

**Economic and Social Council**

Distr.: General
30 January 2012
Original: English

Advance unedited version

Commission on Population and Development**Forty-fifth session**

23-27 April 2012

Item 3 of the provisional agenda*

Adolescents and youth**Adolescents and youth****Report of the Secretary-General***Summary*

This report was prepared in response to decision 2010/101 of the Commission on Population and Development in which the Commission decided to consider in 2012 the theme of adolescents and youth. The report presents an overview of the demography of adolescents and youth, describing current and expected trends for that population, their experience in regard to marriage, childbearing and the use of contraception, challenges to their health and survival, and their participation in international migration. The report also presents suggestions for action to ensure that young people have access to the services and guidance they need to make crucial life transitions safely and thus enable them to participate more fully and effectively in society. Those recommendations would also contribute to accelerate the achievement of the goals and objectives of the ICPD Programme of Action in regard to adolescents and youth.

* E/CN.9/2012/2.

Contents

	<i>Paragraphs</i>	<i>Page</i>
Introduction	1-6	3
I. Trends in the population of adolescents and youth	7-14	4
II. Marriage	7-14	4
III. Childbearing and sexual activity among adolescents and youth.....	21-24	12
IV. Family planning	25-34	16
V. The health of adolescents and youth	35-44	20
VI. International migration of youth.....	45-50	24
VII. Conclusions and recommendations.....	51-61	25
 Tables		
1. Population aged 12-24 by region, 2012 to 2100 (<i>millions</i>)		5
2. Percentage ever-married or in consensual union by age, sex and region, 1990 and 2005		12
 Figures		
I. Regional distribution of the population of adolescents and youth, 1950-2100.....		6
II. Population aged 10-24 according to three projection variants, 1950-2100.....		7
III. Population aged 12-24 as a percentage of that aged 12-64, 1950-2100.....		8
IV. Percentage of women aged 20-24 who married before age 15 vs. minimum legal age at marriage with parental consent by region		10
V. Percentage of women aged 20-24 who married before age 15 vs. percentage of girls completing primary education by region.....		11
VI. Adolescent birth rate vs. the percentage of ever-married women aged 15-19		13
VII. Percentage of women aged 20-24 who were sexually active before age 20 vs. those who married before age 20		14
VIII. Adolescent birth rate vs. the percentage of women aged 20-24 who were sexually active before age 20		14
IX. Percentage of men aged 15-19 who became sexually active before age 15 vs. percentage of women aged 15-19 who became sexually active before age 15.....		15
X. Contraceptive prevalence and unmet need for contraception among women aged 15-19 and 20-24 by purpose		17
XI. Percentage of contraceptive users relying on traditional methods		19
XII. Death rate by age, sex and region, 2008 (per 100,000).....		21
XIII. Percentage distribution of deaths by major cause, age and sex, 2008		23

Introduction

1. Adolescence is the period of transition between childhood and adulthood. Adolescence is considered to begin with puberty, a process of physical, psychological and emotional development triggered by a cascade of endocrine changes that lead to sexual maturation and reproductive capability. In girls, a key marker of puberty is menarche (i.e. the first menstruation), but there is not such a clear marker in boys. In girls, the mean age at menarche is between 12 and 13 years in developed countries¹ and it is likely similar or higher in developing countries. In boys, signs of sexual maturation become evident at around 13 or 14 years of age. Among both girls and boys, the start of puberty can vary by 4 or 5 years around the mean. Although puberty generally lasts 2 to 4 years, there is no strict definition of when adolescence begins and ends. In many societies, where adolescents and young people are expected to remain in school for long periods and legal provisions set the age at majority generally at age 18 or higher, one approach to determining the period of adolescence would be to focus on persons aged 12 to 17 years.

2. Similarly, there is no established definition of youth. However, in preparing for the first International Youth Year in 1985, an Advisory Committee to the United Nations noted that: “A chronological definition of who is young, as opposed to who is a child or who is an adult, varies with each nation and culture. However, the United Nations, for statistical purposes, defines those persons between the ages of 15 and 24 as youth without prejudice to other definitions by Member States.”² The use of 15 as the lower bound for youth, instead of 18, was indeed driven by statistical considerations since data are very often available by five-year age groups only. In practice, studies on adolescents and youth have defined those groups flexibly. This report will mainly focus on young people aged 12-24 but the term “adolescents and youth” will refer to varying age groups because of data limitations.

3. Among the 1.6 billion persons aged 12-24 today, 0.85 billion are aged 18-24. The overall number of adolescents and youth is expected to change little over the coming decade and, provided fertility and mortality levels in developing countries continue to decline, may remain relatively stable over the rest of the century. However, the population aged 12-24 is still increasing rapidly in Africa while it is declining or will soon decline in all other regions. Consequently, the proportion of the world’s adolescents and youth living in Africa is expected to rise from 18 per cent in 2012 to 28 per cent by 2040, while the shares of all other regions will decline. Asia and the Pacific is expected to experience the sharpest decline, from 61 per cent today to 52 per cent in 2040.

4. Most adolescents and youth live today in a different world from that in which their parents grew up. Compared to young people 20 years ago, adolescents today are healthier and more likely to spend their adolescence in school, to postpone entry into the labour force and to delay marriage and childbearing. However, because change is not happening

¹ G. C. Patton and R. Viner, Pubertal transitions in health, Adolescent Health Series No. 1, *The Lancet*, March 2007.

² United Nations (1981). Report of the Advisory Committee for the International Youth Year. A/36/215, annex.

at the same pace everywhere, there are also growing disparities among adolescents and youth within and across countries. In particular, young people who live in poverty face major disadvantages. They are more likely to work as children, never to attend school or to drop out of it, to engage in risky sexual behaviours, and to marry and bear children early.

5. To reduce disparities among young people, it is urgent to focus on the services that can make major differences in their lives. Declining fertility and improvements in child health have increased demand for schooling. Ensuring universal primary education and expanding enrolment at the secondary level can yield many dividends, especially in improving skills for productive employment, reducing risky behaviours, and developing habits that can influence health for the rest of young people's lives. To reap the greatest benefits from education both its length and contents are important. More than ever before, young people not only need to be taught, they need to be active participants in learning and to develop the behavioural skills that living in rapidly changing societies require.

6. The adolescents and youth of today are central to realizing development that is sustainable and equitable. Greater investments in their education, health and labour market opportunities can shape the well-being of tomorrow's adults and, in the process, ultimately narrow the gaps between countries in human development. This report provides a demographic overview of adolescents and youth, beginning with their numbers and share of the working-age population because the absolute and relative sizes of youth cohorts have consequences for the demands placed on public sector services and the supply of labour. The report also describes their family formation patterns, sexual and reproductive health, main causes of morbidity and mortality and selected aspects of migration, and presents recommendations to improve outcomes for adolescents and youth in these key population-related areas.

I. Trends in the population of adolescents and youth³

7. Globally, the number of adolescents and young people is at an all time high but it might not increase much more in coming decades if global fertility continues to decline. In 2012, the world had 1.6 billion persons aged 12-24, of which 721 million were adolescents aged 12-17 and 850 million were youth aged 18-24 (table 1). Provided global fertility and mortality continue to decline, the numbers in both age groups are projected to remain within narrow ranges during the rest of the century, varying between 721 million in 2015 and a peak of 762 million in 2030 in the case of adolescents, and between 835 million in 2020 and 884 million in 2065 in the case of youth. In 2040, the world is expected to have 755 million adolescents and 883 million youth.

³ All estimates presented in this section are derived from *World Population Prospects: The 2010 Revision*, Extended dataset, United Nations publication, Sales No. 11.XIII.7.

Table 1.
Population aged 12-24 by region, 2012 to 2100 (*millions*)

<i>Region</i>	<i>2012</i>	<i>2040</i>	<i>2100</i>
<i>Adolescents aged 12-17</i>			
World	721	755	731
Africa	142	225	305
Asia and the Pacific	432	387	293
Latin America and the Caribbean	66	58	43
Developed countries	82	85	90
<i>Youth aged 18-24</i>			
World	850	883	859
Africa	144	241	353
Asia and the Pacific	521	469	349
Latin America and the Caribbean	74	70	51
Developed countries	111	104	106

8. The relative stability of global numbers of adolescents and youth masks important changes by region (figure I). Thus, whereas in most regions the numbers of both adolescents and youth are expected to decline or change little over the coming decades, they will increase markedly in Africa (by 62 per cent and 70 per cent by 2040, respectively). As a result, Africa's share of the world's adolescents and youth will rise from 18 per cent in 2012 to 28 per cent in 2040 and could reach 41 per cent by 2100. The fast growth in the number of young people in Africa will likely have profound social and economic implications because it is occurring in places where the proportion of youth who are unemployed and the proportion of working youth who are poor are higher in comparison with adults.⁴

