A 3 Quels sont les moyens de contraception les plus utilisés i) en général (adultes) et ii) par les adolescents (10 à 19 ans) dans votre pays?

*Sélectionnez les 3 moyens les plus populaires en indiquant leur ordre par 1, 2, 3.

	i) adultes	ii) adolescents
Condoms masculins		
Condoms féminins		
Pilule		
Depo Provera ou autre médicament injectable		
Norplant		
Stérilet		
Diaphragme		
Aérosol, gels, suppositoires, éponges, films spermicides		
Stérilisation (féminine)		
Stérilisation (masculine)		
Coït interrompu		
Planning familial naturel/abstinence périodique		
Pilule post-coïtale (contraception d'urgence)		
Méthodes traditionnelles comme des herbes médicinales		

Autre, donnez des détails:

Veuillez citer la source des informations. (par ex., enquête nationale, statistiques nationales, etc.)

A 4 Quelles sont les sources d'approvisionnement principales

Sélectionnez les 3 sources les plus utilisées en indiquant leur ordre par 1, 2, 3.

- [ ] Cliniques, personnel ou pharmacies de l'Association du Planning Familial
- [ ] Cliniques, personnel ou pharmacies gouvernementaux
- [ ] Autres cliniques, établissements médicaux et pharmacies privés (non gouvernementaux) n'appartenant pas à l'Association du Planning Familial
- [ ] Supermarchés, pharmacies, commerces ou autres points de vente commerciale
- [ ] Associations de jeunes, clubs de jeunes
- [ ] Écoles, cliniques des écoles
- [ ] Distributeurs
- [ ] Accoucheuses traditionnelles
- [ ] Bénévoles sanitaires des collectivités
- [ ] Autre. Donnez des détails:

Veuillez citer la source des informations. (par ex., enquête nationale, statistiques nationales, etc.)

A 5 Quel est le prix des contraceptifs lorsque des adolescents désirent en acheter?

a. Quel est le prix en monnaie locale?

	*en monnaie locale
Pilule	
Condom	
Contraception d'urgence	
*Taux de change en US$	

b. Combien coûte un hamburger MacDonald standard dans votre pays?
(En comparaison du prix des contraceptifs)

	*en monnaie locale
Un hamburger MacDonald standard	

A 6 Votre organisation fournit-elle des contraceptifs?

a. pour adultes?

☐ Oui (passez à A7, A8)
☐ Non

b. pour adolescents?

☐ Oui (passez à A7, A8)
☐ Non

A 7 Si oui, sous quelles conditions? Par exemple, y a-t-il des restrictions concernant la contraception hormonale?

a. Avec ou sans conditions?

☐ Avec
☐ Sans

b. Quelles conditions ou restrictions? * Type de conditions?

☐	Conditions médicales	
☐	Statut marital (marié ou célibataire	
☐	Pour les cas séropositifs	
☐	Autres Donnez des détails	

A 8 Si vous fournissez des contraceptifs, quel en est le prix comparé au prix du marché?

	Votre organisation	Comparée au prix du marché
Pilule		
Condom		
autres		

* en monnaie locale

A 9 Votre organisation propose-t-elle un service de counseling/des programmes éducatifs pour les jeunes?

☐ Pas du tout (passez à A11-b)
☐ Oui

A 10 Si oui, de quel type? (*Vous pouvez sélectionner plus d'une réponse.)

Organisé par des professionnels	✓	*Organisé par des jeunes/pairs*	✓
assistance télé phonique/counseling t éléphonique		assistance télé phonique/counseling téléphonique	
counseling de groupe		counseling de groupe	
counseling individuel		counseling individuel	
manifestations, rencontres spé cialement organisées		manifestations, rencontres spé cialement organisées	
camps et retraites		camps et retraites	
émissions de radio		émissions de radio	
émissions télévisées		émissions télévisées	
articles dans les journaux		articles dans les journaux	
articles dans les magazines		articles dans les magazines	
Autres. Donnez des dé tails		Autres. Donnez des d étails	

A 11 a) Pour l'article A10 ci-dessus, qui fournit la plus grande aide financière pour les services de counseling/programmes éducatifs pour les jeunes?

*Sélectionnez les 3 plus grandes sources de soutien financier par 1, 2, 3.

- ☐ Dons de bienfaiteurs individuels
- ☐ Subventions gouvernementales
- ☐ Fédération Internationale pour la Planification Familiale
- ☐ Oeuvres de bienfaisance (étrangères)
- ☐ Oeuvres de bienfaisance (locales)
- ☐ Revenus produits par d'autres services
- ☐ Autres. Donnez des détails: ____

b) Dans le cas où votre organisation ne propose pas de counseling/programmes éducatifs pour les adolescents, qui offre ces services dans votre pays ?

Veuillez spécifier: ____

A 12 Dans votre pays, des informations sur les moyens de contraception sont-elles inclues dans le programme standard d'éducation sexuelle dans les écoles?

- ☐ Oui
- ☐ Non

Si oui, pour quelles classes? Veuillez spécifier (par ex., classes en primaire, secondaire ou niveau supérieur?)

____

A 13 Dans votre pays, y a-t-il des groupes s'opposant aux programmes d'éducation sur la contraception à l'école?

- ☐ Il y a de l'opposition (passez à A14)
- ☐ Il n'y a pas opposition de la part d'un groupe particulier

A 14 Quels groupes?

*Sélectionnez les 3 groupes les plus importants qui pourraient montrer de l'opposition (si possible en indiquant leur ordre par 1, 2, 3).

- ☐ Parents, tuteurs
- ☐ Enseignants
- ☐ Figures et groupes religieux
- ☐ Agents sanitaires (y compris le personnel du Planning familial et les accoucheuses traditionnelles)
- ☐ Jeunes
- ☐ Chefs traditionnels de la communauté
- ☐ Groupes politiques
- ☐ Autres ____

Pourquoi?

