partners, is also substantial in two countries, Guatemala and Honduras and, as with knowing about using condoms, knowledge is greater among men than women.⁸² However, there is much less difference by gender in knowledge about limiting the number of partners in Nicaragua and El Salvador.

Nonuse of condoms and risky behavior remain common

What, then, is young people’s actual level of condom use? Partly because of longstanding cultural norms that associate condom use with prostitution and infidelity,^{19,84} very low proportions of married young men (2–7%) and women (2–5%) across the region report having used a condom at last sex (Figure 6.1).⁸² The picture is very different for single young people: Among single men, the proportion who used a condom at last sex ranges from 43% in Honduras to 66% in El Salvador. The corresponding proportions reported by young single women are lower, from 11–12% in Guatemala, Honduras and Nicaragua to 26% in El Salvador.

^L Because of variations in the wording and flow of items assessing spontaneous knowledge of ways to prevent HIV between the 1998 (men’s) and 2001 (women’s) surveys in Nicaragua, to assure direct comparability, all data cited here come from the same source—the 1998 survey.

If young people fail to correctly and consistently use condoms during serial—or, even more critical, concurrent—sexual relationships, they and their partners are at heightened risk of contracting STIs, including HIV. The available data—for single and married men in three countries—indicate that slightly more than half of Guatemalan and Salvadoran young men with multiple partners in the past year used a condom at last sex; the proportion among Honduran men was even lower (40%).⁸²

And sex with multiple partners is not uncommon, at least among sexually active single men: One-half of such men in Honduras (50%), two-fifths in El Salvador (41%) and one-third in Guatemala (32%) have had two or more partners in the past year.⁸² Among similar women in the two countries with data, Honduras and Nicaragua, roughly 3% said they had had multiple partners in the past year. Although such risk behaviors are likely to be underreported, the far lower prevalence among young women is expected in a cultural climate that is especially punishing of deviations from ideals of female chastity.^{17,19–21}

As expected, the situation is quite different among married youth: The proportion of married men who have had sex with multiple partners in the past year ranges from almost one-tenth in Guatemala to one-quarter in El Salvador.⁸² (Data are unavailable for Nicaraguan men.) These levels of multiple sexual partnerships have clear repercussions for the men's wives. Contrary to the commonly held belief that marriage protects young women from HIV, in countries where early marriage is the norm, young wives are often at higher risk for HIV and other STIs than are sexually active single women. Young wives cannot rely on two of the three HIV prevention methods, since they are often not in a position to be abstinent or to insist that their husbands use condoms.³¹

Few young people think they are at risk for HIV

Although Honduran youth have the highest rates of HIV in the four countries, that fact does not necessarily mean that they are also likeliest to consider themselves at risk for HIV (Figure 6.2).⁸² (Data are unavailable for Guatemala.) Given young people's usual sense of invulnerability,⁸⁵ the relatively high level of self-perceived risk among Nicaraguan men is unexpected. Overall, Honduran men's situation is particularly troubling: They live in the country with the highest prevalence of HIV in the subregion, but they are the least likely to perceive themselves to be at risk of HIV.⁸² Further, among single male youth in the four countries, Honduran men have the highest level of multiple partnerships over the past year, and the lowest levels of condom use at last sex.

The limited data available show that roughly two-thirds of youth familiar with HIV have heard of a test for it.⁸² Although we lack information on the extent to which HIV testing is available, for the three countries with available data, the demand appears to be moderately strong only in El Salvador; the demand is unfortunately not as strong in Honduras (Figure 6.3), where the need for testing is likely greatest. Finally, youth clearly need to be better informed about where to go for testing, since 35–45% of those who want the test do not know where to obtain it.

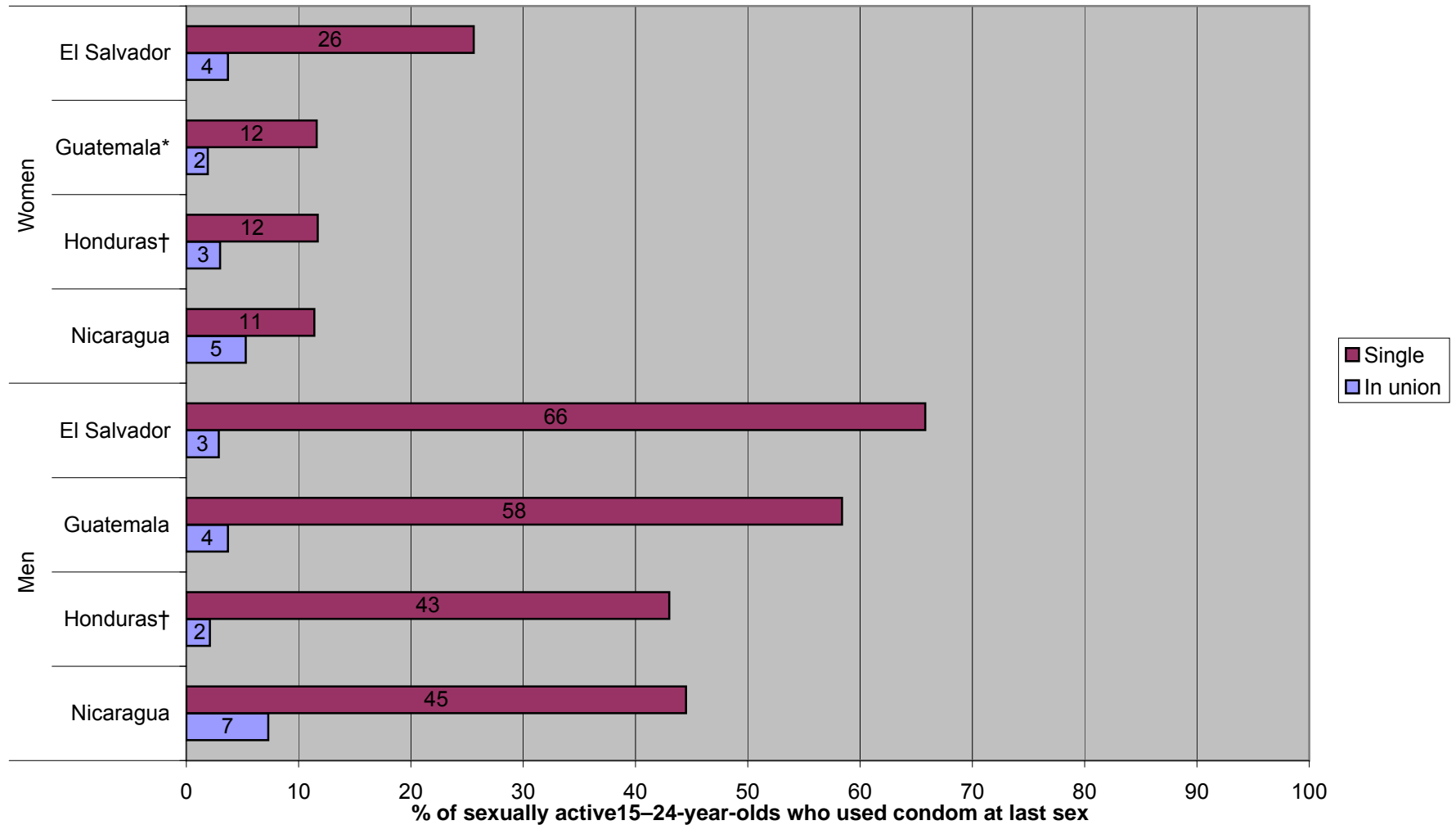
Table 6.1 Percentage of 15–24-year-old women and men who spontaneously identify each of three methods of avoiding HIV, by country

	Use condoms		Practice monogamy/limit partners		Abstain from sex	
	Women	Men	Women	Men	Women	Men
El Salvador	29.8	64.3	24.4	18.5	14.5	14.2
Guatemala	32.2	49.4	36.8	54.2	22.0	4.4
Honduras*	52.0	66.0	39.5	53.9	22.0	7.2
Nicaragua†	51.6	68.3	20.2	17.4	7.9	8.2

Notes *Data are from the 2001 survey. †All data, for both men and women, are from the 1998 survey.

Source Reference 82.