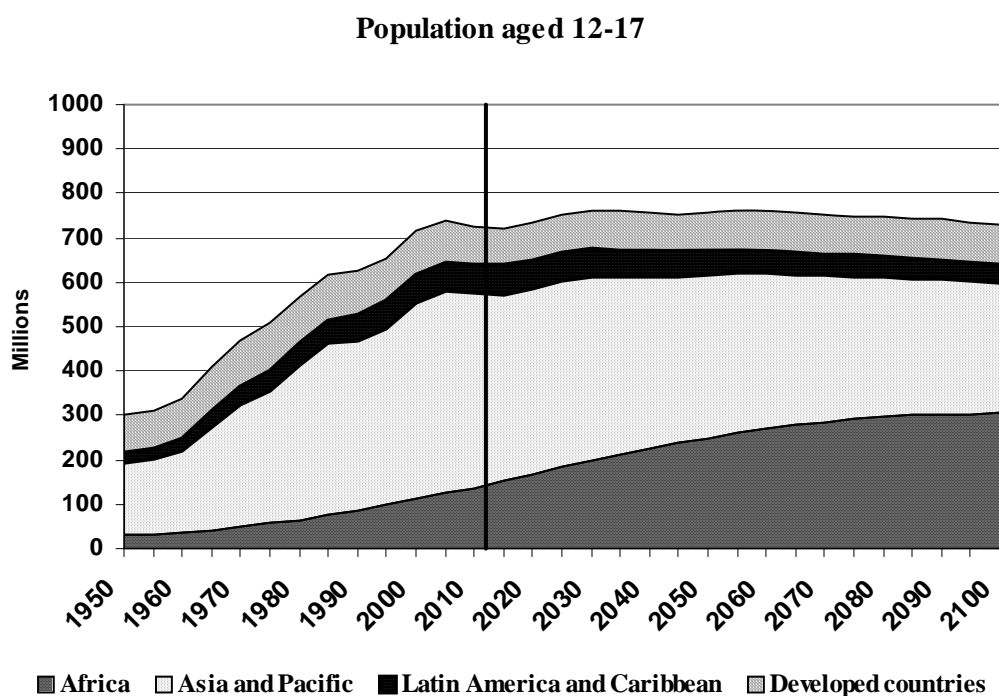
9. The population aged 12-24 is declining or will soon do so in all major regions except Africa. In developed countries the number of adolescents and youth is falling fast, at -1.4 per cent annually. However, increases in fertility in recent years plus net migration gains at younger ages will reduce the speed of decline and even lead to short periods of growth in the future. In Asia and the Pacific, the population aged 12-24 is declining at -0.6 per cent annually and reductions are projected over the foreseeable future. In Latin America and the Caribbean, the number of adolescents and youth is increasing slowly, at 0.2 per cent annually, but is projected to decline at an accelerating rate after 2015.

10. In sharp contrast, the population aged 12-24 in Africa is rising at 1.9 per cent annually and will continue to grow rapidly well beyond 2040 even if Africa's fertility falls from 4.5 children per woman today to 3.1 children per woman by 2040. Slower fertility decline will produce a more rapid increase of that population.

⁴ *Global Employment Trends 2012* (Geneva, International Labour Office, 2012).

11. The future stabilization of the number of adolescents and youth is not assured. Even small differences in future fertility can mean major changes in their numbers. For the population aged 10-24⁵ to fluctuate between 1.8 billion and 1.9 billion over the rest of the century, global fertility must drop from 2.5 children per woman in 2010 to 2.0 in 2100. If future fertility were to remain just half a child above those levels, the population aged 10-24 could rise to 2.3 billion in 2040 and 3.4 billion in 2100. If fertility were to drop faster and remain about half a child below the path described above, the population aged 10-24 could decline to 1.5 billion by 2040 and drop to 0.9 billion by 2100 (figure II).

Figure I.
Regional distribution of the population of adolescents and youth, 1950-2100



⁵ Data for different fertility projection variants are only available for 5-year age groups.

Figure I (continued)
Regional distribution of the population of adolescents and youth, 1950-2100

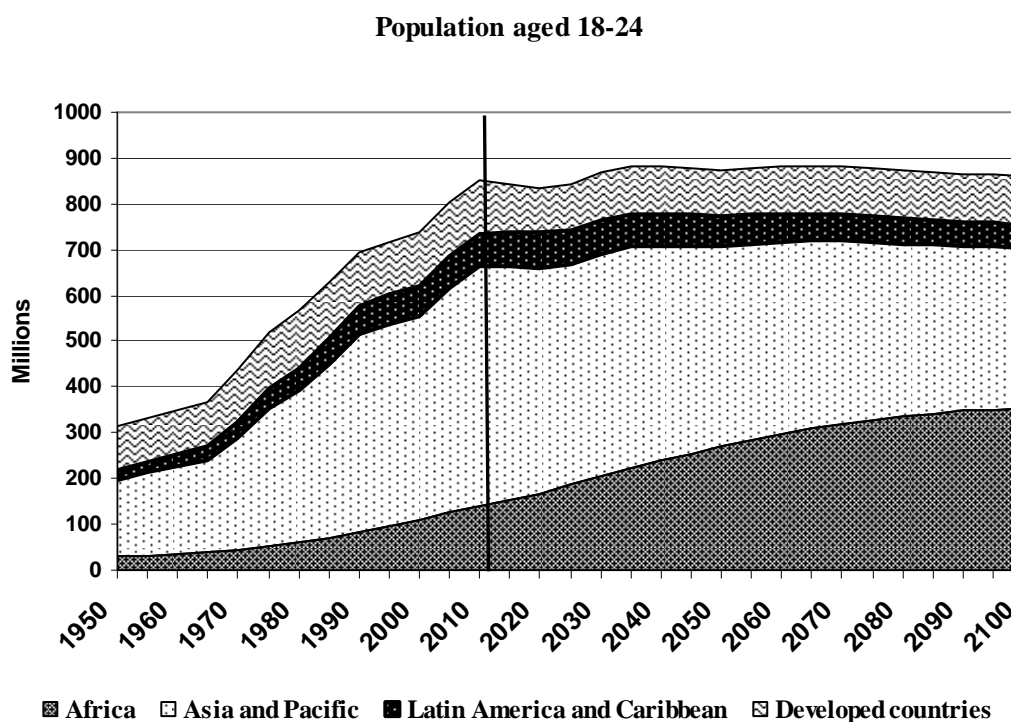
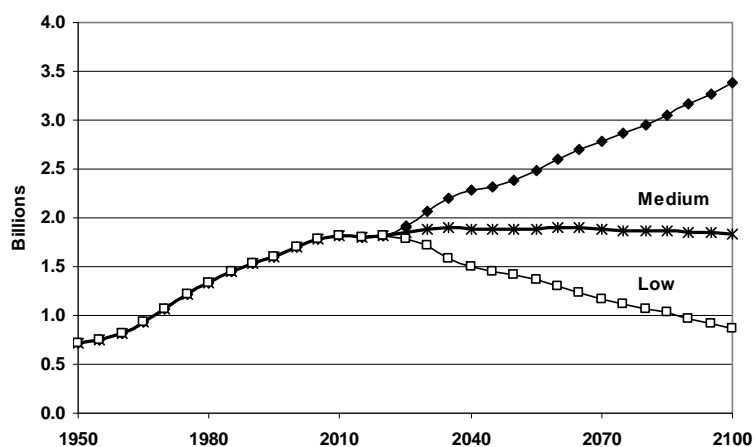


Figure II.
Population aged 10-24 according to three projection variants, 1950-2100



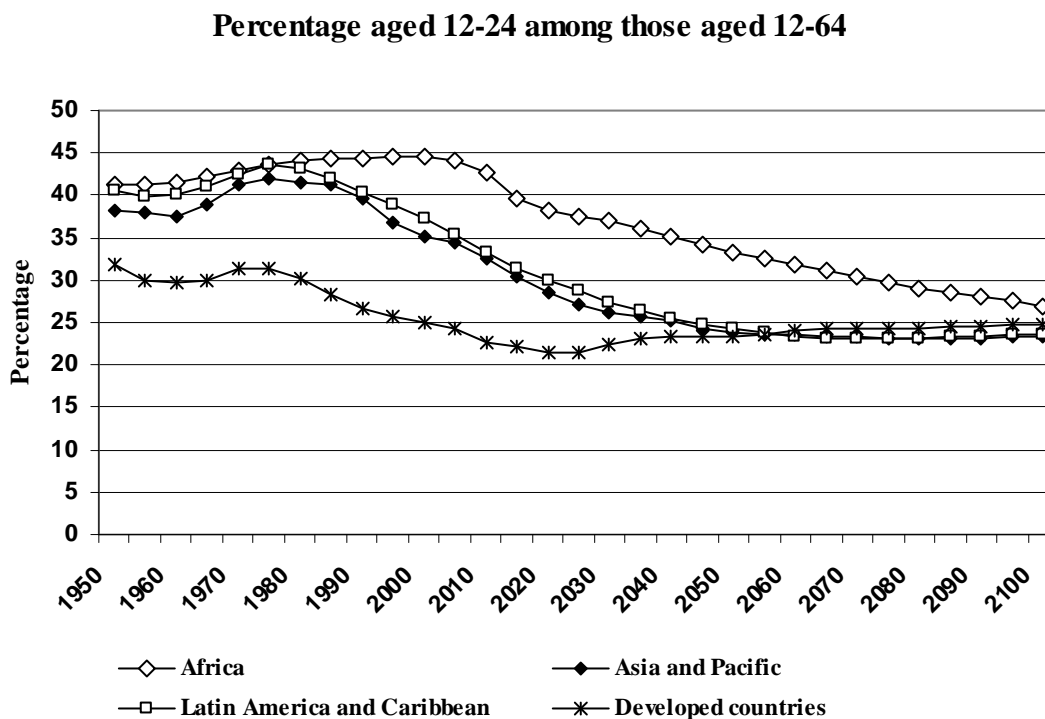
12. There is concern about the high proportion of young people in the population, yet globally that proportion peaked in 1985 at 26 per cent. As a share of the “working-age” population aged 12-64, they reached a maximum in 1975 at 39 per cent. That year, both Asia and the Pacific, and Latin America and the Caribbean also saw their share of young people aged 12-24 among persons aged 12-64 peak, at 42 and 44 per cent respectively. In developed countries the maximum was reached in 1970 at 31 per cent. Even in Africa, the

share of young people in the working-age population was highest in 2000, at 45 per cent. Today, the share of those aged 12-24 among persons aged 12-64 is decreasing in all regions and is expected continue dropping provided the reduction of fertility in developing countries continues (figure III).