1) ____
2) ____
3) ____

A 15 Les jeunes garçons et filles ont-ils un accès égal aux informations sur la contraception (par exemple, en comparant la couverture médiatique dans les magazines féminins et masculins)?

- ☐ Les filles reçoivent en général plus d'informations sur la contraception que les garçons
- ☐ Les garçons reçoivent en général plus d'informations sur la contraception que les filles
- ☐ Niveau à peu près similaire

✓ *Veuillez cocher l'article ci-dessous.

☐ Source d'informations (pour les informations ci-dessus) si cela est possible.

☐ Basé sur les impressions/l'expérience au travail.

A 16 Quels moyens de communication utilisez-vous pour éduquer les adolescents?

✓ *Sélectionnez les 3 moyens les plus utilisés actuellement

☐ Rencontres individuelles
☐ Rencontres en groupe
☐ Affiches
☐ Panneaux publicitaires
☐ Télévision (par ex., sketchs, annonces)
☐ Radio (par ex., sketchs, annonces)
☐ Articles de magazines
☐ Prospectus, dépliants, brochures, papillons
☐ Autres matériaux éducatifs tels que des autocollants, badges, articles de papeterie avec des messages
☐ Écoles/enseignants
☐ Internet/Sites Web
☐ Autres. Donnez des détails:

✓ *Sélectionnez les 3 moyens que vous souhaiteriez utiliser s'ils étaient disponibles et accessibles.

☐ Rencontres individuelles
☐ Rencontres en groupe
☐ Affiches
☐ Panneaux publicitaires
☐ Télévision (par ex., sketchs, annonces)
☐ Radio (par ex., sketchs, annonces)
☐ Articles de magazines
☐ Prospectus, dépliants, brochures, papillons
☐ Autres matériaux éducatifs tels que des autocollants, badges, articles de papeterie avec des messages
☐ Écoles/enseignants
☐ Internet/Sites Web
☐ Autres. Donnez des détails:

A 17 Veuillez citer ce que votre organisation considère être les problèmes les plus urgents dans votre pays concernant l'utilisation et l'accès des adolescents à la contraception, l'éducation sur la contraception ainsi que l'attitude de la jeunesse et de la société vis-à-vis de la contraception pour les jeunes.

Cuestionario para el estudio de la prevención del embarazo no deseado en adolescentes (2007)

Por favor conteste las siguientes preguntas lo mejor que pueda y con la mayoría de datos disponibles en su organización y su trabajo. Nos gustaría solicitar a un funcionario responsable de la dirección del programa de adolescentes y jóvenes en la organización y/o un funcionario responsable del trabajo de investigación/estudio en esta área en la organización para responder a este cuestionario. La informació n proporcionada será utilizada sólo para fines del estudio. Se agradecerá si adjuntan materiales de referencia o citan fuentes oficiales cuando sea apropiado y estén disponible. El término "adolescente (teenager)" se refiere a jóvenes de edades entre 10 y 19. Por favor, pase a máquina este formulario o escriba directamente con letra de molde. Y envíenoslo vía correo electrónico (e-mail: **program@joicfp.or.jp**) o correo postal, por favor.

País:	
Organización:	
Nombre y título de la persona que contesta este	

A Anticoncepción

A. 1 ¿Cuál es la ley en su país que rige el acceso de adolescentes (de 10 a 19 años) a la contracepción? (puede seleccionar más de uno)

- ☐ Ilegal, adolescentes no tiene acceso legal a la anticoncepción
- ☐ Legal, igual que los adultos
- ☐ Legal, pero se requiere consentimiento de los padres
- ☐ Legal, pero hay un limite de edad

  Favor indicar a que edad los adolescentes pueden acceder a contraceptivos: ☐ años de edad o mayor
- ☐ Accesible sólo a adolescentes casados
- ☐ No hay una ley definida aun, no está definido por el gobierno.
- ☐ Otra respuesta. Favor explicar:

Favor facilitar la fuente de información.

A 2 a. ¿En su país, qué métodos anticonceptivo están disponibles sin receta?

b. ¿ Lo mencionado arriba también está accesible para adolescentes?

A 3 ¿Cuáles son los métodos anticonceptivos usados más corrientemente en su país?
i) en general (adultos), y ii) por adolescentes (de10 a 19 años de edad).

*Favor marcar los 3 más populares indicando el orden del 1 al 3.	i)	ii)
Condón masculino		
Condón femenino		
Píldoras		
Depo Provera u otros inyectables		
Norplant		
DIU		
Diafragma		
Espumas espermicidas, gelatinas, supositorios, esponjas, películas		
Esterilización (Femenina)		
Esterilización (Masculina)		
Retiro		
Planificación familiar natural/abstinencia periódica		
Píldoras del día siguiente (Anticoncepción de emergencia)		
Métodos tradicionales como hierbas medicinales		

Otros, favor explicar.

Favor facilitar la fuente de información. (ej. Investigación nacional, Servicio estadístico, etc.)

A 4 ¿Cuáles son las fuentes principales del suministro de anticonceptivos a adolescentes?
*Favor marcar las 3 fuentes más utilizadas indicando el orden del 1 al 3.

- [ ] Clínicas de asociaciones de planificación familiar, trabajadores o farmacias afiliados
- [ ] Clínicas, trabajadores o farmacias gubernamentales
- [ ] Otras clínicas privadas (no gubernamental), médicos y farmacias no afiliados a la Asociación de Planificación Familiar.
- [ ] Supermercado, farmacias, vendedores en mercados u otros comercios minoristas
- [ ] Asociación de jóvenes o clubes de adolescentes
- [ ] Escuelas, clínicas escolares
- [ ] Vendedoras automáticas
- [ ] Parteras empíricas
- [ ] Voluntarios de salud comunitarios
- [ ] Otros. Favor explicar

Favor facilitar la fuente de información. (ej. Investigación nacional, Servicio estadístico, etc.)