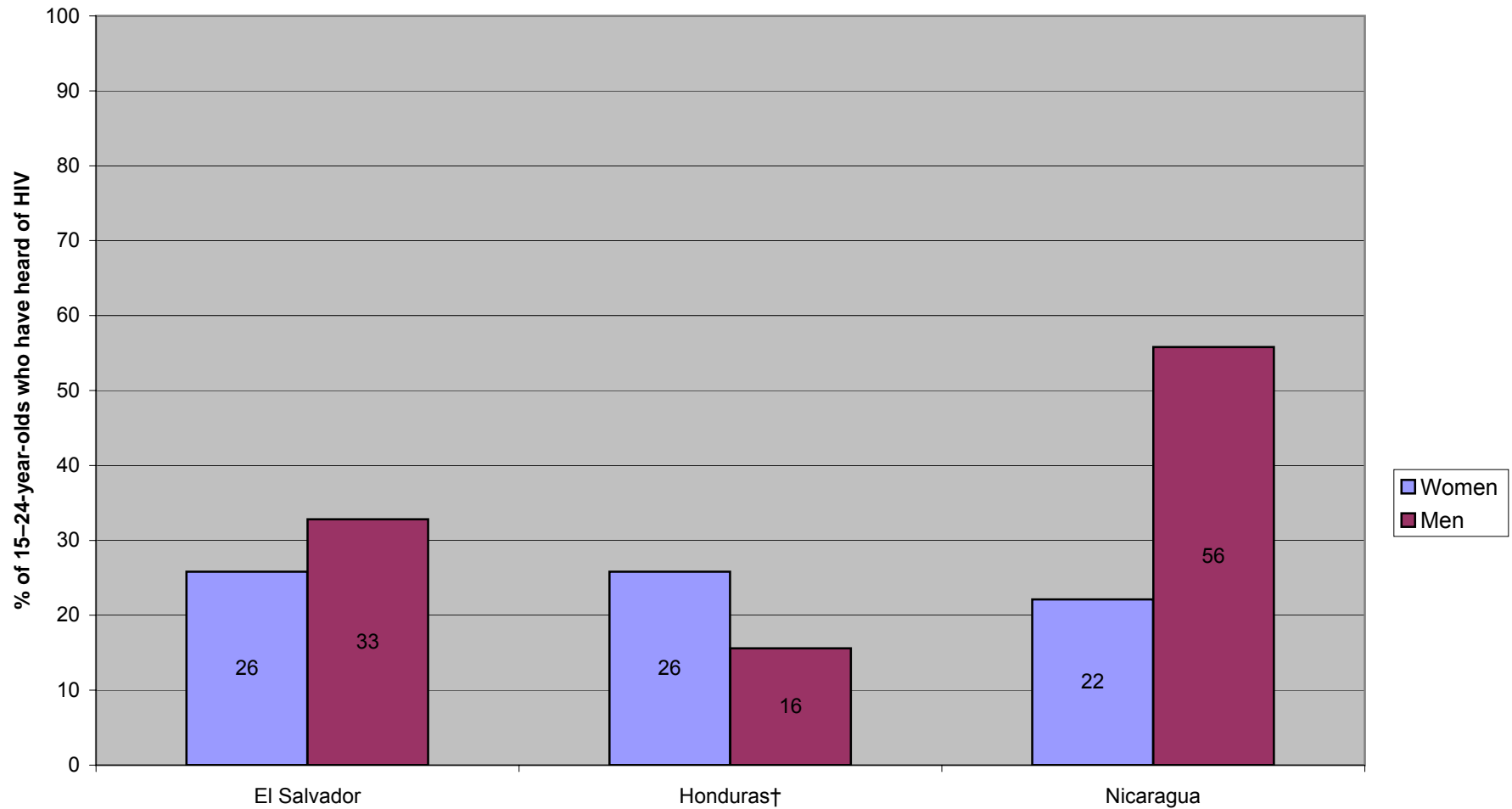
Figure 6.1 Use of the condom at last sex is much lower among married than single sexually active youth.



Note *For single women, N=46. †Data are from the 2001 survey.

Source Reference 82.

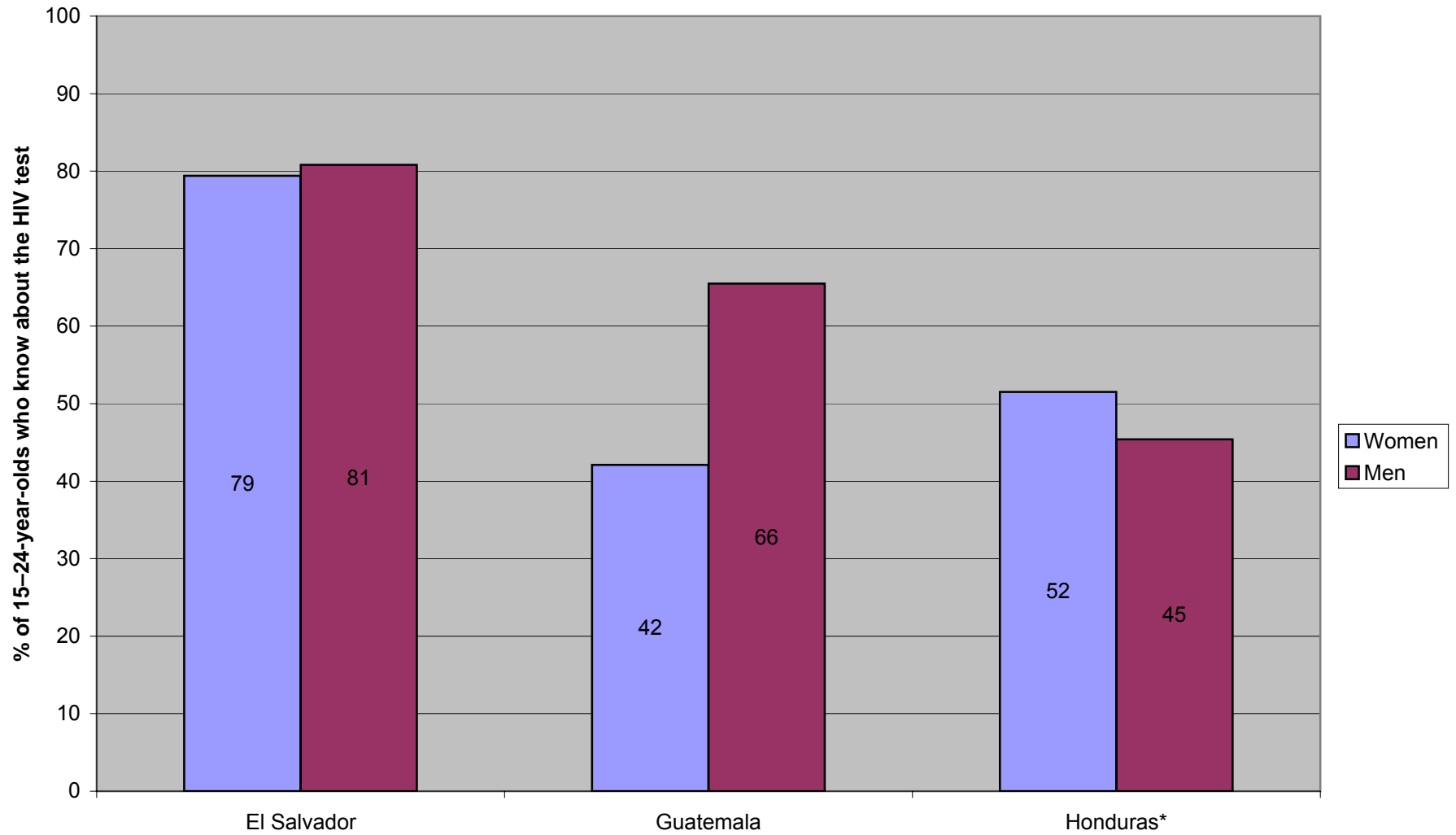
Figure 6.2 Relatively few young people believe they are at risk* of HIV infection.



Note *For Nicaragua and Honduras: at risk if youth reported low, moderate or high risk of becoming infected; for El Salvador: at risk if youth replied "yes" when asked if they were at any risk of becoming infected. †Data are from 2001.

Source Reference 82.

Figure 6.3 Demand for the HIV test is highest among Salvadoran youth.



Note *Data are from 2001.

Source Reference 82.

Chapter 7: Policies and Programs for Youth

The data presented in previous chapters reveal young people's many and varied needs for sexual and reproductive information and services, raising the question of how their governments are responding to those needs. To what extent has each country established and implemented a legal policy and program framework that helps young people attain the highest possible standard of sexual and reproductive health? What, specifically, are the fiscal and political commitments these countries have made to provide young people with both the knowledge of how to protect themselves and the means to do so? To answer these questions, we conducted interviews with a range of key informants in three of the four focus countries—Guatemala, Honduras and Nicaragua—and collected qualitative data on the current policy and program climate. This chapter draws on the content of these interviews and overviews of the policy climate provided by the study partners.

Promising policies are now on the books

Following calls to meet the “special needs of adolescents and youth” made at the International Conference on Population and Development held in Cairo in 1994, the late 1990s and early- to mid-2000s saw a flurry of youth-focused policy developments in many countries. Unfortunately, all four Central American countries covered in this report expressed objections to the conference's Programme of Action.⁸⁶ Yet the progress over the past five years is encouraging: Of the three countries in which interviews were conducted, Guatemala has made the most organized effort to adopt policies and pass legislation that are either specific to young people or include specific provisions on reproductive health education and services for youth. Honduras has also made some progress in this area, although few of its policies are specific to young people. Nicaragua has the most catching up to do in creating an organized policy environment to advance the reproductive health of its youth.

From a practical standpoint, the three most relevant areas covered in elements of these countries' nascent youth policies are the design and implementation of sex education programs that cover HIV and pregnancy prevention; the delivery of youth-friendly family planning and STI services; and the provision of maternal and child health services, including prenatal and delivery care by trained providers.

Policies in this last area, safe motherhood services, have encountered the fewest obstacles to implementation, and these countries have at least stated their intent to lower maternal mortality by increasing access to maternal and child health services for all women, adolescents included. In Nicaragua, for example, the government has demonstrated its concern by collecting and analyzing adolescent (ages 10–19) maternal deaths as part of a national maternal mortality monitoring program.⁸⁷ Moreover, there has been recent measurable progress, especially in Honduras, where the national maternal mortality ratio fell precipitously in a short time (from 182 maternal deaths per 100,000 live births in 1990 to 108 in 1997).⁸⁸ However, in all these countries, the coverage of prenatal and delivery care among women who are marginalized by their socioeconomic or ethnic status is still far below the national average.

As of mid-2007, the large number of new laws and policies on the books in these three countries has had the laudable effect of raising awareness of the issues that compelled their passage in the first place. The mere adoption of laws and policies, however, does not lead immediately to their enforcement and implementation, and nearly every key informant interviewed acknowledged that few of these policies have been fully implemented. The results of efforts by advocates and governments to effect such fundamental changes can take a long time to extend throughout the population, especially to traditionally underserved subgroups.