13. Currently, persons aged 12-24 still comprise a major share of the working-age population. That share is highest in Africa (43 per cent), followed by Asia and the Pacific and Latin America and the Caribbean (33 per cent in each) and by developed countries (23 per cent). By 2040, persons aged 12-24 are projected to constitute 27 per cent of the population aged 12-64 worldwide, and 35 per cent in Africa, 25 per cent in both Asia and the Pacific and Latin America and the Caribbean, and 23 per cent in developed countries.

14. Globally, males outnumber females among people aged 12-24, with 106 males for every 100 females. That ratio is lowest in Africa and in Latin America and the Caribbean, at 102, and highest in Asia and the Pacific at 109. In developed countries the sex ratio among young people is 105.

Figure III.
Population aged 12-24 as a percentage of that aged 12-64, 1950-2100



II. Marriage

15. Marriage is a major milestone in the path to adulthood. Historically, in most societies marriage marked the start of a couple's reproductive life. Currently, societies vary considerably with respect to whether or not marriage coincides with the beginning of childbearing. In addition, consensual unions have been a common alternative to marriage in many societies and their formation may not have as clear a starting date as formal marriage.

16. When life expectancy was low, many children died early in childhood and maternal mortality was high, societies encouraged early marriage to maximize the reproductive life of couples. Today, life expectancy is high by historical standards in all countries and the vast majority of children survive to adulthood. Moreover, the importance of providing a minimum period of schooling to all children is a universally shared goal among countries. As the years of mandatory schooling increase and societies provide more options for young people to work and be productive, the aspirations of young people rise and they tend to postpone marriage. Moreover, it is well established that bearing children too early in life carries greater risks for both mothers and children. Societies have acknowledged that it is better to postpone marriage until women and men reach adulthood by adopting laws setting a minimum age at marriage. Thus, among the 187 countries with information on the minimum legal age at marriage, 158 allow women to marry without parental consent at age 18 or higher and 180 allow men to marry without parental consent at age 18 or higher.

17. Although the majority of countries forbid women from marrying before age 18 without parental consent or the approval of a pertinent authority, there are 29 countries where marriage without such approval can occur earlier, 16 of which are in Asia or the Pacific, 7 in Africa, two in the Caribbean and four are developed countries. In seven of those countries, women as young as 15 can marry without parental consent. In addition, the laws of at least 146 countries allow women under 18 to marry provided their parents or a pertinent authority approve and in at least 27 of them the age at marriage can be lower than 15. In the case of men, 107 countries allow marriage before age 18 with the consent of parents or of a pertinent authority.

18. In numerous countries a significant proportion of women marry at very young ages either because their laws allow early marriage with parental consent or because enforcement of the minimum legal age at marriage is lax. In some countries, laws might include expectations for some ethnic or religious groups or forms of marriage. Data from recent surveys conducted in 80 countries indicate that in 23 of them at least 10 per cent of women aged 20-24 at the time of interview had married before age 15. Among those countries, 16 were in Africa, 5 in Asia and the Pacific, and two in Latin America and the Caribbean. However, the association between the percentage of women marrying at young ages and the minimum age at marriage allowed when parents consent is weak (figure IV). Even when the minimum age at marriage with parental consent was 15 or 16, several

countries had high proportions of young women who had married before age 15. Furthermore, in countries where no minimum age was stipulated for women marrying with parental consent, the percentage of young women married before age 15 varied markedly. This evidence suggests that legislative action is not sufficient to reduce the prevalence of early marriage among women. When parents allow or even promote the early marriage of their young daughters, delaying marriage hinges on changing the views of parents about the acceptability of early marriage and addressing the real or perceived benefits associated with it.

19. When girls have access to education they are less likely to marry early. Thus, the higher the level of illiteracy among women aged 15-24, the higher the propensity to marry early. Furthermore, the percentage of women aged 20-24 who had married before age 15 tends to be higher in countries with low proportions of girls completing primary education (figure V) and, according to surveys, the propensity of women to marry early is higher among women with no education or even primary education than among those with secondary education. When societies value the education of girls, their marriage tends to be delayed.

Figure IV.

Percentage of women aged 20-24 who married before age 15 vs. minimum legal age at marriage with parental consent by region

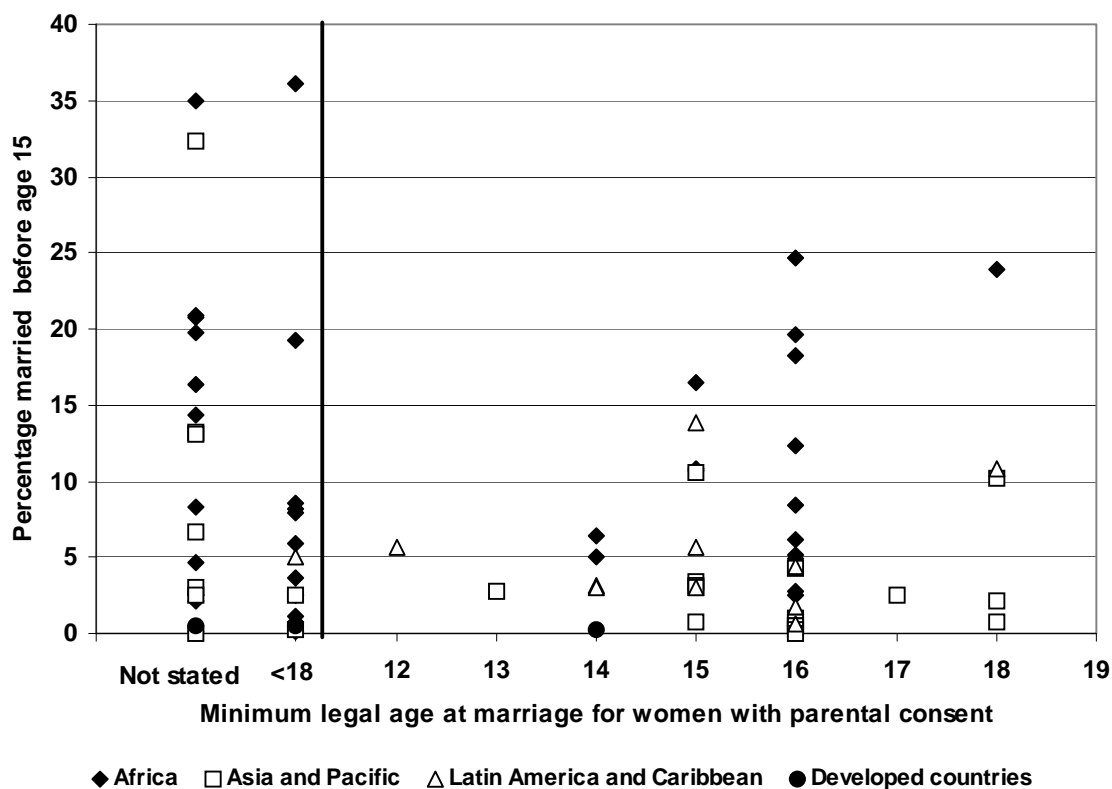
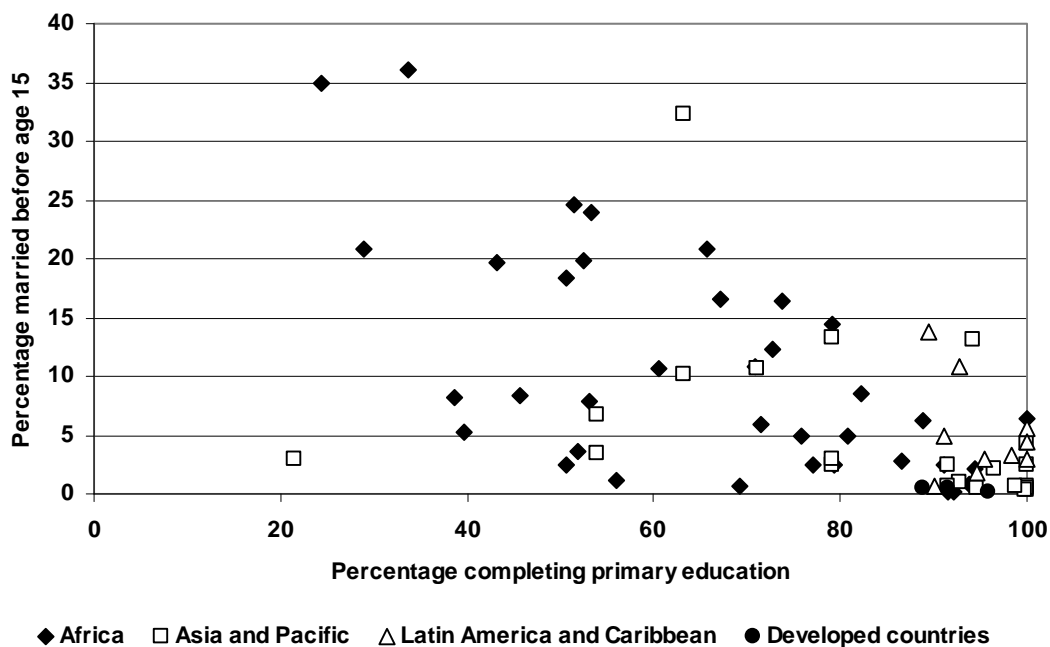