A 5 ¿Cuál es el costo de los anticonceptivos si los adolescentes desean comprarlos?

a. ¿Cuánto cuesta en moneda local?

	*en moneda local
Píldora	
Condón	
Anticonceptivo de emergencia	
*Tasa de cambio a US$	

b. ¿Cuánto cuesta una hamburguesa regular de MacDonald en su país?
(Comparando con precio de anticonceptivos)

Una hamburguesa regular de Ma

*en moneda local

A 6 ¿Su organización suministra anticonceptivos?

a. ¿para adultos?

☐ Sí (ir a A7, A8)

☐ No

b. ¿A adolescentes?

☐ Sí (ir a A7, A8)

☐ No

A 7 Cuando contesta que sí, bajo qué condición? Por ejemplo, hay alguna restricción del uso de anticonceptivos hormonales?

a. ¿Se requiere alguna condición?

☐ Sí

☐ No

b. ¿Qué condiciones o restricciones existen?

		* Tipo de condiciones
☐	Condición médica	
☐	Estado civil (casado/a o soltero/	
☐	Caso de VIH positivo	
☐	Otros Especifique, por favor.	

A 8 ¿Si usted proporciona anticonceptivos a adolescentes, cuál es el costo, comparado con el precio del mercado?

	Su organización	Comparado al precio del mercado
Píldora		
Condón		
Otros		

*en moneda local

A 9 ¿Emprende su organización servicios de consejería/programa educativo para adolescentes?

☐ Ninguno (ir a A11-b)

☐ Sí

A 10 Si contesta que sí, ¿qué tipo de programa? (*puede seleccionar más de uno)

Controlado por profesionales	✓	*Controlado por jóvenes/pares*	✓
hotline/consejería		hotline/consejería	
Consejería en grupo		Consejería en grupo	
consejería de uno a uno		consejería de uno a uno	
eventos y ncuentros organizados especialmente		eventos y encuentros organizados	
campamentos y retiros		campamentos y retiros	
programa de entrevistas por radio		programa de entrevistas por radio	
programa de televisión		programa de televisión	
Columnas de diario		Columnas de diario	
Columnas de		Columnas de revistas	
Otros. Favor		Otros. Favor explicar	

A 11 a) En A10 arriba mencionado, ¿quién provee el apoyo financiero más importante al programa de consejería/educativo para adolescentes?
*Favor marcar las 3 fuentes más importantes que brindan apoyo indicando el orden del 1 al 3.

- ☐ Donación por donantes individuales
- ☐ Subsidios gubernamentales
- ☐ IPPF
- ☐ Fundación Altruista (extranjera)
- ☐ Fundación Altruista (local)
- ☐ Ingreso generado de otros servicios
- ☐ Otros. Favor esplicar

b) ¿En caso de que su organización no emprende ningún programa de consejería/educación para adolescentes, quién propociona estos servicios en su país?

Especifique, por favo

A 12 En su país, ¿La información sobre anticonceptivos será suministrado a adolescentes como parte de la educación sexual dentro del curriculo escolar oficial?

- ☐ Sí
- ☐ No

Si contesta que sí, a qué nivel? Especifique, por favor. (ej. grados en primaria, secundaria o mayor?)

A 13 En su país, ¿hay grupos que se oponen a la educación anticonceptiva en las escuelas?

- ☐ Hay oposición
- ☐ No hay ninguna oposición de algún grupo en particular. (ir a A14)

A 14 ¿Cuáles grupos?
*Indique los 3 primeros grupos que se podrían oponer (si es posible indicando el orden del 1 al

- ☐ Padres, protectores
- ☐ Maestros
- ☐ Líderes y grupos religiosos
- ☐ Proveedores de salud (incluyendo trabajadores de PF y parteras empíricas)
- ☐ Jóvenes
- ☐ Líderes tradicionales en la comunidad
- ☐ Grupos políticos
- ☐ Otros

¿Por qué? 1)
2)
3)

A 15 ¿Tienen los/as adolescentes igual acceso a la información anticonceptiva (por ejemplo, consideren la cobertura de medios de comunicación en revistas femeninas contra

- ☐ Las muchachas generalmente consiguen más información sobre anticonceptivos que los muchachos.
- ☐ Los muchachos generalmente consiguen más información sobre anticonceptivos que las muchachas.
- ☐ Casi lo mismo.

✓ *Marque lo siguiente, por favor.

- ☐ Por favor, indique la fuente de información (para lo de arriba) si está disponible.
- ☐ o en base a su impresión/experiencia de su trabajo.

A 16 ¿Qué tipo de canales de comunicación suele usar usted para educar a adolescentes?

✓ *Marque por favor los 3 canales más usados actualmente.

- [ ] Sesiones de uno a uno
- [ ] Sesiones en grupo
- [ ] Afiches
- [ ] Carteleras
- [ ] TV (ej. espacios publicitarios, anuncios)
- [ ] Radio (ej. espacios publicitarios, anuncios)
- [ ] Artículos de revistas
- [ ] Octavillas, panfletos, folletos, volantes,
- [ ] Otros materiales educativos como etiquetas, pines y artículos de escritorio con mensajes
- [ ] Escuelas/maestros de escuelas
- [ ] Internet/Página Web
- [ ] Otros. Favor explicar

✓ *Favor marcar los 3 canales que usted piensa usar si están disponibles y accesibles.

- [ ] Sesiones de uno a uno
- [ ] Sesiones en grupo
- [ ] Afiches
- [ ] Carteleras
- [ ] TV (ej. espacios publicitarios, anuncios)
- [ ] Radio (ej. espacios publicitarios, anuncios)
- [ ] Artículos de revistas
- [ ] Octavillas, panfletos, folletos, volantes,
- [ ] Otros materiales educativos como etiquetas, pines y artículos de escritorio con mensajes
- [ ] Escuelas/maestros de escuelas
- [ ] Internet/Página Web
- [ ] Otros.. Favor explicar

A 17 Por favor, describa lo que su organización considera los problemas más urgentes en su país en cuanto al uso de anticonceptivos por adolescentes y el acceso a la contracepción, la educación sobre anticonceptivos, así como las actitudes de los/as jóvenes y la sociedad contra la anticoncepción alrededor de la juventud.