Funding shortfall is a formidable hurdle

Not surprisingly, key informants cited the problem of inadequate funding and insufficient resources as one of the most important obstacles to better implementation of policies for youth.⁸¹ Too often, laws are enacted without funding for enforcement or monitoring, and programs are set up without sustainable funding mechanisms. The exception once again is Guatemala, which recently passed a law to expand access to public-sector family planning services that had a line item in the government's budget written into the law.⁸⁹ In the main, however, the absence of funding and of political will to secure it has resulted in only a limited number of programs on the ground, and in even fewer in the very locations that need them most—in rural areas where unmet need for sex education and contraceptive services is especially high.

The financial shortfall is often exacerbated by wasteful duplication of efforts created by insufficient collaboration between responsible governmental agencies and departments. For example, many Ministries of Health, Education, and Youth and Family run overlapping or competing programs. In addition, although many nongovernmental organizations (NGOs) are highly committed to improving availability and accessibility of sexual and reproductive health information and services for young people in these countries, the organizations are often underfunded and rely on erratic international support, which limits the impact of their advocacy and the coverage of their programs.⁸¹

Religious and cultural opposition prevents full implementation

Strong opposition from religious conservatives—from both the Roman Catholic and Evangelical Protestant churches—catalyzes objections from politicians and parents over policies establishing sex education programs and youth-friendly reproductive health services. Thus, even when adequate funding can be secured, political commitment to pushing ahead is scarce. In 2003, strong pressure from religious officials prompted the Honduran secretary of education, and the Nicaraguan president, to withdraw manuals for teachers of sex education courses in their respective countries.⁹⁰

According to the interviews with policymakers, opponents use the argument that teaching children about sex and HIV prevention in school means denying parents' rights to do so. Opponents also claim that teaching young people about sex will lead them to become sexually active, a claim that has been consistently refuted by research showing that well-designed sex education programs, when started early, help delay the age of sexual debut and decrease sexual risk-taking among those who are already sexually active.⁹¹

It should be mentioned that, at least in Guatemala, the existing national sex education curricula offer no specific information on modern contraceptives.⁸¹ In all three countries, the current limited curricula focus on family life education and HIV prevention, but do not include specific information on pregnancy prevention. Indeed, several respondents asserted that there is currently a disproportionate emphasis on HIV prevention to the exclusion of pregnancy prevention in sex education programs.

Additional barriers to implementing sex education policies include the lack of a gender-equitable perspective; teachers' discomfort with imparting information on sexuality or unwillingness to do so; and inadequate instructional materials and curricula. Teacher training in this area needs special attention, given the sensitive and highly personal nature of these topics.

Conflicting provisions across laws and policies have yet to be harmonized

Two important barriers to the effective implementation of youth-centered policies in the area of family planning services are the contradictions across laws and the burdensome provisions that undermine the usefulness of policies to benefit youth. For one, conflicting guidelines can create loopholes and legal confusion in enforcement. Take, for example, Honduras's Comprehensive Health Care Program for Adolescents, a program that is supposed to supply family planning services to adolescents aged 15–19, irrespective of their marital status. Yet that country's Code of Children and Adolescents requires that minor clients younger than age 21 be accompanied by a parent to receive services; adolescents in union are considered emancipated and are therefore unaffected by this law. Single adolescents, however, still need to be accompanied by a parent when seeking family planning through the comprehensive care program, which lowers their likelihood of doing so.

Guatemala's HIV testing guidelines provide another example of how regulations can be so burdensome as to defeat policies designed to help young people. In that country, guidelines require parental authorization for a minor (those aged 17 or younger) to be tested for HIV. This requirement discourages many young people from getting tested out of fear that their parents will find out that they are sexually active.⁸¹ Similarly, the guarantee of confidential HIV testing that is written into the Honduran Special Law on HIV/AIDS conflicts with the requirement in the Code of Children and Adolescents that parental consent be obtained before unemancipated minors receive such services.

The right to education is jeopardized by pregnancy-based expulsions

Finally, although laws are now on the books in Honduras and Guatemala that guarantee young women's right to education by preventing pregnancy-based expulsions from school,^{*M} bureaucratic loopholes or parental intervention can effectively nullify that guarantee. In Honduras, for example, school officials get around the law by assigning pregnant students to night school, a move that can create personal safety issues and effectively prevent young from

^MThe prevention of pregnancy-based expulsions is guaranteed by provisions in the Law of Social Development, Decree 42–2001 in Guatemala, and in Article 35 of the Law of Equal Opportunities for Women in Honduras.

continuing their education.⁸¹ The same practice is common in Nicaragua, where expulsions are not strictly prohibited by law. Pregnant adolescents need viable options for completing their education. It should be noted that in Guatemala, parents typically are the ones who insist on pulling their pregnant daughters out of school.⁸¹

Only a minority—roughly 41–45%—of young women in Guatemala and Honduras who drop out of secondary school because of pregnancy go back and finish, and just 10–15% of those who leave primary school for that reason resume their studies.³ Making sure that adolescents who wish to postpone motherhood can avoid pregnancy will help them continue their education.

Chapter 8: Conclusions and Recommendations

Many aspects of young Central Americans' lives are currently undergoing fast-paced change as their countries cope with the myriad costs and benefits of increased globalization, modernization and urbanization.²⁹ Youth in El Salvador, Guatemala, Honduras and Nicaragua have experienced a great deal of positive change lately, but they continue to encounter major, and in some cases increasing, challenges to their sexual and reproductive health.

The considerable gains that young people, and women in particular, have made in education is one especially notable positive trend. It cannot be emphasized enough that continued investments in extending schooling will eventually yield long-term effects in improving young people's sexual and reproductive health. Gains in every facet of young people's reproductive lives—including lower rates of early union, lower rates of early pregnancy and greater use of contraceptives—will spread more evenly throughout the population as the numbers of better educated women and men continue to grow.

Another beneficial trend for women is the decline over the past two decades in marriage at a young age: The proportion of women who entered into union before age 20 fell substantially in every study country (though less so in Honduras than in the other three). However, these declines in early marriage have not necessarily translated into subsequent declines in early first births. In three of these countries, the proportion of women who become mothers as teenagers barely changed and remains quite high. The comparatively little change in the timing of first births may result from pressure to have a child sooner after a delayed marriage, an increase in premarital conceptions and births over time, or both.

Overall, the rates of adolescent fertility in El Salvador, Guatemala, Honduras and Nicaragua persist as among the highest in Latin America. Unfortunately, a growing proportion of that fertility appears to have not been part of the young woman's plans: Births described by the mother as unplanned—mistimed or unwanted—have increased in each of the four countries over a very short period of time.

Currently, young women's levels of unmet need for effective contraception are unacceptably high, a situation that underlies the elevated rates of unplanned childbearing. High levels of unmet need also imply that adoption of contraceptive practice is not keeping pace with desires to postpone childbearing. The issue is particularly acute in these countries where the problem of unintended pregnancy is too often solved by unsafe clandestine abortion.

Current patterns of contraceptive use suggest that young women are having more success at postponing a second birth than in delaying the all-important transition to motherhood. Far lower proportions use a method to prevent a first birth than to postpone a second one. Avoiding early unintended first pregnancies will go a long way toward allowing young women to finish school so they are better prepared for their future. That 41% of *first* pregnancies among 15–24-year-olds in El Salvador, 36% of those in Honduras and 27% of those in Guatemala were unplanned³ (data are unavailable for Nicaragua) underscores the importance of helping young people postpone early first pregnancies.

The choice to become a mother as an adolescent is often consistent with young women's limited prospects for other options in life and with the wide gender divide in "appropriate" roles for men and women. The double standard in socialization that strongly stigmatizes

sexual experimentation among women but tolerates and even encourages it among men threatens the health of youth of both sexes. Encouraging gender equality among today's young people will empower them as adults and allow them to exert more control over their reproduction and future.

At this crucial point in time, governments throughout the region are increasingly aware of the threats to young people's sexual and reproductive health. Much more can be done to neutralize these threats and better protect youth. The following are a few starting-point recommendations to make that happen.

Improve young people's knowledge and understanding

- Culturally and developmentally appropriate sex education needs to be introduced and expanded, and the policies mandating such education need to be more fully implemented. It is important to dispel myths about sex education and to reach out to all influential stakeholders—adolescents, parents, teachers, the media, politicians and church officials—to do their part in fostering open and honest discussion. Teachers need to be trained and feel comfortable imparting sensitive information.
- Parents should be reminded of their essential role in educating their children, monitoring their children's activities and making sure their children have the information, skills and medical care they need. Parents also have the potential to change harmful patterns of gender socialization, but need to be given the knowledge and tools to do so.
- Because many of the young people who lack detailed knowledge about both HIV and pregnancy prevention are not in school, programs to educate youth through alternative informal sources, such as the mass media, are essential. The media, especially the Internet—whose reach is expanding through affordable and accessible cybercafés⁹²—have an invaluable role to play.

Address young people's barriers to needed services

- Many obstacles to meeting young people's needs for services can be overcome by reorienting existing programs or modifying outdated policies. Creating youth-friendly services for adolescents and young people is essential. The imposition by providers of age, marital or parental consent requirements that have no basis in regulation or policy can be remedied by educating providers about what is mandated, once conflicting provisions in those policies and regulations have been harmonized.
- Providers need to make young people, especially single young people, feel comfortable and not subject them to judgmental treatment that could discourage them from taking steps to avoid unintended pregnancy and STIs. Since large proportions of youth, men in particular, prefer getting contraceptives from pharmacies, pharmacists and other staff at these stores need to be sensitized to young people's special needs. Services should be strengthened where the need for them is greatest—for example, in underserved rural areas.
- Adolescents need to be given the opportunity to use contraceptives to space their pregnancies at healthy intervals, receive adequate prenatal care and deliver in safe medical settings. The great strides in reducing overall maternal mortality in these countries need to be

extended to reducing mortality where it remains most entrenched—in poor rural and periurban areas and in indigenous communities.