Figure V.
Percentage of women aged 20-24 who married before age 15 vs. percentage of girls completing primary education by region



20. Globally, the age at marriage has been increasing and, consequently, the proportion ever-married among young people has been decreasing (table 2). In 1990, 18 per cent of women aged 15-19 had ever been married, but by 2005 only 15 per cent had. For men, the equivalent proportions were 4 per cent and 2 per cent, respectively. At ages 20-24, the decline in the proportion ever-married was from 60 per cent to 51 per cent among women and from 31 per cent to 23 per cent among men. Differences in the timing of marriage among regions are marked, especially for women. In 2005, the regions with the highest percentage of ever-married women among those aged 15-19 were Western and Middle Africa (33 per cent and 29 per cent, respectively), Southern Asia (28 per cent), Eastern Africa (26 per cent) and Central America (20 per cent). In contrast, delayed marriage in developed countries has meant that even at ages 20-24, only 26 per cent of women have ever been married or lived in a consensual union. The postponement of marriage is also common in Southern Africa and Eastern Asia where only 23 per cent and 37 per cent, respectively, of women aged 20-24 in 2005 had ever been married.

Table 2.
Percentage ever-married or in consensual union by age, sex and region, 1990 and 2005

<i>Region</i>	<i>Women</i>				<i>Men</i>			
	<i>1990</i>		<i>2005</i>		<i>1990</i>		<i>2005</i>	
	<i>15-19</i>	<i>20-24</i>	<i>15-19</i>	<i>20-24</i>	<i>15-19</i>	<i>20-24</i>	<i>15-19</i>	<i>20-24</i>
World	18	60	15	51	4	31	2	23
Africa	27	65	24	61	4	25	2	21
Asia and the Pacific	19	66	15	56	5	36	2	24
Latin America and the Caribbean	16	52	16	48	4	32	4	32
Developed countries	5	37	4	26	1	19	2	14

III. Childbearing and sexual activity among adolescents and youth

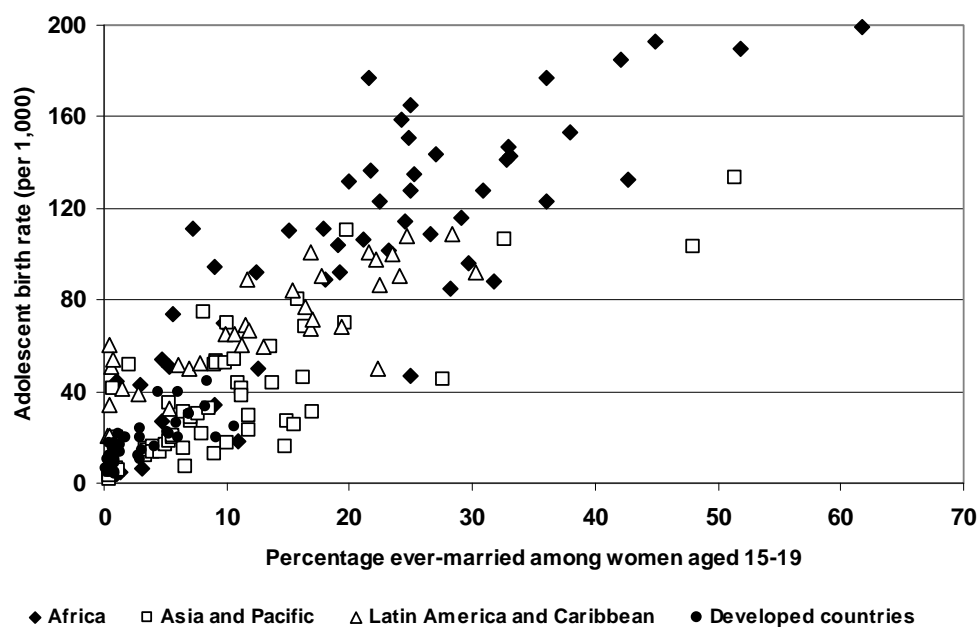
21. The start of marriage or a consensual union is generally related to the wish to procreate and therefore fertility levels among adolescents are closely associated with the percentage who are married or in union. Data for 82 countries, including 42 in Africa, show that adolescent birth rates rise with the percentage of ever-married women aged 15-19 (figure VI). The adolescent birth rate has declined in all regions since 1990, but it is still high in Africa (101 births per 1,000 women aged 15-19 in 2008), Southern Asia (77 births per 1,000) and in Latin America and the Caribbean (73 per 1,000). Globally, the adolescent birth rate was 56 births per 1,000 in 2008, more than double that in developed countries (24 per 1,000).⁶

22. Young mothers account for important proportions of all births. In 2010, women aged 15-19 gave birth to 12 per cent of the 135 million children born that year and women aged 20-24 bore a further 32 per cent. In Africa and Latin America and the Caribbean, young mothers aged 15-19 bore 15 and 18 per cent, respectively, of all births. In Asia and the Pacific and in Latin American and the Caribbean, women aged 15-24 bore 47 per cent of all births and in Africa, they bore 42 per cent. Their share of all births was lower in developed countries at 25 per cent.⁷

⁶ *World Population Prospects: The 2010 Revision*, op.cit.

⁷ *Ibid.*

Figure VI.
Adolescent birth rate vs. the percentage of ever-married women aged 15-19



23. In many societies young people become sexually active before marriage. Data for 53 countries, including 31 in Africa, indicate that the share of women beginning sexual activity before marriage is large. Thus, the percentage of women aged 20-24 at the time of interview who reported having begun sexual activity before age 20 is generally higher than the percentage who married before age 20 (figure VII), with a few countries in Asia being the exception. Because contraceptive use is low among adolescent women, early initiation of sexual activity, whether after marriage or before, is associated with higher levels of adolescent fertility (figure VIII).

Figure VII.
 Percentage of women aged 20-24 who were sexually active before age 20 vs. those who married before age 20

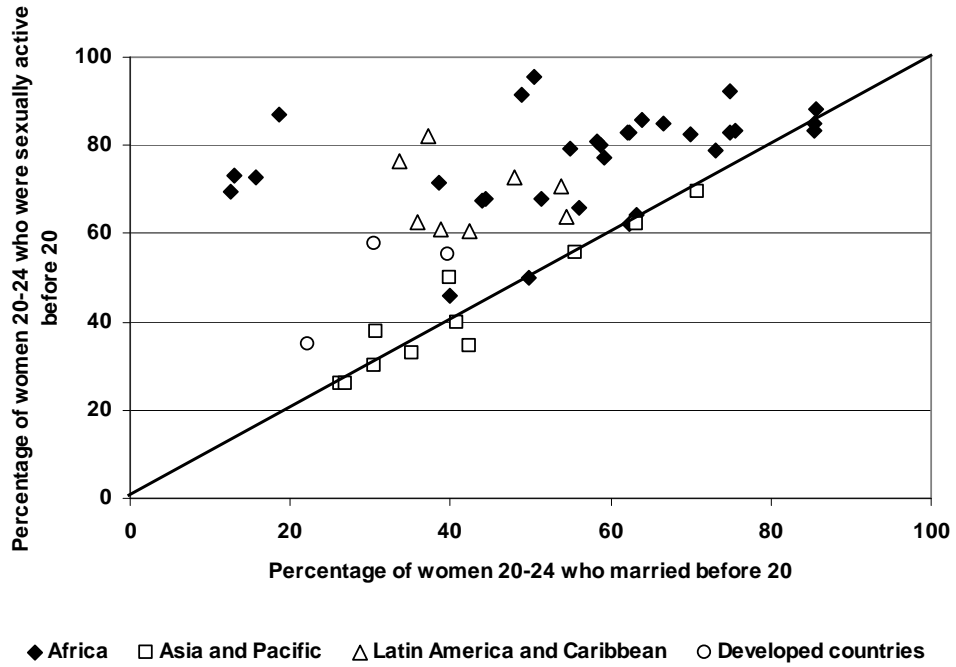
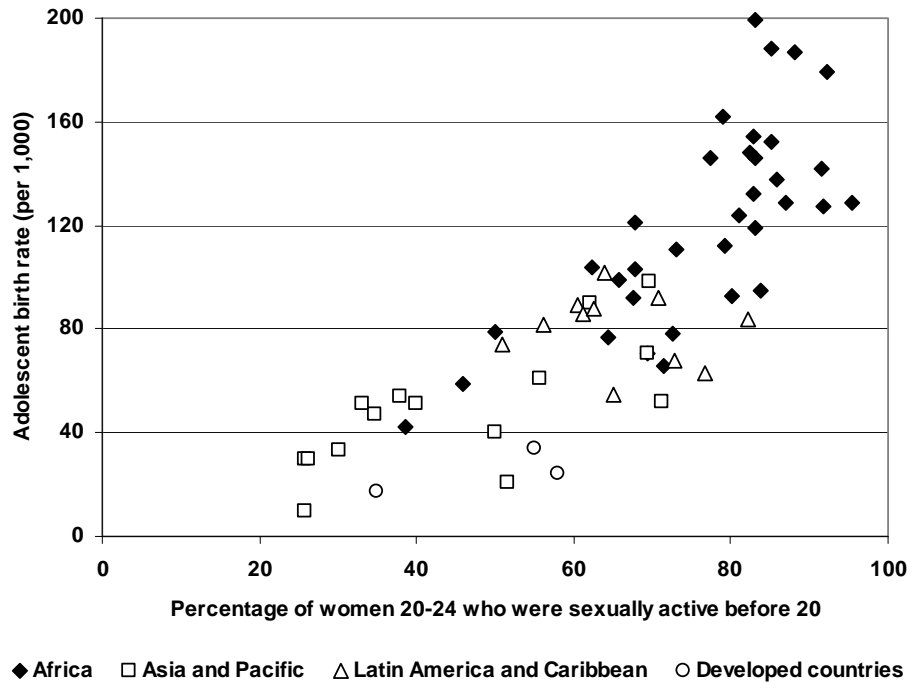