B Embarazo

B 1 ¿Cuál es el número estimado de nacimientos vivos en su país (favor indicar el año)?
(*Conteste lo que sea posible y tanto como sea posible, por favor.)

Año		Número	
Favor indicar la fuente de dato:			

B 2 ¿Según las últimas estadísticas oficiales, cuántos partos se encontraron a las mujeres de 19 años y menor? Favor indicar el año y fuente de datos.

B 3 ¿En su país, cuál es la edad legal para casarse?
Para hombres ☐ años de edad
Para mujeres ☐ años de edad

B 4 ¿En su país, cuál es la edad promedio del primer casamiento?
Para hombres ☐ años de edad
Para mujeres ☐ años de edad
✓ *Favor marcar:
☐ Dato disponible: Fuente:
☐ por su impresión/experiencia

B 5 ¿En su país, cuál es la edad promedio en que las mujeres tienen el primer hijo?
Edad promedio del primer parto ☐ años de edad
✓ *Favor marcar:
☐ Dato disponible: Fuente:
☐ por su impresión/experiencia

B 6 ¿Cuál es la Ley que estipula la educación obligatoria de los niños en su país?

B 7 ¿En su país, qué porcentaje de adolescentes asiste a la escuela secundaria?
Muchachos ☐ %
Muchachas ☐ %
*Favor indicar fuente de datos, en caso disponible.

B 8 ¿Cuál es la edad media para tener la primera relación sexual?
Muchachos ☐ años de edad
Muchachas ☐ años de edad
✓ *Favor marcar:
☐ Dato disponible: Fuente:
☐ por su impresión/experiencia

B 9 ¿Qué le pasará a una muchacha embarazada que decide seguir su embarazo mientras todaví a está en la escuela?
☐ La escuela expulsará a la muchacha.
☐ Ella no será expulsada de la escuela, pero habrá una fuerte presión social para que ella deje la escuela.
☐ La escuela anima a la muchacha a seguir la educación después de dar a luz al niño.
☐ Otros
✓ *Favor marcar:
☐ Dato disponible: Fuente:
☐ por su impresión/experiencia

C Aborto provocado

C 1 ¿Es el aborto legal en su país?

- ☐ Sí, disponible a demanda.
- ☐ Sí, bajo ciertas condiciones. (ir a C4 para describir detalle)
- ☐ No, bajo ninguna circunstancia. (salte a C9)

C 2 ¿Cuál es el número estimado de abortos provocados en su país (favor indicar el año)?

(*Conteste a lo posible, por favor.)

Favor indicar la fuente de dato	

C 3 ¿Cuál es el número de abortos provocados que ocurren a adolescentes en su país? (Indique el grupo etáreo sí los datos no cubren edades de 10–19 años)

Favor indicar la fuente de dato	

C 4 ¿Cuáles son las condiciones o criterios bajo los cuales el aborto provocado es permitido (incluyendo restricción en número de semanas de gestación)? Favor contestar para ambos, en el caso de adolescentes y en el caso de mujeres adultas, si para ellas son diferentes.

C 5 ¿Necesita una adolescente el consentimiento de su compañero o su protector para conseguir un aborto legalmente?

- ☐ No
- ☐ Sí, su compañero
- ☐ Sí, su compañero o protector
- ☐ Sí, ambos su compañero y protector
- ☐ Otros

C 6 ¿Dónde se les práctica el aborto a la mayoría de adolescentes?

- ☐ Hospital o clínica gubernamental
- ☐ Hospital o clínica privado
- ☐ Clínica de Asociación para Planificación Familiar
- ☐ Comadrona o partera empírica
- ☐ Médico tradicional, no de medicina occidental
- ☐ Proveedores sin capacitación médica
- ☐ Otros. Favor esplica

*Si hay disponible alguna fuente de datos, escríbala, por favor.

C 7 ¿Quién suele pagar el aborto?

- ☐ Está disponible sin costo.

- [ ] La muchacha embarazada lo paga.
- [ ] El compañero de la muchacha embarazada lo paga.
- [ ] La pareja lo pagan juntos.
- [ ] La familia de la muchacha embarazada lo paga.
- [ ] La familia del compañero lo paga.
- [ ] Otros. Favor explica

*Si hay disponible alguna fuente de datos, escríbala, por favor.

C 8 ¿Su organización o el gobierno proporcionan sistemáticamente la consejería de anticoncepción post-aborto y servicios a mujeres para prevenir embarazos no deseados?

- [ ] Sí
- [ ] No

Si contesta que sí,

- [ ] por su organización
- [ ] por el gobierno
- [ ] por otros Favor explicar:

C 9 ¿Cuál es el número comunmente reportado de abortos ilegales en su país por año?

Fin del cuestionario

Le agradecemos mucho por su tiempo.

2007 Comprehensive Study towards the Reduction of Induced Abortion
Study Team under the Support of Ministry of Health, Labor and Welfare, Japan

A Study on the Prevention of Unintended Teenage Pregnancies - Situation regarding Contraception, Pregnancy, Abortion and Childbirth among Adolescents in the World - Summary Report

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1. Background

Globally adolescent sexual and reproductive health has now become recognized as a key issue since International Conference on Population and Development (ICPD) in 1994 and subsequent major international meetings. As a result, measures and programs are being expanded to ensure increased access by adolescents and youth to information and services regarding sexual and reproductive health in many countries in the world. This includes the provision of contraceptive services for young people, such as oral contraceptives (the pill) and emergency contraceptives in many countries, which would lead to reducing unintended pregnancies. Yet in Japan, the use of such oral contraceptives is still very limited. Rather condoms and withdrawal are the major methods used. In the case of unintended pregnancies, a tendency to resort to induced abortion is still found.