- Abortions are especially dangerous in settings where the procedure is severely legally restricted.⁴ Reducing the risk of unintended pregnancy reduces the likelihood that young women will need to turn to unsafe abortion. The provision of high-quality postabortion services, which include contraceptive counseling and services, would help contain the damage.

Expand young people's contraceptive choices

- To give young people a wider choice of contraceptive methods, providers need to learn more about each method's side effects, and about how to nonjudgmentally counsel young people about them. Since the four study countries are at the tail end of the gradual phase-out of contraceptive supplies donated by the U.S. Agency for International Development's (USAID), they can learn from successful procurement strategies that have been used in other Latin American countries when foreign support for these programs ceased.⁹³
- Emergency contraception should be made more available to young people, especially given the unplanned and sporadic nature of their sexual activity, their low level of contraceptive use when they first have sex and the likely high incidence of sexual violence. Although the method is included in each of these countries' national family planning guidelines,⁹⁴ registered products have only recently been made available, especially in Guatemala, where a dedicated product was approved as recently as September of 2007.⁹⁵

Improve data collection and quality

- The lack of reliable data on a wide range of sexual and reproductive health topics is an ongoing problem. Such information is needed to identify problems, detect recent changes, and monitor the impact of programs and interventions. The four focus countries fortunately had nationally representative surveys, but such surveys are among the few sources of systematically collected data on these issues, and their existence depends on foreign aid. Future surveys are essential and will continue to need outside support; ongoing aid is needed to strengthen local capacity and systems to make essential data collection and monitoring less vulnerable to fluctuations in foreign financing.

Optimize use of resources available to meet youth's needs

- To avoid costly overlap, more coordination is needed among the various ministries and departments that administer youth programs and services. To prevent dependence on uncertain international NGO funding, which is already subject to conditions imposed by major donors such as USAID,⁹⁶ the political commitment to youth-friendly programs needs to be backed up by the allocation of sufficient economic resources. Youth policies and programs should be institutionalized as government policy and made a high priority in overall national development plans.
- To make the most of scarce resources and lessen stigma associated with HIV-only services, youth-friendly contraceptive services should be integrated with HIV testing and counseling services. Improvements in the content and reach of HIV and AIDS education are especially

crucial in the high-prevalence country of Honduras. Given the cost-effectiveness of prevention over treatment, these countries' health budgets cannot afford to risk having to support large-scale treatment programs.

Close examination of the complex panorama of young people's behaviors and needs reveals a picture of a population largely underserved in its basic sexual and reproductive health requirements. The proportion of young women at risk of becoming pregnant before they want to be—those with an unmet need for effective contraception—is highest among the group of young women who are stigmatized most, namely, sexually active single young women, especially adolescents.

And although no data exist to measure the extent to which both men and women have an unmet need to protect themselves from STIs, the relatively high proportions of young men who have multiple partners and the overall low use of the condom in the region implies that young Central Americans need to do more to prevent STIs and keep HIV levels from escalating. Honduran men seem to be at a special disadvantage, as they are most likely to engage in high-risk behaviors, yet least likely to perceive that they are at risk of infection themselves and least likely to want to be tested.

While there has been encouraging recent progress—such as gains in education and declines in early marriage and second births during adolescence—much more still needs to be accomplished. All young people must have options to protect their sexual and reproductive health, and these options should be ensured by their country's social and health systems. We adults must assure that they have every opportunity to make the positive, fundamental decisions that direct the course of their lives, such as to decide to delay marriage; be abstinent if single; reduce their number of partners; use condoms and contraceptives; seek professional prenatal and delivery care; get tested for HIV and STIs; and obtain appropriate treatment. More sustained and informed efforts to help them exercise as many of these options as possible will yield incalculable long-term benefits.

It is hoped that El Salvador, Guatemala, Honduras and Nicaragua will openly consider the issues raised here, take advantage of the information now available, and design programs that effectively address the needs of their young people, thus ensuring a brighter future for all.

References

1. World Bank, *World Development Report 2007: Development and the Next Generation*, Washington, DC: World Bank, 2006.
2. United Nations Population Division, *World Population Prospects: The 2006 Revision Population Database*, <<http://esa.un.org/unpp/>>, accessed Apr. 2, 2007.
3. Monteith RS, Stupp PW and McCracken SD, *Reproductive, Maternal, and Child Health in Central America: Trends and Challenges Facing Women and Children*, Atlanta, GA, USA: Division of Reproductive Health, Centers for Disease Control and Prevention (CDC) and U.S. Agency for International Development (USAID), 2005.
4. Singh S, Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries, *Lancet*, 2006, 368(9550):1887–1892.
5. Joint United Nations Programme on HIV/AIDS (UNAIDS), *AIDS Epidemic Update*, December 2006, <http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf>, accessed Dec. 10, 2007.
6. UNAIDS, *2006 Report on the Global AIDS Epidemic*, 2006, <http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf>, accessed Dec. 20, 2006.
7. Centro Centroamericano de Población, *Calendario Poblacional*, 2007, <<http://ccp.ucr.ac.cr/>>, accessed Feb. 20, 2006.
8. Appendix Table 1.
9. United Nations Development Programme (UNDP), *Segundo Informe sobre Desarrollo Humano en Centroamérica y Panamá*, 2003, San José, Costa Rica: UNDP, 2003.
10. International Labour Organization, *Trabajo decente y juventud*, Anexo estadístico del informe regional, 2007, <http://www.oit.org.pe/tdj/anexos/pdfs/anexo_estadistico_reg.pdf>, accessed Dec. 5, 2007.
11. Bureau for Latin America and the Caribbean, Office of Regional Sustainable Development, USAID, *Central America and Mexico Gang Assessment*, Washington, DC: USAID, 2006, <http://www.usaid.gov/locations/latin_america_caribbean/democracy/gangs_assessment.pdf>, accessed Dec. 7, 2007.
12. Couch M et al., *Looking for More: A Review of Social and Contextual Factors Affecting Young People's Sexual Health*, Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University, 2006, <http://www.latrobe.edu.au/arcshs/assets/downloads/reports/looking_for_more.pdf>, accessed Dec. 10, 2007.
13. International Labour Organization, *International Programme on the Elimination of Child Labour*, *Explotación sexual comercial de personas menores de edad en Centroamérica, Panamá y República*

- Dominicana, Síntesis Regional, 2003, <<http://www.ipec.oit.or.cr/ipec/region/areas/esc/honduras.shtml>>, accessed Dec. 5, 2007.
14. Benaouett R, Background paper prepared for the Education for All Global Monitoring Report, 2006: School Fees, 2007, <<http://unesdoc.unesco.org/images/0014/001459/145944e.pdf>>, accessed Mar. 10, 2007.
15. Tomasevski K, *The State of the Right to Education Worldwide, Free or Fee: 2006 Global Report*, 2006, <http://www.katarinatomasevski.com/images/Global_Report.pdf>, accessed Mar. 10, 2007.
16. Machinea JL, Bárcena A and León A, *The Millennium Development Goals: A Latin American and Caribbean Perspective*, Santiago, Chile: Economic Commission for Latin America and the Caribbean, 2005, <<http://www.eclac.cl/publicaciones/xml/0/21540/lcg2331.pdf>>, accessed Dec. 13, 2007.
17. Anderson H, Marcovici K and Taylor K, *The UNGASS, Gender and Women's Vulnerability to HIV/AIDS in Latin America and the Caribbean*, Washington, DC: Pan American Health Organization (PAHO), 2002, <http://www.synergyaids.com/documents/UNGASS_GenderandHIV_LAC.pdf>, accessed Feb. 16, 2007.
18. Rani M, Figueroa ME and Ainsle R, The psychosocial context of young adult sexual behavior in Nicaragua: looking through the gender lens, *International Family Planning Perspectives*, 2003, 29(4):174–181.
19. Aguirre R and Güell P, *Hacerse Hombres: La Construcción de la Masculinidad en los Adolescentes y Sus Riesgos*, Washington, DC: PAHO, 2002.
20. Zelaya E et al., Gender and social differences in adolescent sexuality and reproduction in Nicaragua, *Journal of Adolescent Health*, 1997, 21(1):39–46.
21. Berglund S et al., The background of adolescent pregnancies in Nicaragua: a qualitative approach, *Social Science & Medicine*, 1997, 44(1):1–12.
22. Appendix Table 2.
23. Special tabulations of data from Encuesta Nacional de Salud Familiar, FESAL, 2002–2003, El Salvador.
24. Remez L et al., Protecting the sexual and reproductive health of Guatemalan youth, *In Brief*, New York: Guttmacher Institute, 2007, No. 1.
25. Audam SA et al., Protecting the sexual and reproductive health of Honduran youth, *In Brief*, New York: Guttmacher Institute, 2007, No. 3.
26. Wulf D et al., Protecting the sexual and reproductive health of Nicaraguan youth, *In Brief*, New York: Guttmacher Institute, 2007, No. 2.