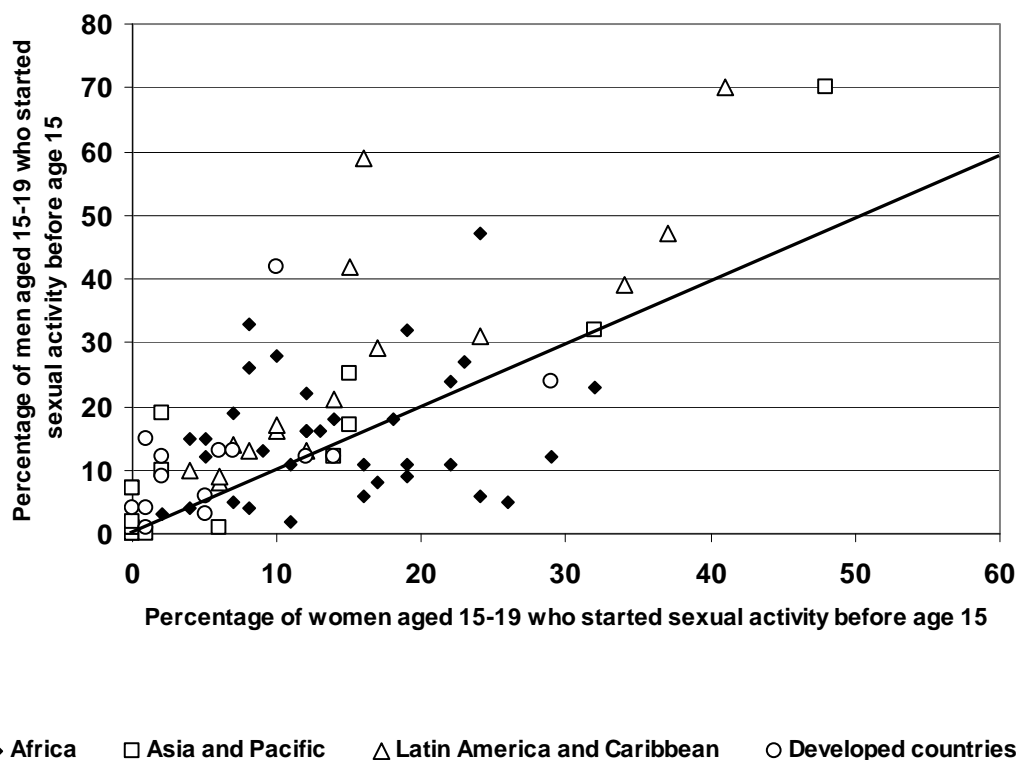
Figure VIII.
 Adolescent birth rate vs. the percentage of women aged 20-24 who were sexually active before age 20



24. In many countries first sex occurs in early adolescence, before age 15, and adolescent males tend to start sexual activity earlier than adolescent females. In the 82 countries with data (mainly in Africa and Latin America and the Caribbean), the percentage of males aged 15-19 who became sexually active before age 15 surpasses that of females in 55 countries (figure IX). In 27 of the countries considered at least 15 per cent of adolescent females had become sexually active by age 15 and in 36, at least 15 per cent of adolescent males had done so. Initiation of sexual activity in early adolescence has been linked to a higher likelihood that coercion or force was used than when sexual activity begins at older ages, and coercive experiences at first sex are associated with a host of negative outcomes, such as risky sexual behaviours that heighten the likelihood of unintended pregnancy or sexually transmitted infections, including HIV, as well as mental health disorders, such as anxiety, depression or suicide.

Figure IX.

Percentage of men aged 15-19 who became sexually active before age 15 vs. percentage of women aged 15-19 who became sexually active before age 15



IV. Family planning⁸

25. Data on family planning among adolescents and youth is mostly limited to developing countries. The 64 recent surveys with relevant data are representative of 26 per cent of all women aged 15-24 globally, but they represent 43 per cent of young women in Africa, 27 per cent in Asia, and 29 per cent in Latin America and the Caribbean. This section is based mainly on the results of those surveys and, consequently, focuses mostly on developing countries.

26. About half of married young women wish to have children soon. Thus, among the currently married women aged 15-19 covered by the 64 surveys, 56 per cent wish to have a child soon or are intentionally pregnant, 20 per cent are using contraception and 24 per cent do not wish to get pregnant but are not using any method of contraception, implying that their need for contraception is unmet. Among married women aged 20-24, 42 per cent are or wish to get pregnant, 37 per cent use contraception and 21 per cent have an unmet need for contraception.

27. In both Africa and Asia, the number of young women who are pregnant or wish to become pregnant is higher than the number using contraception. Thus, in 26 African countries and 11 Asian countries out of the 64 countries with data, that pattern holds among married women aged 15-19, as it does in 20 countries in Africa and three in Asia among married women aged 20-24. In contrast, in all Latin American countries with data, more young married women are using contraception than are pregnant or wishing to become pregnant.

28. Contraceptive use among young married women is highest in Latin America and the Caribbean, where half of married women aged 15-19 use contraception (37 per cent use to space and 13 per cent use to limit) and 62 per cent of those aged 20-24 use contraception (36 per cent use to space and 26 per cent use to limit) (figure X). In both Asia and Africa contraceptive use among married women aged 15-19 is considerably lower, at 20 per cent and 12 per cent, respectively. In both regions contraceptive prevalence nearly doubles by age 20-24, to reach 38 per cent in Asia and 24 per cent in Africa.

29. In contrast to contraceptive prevalence, unmet need for contraception is similar in all regions and slightly higher among married women aged 15-19. For the latter, unmet need ranges from 22 per cent in Latin America and the Caribbean to 25 per cent in Asia. For women aged 20-24, it is lowest in Latin America and the Caribbean (17 per cent) and highest in Africa (25 per cent). Unmet need among young married women is especially high in Africa, where it is double the level of contraceptive use for those aged 15-19 and is slightly higher than contraceptive use among those aged 20-24. In Asia, unmet need surpasses contraceptive use among married women aged 15-19.

⁸ The estimates presented in this section were derived from the most recent data from the Demographic and Health Surveys, which refer mostly to data from 2005 or later. The data were accessed via Measure DHS Statcompiler at <http://www.statcompiler.com>.

30. Young married women aged 15-19 use contraception mainly to space births. Thus, 83 per cent of contraceptive users in that group wish to lengthen birth intervals. As women reach the number of children they desire, more of them use contraception to limit family size and, consequently, the proportion using contraception for limitation purposes increases with age while that using it for spacing purposes diminishes. By age 20-24, 42 per cent of contraceptive users wish to limit family size. The desire to limit family size is lowest in Africa, where just 17 per cent of contraceptive users aged 20-24 reported that objective. Use of contraception for limitation purposes is high in Asia, reaching 48 per cent at ages 20-24, and in Latin America and the Caribbean where 42 per cent of contraceptive users aged 20-24 wish to stop childbearing altogether and, remarkably, 25 per cent of those aged 15-19 wish the same.