Based upon the above situation, the 3-year comprehensive study towards the reduction of induced abortion in Japan" was launched including nation-wide surveys under the Ministry of Health, Labor and Welfare (MHLW), Japan (April 2006 – March 2009). As part of this comprehensive study, the current study on the prevention of unintended teenage pregnancies was conducted by the research team. The study was aimed to obtain and grasp useful information on the current situation of adolescents concerning contraception, pregnancy, abortion and childbirth, and measures and programs undertaken globally. Based upon the study outcome, reference to Japan's situation as well as possible recommendations were made for future measures and policies for Japan as well as needs for further studies in the area of adolescent sexual and reproductive health.

Key Words: Adolescent sexual behavior, prevention of unintended pregnancies, contraceptive choice, abortion, financial burden

2. Methods and Procedure

A survey with a questionnaire was conducted for the period from October to December 2007 in collaboration with International Planned Parenthood Federation (IPPF) and Member Associations (MAs), recognizing their vast global network as well as their pioneering and important roles MAs play in the area of sexual and reproductive health at the country level, particularly for adolescents and youth. The 8-page English questionnaire was developed by the research team with the input from the research advisory committee as well as IPPF officers concerned at the headquarters. The questionnaire was sent to each MA globally through e-mail. In order to encourage the response, the questionnaire was also translated into Spanish and French and sent to the countries concerned together with the English version.

A total of 65 countries responded to the questionnaire out of 141 countries reached through e-mail with the response rate of 46%.[1] The number of responses by the French version and by the Spanish version was 6 countries and 10 countries respectively, while the rest was by the English version.

The survey questionnaire was composed of 3 main areas; A – Contraception including counseling and education programs, B – Pregnancy, childbirth and marriage, C – Abortion. The target of the study was adolescents, aged from 10 to 19 years old. A majority of questionnaires were responded by Executive Director, program managers/officers responsible for adolescent programs or research and evaluation in the respective associations

A few limitations of the study were noted. The questionnaire consisted of statistical data and information, particularly Part B and C. Responses were missed out or left blank to these questions, especially in the questions concerning abortion due to the sensitivity of this issue and the unavailability of data. Some responses were based upon their experiences and impressions through their work. Other supplementary data were utilized from the available UN data and other existing research and studies. The survey targeted the IPPF member associations only, not other government and NGO/private programs and services. Therefore, the study result may not depict the whole situation in each country since the survey did not fully include government and other existing NGO/private programs and services.

3. Results

In the consolidation and analysis of the survey results, all the 65 respondent countries were divided into 2 groups based upon the categorization by the United Nations Population Division; one is "More-developed regions" and "Less-developed regions." In the total respondents, the number of respondents in "more-developed regions" was 14, while the number in "less-developed regions" was 51.[2]

A. Contraception, and counseling and education

1) Access to contraception

Access to contraception by adolescents is still limited in many countries in the world. In more-developed regions, 10 out of 14 countries (about 70%) allow legal access of adolescents to contraceptives equally as adults, while in less-developed regions 17 countries out of 51 (about one-third) adolescents have legal access with one country not allowing legal access of teenagers to contraception. Among countries in more-developed regions, one country requires parental consent, 2 countries have age limit and one country has no defined law yet. In less-developed regions, on the other hand, 19 countries (37.3%) responded "no defined law yet / no government regulations," 9 countries (17.6%) allow legal access for only married adolescents, 7 countries have age limit and 4 countries require parental consent.

Male/female condoms and spermicides are available without prescription (over-the-counter), while in 17 countries (50% of more-developed regions and 20% of less-developed regions) emergency contraceptives are also accessible without prescription.

2) Popular contraceptive methods and source and cost of contraceptives

As for adults, the three most popular contraceptive methods used are the pill (83.9 % of all respondents), male condoms (69.4%) and injectables (53.2%). There are some differences between more-developed and less-developed regions. The use of injectables is low in more-developed regions and the most used methods are first male condoms, second the pill and third IUD, while in less-developed regions this order becomes first the pill, second male condoms and injectables and third IUD. Female sterilization is also high in less-developed regions.

As for teenagers in all respondents, the three most utilized methods are male condoms (80.4%), pills (76.5%) and injectables (41.2%). However, withdrawal (23.5%), abstinence (17.6%) and emergency contraceptives (17.6%) are also well practiced. The most utilized methods in more-developed regions are male condoms, pills and withdrawal and in less-developed regions male condoms, pills and injectables. For both adults and adolescents, in Japan the major contraceptive method utilized is male condom and this indicates a very different contraceptive usage pattern compared with other countries.

The main sources of contraceptive supplies for adolescents are IPPF/Member Associations (MAs) clinics and other private clinics followed by commercial outlets (supermarkets/private pharmacies) and government clinics in both more and less developed regions. In more developed regions, "vending machines" serve as a good supply outlet for adolescents, while in less developed regions, youth association/youth clubs and community volunteers also provide contraceptives to adolescents. In the case of Japan, the number one outlet is "commercial outlets" and the second is "vending machines, " and clinics (private) are only in the third place. This situation is also different from other countries.

Cost of contraceptives also becomes a barrier for access to contraception among young people in addition

to physical and psychological barriers. The cost of the pill, condoms and emergency contraception was compared among countries and with a regular MacDonald hamburger in respective countries. In more-developed regions, there are two cases found among countries; the one group is characterized with less economic burden to adolescents with the government subsidies or public health insurance schemes to provide adolescents and young people with contraceptives for free or with minor charges, while the other group with the high cost required like in the case of Japan without such government support or health insurance. For example, the cost for the pill, which includes consultation/examination fees without health insurance coverage, turns to be expensive, particularly for young people. Among the countries in less-developed regions, contraceptives (e.g. one cycle of the pill, one dozen of condoms) are cheaper than regular MacDonald hamburgers or often free under the government program or with donor support.