27. Fenton KA et al., Measuring sexual behaviour: methodological challenges in survey research, *Sexually Transmitted Infections*, 2001, 77(2):84–92.
28. García-Moreno C et al., *WHO Multi-Country Study on Women's Health and Domestic Violence against Women*, Geneva: World Health Organization (WHO), 2005.
29. Lloyd CB, ed., *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, Washington, DC: National Academies Press, 2005.
30. Economic Commission for Latin America and the Caribbean and United Nations Children's Fund (UNICEF), Teenage motherhood in Latin America and the Caribbean: trends, problems and challenges, *Challenges*, New York: United Nations, 2007, No. 4, pp 4–9.
31. Clark S, Bruce J and Dude A, Protecting young women from HIV/AIDS: the case against child and adolescent marriage, *International Family Planning Perspectives*, 2006, 32(2):79–88.
32. Flórez CE and Núñez J, Teenage childbearing in Latin American Countries, in: Duryea S, Cox Edwards A, and Ureta M, eds., *Critical Decisions at a Critical Age: Adolescents and Young Adults in Latin America*, Washington, DC: Inter-American Development Bank, 2003.
33. Hallman K and Quisumbing AR, Marriage in transition: evidence on age, education, and assets from six developing countries, in: Lloyd CB, ed., *The Changing Transitions to Adulthood in Developing Countries, Selected Studies*, Washington, DC: National Academies Press, 2005.
34. UNICEF, *Early Marriage: A Harmful Traditional Practice*, New York: UNICEF, 2005.
35. McIntyre Peal, *Adolescent Friendly Health Services—An Agenda for Change*, Geneva: WHO, 2002.
36. Buvinic M, The costs of adolescent childbearing: evidence from Chile, Barbados, Guatemala and Mexico, *Studies in Family Planning*, 1998, 29(2):201–209.
37. Singh S, Adolescent childbearing in developing countries: a global review, *Studies in Family Planning*, 2007, 29(2):117–136.
38. *Qué más podía hacer, sino tener un hijo? Bases socioculturales del embarazo de las adolescentes en Nicaragua*, Managua, Nicaragua: UNFPA and Instituto Nicaragüense de la Mujer, 1999.
39. Instituto Nacional de Estadísticas y Censos (INEC) and Ministerio de Salud, *Encuesta Nicaragüense de Demografía y Salud, 2001*, Managua, Nicaragua: INEC; and Calverton, MD, USA: ORC Macro, 2002.
40. Asociación Demográfica Salvadoreña (ADS), *Encuesta Nacional de Salud Familiar, FESAL 2002/03*, San Salvador, El Salvador: ADS; and Atlanta, GA, USA: CDC, 2004.
41. Ministerio de Salud Pública y Asistencia Social (MSPAS) et al., *Encuesta Nacional de Salud Materno Infantil 2002*, Guatemala City, Guatemala: MSPAS, 2003.

42. Secretaría de Salud, Instituto Nacional de Estadística (INE) and Macro International, *Honduras: Encuesta Nacional de Demografía y Salud, ENDESA 2005–2006*, Tegucigalpa, Honduras: Secretaría de Salud and INE; and Calverton, MD, USA: Macro International, 2006.
43. Appendix Table 3.
44. Blandón L et al., Early childbearing in Nicaragua: a continuing challenge, *In Brief*, New York: Guttmacher Institute, 2006, No. 3.
45. Figueroa W et al., Early childbearing in Guatemala: a continuing challenge, *In Brief*, New York: Guttmacher Institute, 2006, No. 5.
46. Special tabulations of data from Encuesta Nacional de Salud Materno Infantil, 2002, Guatemala.
47. Special tabulations of data from Encuesta Nicaragüense de Demografía y Salud, 2001.
48. Special tabulations of data from Encuesta Nacional de Demografía y Salud, 2005–2006, Honduras.
49. ADS, *Encuesta Nacional de Salud Familiar, FESAL–85*, San Salvador, El Salvador: ADS; and Columbia, MD, USA: Institute for Resource Development/Westinghouse, 1987.
50. Secretaría de Salud and Asociación Hondureña de Planificación de Familia (ASHONPLAFA), *Honduras: Encuesta Nacional de Epidemiología y Salud Familiar, 1996*, Tegucigalpa, Honduras: Secretaría de Salud and ASHONPLAFA; and Atlanta, GA, USA: CDC, 1997.
51. WHO, *Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13–15 June 2005*, Geneva: WHO, 2006.
52. MSPAS, *Línea Basal de Mortalidad Materna para el Año 2000*, Guatemala City: MSPAS, 2003.
53. ADS, *Encuesta Nacional de Salud Familiar, Informe Final: FESAL-98*, San Salvador, El Salvador: ADS; and Atlanta, GA, USA: CDC, 2000.
54. Special tabulations of data from Encuesta Nicaragüense de Demografía y Salud, 1998.
55. Special tabulations of data from Encuesta Nacional de Salud Familiar, FESAL-1998, El Salvador.
56. Special tabulations of data from Encuesta Nacional de Salud Materno Infantil, 1995, Guatemala.
57. Special tabulations of data from Encuesta Nacional de Epidemiología y Salud Familiar, 2001, Honduras.
58. Center for Reproductive Rights, *The World’s Abortion Laws*, May 2007, <http://www.reproductiverights.org/pdf/pub_fac_abortionlaws.pdf>, accessed July 20, 2007.
59. Guatemala Penal Code, Decree no. 17-73, article 137, 1973, <http://www.oas.org/juridico/MLA/sp/gtm/sp_gtm-int-text-cp.pdf>, accessed May 24, 2006.

60. Grajeda R et al., Organización Mundial de Salud—Estudio Multicentro Sobre el Aborto: País Guatemala, Biblioteca INCAP, 1995, Publicación DCE/020.
61. Guzmán JL, Contreras JM and Hakkert R, La situación actual del embarazo adolescente y aborto, in Guzmán JM et al., eds., *Diagnóstico sobre salud sexual y reproductiva de adolescentes en América Latina y el Caribe*, Mexico City: UNFPA, 2001.
62. Singh S and Wulf D, The likelihood of induced abortion among women hospitalized for abortion complications in four Latin American countries, *International Family Planning Perspectives*, 1993, 19(4):134–141.
63. Cambacho Hubner AV, Perfil de salud sexual y reproductiva de los y las adolescentes y jóvenes de América Latina y el Caribe: revisión bibliográfica, 1988–1998, Washington, DC: PAHO, 2000, Serie OPS/FNUAP, No. 1.
64. Shah I and Ahman E, Age patterns of unsafe abortion in developing country regions, *Reproductive Health Matters*, 2007, 12(24 Suppl.):9–17.
65. Sedgh G et al., Induced abortion: estimated rates and trends worldwide, *Lancet*, 2007, 370(9595):1338–1345.
66. Prada E et al., *Embarazo no planeado y aborto inseguro en Guatemala: causas y consecuencias*, New York: Guttmacher Institute, 2006.
67. Singh S, Prada E and Kestler E, Induced abortion and unintended pregnancy in Guatemala, *International Family Planning Perspectives*, 2006, 32(3):136–145.
68. Appendix Table 4.
69. Parker C, Creating youth-friendly pharmacies, *YouthLens on Reproductive Health and HIV/AIDS*, 2005, No 17.
70. Centeno Monge HL and Cáceres Rodas R, La salud sexual y reproductiva de las jóvenes de 15 a 24 años en El Salvador, un reto para las políticas de salud, *Población y Salud en Mesoamérica*, 2005, Vol. 2, No. 2.
71. McCauley AP and Salter C, Meeting the needs of young adults, *Population Reports*, 1995, Series J, No. 41.
72. Garcia SG et al., Emergency contraception in Honduras: knowledge, attitudes, and practice among urban family planning clients, *Studies in Family Planning*, 2006, 37(3):187–196.
73. Martin A, La anticoncepción de emergencia en América Latina y el Caribe, *Revista Panamericana de Salud Pública*, 2004, 16(6):424–431.

74. Paredes J and Castellanos A, Planificación familiar y salud sexual serán universales, *Prensa Libre*, Nov. 17, 2005, p. 5, <<http://www.prensalibre.com/pl/2005/noviembre/17/128046.html>>, accessed Nov. 3, 2006.
75. Dehne KL and Reidner G, *Sexually Transmitted Infections among Adolescents*, Geneva: WHO and Eschborn, Germany: Deutsche Gesellschaft für Technische Zusammenarbeit, 2005.
76. Department of Reproductive Health and Research, WHO, *Sexually Transmitted and Other Reproductive Tract Infections: A Guide to Essential Practice*, Geneva: WHO, 2005.
77. Special tabulations of United Nations 2004 population estimates and UNAIDS 2004 HIV prevalence data.
78. Soveida Padilla I and Soto RJ, Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras, Tegucigalpa, Honduras: Secretaría de Salud, Departamento de ITS/VIH/SIDA, 2003.
79. UNAIDS and WHO, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Honduras, 2004 Update*, 2004, <http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS_PDFs/EFS2004_HN.pdf>, accessed Nov. 27, 2006.
80. Hirschmann A, *Informe Sobre los Avances en la Declaración de UNGASS, Informe de País: Guatemala*, Guatemala City, Guatemala: Programa Nacional de ITS/VIH/SIDA, 2005, <http://data.unaids.org/pub/Report/2006/2006_country_progress_report_guatemala_es.pdf>, accessed Dec. 18, 2006.
81. Guttmacher Institute, 2006 Survey of Key Informants on Youth-Related Policies and Programs in Guatemala, Honduras and Nicaragua.
82. Appendix Table 5.
83. Rottingen JA, Cameron DW and Garnett GP, A systematic review of the epidemiologic interactions between classic sexually transmitted infections and HIV: how much really is known? *Sexually Transmitted Diseases*, 2001, 28(10):579–597.
84. The Alan Guttmacher Institute (AGI), *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide*, New York: AGI, 2003.
85. Kiragu K, Youth and HIV/AIDS: can we avoid catastrophe? *Population Reports*, 2001, Series L, No. 12.
86. UNFPA, *Programme of Action of the International Conference on Population and Development*, 1994, <http://www.unfpa.org/icpd/icpd_poa.htm#pt2ch1>, accessed July 24, 2007.
87. *Mortalidad Materna en Adolescentes y Mortalidad en Hijos de Madres Adolescentes en Nicaragua*, Managua, Nicaragua: PAHO, 2007.