Figure X.
Contraceptive prevalence and unmet need for contraception among women aged 15-19 and 20-24 by purpose

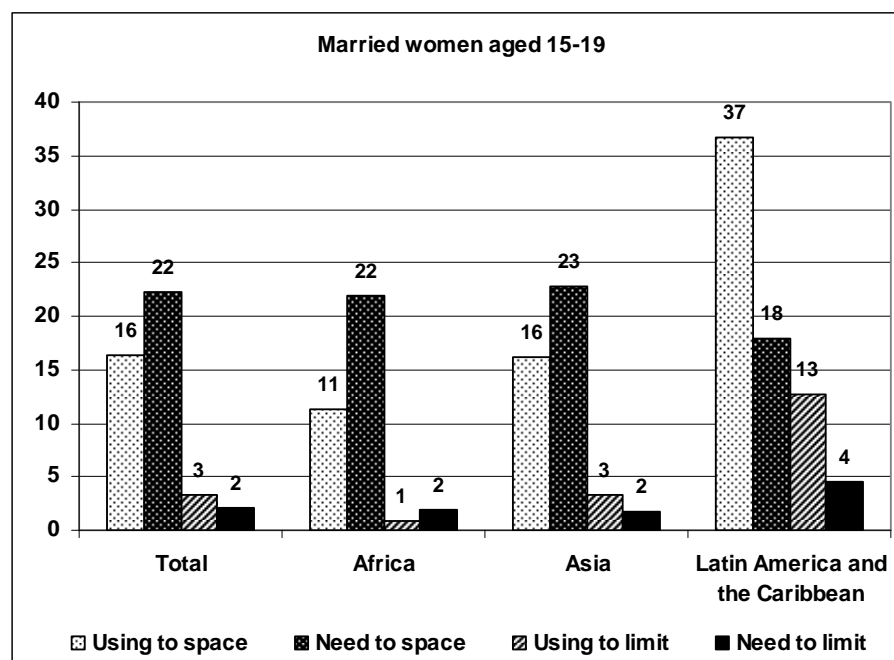
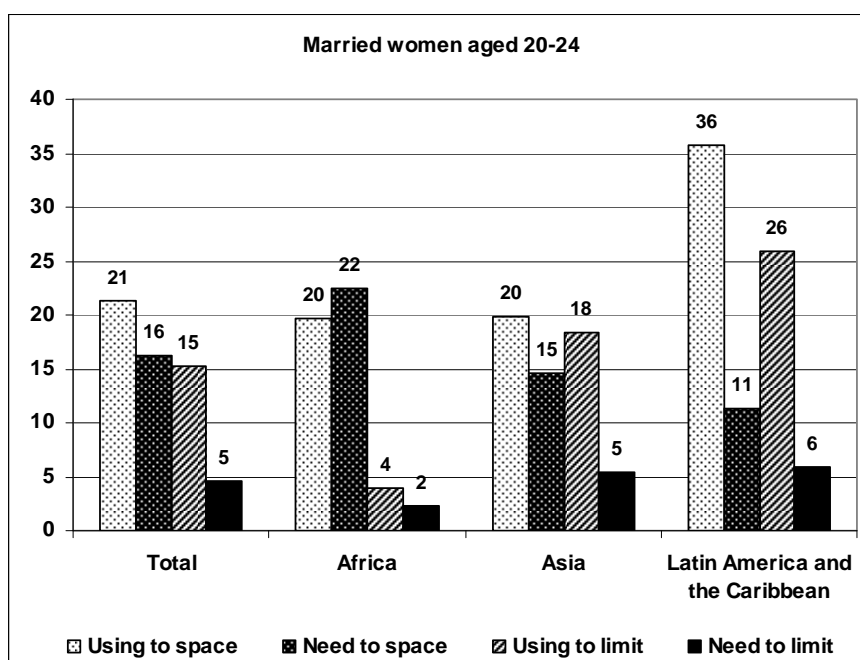


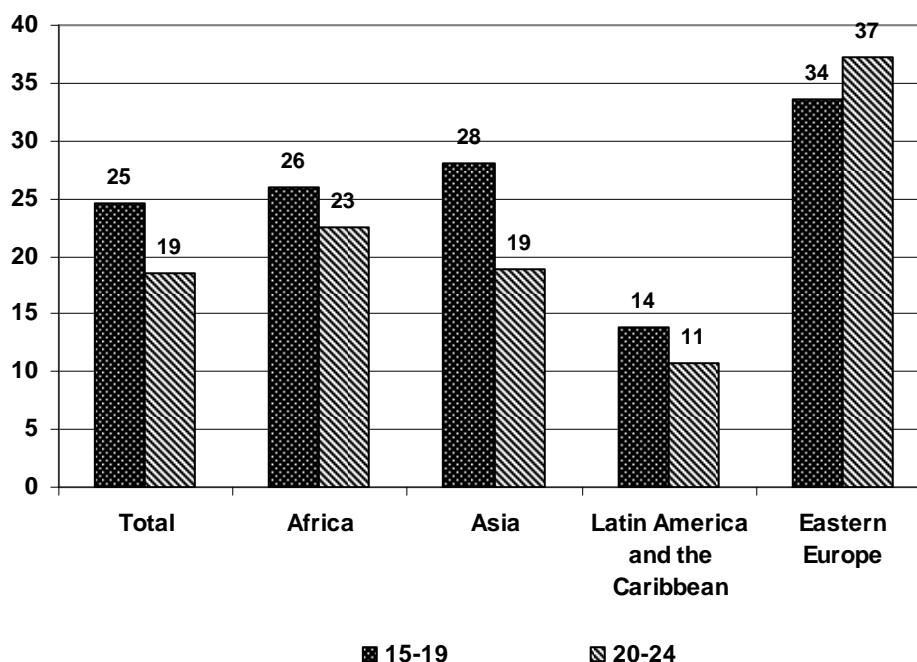
Figure X (continued)
 Contraceptive prevalence and unmet need for contraception among women aged 15-19 and 20-24 by purpose



31. Most young women having an unmet need for contraception also wish to space births rather than limit family size. Thus, at ages 15-19, 92 per cent of married women in Africa and Asia with an unmet need for contraception want to delay the following pregnancy. The equivalent figure in Latin America and the Caribbean is 80 per cent.

32. Not only is there a significant unmet need for contraception among young women who are not using any method but, in addition, large proportions of contraceptive users still rely on traditional methods of contraception which are less effective than modern methods (figure XI). In the 83 countries with data on type of method used, 25 per cent of contraceptive users aged 15-19 rely on a traditional method and 19 per cent of those aged 20-24 also do so. In addition, in all developing regions, younger women are more likely to use traditional methods than those aged 20-24.

Figure XI.
Percentage of contraceptive users relying on traditional methods



33. Demand for contraceptives is also significant among unmarried, sexually active young women who have a greater interest in preventing pregnancy and are therefore more likely than married women to use contraception. Among the 62 countries with relevant data, in all but five, contraceptive prevalence among sexually active unmarried women surpassed that of their married peers at ages 15-19 and in all but 10 it did so at ages 20-24. However, in 30 countries, including 22 in Africa, fewer than half of the sexually active women aged 15-19 were using contraception and in 17 countries, including 12 in Africa, the same held true for sexually active women aged 20-24. Overall, in the 62 countries considered, about 10 per cent of unmarried women were sexually active and using contraception at ages 15-19 and 27 per cent were doing so at ages 20-24. Although use of modern contraception was common, 23 per cent of the unmarried contraceptive users aged 15-19 and 16 per cent of those aged 20-24 relied on traditional methods and, in Africa, those figures rose to 29 per cent and 20 per cent, respectively.

34. In sum, many women aged 15-24 are already using contraception to delay or space pregnancies. At the same time, large numbers of young women still have an unmet need for contraception to space births and significant numbers rely on traditional methods, especially those living in Africa or aged 15-19. Furthermore, high proportions of unmarried young women are sexually active but not using contraception. The result is that over 6 million unintended pregnancies occur annually in developing countries⁹ and often end in unsafe abortion. Improving access to family planning for all adolescent and young

⁹ Guttmacher Institute and IPPF, Facts on the sexual and reproductive health of adolescent women in the developing world, 2010.

women who need it is an effective strategy to reduce the number of unintended pregnancies and unsafe abortions. Governments have the responsibility of enabling young people to have the means to build their families responsibly.

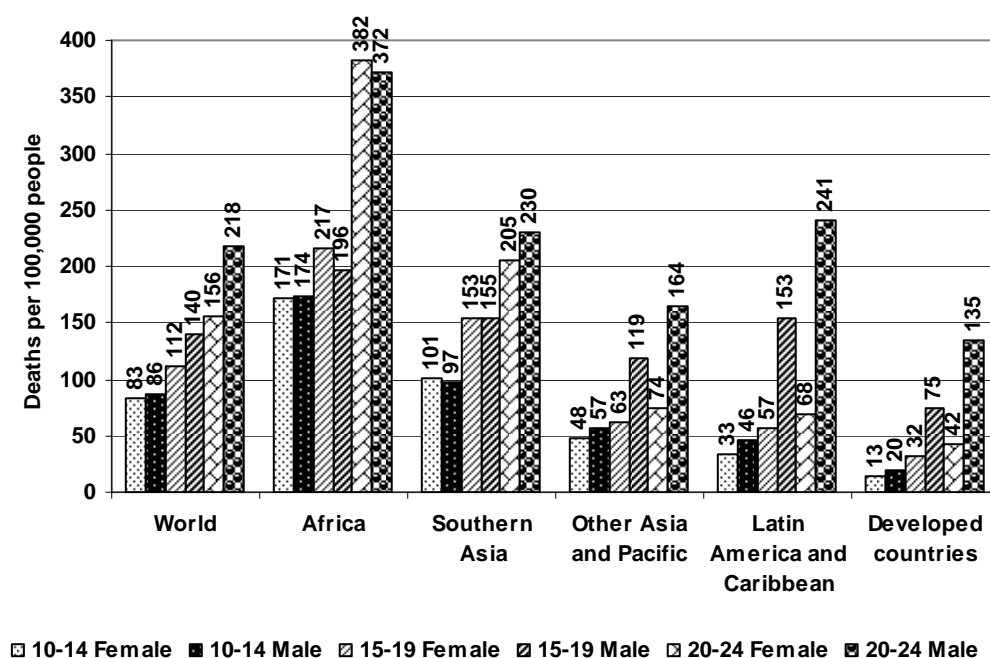
V. The health of adolescents and youth¹⁰

35. Adolescence is generally the healthiest period in life, when human beings reach peaks in strength, speed, fitness and many cognitive abilities. Yet, puberty is also a period when major physiological changes occur and health risks with potentially life threatening consequences become prominent. Adolescent behaviours with long-term implications for health include smoking, drinking and use of illicit drugs. Eating and exercise habits also become set during this period of life. Reproductive maturity and the initiation of sexual activity expose young people to the risk of contracting sexually transmitted infections, including HIV. For adolescent women, early pregnancy and childbearing are associated with higher risks of morbidity and mortality, particularly in developing countries. For male adolescents and young men, the risks of injury increase, especially because they are more likely than young women to be involved in traffic accidents, violence or war. Puberty also witnesses the onset of certain mental disorders which increase the risk of suicide. The result is a morbidity profile that changes markedly from early adolescence to young adulthood.