3) Information and Education for adolescents

As for the information on contraception as part of sexuality education, most countries in more-developed regions (except one country without response) have information on contraception as part of sexuality education in their regular school curricula, mostly from secondary level. In less developed regions, only 21 countries (41.2%) have sexuality education including contraception in the regular school curricula.

In 2004, IPPF introduced the strategic framework called "the Five A's", which stands for Abortion, Access, Adolescents, Advocacy and AIDS/HIV, as the focal points of its work. Since then the work for adolescents and youth has become a key focus among its Member Associations (MAs), as the result of this survey also shows this emphasis. All the respondents (IPPF/MAs) are providing information and educational services and activities to adolescents and young people. As for the provision of services, 83.1% and 84.6% of all respondents provide contraceptive services to adults and youth respectively.

As for education and counseling programs for adolescents, a variety of programs are being organized by professionals as well as young people themselves among the respondents. In both more and less developed regions, for those run by professionals, hotlines/telephone counseling, one-to-one and group counseling, specially organized events/meetings are most commonly undertaken. As for those run by young people themselves, camps/retreats and radio talk shows as well as one-to-one and group counseling and specially organized events/meetings are more common. Radio talk shows, TV shows and magazine and newspaper columns are well utilized by youth-run programs, particularly among less-developed regions. Youth-run programs may be still limited since there were 12 countries with no responses in this question, compared to 2 no response cases for professionals-run programs.

Regarding the source of support for such counseling and education programs for youth, in more developed regions, the 3 highest sources are the order of government subsidies, income generated from other services and local donors. Private companies, such as condom companies, pharmaceutical companies, and local governments, also provide support. In less developed regions, the support depends on IPPF and other international donors (foundations and international organizations) mostly, but the support from income generated from other services and government subsidies are becoming an important source.

4) Opposition Groups to sexuality and contraception education

A majority of countries, both in more and less developed regions, have opposition groups toward the sexuality and contraception education for adolescents; 51 countries (78%), with 10 countries without opposition groups, 4 countries with no response. The biggest opposition group is religious leaders/organizations (80% of the respondents), followed by political groups and parents/guardians. In less-developed regions, parents/guardians, community leaders and teachers are also exerting their influence. The reasons for opposition are similar among countries. The major one is that contraceptive information is too early for adolescents and it only promotes early sexual activity among youth.

5) Communication channels for adolescents

Various approaches and channels for communication have been utilized for information and education activities by IPPF/MAs. In more-developed regions, major channels utilized are schools/teachers, internet/website, one-to-one or group meetings, leaflets/pamphlets/booklets, while in less-developed

regions, group meetings, leaflets/pamphlets/booklets and one-to-one meetings are the 3 top channels utilized. This may be due to the fact that in more-developed regions, sexuality education is incorporated in school curricula and access to internet facilities is more available. In less-developed regions, although group and one-to-one meetings as well as printing materials are more utilized, radio programs (skits/announcements) seem to be popular. For future utilization as communication channels, in more-developed regions, high expectation was expressed for the channels of schools/teachers and internet/website, while in less-developed regions for the channels of TV and radio programs, internet and schools/teachers. New information communication technology such as internet and mobile phone sites, mass media and regular school channels are noted as key channels for communication with adolescents and youth.

B. Pregnancy, Childbirth and Marriage

Legal age for marriage, both in more-developed and less-developed regions, is mainly 18 years of age for both men and women with a few exceptions. In some cases, approval from parents/guardians is required (e.g. for those under 18). Although the reported data was limited, the average age at first marriage is higher among more-developed regions (late 20s to early 30s) than less-developed regions. Especially the age at first marriage is found to be younger, in Latin America, Africa and South Asia, in some countries among teenage girls.

Similarly, age at first childbirth for women is higher in more developed regions than less-developed regions, with the age of late 20s and early 30. It is also noted that the average age at first marriage is later than the age at first childbirth for women in some countries, which implies the existence of childbirth out of wedlock, not necessarily the pattern of childbirth following formal marriages. High teenage pregnancy and childbirth are found among countries in less-developed regions, i.e. Africa, Latin America and South Asia. Among countries in more-developed regions, the U.S. shows high prevalence of teenage pregnancy and childbirth, while Japan shows comparatively lower teenage pregnancy and childbirth.

Sexual activity starts around late teens (15 to 19 years old) in most counties, regardless of marriage, for both in more and less developed regions. The tendency towards the later marriages in many countries, particularly in more-developed regions, leads to the longer sexually active pre-marital period among young people. The start of sexual activity among young people in Japan has not become younger to the degree compared to other countries in more-developed regions,

In the case of teenage pregnancy and childbirth, girls still need to shoulder difficulties both in more and less developed regions. In the case of more-developed regions, the response was high (63.6%) for "school encourages girls to continue education after childbirth," but still girls are obliged to leave school out of social pressure (27.3%). In the case of less-developed regions, more severe situation is found. 20% of the respondents noted that girls are expelled from school when they become pregnant, and nearly a half of the countries mentioned that girls are obliged to leave school with social pressure.

C. Abortion

Among the respondents, 11 countries (17%) mentioned as "abortion available upon request," 39 countries (60%) as "available under certain conditions," 7 countries (11%) as" no under any circumstances" and 8 countries (12%) without responses. In more-developed regions, a half of the countries are for "available upon request" compared to 4 countries in less-developed regions. A majority of countries in less-developed regions (34 countries, 67%) responded for "available under certain conditions" and 7 countries reported that abortion is not available under any circumstances. In some countries, conditions applied for abortion differ within different parts of the country, governed by local governments/states. To save the life of pregnant women is considered as the condition for abortion under the principle of necessity in most countries with the different degree of interpretation and procedures.