88. Meléndez JH, Ochoa Vasquez JC and Villanueva Y, *Investigación Sobre Mortalidad Materna y de Mujeres en Edad Reproductiva en Honduras: Informe Final Correspondiente al Año 1997*, Tegucigalpa, Honduras: Secretaría de Salud de Honduras, 1999.
89. Congreso de la República de Guatemala, Ley de Acceso Universal y Equitativo de Servicios de Planificación Familiar y su Integración en el Programa Nacional de Salud Reproductiva, Decreto Número 87-2005, 2006.
90. Clulow M, *Sexual and Reproductive Rights in Central America: Towards an Agenda for Action*, London: One World Action, 2005,
<http://www.oneworldaction.org/_uploads/documents/Sexual&Repr_CentralAmer_English.pdf>, accessed Dec. 3, 2007.
91. Kirby D, Larib B and Roller L, Sex and HIV education programs: their impact on sexual behaviors of young people throughout the world, *Journal of Adolescent Health*, 2007, 40(3):206–217.
92. Bank A, Puntos de Encuentro, Managua, Nicaragua, personal communication, Sept. 13, 2007.
93. Sarley D et al., *Options for Contraceptive Procurement: Lessons Learned from Latin America and the Caribbean*, Arlington, VA, USA: DELIVER; and Washington, DC: Health Policy Initiative for USAID, 2006.
94. International Consortium for Emergency Contraception, EC status and availability, 2007,
<<http://www.cecinfo.org/database/pill/viewAllCountry.php>>, accessed July 25, 2007.
95. Puig Borràs C, Family Care International, New York, personal communication, Dec. 4, 2007.
96. Global Gag Rule Impact Project, *The Global Gag Rule and Contraceptive Supplies*, undated,
<http://www.globalgagrul.org/pdfs/issue_factsheets/GGR_fact_contraceptive.pdf>, accessed Dec. 1, 2007.

Appendix Table 1. Context of young people's lives in El Salvador, Guatemala, Honduras and Nicaragua

Indicator	El Salvador		Guatemala		Honduras		Nicaragua	
(1) United Nations Human Development Index (HDI), 2006	0.729		0.673		0.683		0.698	
(2) Gross national income (GNI),* 2005	\$5,120		\$4,410		\$2,900		\$3,650	
(3) % of population living in poverty†	45.5		56.2		71.6		45.8	
% of population living in rural areas								
(4) 1980	55.9		62.6		65.1		49.7	
(5) 2005	39.9		52.8		53.6		41.9	
(6) Secondary school enrollment ratio (girls per boys), 2005‡	1.01		0.90		1.24		1.15	
(7) HIV prevalence among 15–24-year-olds (2004)	0.7		1.1		1.8		0.2	
	Women	Men	Women	Men	Women	Men	Women	Men
(8) % aged 15–24 whose homes have electricity	87.5	87.2	83.0	82.7	65.2	58.9	74.9	u
(9) % aged 15–19 currently in school	50.8	54.1	39.9	55.3	32.9	31.7	u	51.5
(10) % aged 40–44 who attended secondary school	33.1	35.7	21.6	36.1	20.5	20.8	31.5	33.3
(11) % aged 20–24 who attended secondary school	63.7	66.1	39.4	39.6	35.8	27.4	53.4	44.9
(12) % aged 15–24 who listen to the radio daily or almost daily	u	u	79.0	84.0	u	u	76.3	88.7
(13) % aged 15–24 who watch TV weekly§	u	u	69.2	80.7	u	u	71.4	77.4
(14) % aged 15–24 who read a newspaper weekly§	u	u	61.5	81.5	u	u	46.2	59.0
(15) Maternal mortality ratio**	150	na	240	na	110	na	230	na
Percentage distribution of 15–24-year-olds by work and school status, 2005††								
(16) In school, not working	33	32	19	17	24	21	36	28
(17) Not in school, working	22	45	26	59	20	59	22	49
(18) In school, working	5	9	6	14	5	7	9	12
(19) Not in school, not working	39	14	48	10	51	13	33	11
*In international dollars, adjusted for purchasing power parity. An international dollar has the same purchasing power as a U.S. dollar in the United States. The World Bank favors this measure because it substitutes global prices for locally determined prices, thereby more accurately reflecting the real value of the good or service in question. This is especially true of nontradeable services (haircuts are an example), which are assumed to produce the same level of comfort from one country to another, but vary widely in their locally measured price. †National per capita annual poverty lines are the following: For El Salvador (2000), 5,286 colones or \$1,290 international dollars adjusted for purchasing power parity (PPP); for Guatemala (2000), 4,318 quetzales or \$1,278 international dollars PPP; for Honduras (2002), 13,176 lempiras or \$2,128 international dollars PPP; and for Nicaragua (2001), 5,158 cordobas or \$1,904 international dollars PPP.								
‡Secondary school enrollment ratio (secondary school gender parity index) is the female-to-male ratio of gross enrollment in secondary education. A ratio of 1.0 indicates parity between sexes; a ratio of less than 1.0 indicates fewer girls than boys are enrolled. §Includes almost every day and at least once a week. **Maternal deaths per 100,000 live births. ††Guatemalan data are for 2004.								
Notes When estimates by gender are unavailable, we present totals for both sexes. u=unavailable. na=not applicable.								
Sources Row 1 —Watkins K, Beyond scarcity: power, poverty and the global water crisis, <i>Human Development Report</i> , New York: United Nations (UN) Development Programme, 2006, < http://hdr.undp.org/en/media/hdr06-complete.pdf >, accessed Dec. 3, 2007. Row 2 —World Bank, World development indicators database, July 1, 2006, < http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf >, accessed Jan. 9, 2007. Row 3 —Proyecto Estado de la Región, <i>Segundo Informe sobre Desarrollo Humano en Centroamérica y Panamá</i> , 2003, San José, Costa Rica: UN Development Programme, 2003. Rows 4 and 5 —UN Population Division, UN Population Prospects: 2006 Revision Population Database, 2006, < http://esa.un.org/unpp/index.asp?panel=1 >, accessed Jan. 9, 2007. Row 6 —World Bank Group, Global Country Data, 2002, < http://devdata.worldbank.org/edstats/cd5.asp >, accessed Jan. 9, 2007. Row 7 —Machinea JL, Bárcena A and León A, <i>The Millennium Development Goals: A Latin American and Caribbean Perspective</i> , Santiago, Chile: Economic Commission for Latin America and the Caribbean, 2005, Annex Table 2, 2005, < http://www.undp.org/rblac/mdg/RegionalInteragency.pdf >, accessed Dec. 3, 2007.								
Rows 8–14 —Special tabulations of the following surveys: El Salvador—2002–2003 FESAL; Guatemala—2002 ENSMI and 2002 ENSM; Honduras—2001 ENESF; and Nicaragua—2001 ENDESA (women) and 1998 ENDESA (men). Row 15 —World Health Organization, UN Children's Fund and UN Population Fund, <i>Maternal Mortality in 2000</i> , 2004, < http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf >, accessed Dec. 3, 2007. Rows 16–19 —International Labour Organization, <i>Trabajo decente y juventud</i> , Lima, Perú: International Labour Organization, 2007, Anexo estadístico con datos desagregados por sexo, rango de edad y ámbito, OIT, 2007, Cuadro 2.1, < http://white.oit.org.pe/tj/anexos/pdfs/anexo_estadistico_desagregado.pdf >, accessed Dec. 3, 2007.								

Appendix Table 2. Sexual relationships and unions in El Salvador, Guatemala, Honduras and Nicaragua.