36. In most human populations, mortality is lowest at ages 10-14. Globally, the death rate of males aged 10-14 is 86 per 100,000 and that of females is 83 per 100,000 (figure XII). After those ages, mortality increases markedly but the increase is steeper for males than for females. Thus, the death rate among males aged 20-24 is 2.5 times higher than that at ages 10-14, while for females the death rate increases 1.9 times between ages 10-14 and 20-24.

¹⁰ Unless otherwise indicated, the data presented in this section were derived from special tabulations of the mortality estimates by cause, age, and sex for 2008 produced by the World Health Organization.

Figure XII.
Death rate by age, sex and region, 2008 (per 100,000)



37. Death rates among adolescents and youth are generally higher among males than among females, often by large margins. The exceptions are death rates at ages 15-24 in Africa and at 10-14 in Southern Asia. In Africa, high levels of maternal mortality and HIV/AIDS prevalence are largely responsible for maintaining the mortality of young women higher than in other regions. In Southern Asia, the low status of women is the root cause of the relatively high mortality of adolescents and young women, since it leads to early marriage, early childbearing and insufficient access to health services for young women. In the rest of Asia and the Pacific, in Latin America and the Caribbean and in developed countries, female mortality at ages 15-24 is markedly lower than that of males. The high mortality of young males and its rapid rise with age owes much to the increasing death toll caused by injuries, including road traffic accidents, homicides and suicides.

38. WHO classifies the causes of death into three groups. Group I includes infectious and parasitic diseases, respiratory infections, and maternal and perinatal conditions.¹¹ Group II encompasses the non-communicable diseases, including neoplasms (cancer); cardiovascular, respiratory and digestive diseases; diabetes, nutritional and endocrine disorders, and neuropsychiatric disorders. Group III includes all injuries, whether intentional or unintentional. The decline of mortality achieved since 1950 owes much to the success in controlling the spread of communicable diseases and in treating them. Consequently, in most countries today, communicable diseases cause low proportions of all deaths. Major exceptions are countries in sub-Saharan Africa and Southern Asia, where

¹¹ The term “communicable diseases” is used here to refer to Group I causes, while recognizing that many maternal and perinatal deaths are not due to infectious causes. The term “non-communicable diseases” refers here to all Group II causes, even though some cancers, for example, have been shown to have infectious origins.

communicable diseases are still major causes of death. Because people aged 10-24 are less likely than older persons to die from non-communicable diseases, communicable diseases account for a high share of their deaths in both Africa and Southern Asia (figure XIII). In Africa, communicable diseases, which include maternal causes and HIV/AIDS, are still the major killer of women aged 10-24, causing 70 per cent of their deaths and 44 per cent of those of their male peers. In Southern Asia, communicable diseases cause 40 per cent of female deaths and 29 per cent of male deaths at ages 10-24. Globally, 47 per cent of female deaths and 26 per cent of male deaths at ages 10-24 are due to communicable diseases, including maternal causes in the case of females.

39. Ninety per cent of maternal deaths to women aged 15-24 occur in Africa and Southern Asia. Early childbearing, high fertility among young women and lack of access to adequate maternal health services, including trained birth attendants, contribute to produce high numbers of maternal deaths in those regions. In addition, maternal mortality and morbidity in adolescents is a major public health challenge in the majority of developing countries. Women aged 15-19 are twice as likely to die during pregnancy or childbirth than their peers aged 20-24. Recourse to abortion under unsafe conditions which endanger the lives of women is another major health concern. An estimated 3 million unsafe abortions among women aged 15-19 occurred in 2008.¹² Preventing them requires reducing the incidence of unintended pregnancies among adolescent women, especially by facilitating their access to modern contraception.

40. A major cause of death in Africa is HIV/AIDS. In 2008, Africa accounted for 83 per cent of deaths at ages 10-24 caused by HIV/AIDS. UNAIDS estimates that 3.4 per cent of women aged 15-24 in Africa and 1.4 per cent of their male counterparts are living with HIV, but prevalence varies markedly among countries.¹³ In the highly affected countries of Botswana, Lesotho, South Africa and Swaziland, between 12 per cent and 16 per cent of women aged 15-24 are living with HIV. Because the epidemic began in the 1980s or 1990s in most countries, children who acquired HIV from their mothers are among the adolescents and youth living with HIV today. With increasing coverage of antiretroviral therapy, the numbers of perinatally infected children that survive to adolescence and young adulthood will grow. In general, however, most people acquire the disease through unprotected sexual intercourse.

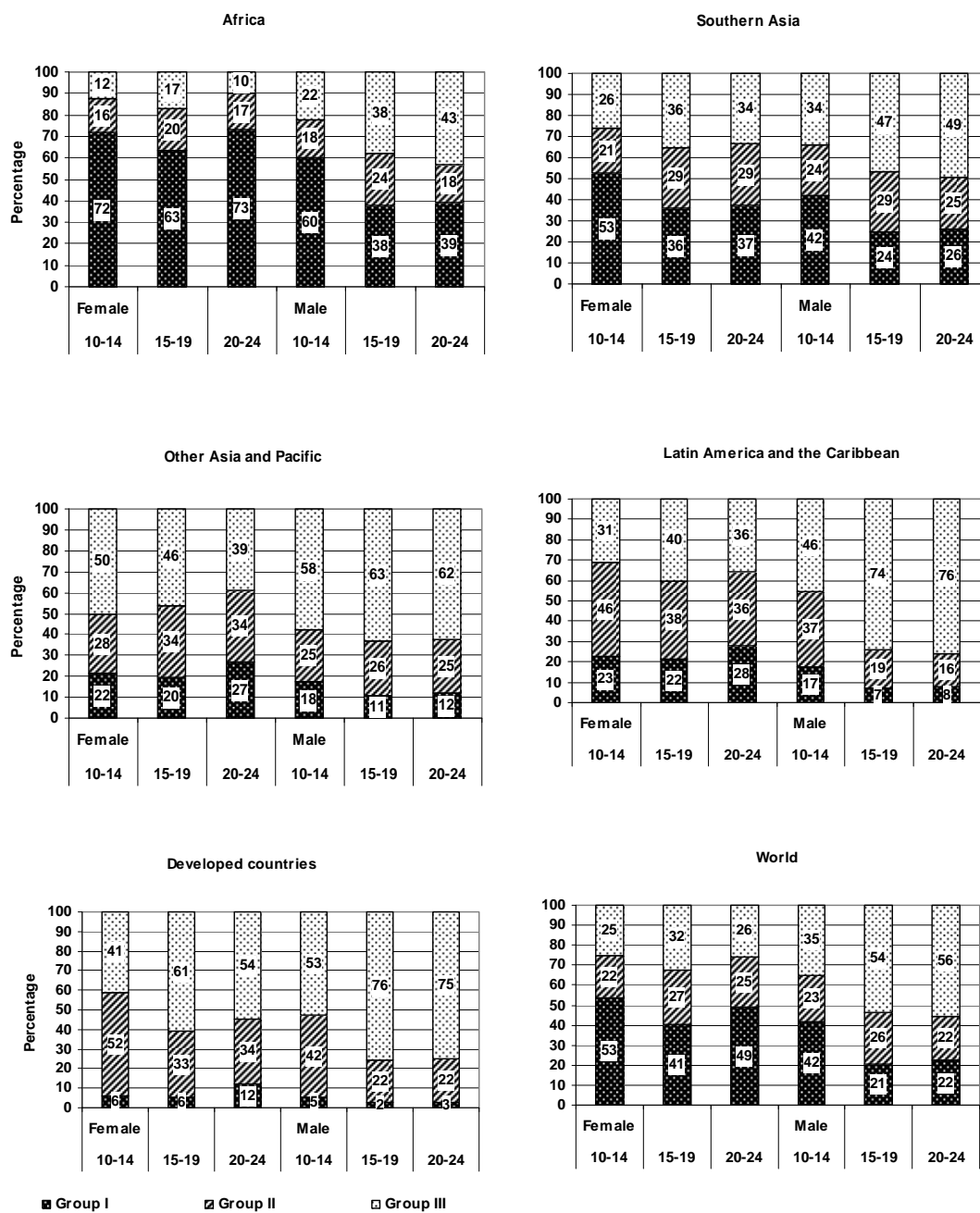
41. Injuries are a major killer of young people and they are a special threat for young men. Globally, injuries cause 51 per cent of male deaths and 28 per cent female deaths at ages 10-24. Injuries cause most deaths among males aged 10-24 in developed countries (73 per cent), Latin America and the Caribbean (72 per cent), and other Asia and the Pacific (62 per cent) and they are also the major killer of females aged 10-24 in developed countries, causing 55 per cent of their deaths. In Southern Asia, injuries cause a higher percentage of deaths among young males than communicable diseases (45 per cent vs. 29 per cent) and they are the second most important cause of death for females, accounting

¹² *WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries* (Geneva, World Health Organization, 2011).