In the case for teenagers to obtain abortions, a half of the countries which responded in the more-developed regions mentioned that teenagers do not need any consent from anybody. Other cases include requirement for consent from the partner, parental consent required depending on the ages of adolescents (e.g. under 16, below 15), requirement for parental consent found different in different states within the country. In

less-developed regions, in 10 countries out of the 34 respondents, there is no need for consent, in 8 countries consent from partner or parents/guardians and in 3 countries consent from parents is required. In 4 countries, parental/guardian's consent is required depending upon the ages of adolescents from under 15 to under 18. It is noted, however, that since abortion is illegal, many young people are obliged to make a decision by themselves or with the help of friends and families, often for backdoor unsafe abortions.

As for the places where adolescents receive abortions, in more-developed regions, abortions are undertaken mostly either by government clinics or private clinics. In less-developed regions, private clinics are mostly used and the second choice is government clinics. It needs to be noted that in less-developed regions, non-medical staff such as TBA, non-medically trained persons, traditional healers do provide abortion services, which could lead to unsafe abortions. The cost for abortion is covered mostly by the side of pregnant girls. In some countries in more-developed regions, the cost for abortions is either free under the public institutions or covered under the public health insurance schemes.

The availability of data on abortion is limited mainly due to the sensitivity of this issue in many countries. It is noted in less-developed regions that where the conditions for abortions are more restrictive (especially limited to saving the life of pregnant women), higher prevalence for illegal abortion, which is often unsafe, is a matter of concern, leading to maternal morbidity and mortality.

4. Reference to Japan and Conclusion

In comparing the current data on pregnancy, childbirth and abortion, the situation of adolescents and youth in Japan may not look as the severe picture. According to the previous studies, the increase of sexual activity has been noted among adolescents in Japan in recent years, but not yet at the level of other developed countries. The level of teenage pregnancy and childbirth as well as abortion rate is at the lower level among the developed countries. However, urgent and proper attention is required. It is noted that the abortion rate among adolescents under 20 continues to be at the high level. Yet, the use of contraceptives is still limited. A majority of adolescents rely on condoms and withdrawal and the use of more effective medical method, such as the pill is at the very low level.[3]

In comparison between Japan and other countries (both more and less developed regions), the current study result shows access to contraception as well as contraceptive choice is limited not only for adults but also for adolescents and youth in Japan. Medical procedures required by the doctor for the pill as well as comparatively high cost including doctor's consultation fees pose a big financial burden and a barrier to access to the pill, especially young people, although it is reported that there is a latent demand for the pill. Emergency contraceptive is still not yet legally approved and easily available.

Regarding adolescent sexual and reproductive health, common issues and challenges which need urgent attention are raised by the respondents, both in more and less developed regions similarly. These key challenges are: i) ensuring adolescents to have access to information and services in sexual and reproductive health including contraception through promoting necessary measures and building supportive environment; ii) expanding youth friendly services and programs based upon youth perspectives and participation; iii) incorporating comprehensive sexuality education (including contraception) in regular school curricula; iv) developing human resources and building knowledge and capacity of service providers; v) strengthening advocacy regarding the rights and needs of young people towards policy makers, community and religious leaders, teachers and parents.

Noting the above study result, the following recommendations are drawn for Japan.

1) To expand the comprehensive sexuality education (including contraception) at school through regular school curricula; to develop curricula from elementary to secondary level depending on age groups and their needs, and prepare and produce appropriate educational materials. Gender perspectives and good gender relations/partnership building should be also included in the curricula.
2) To ensure access for adolescents/youth to contraceptive services by expanding contraceptive choices and making modern contraceptive, such as oral contraceptives and emergency contraceptives more accessible and affordable for adolescents and youth. Measures need to be taken to create more conducive environment for your people to have access to contraceptives, for example the legalization

of emergency contraceptives, reduction of the cost as well as relaxing the medical procedure for oral contraceptives, easy access to condom, and public support to contraceptive services for young people.

3) To ensure safe and accessible abortion services from the point of reproductive health and right with the reduction of its cost as well as the possible coverage by the public health insurance schemes. Consideration is to be made for the introduction of "medication abortion" during the early stage of pregnancy, which has been undertaken widely abroad.
4) To expand youth-driven youth programs and youth-friendly services, with special consideration on strengthening organizations and networks for peer counseling/peer counselors. Building support systems for peer counselors should be made involving communities, schools and parents.
5) To undertake a comprehensive approach to adolescents and youth, through expanding the number and the network of clinics specifically intended for young people nation-wide, expanding the nation-wide telephone counseling, utilizing new information and communication technology, internet, mobile phones and other innovative channels to reach young people.
6) To expanding training for parents, teachers and service providers on sexuality education and to develop human resources with appropriate knowledge and skills for sexuality education promoters (including among young people themselves).
7) To promote the understanding and responsibility of mass media on the adolescent sexuality and undertake regular monitoring on mass media reports and coverage in this area.
8) To promote appropriate regulations on the part of providers for pornographic and other harmful magazines, video, internet sites which can be easily accessed by adolescents and youth. Finally,
9) To call for the government of Japan to make further commitment and financial support to the promotion and improvement of adolescent sexual and reproductive health and to the healthy development of young people through all sectors and channels concerned.

In the current changing society, the issue of teenage pregnancy needs to be considered not only from the health perspective, but also from other areas such as education, labor, economic and social aspects and family situation. In order to take above measures, commitment and support from all concerned sectors would be imperative towards recognizing the needs and rights of young people. Continued comparative studies and sharing of experiences and lessons learned with other countries would provide good insights towards future policy making and programming for adolescent and sexual and reproductive health in Japan.