Indicator	El Salvador		Guatemala		Honduras			Nicaragua	
	Women 2002–2003	Men 2002–2003	Women 2002	Men 2002	Women 2001	Women 2005–2006	Men 2001	Women 2001	Men 1998
SEXUAL ACTIVITY									
% 15–19 who have ever had sex	32.5	50.3	23.5	40.2	38.1	31.5	48.7	34.8	58.4
% 20–24 who have ever had sex	74.4	86.5	67.4	88.7	77.1	75.2	84.3	76.5	95.9
% 15–24 who have ever had sex	51.7	66.4	43.2	58.0	55.8	51.3	64.7	52.9	74.3
% 40–44 who had sex before age 15	15.6	46.2	11.5	24.5	13.0	12.8	35.0	18.3	40.1
% 20–24 who had sex before age 15	10.9	30.1	12.2	27.9	14.0	12.3	26.5	14.3	34.6
% 40–44 who had sex before age 18	49.2	75.0	49.1	65.3	47.0	46.5	75.4	54.0	84.2
% 20–24 who had sex before age 18	40.9	68.6	41.7	62.6	47.3	45.4	66.8	48.7	79.8
% 40–44 who had sex before age 20	69.0	87.0	71.0	83.0	70.2	67.5	89.1	72.4	92.8
% 20–24 who had sex before age 20	60.6	80.5	57.6	82.5	66.7	64.0	79.3	66.7	91.6
% 40–44 who had premarital sex before age 20	25.2	80.8	12.5	69.6	13.4	20.8	85.5	17.1	91.8
% 20–24 who had premarital sex before age 20	29.9	74.8	17.7	73.9	20.6	21.0	76.0	19.2	83.2
% 15–19 currently sexually active*	27.4	26.2	19.4	23.3	30.7	25.0	29.9	27.8	44.2
% 20–24 currently sexually active	63.9	66.3	59.8	70.1	64.8	62.1	64.0	63.5	85.3
% 15–24 currently sexually active	44.1	44.1	37.5	40.6	46.2	41.8	45.2	43.3	61.6
Median age at first sex (among 20–24-year-olds)	18.8	16.2	19.0	16.9	18.2	18.4	16.7	18.1	15.8
% of women who experienced sexual abuse† (15–24-year-olds)	9.9	na	5.6	na	12.6	11.0	na	u	na
% of women whose first partner was ≥ 5 years older (15–24-year-olds)	41.5	na	35.9	na	50.5	48.0	na	u	na
Percentage distribution by first partner (15–24-year-olds)									
Spouse/partner	27.3	2.2	64.0	9.3	51.2	u	3.4	u	u
Boyfriend/girlfriend/fiancee/lover	67.0	44.1	33.9	54.3	43.8	u	52.4	u	u
Friend/acquaintance/other	5.3	47.6	1.8	26.8	4.8	u	42.9	u	u
Commercial sex worker	u	5.3	0.0	9.4	u	u	1.0	u	u
Percentage distribution of sexually active in past year by most recent partner (15–24-year-olds)									
Spouse/partner	u	29.2	u	36.7	u	76.3	32.7	79.9	u
Boyfriend/girlfriend/fiancee/lover	u	43.6	u	35.7	u	12.4	37.1	9.9	u
Friend/acquaintance/other	u	21.0	u	14.7	u	1.7	22.6	2.4	u
Commercial sex worker	u	3.5	u	5.1	u	u	0.0	0.0	u
% 15–24 who were sexually active in past year with ≥ 2 partners	u	36.1	u	23.5	1.1	2.1	41.2	1.4	u
FORMATION OF UNIONS‡									
% 15–19 currently in union	19.2	1.7	18.1	5.7	26.0	20.3	5.0	22.3	7.5
% 20–24 currently in union	51.5	36.3	56.9	42.0	57.7	54.4	33.5	55.5	47.6
% 15–24 currently in union	34.0	17.1	35.5	19.1	40.4	35.7	17.8	36.7	24.5
% 15–19 currently sexually active and single	8.2	24.5	1.3	17.6	4.7	4.7	24.9	5.5	36.7
% 20–24 currently sexually active and single	12.4	30.0	2.9	28.1	7.1	7.7	30.5	8.0	37.7
% 15–24 currently sexually active and single	10.1	27.0	2.0	21.5	5.8	6.1	27.4	6.6	37.1
% 15–19 ever been in union	21.8	2.0	19.9	6.1	32.1	24.8	6.4	30.4	10.0
% 20–24 ever been in union	59.5	40.8	61.6	44.2	70.0	65.8	38.7	69.3	56.3
% 15–24 ever been in union	39.1	19.3	38.6	20.1	49.3	43.4	20.9	47.3	29.5
Percentage distribution of youth in union by type of union									
15–19, legal	14.4	§	40.7	52.4**	12.3	10.0	11.8	23.1	5.0
15–19, consensual	85.6	§	59.3	47.6**	87.7	90.0	88.2	76.9	95.0
20–24, legal	31.5	22.8	58.2	53.2	30.4	24.3	23.4	35.6	30.6
20–24, consensual	68.5	77.2	41.8	46.8	69.6	75.7	76.6	64.4	69.4
15–24, legal	26.3	21.5	53.3	53.1	24.1	19.8	21.6	31.3	26.1
15–24, consensual	73.7	78.5	46.7	46.9	75.9	80.2	78.4	68.7	73.9
Median age at first union (women aged 20–24, men aged 25–29)	20.8	23.6	20.0	23.1	19.0	19.4	22.8	18.7	21.2
% who entered into union during adolescence									
All 40–44	56.9	27.1	65.3	26.0	63.6	59.9	20.1	70.4	29.1
All 20–24	44.6	20.9	50.3	27.9	57.6	54.4	21.3	60.1	38.7
40–44 with < 7 yrs. of education	69.1	27.3	73.2	28.6	71.0	69.8	22.2	79.7	37.4
20–24 with < 7 yrs. of education	64.8	37.1	66.0	33.5	71.2	68.6	24.8	79.2	46.4
40–44 with ≥ 7 yrs. of education	32.1	26.5	36.7	21.3	34.8	30.6	11.1	50.1	12.6
20–24 with ≥ 7 yrs. of education	33.0	12.2	26.3	19.5	33.3	33.3	11.9	43.4	29.3
40–44 in rural areas	66.6	26.2**	72.9	32.8	67.9	68.6	15.2	80.0	31.3
20–24 in rural areas	50.7	24.2	56.8	31.4	70.1	62.2	24.4	73.1	43.5
40–44 in urban areas	50.3	27.8	55.6	15.1	59.0	52.7	25.7	65.6	27.8
20–24 in urban areas	40.2	18.1	40.8	23.4	46.3	47.4	17.6	52.5	35.3

Appendix Table 2. Sexual relationships and unions in El Salvador, Guatemala, Honduras and Nicaragua.

Indicator	El Salvador		Guatemala		Honduras			Nicaragua	
	Women 2002–2003	Men 2002–2003	Women 2002	Men 2002	Women 2001	Women 2005–2006	Men 2001	Women 2001	Men 1998
Unweighted Ns									
Total aged 15–19	1,839	204	1,601	461	1,512	4,566	570	3,146	679
Total aged 20–24	1,914	210	1,757	344	1,627	3,786	551	2,402	500
Total aged 15–24	3,753	414	3,358	805	3,139	8,352	1,121	5,548	1,179
Sexually experienced, aged 15–24	2,155	307	1,946	506	2,061	4,318	802	2,992	871
Currently sexually active, aged 15–24	1,856	219	1,764	395	1,799	3,513	610	2,447	726
In union, aged 15–24	1,591	90	1,718	239	1,645	3,039	331	2,151	288
Not in union and sexually active, aged 15–24	265	129	46	156	154	474	279	296	438
*Unless specified otherwise, sexually active refers to all who are currently in union and those who are single and who have had intercourse in the past three months. †Sexual abuse is defined as being touched in a sexual manner by an older person or forced to perform a sexual act while younger than age 12, or being physically forced to have sex or perform sexual acts after age 12. ‡All measures referring to union or marital status include formal and consensual unions. §N<25. **N=25–49.									
Notes u=unavailable. na=not applicable.									
Sources Special tabulations of data from the following surveys: El Salvador —2002–2003 FESAL; Guatemala —2002 ENSMI and 2002 ENSM; Honduras —2001 ENESF and 2005–2006 ENDESA; and Nicaragua —2001 ENDESA (women) and 1998 ENDESA (men).									

Appendix Table 3. Early childbearing and pregnancy in El Salvador, Guatemala, Honduras and Nicaragua

Indicator	El Salvador		Guatemala		Honduras			Nicaragua	
	Women 2002–2003	Men 2002–2003	Women 2002	Men 2002	Women 2001	Women 2005–2006	Men 2001	Women 2001	Men 1998
FERTILITY									
% 15–19 who ever had a child	18.7	0.7	16.0	3.7	23.2	17.2	4.2	20.6	3.9
% 20–24 who ever had a child	59.6	38.0	59.2	37.1	66.8	62.9	31.5	63.7	45.9
% 15–24 who ever had a child	37.4	22.7	35.4	16.0	43.0	37.9	16.5	39.3	21.6
% of all births in past 5 yrs. to women aged 15–19	22.7	na	19.8	na	22.2	21.3	na	25.4	na
% 20–24 who had a child before age 20									
< 7 yrs. of education	65.9	na	57.7	na	60.3	60.1	na	69.5	na
≥ 7 yrs. of education	28.9	na	21.7	na	29.4	26.0	na	29.0	na
Rural	49.3	na	49.2	na	59.7	54.4	na	62.3	na
Urban	37.4	na	35.0	na	39.8	39.2	na	39.5	na
Low socioeconomic bracket	60.0	na	62.4	na	63.6	61.6	na	67.5	na
Middle socioeconomic bracket	41.8	na	52.2	na	50.5	48.1	na	52.4	na
High socioeconomic bracket	24.5	na	27.1	na	32.3	28.7	na	32.0	na
% of women who had first birth before each age									
% 40–44 who had first birth before age 15	2.0	na	2.7	na	3.4	3.1	na	6.9	na
% 20–24 who had first birth before age 15	2.2	na	2.6	na	3.3	2.8	na	4.4	na
% 40–44 who had first birth before age 18	22.9	na	24.9	na	26.2	25.7	na	33.2	na
% 20–24 who had first birth before age 18	24.4	na	24.4	na	28.1	26.1	na	28.1	na
% 40–44 who had first birth before age 20	45.6	na	48.9	na	50.0	48.3	na	56.2	na
% 20–24 who had first birth before age 20	42.4	na	43.5	na	49.3	46.4	na	47.9	na
Median age at first birth among women 20–24	21.2	na	20.9	na	20.1	20.5	na	20.3	na
% 15–19 with ≥ 2 children	3.1	0.0	4.3	1.1	5.6	2.3	0.8	4.0	1.0
% 20–24 with ≥ 2 children	29.8	13.0	36.7	16.7	39.4	31.1	12.8	32.7	21.0
% 20–24 who had nonmarital birth before age 20	9.4	na	3.9	na	5.5	4.9	na	3.7	na
% of 15–24-year-old mothers whose first birth occurred <7 mos. after entering union	13.4	na	11.1	na	8.5	5.6	na	8.2	na
Mean no. of months between first 2 births among women 15–24 with ≥2 births	30.7	na	26.3	na	27.5	30.5	na	28.9	na
FERTILITY PREFERENCES									
% of births to adolescents in past 5 years that were unplanned*	42.6	na	29.3	na	39.8	47.3	na	44.7	na
% of births to women aged 15–24 in past 5 years that were unplanned*	40.9	na	26.9	na	43.0	48.6	na	45.0	na
% of sexually active† 15–24-year-olds who do not want a child soon‡									
All sexually active	77.6	69.4	89.4	83.2	76.4	87.4	49.5	87.3	80.2
In union§	75.8	63.7	89.3	85.8	76.6	87.4	55.5	86.8	79.0
No children	32.3	na	67.8	na	43.3	62.3	na	65.7	na
1 child	82.5	na	89.6	na	79.4	91.8	na	88.3	na
≥2 children	87.6	na	95.8	na	88.0	95.6	na	96.6	na
Not in union	83.7	73.0	91.1**	80.9	74.8	87.3	45.6	89.9	81.1
PRENATAL AND DELIVERY CARE									
% 15–24 who received professional prenatal care††	86.0	na	70.8	na	67.0	67.6	na	86.7	na
% 15–24 who received professional delivery care††	76.6	na	51.6	na	65.7	74.5	na	73.8	na
*Includes both births that were unwanted and those that were mistimed. †Sexually active refers to all who are in union and those who are single and who have had intercourse in the past three months. ‡Want no children or want to wait two or more years before their next birth. §All measures referring to union or marital status include formal and consensual unions. **N=25–49. ††Professional care is care provided by doctors and nurses at private- and public-sector hospitals and clinics.									
Notes na=not applicable. For unweighted Ns, see Appendix Table 2.									
Sources Special tabulations of data from the following surveys: El Salvador —2002–2003 FESAL; Guatemala —2002 ENSMI and 2002 ENSM; Honduras —2001 ENESF and 2005–2006 ENDESA; and Nicaragua —2001 ENDESA (women) and 1998 ENDESA (men).									