¹³ *UNAIDS report on the global AIDS epidemic 2010* (Geneva, Joint United Nations Programme on HIV/AIDS, 2010).

for 33 per cent of female deaths at ages 10-24. Even in Africa, 36 per cent of male deaths at ages 10-24 are caused by injuries.

Figure XIII.
Percentage distribution of deaths by major cause, age and sex, 2008



42. Injuries are classified into intentional and unintentional. Intentional injuries include suicide and homicide, whether by violence or war. Unintentional injuries comprise all accidents, including road traffic accidents, poisonings, drowning, fires and falls. Globally, the share of unintentional injuries among all injury deaths at ages 10-24 is the same for males and females at 63 per cent. Unintentional injuries account for the major share of deaths from injury among both young males and females in all regions except Latin America and the Caribbean, where intentional injuries, mostly from violence, are the major killer of young men (they account for 60 per cent of male deaths from injury at ages 10-24 with violence alone being responsible for 50 per cent). Violence kills five times more males than females at ages 10-24 and 69 per cent of deaths from violence occur in Africa and Latin America and the Caribbean.

43. Road traffic accidents kill four times more males than females at ages 10-24 and, globally, they account for 30 per cent of male deaths from injuries at those ages. The toll of road traffic accidents is particularly important among both young men and women in developed countries and among young men in Other Asia and the Pacific. Suicide, another important cause of death from injury among young people, is especially high in Asia, where 75 per cent of all suicides in the world occur. In Southern Asia, 40 per cent of all female deaths from injuries at ages 10-24 are suicides.

44. Given that the major causes of death among adolescents and youth vary considerably among regions and countries, a wide array of interventions must be considered to reduce mortality and morbidity at young ages. They will be outlined in the recommendations included in this report.

VI. International migration of youth

45. In 2010, the world had 214 million international migrants of which 35 million were aged 10-24. As in the overall population, the proportion of migrants aged 10-24 in the migrant population has been decreasing. Furthermore, the migrant population's share of adolescents and youth is smaller than that of the overall population (17 per cent vs. 26 per cent), indicating that the migrant population is older.

46. Half of the international migrants aged 10-24 live in developed countries, compared to 60 per cent of the total migrant population. By contrast, all developing regions have higher shares of the migrants aged 10-24 than their respective shares of the overall migrant population. The higher concentration of migrant adolescents and youth in developing regions also gives rise to younger migrant populations in those regions. That is, the share of migrants aged 10-24 among all migrants is higher in all developing regions, where it ranges from 19 per cent in Asia and the Pacific to 26 per cent in Africa, than in developed countries, where it is a low 14 per cent.

47. The overall migrant population has a higher proportion of females (49 per cent) than migrants aged 10-24 (48.4 per cent). However, in the developing regions, young girls and women constitute a higher percentage of migrants aged 10-24 than they do among all international migrants. Thus, 52.5 per cent of migrants aged 10-24 in Africa are female,

whereas females constitute 46.8 per cent of all international migrants in that region. In developed countries, the reverse holds: the female share of the overall migrant population (51.5 per cent) is higher than that of migrants aged 10-24 (48.9 per cent).

48. Estimates of the net number of people who moved at ages 10-24 during 2000-2010 from their countries of birth to other countries so that their ages in 2010 ranged from 20 to just under 25 years amounted to 6.9 million, 62 per cent of whom moved to developed countries. Compared to 1990-2000, the size of that flow increased by 28 per cent during 2000-2010. In addition, persons who migrated at ages 15-24 also contributed to the net increase of migrants aged 25-29 in 2010, which amounted to 9.1 million.

49. Young people migrate for different reasons. Adolescents under 18 may migrate accompanying their parents or to reunite with them. Young people may also migrate to study abroad. According to UNESCO, there were 2.8 million foreign students pursuing tertiary education abroad in 2008, 49 per cent of whom were in Europe, 22 per cent in Northern America, 15 per cent in Asia and 9 per cent in Oceania. Most of those students originated in developing countries, including 53 per cent in Asia, 12 per cent in Africa and 6 per cent in Latin America and the Caribbean. The 31 per cent originating in developed countries included 25 per cent from European countries and 3 per cent from Canada and the United States.

50. Although the level of youth participation in labour migration cannot be quantified because of lack of data by age, indirect evidence suggests that young people may account for significant proportions of migrant worker admissions. Even when young people migrate for reasons other than employment, they often work abroad. However, like their native peers, young migrants are likely to experience high unemployment and often have higher unemployment rates than natives, partly because they lack fluency in the local language. Studies in selected countries suggest that when persons migrate as children, they are more likely to adapt to the host society and become fluent in the local language, a major advantage in later life. When migrants move as teenagers, language acquisition is more difficult and access to educational opportunities at destination becomes more crucial to ensure a successful adaptation.

VII. Conclusions and recommendations

51. In countries where high proportions of girls marry before age 18, Governments need to develop and implement culturally sensitive programmes to promote marriage at later ages, including programmes that focus on reducing the practice of dowry and bridewealth payments. Governments should also examine their laws on marriage to ensure that they grant men and women “the same right freely to choose a spouse and to enter marriage only with their free and full consent” as established by the UN Convention on the Elimination of All Forms of Discrimination Against Women. Ensuring that the courts follow through with the enforcement of existing laws is also important. Ultimately, improving living conditions for the poor and supporting adolescents, particularly girls, to continue their education are crucial to reducing incentives to marry at very young ages.

52. Because sexual activity among young people is a reality, there is urgent need to empower them to make responsible decisions regarding their sexual lives by improving their negotiating skills, addressing gender double standards, developing supportive family and institutional environments, and taking measures to prevent intimate partner violence and all forms of sexual violence. Programmes on sexuality education and HIV prevention deserve support because they give adolescents an understanding of what responsible sexual and reproductive behaviour entails and the skills to help them achieve it.

53. Special efforts are needed to provide family planning services to young women and men, whether they are married or unmarried. In developing strategies to reach young people, account must be taken of their diversity of circumstances, since some may attend school while others do not, some might work while others might not, and some may be parents already. Community-based reproductive-health programmes with multiple components permit using several strategies to reach young people and to sensitize community leaders and parents. To be effective, those programmes must be culturally appropriate, sensitive to the expressed needs of adolescents and youth, and built on the strength of local institutions.

54. Sexual and reproductive health-care services should be an integral part of the minimum health-care package offered to adolescents and young people at all levels of the health-care system, but particularly under primary care. In order to reach low-income youth, legal, financial and cultural obstacles that prevent or limit their access to sexual and reproductive health-care services should be removed. Young pregnant women should receive a package of care that includes at least four antenatal visits to maternal care facilities, the attendance of skilled personnel at delivery, the use of proper equipment and medications, the capacity to refer and transport them to emergency obstetric services if complications arise, and postnatal follow-up and counseling.

55. A combination of strategies is necessary for HIV/AIDS prevention and treatment among young people. They include increasing knowledge of the mechanisms of transmission and of all ways of preventing infection, especially for young people at higher risk of infection; developing accessible youth-friendly services, in particular by training health personnel to be non-judgmental in caring for young people, including young people living with HIV; promoting voluntary counseling and testing and offering anti-retroviral therapy for those who need it; providing diagnosis and treatment of other sexually transmitted infections, and implementing public education campaigns to reduce stigma and foster a safe and supportive environment.

56. In low-income countries, it is still crucial to combat infectious diseases, particularly tuberculosis and lower respiratory tract infections that account for numerous deaths of young people but fail to attract sufficient policy attention.

57. Improving health and health prospects demands action outside the health system. Preventing tobacco use among young people, for instance, can be achieved not only through education campaigns about the risks associated with smoking but, especially, by increasing the price of cigarettes through taxation. Prevention of alcohol abuse can be achieved by raising prices of alcoholic beverages, banning or reducing advertising directed at young people, and adopting and enforcing laws banning the public consumption of alcohol by minors.

58. To reduce road traffic accidents, preventive measures include investment in road infrastructure, the compulsory use of seat belts in cars and helmets when using motorcycles, and the enforcement of legislation prohibiting driving after drinking alcohol or under the influence of drugs.

59. Because firearms are responsible for the vast majority of deaths caused by violence, strengthening gun control can contribute to reducing mortality among the young.

60. To the extent that unemployment is at the root of social problems affecting youth and considering that unemployment and poverty rates, even for those who are employed, are especially high among youth, Governments should give particular attention to policies and programmes that foster decent work opportunities for young people.

61. Facilitating migration for education can bring benefits beyond the improvement of educational attainment. Young migrant students can become bridges between societies and cultures. Their migration facilitates the transfer of know-how and expertise. The skills they acquire as they adapt to the host society can empower them to function more effectively in a globalized world. To derive the greatest benefits from such migration, countries of origin can promote return by actively maintaining links with students abroad and facilitating the search for jobs at home upon the completion of training.