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[1] International Planned Parenthood Federation, established in 1952, has 150 Member Associations, working in 166 countries (with 17 countries are part of the Caribbean Family Planning Affiliation). Additionally, IPPF is active in further 13 countries where a Member Association is not yet set up. This indicates that the total number of countries in which IPPF is working is 179. All 179 countries were considered for this survey in the original list. Due to the unavailability of e-mail address or the messages were undeliverable and returned, a total of 141 associations/countries were reached through E-mail.

[2] Based upon the categorization by the United Nations Population Division, "More-developed regions" comprise North America, Japan, Europe and Australia-New Zealand. "Less-developed regions" comprise all regions of Africa, Latin America and Caribbean, Asia (excluding Japan), and Melanesia, Micronesia and Polynesia, and countries with economies in transition of the former USSR.

[3] Kitamura, Kunio (2006), Comprehensive Study Towards the Reduction of Induced Abortions under the Ministry of Health, Labor and Welfare, Japan.

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わが国の人工妊娠中絶の動向と要因に関する人口学的分析

----リプロダクティブ・ヘルスの視点から----

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Ⅰ．はじめに

人工妊娠中絶の動向はリプロダクティブ・ヘルス（性と生殖に関する健康）において注目すべき課題の一つであるが、出生率が人口置換水準を下回る少子化が続くわが国では、人口学における不可欠の研究課題でもある（**補論１，２参照**）。日本の人工妊娠中絶については、その届け出数が持続的減少を続けていることもあって人口研究における関心は近年薄れがちだが、人工妊娠中絶が出生に最も密接な近接要因すなわち出生コントロールの最終手段として出生力決定モデルにおいて重要な位置を占めることに変わりはない（**補論３参照**）。とりわけ、人工妊娠中絶率が低下しながら経口避妊薬（ピル）など効果の高い避妊法の普及度も低い日本が超少子化におちいっていることは一見奇異な現象ともいえる。人工妊娠中絶を始めとして避妊、妊孕力など出生力に関する医学生物学的行動的要因（biomedical and behavioral factors）の研究は、日本の少子化の要因を総合的に追究する上で不可欠の研究分野である（**補論４参照**）。本研究のねらいは、人工妊娠中絶の人口統計学分析を通して日本人の性と生殖に関する行動の変化に迫り、リプロダクティブ・ヘルスの視点から少子化の要因研究において理解を深めることである。

本論に入る前に、日本における人工妊娠中絶に関する法的規定について、ここで簡略に述べておく（**注１**）。わが国では明治時代に制定された刑法に堕胎罪が盛り込まれたが、1948 年に制定された優生保護法により優生、母体保護などを理由とする人工妊娠中絶が認められることになった。同法の施行後数年のうちに、「経済的理由により母体の健康を著しく害するおそれのある」場合への適用拡大（1949 年改正）、当初要件とされた審査会による審査の廃止（1952 年改正）など、条件は大幅に緩和された。人工妊娠中絶が可能な時期は、当初妊娠満 28 週未満とされていたが、1977 年から満 24 週未満に、1991 年から満 22 週未満に短縮されている（厚生事務次官通知による）。なお優生保護法は 1996 年、優生条項が削除され、母体保護法に改められた。

本研究は、戦後の日本の人工妊娠中絶の動向を人口統計学的に分析し、その変化の原因を探るものである。わが国の人工妊娠中絶に関する政府統計は配偶関係やパリティ（既往出生児数）の情報が備わっておらず、人口学的分析にとって困難な点が多いことから、従来ほとんど分析がなされていない。本論文においては、まず女性人口における人工妊娠中絶の発生率（中絶率）の変化を２つの要素、すなわち①女性人口における妊娠の発生率（妊娠率）の変化の寄与と②妊娠した場合に人工妊娠中絶をおこなう割合（中絶比）の寄与に要素分解する。次の第Ⅱ節ではこの要素

分解の方法と結果を述べる。その上で、第Ⅲ節において、妊娠の発生、中絶の選択という２つの要素に影響を与える可能性のある人口学的要因の動向を探り、第Ⅳ節でその影響についてまとめて検討する。なお第Ⅴ節（補論）では、本論中の人口学用語あるいは人口学的知見について若干解説する。

Ⅱ．人工妊娠中絶実施率の変化と要素分解

１．資料

届け出のあった人工妊娠中絶の件数と生殖可能年齢（満15～49歳）の女性人口に対する実施率は、1955年から1995年までの各年については「優生保護統計報告」、1996年から2001年までの各年については「母体保護統計報告」として毎年公表されてきたが、2002年度以後、年度集計となり「衛生行政報告例」に収載されることとなった。したがって2002年以降については、年度の数値を年の数値に読み替えて扱うことにする。

人工妊娠中絶に関する上記の政府統計を通してその動向をみると、図１に示したように人工妊娠中絶件数は1955年（117.0万）以来ほぼ一貫して減り続け、1998年には33.3万となった。最近わずかに増加（2001年：34.2万）した後減少に転じ、1955年以降の最少記録を毎年更新している（2005年：28.9万）。満15～49歳女性人口1,000対実施率も同様に1955年の50.2から1996年の10.9までほぼ一貫して低下し、最近わずかに上昇がみられた後減少に転じ2005年（10.3）には1955年以降の最低値を記録した。なお本分析では扱わないが、2006年においては件数(27.6万)、実施率（9.9）ともにさらに減少した。

政府統計は女性の年齢（５歳階級）別に人工妊娠中絶件数と実施率を算定しており、その率の推移を図２に示した（なお、図２と図４～９で人工妊娠中絶に関する比率は1955年から2005年まで５年ごとの国勢調査年について示す）。すなわち20歳代後半以上のいずれの年齢層でも、1955年から2005年にかけて実施率は持続的に低下した。しかし10歳代と20歳代前半の年齢層では近年上昇傾向が見られ、この間、年齢別実施率が最も高い女性の年齢層は30～34歳から20～24歳へと移行した（注２）。