Appendix Table 4. Contraceptive knowledge, use and unmet need in El Salvador, Guatemala, Honduras and Nicaragua

Indicator	El Salvador		Guatemala		Honduras			Nicaragua	
	Women 2002–2003	Men 2002–2003	Women 2002	Men 2002	Women 2001	Women 2005–2006	Men 2001	Women 2001	Men 1998
KNOWLEDGE									
% 15–19 who know a modern method*	96.5	nc	84.8	90.3	98.7	97.9	98.7	96.1	95.5
% 15–19 who know of the condom	91.8	nc	66.1	83.9	94.0	91.1	96.7	89.1	96.3
USE									
% 15–24 currently using a modern method									
All sexually active	47.6	49.8	25.3	32.0	39.6	46.2	34.6	54.5	40.9
In union	52.3	49.4	24.8	24.8	41.0	47.4	36.0	57.5	55.1
Not in union	31.7	50.1	33.9†	38.3	29.9	38.8	33.7	38.2	31.5
% 15–24 sexually active who obtained their modern method in a pharmacy	18.6	61.8‡	21.1	61.4	17.8	22.5	35.0	19.7	45‡
% 15–24 currently using a traditional§ method									
All sexually active	6.6	7.7	6.7	7.4	10.7	7.4	7.8	4.9	3.4
In union	56.9	8.5	6.6	9.9	10.8	7.6	12.4	5.0	3.9
Not in union	9.3	7.2	9.0†	5.1	9.4	6.1	4.9	4.2	3.0
% 15–24 in union currently using any method									
No children	25.3	u	9.2	u	17.4	25.2	u	33.3	u
1 child	60.3	u	43.1	u	59.7	61.5	u	68.4	u
≥2 children	69.9	u	29.9	u	59.5	63.1	u	71.6	u
UNMET NEED FOR A MODERN METHOD**									
% 15–19									
All sexually active	48.7	u	51.9	u	47.9	40.5	u	36.3	u
In union	41.4	u	50.0	u	46.7	37.1	u	29.6	u
Not in union	65.8	u	††	u	54.2	54.9	u	63.5	u
% 20–24									
All sexually active	35.1	u	53.1	u	45.9	37.2	u	27.5	u
In union	29.9	u	53.5	u	44.7	35.8	u	25.6	u
Not in union	57.0	u	44.3†	u	55.7	46.5	u	40.5	u
% 15–24									
All sexually active	39.7	u	52.7	u	46.6	38.2	u	30.7	u
In union	33.4	u	52.5	u	45.4	36.2	u	27.0	u
Low socioeconomic bracket	37.8	u	63.9	u	50.8	43.6	u	32.1	u
Middle socioeconomic bracket	30.4	u	54.0	u	40.5	30.9	u	24.4	u
High socioeconomic bracket	30.1	u	37.3	u	43.7	31.0	u	23.7	u
Not in union	60.9	u	56.7†	u	55.0	50.1	u	51.5	u
Low socioeconomic bracket	53.4	u	††	u	††	61.5	u	56.5	u
Middle socioeconomic bracket	72.0	u	††	u	55.8	45.8	u	55.4	u
High socioeconomic bracket	53.9	u	52.6†	u	49.5†	47.3	u	46.8	u

*Modern methods refer to the pill, the injectable, the implant, male and female sterilization, the IUD, vaginal methods (diaphragm, spermicides, foam, tablets), the male condom and, for some surveys, the female condom and emergency contraception. †N=25–49. ‡Percentage refers to the source for condoms only. §Traditional methods refer to periodic abstinence (rhythm), withdrawal, lactational amenorrhoea and folk methods.**Women are considered to have an unmet need for a modern method if they are sexually active, fecund, do not want a child in the next two years and are not using a modern method.††N<25.

Notes nc=noncomparable, because the FESAL questionnaire for men did not include the condom in the question assessing knowledge of modern methods. u=unavailable. For unweighted Ns, see Appendix Table 2. Sexually active refers to all who are in union and those who are single and who have had intercourse in the past three months. All measures referring to union or marital status include formal and consensual unions. Socioeconomic bracket categorization is based on an index of goods and services and household characteristics.

Sources Special tabulations of data from the following surveys: **El Salvador**—2002–2003 FESAL; **Guatemala**—2002 ENSMI and 2002 ENSM; **Honduras**—2001 ENESF and 2005–2006 ENDESA; and **Nicaragua**—2001 ENDESA (women) and 1998 ENDESA (men).

Appendix Table 5 Knowledge of and risk factors for HIV and other STIs in El Salvador, Guatemala, Honduras and Nicaragua

Indicator	El Salvador		Guatemala		Honduras			Nicaragua	
	Women 2002–2003	Men 2002–2003	Women 2002	Men 2002	Women 2001	Women 2005–2006	Men 2001	Women 2001	Men 1998
% who have ever heard of HIV	94.9	96.9	84.4	93.4	98.8	96.7	99.1	92.0	97.8
% who have ever heard of an STI (other than HIV)	82.6	93.3	54.3	77.8	64.0	53.8	71.4	43.4	u
% who know that a healthy-looking person can have HIV	72.2	82.8	58.5	70.2	80.6	77.1	89.9	72.9	80.3
% who believe there is a cure for AIDS	14.3	11.0	10.5	12.1	8.4	u	7.2	u	u
% who spontaneously identified following means of avoiding HIV*									
Abstinence	14.5	14.2	22.0	4.4	22.0	nc	7.2	7.9	8.2
Using condoms	29.8	64.3	32.2	49.4	52.0	nc	66.0	51.6	68.3
Limiting number of partners	24.4	18.5	36.8	54.2	39.5	nc	53.9	20.2	17.4
Among those who have heard of HIV/AIDS									
% who believe they are at risk of becoming infected	25.8	32.8	u	u	25.8	u	15.6	22.1	55.8
% who believe an infected person should be allowed to work	u	u	48.7	45.7	40.8	u	30.1	u	u
% who believe that an infected teacher should be allowed to continue teaching	54.2	53.7	u	u	u	56.4	u	42.8	u
% who believe condom should be taught to adolescents	u	u	80.2	91.4	74.3	u	86.4	u	u
% of sexually active 15–24-year-olds with ≥ 2 partners in past 12 months									
All sexually active	u	36.1	u	23.5	1.1	2.1	41.2	1.4	u
In union	u	23.6	u	9.4	0.7	0.6	21.1	0.7	u
Not in union	u	41.1	u	31.6	2.7	6.2	50.3	3.1	u
Among those with ≥2 partners in past 12 months, % used condom at last sex	u	55.1	u	51.4	†	27.2	39.5	38.7‡	u
% of sexually active who used condom at last sex									
All sexually active	8.7	41.4	2.5	32.7	4.1	5.6	26.9	6.3	29.7
In union	3.7	2.9	1.9	3.7	3.0	3.1	2.1	5.3	7.3
Not in union	25.6	65.8	11.6‡	58.4	11.7	20.2	43.0	11.4	44.5
% who ever used condom for STI prevention	70.6§	83.5§	u	25.3	4.8	u	51.9	u	38.5
Among those who have heard of HIV, % who know about the HIV test	65.2	67.9	54.3	63.1	67.6	u	71.8	u	u
Among those who know about the HIV test, % who want to be tested	79.4	80.8	42.1	65.5	51.8	u	45.4	u	u
Among those who know about the HIV test, % who know a place for testing	55.7	55	62	56.3	50.8	u	65.3	u	u
% who have ever had an STI**	u	u	3.3	4.5	u	1.2	u	0.7	4.6
Among those who have had an STI,** % who sought treatment	u	u	80.9	98.8‡	u	66.5	u	†	u

*Data for Nicaraguan women come from the 1998 survey. †N<25. ‡N=25–49. §At last sex.**Among those who are sexually experienced and have heard of STIs, percentage who have ever had an STI (Guatemala) or percentage who have had an STI in the past 12 months (Honduras and Nicaragua).

Notes u=unavailable. nc=noncomparable because the ordering and wording of items in the 2005–2006 ENDESA questionnaire do not match the others (i.e., prompts about whether the respondent knows specific methods of HIV prevention precede the question asking respondent to spontaneously mention any other ways of prevention). All measures referring to union or marital status include formal and consensual unions. Sexually active refers to all who are currently in union and, for those who are single, it includes youth who had intercourse in the past year for multiple partner measures, and in the past three months for condom at last sex in general. For unweighted Ns, see Appendix Table 2.

Sources Special tabulations of data from the following surveys: **El Salvador**—2002–2003 FESAL; **Guatemala**—2002 ENSMI and 2002 ENSM; **Honduras**—2001 ENESF and 2005–2006 ENDESA; and **Nicaragua**—2001 ENDESA (women) and 1998 ENDESA (men).