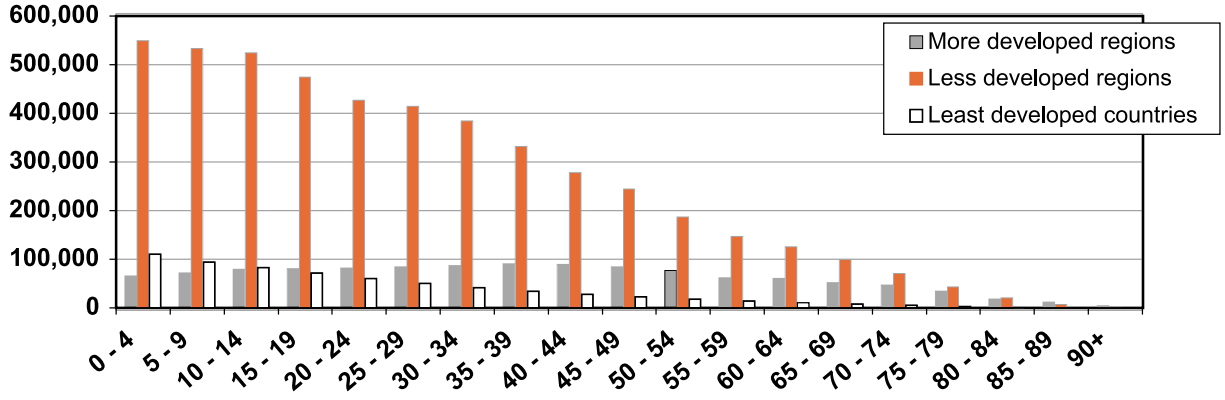
Chapter 4. YOUTH & HEALTH ISSUES

An overview of the health situation of youth today is provided in this chapter, which also explores the serious health challenges this vulnerable group is facing within the context of local and global developments. Socio-economic, cultural, educational and other factors affecting young people's health are examined, and reference is made to particular issues and areas of concern. Emphasis is given to the importance of involving young people in identifying problems and developing solutions to ensure that programmes, policies and health services address their needs.

INTRODUCTION

The young are the future of society, but they are also very much its present. Around half of the world's inhabitants are under the age of 20 (*see figure 4.1*). As evidence from statistics and the experience of youth-serving NGOs show, adolescents who are healthy and happy are better equipped to contribute to their communities as young citizens despite the major shifts occurring in the world they are about to inherit.[1]

Figure 4.1
Male-Female population distribution in developed and developing regions, 2000



Source: United Nations Population Division, Department of Economic and Social Affairs, 2002.

Bad habits and poor hygiene, persistent behavioural risks, poor basic sanitation, and new and emerging diseases are contributing to a deadly mix that is changing the classic picture of healthy youth. Despite the obvious international epidemiological demographic shifts and certain policy improvements, the state of programme delivery and research in the field of adolescent and youth health is scarcely adequate to make the world "fit for children" as foreseen by the twenty-seventh special session of the General Assembly on Children in 2002. Many young people bear the burden of poor health owing to the effects of accidents and injuries including those caused by insecurity, war and occupation. In all countries, whether developing, transitional or developed, disabilities and acute and chronic illnesses are often induced or compounded by economic hardship, unemployment, sanctions, embargoes, poverty or poorly distributed wealth. The cumulative toll of violence, HIV/AIDS and now tuberculosis on youth is adding to the already heavy price still being paid by child victims of malaria

and vaccine-preventable diseases. All of this exists in stark contrast to the many gains made through the efforts of national authorities, young people themselves and the local communities in which they live, supported by the achievements of international development agencies working to ensure that the special needs of this important population and their right to good health are understood and met.[2]

Global interest in the health of adolescents and youth has manifested itself in the many expressions of commitment to their healthy personal, spiritual, social, mental and physical development. The 1990s saw the affirmation of worldwide commitments to adolescent and youth health that have been shaped within an international legal framework that has as its foundation the United Nations Charter[3] and that reflects the WHO definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[4] One implication is that the international public health community must adopt an approach to adolescents and youth that goes beyond the health sector to elicit the active participation of all social actors, including young people themselves as agents of change.[5] The services, commodities, information and skills needed to sustain healthy behaviour must be provided in the safest and most supportive of environments, building on the protective factors of family and community.[6]

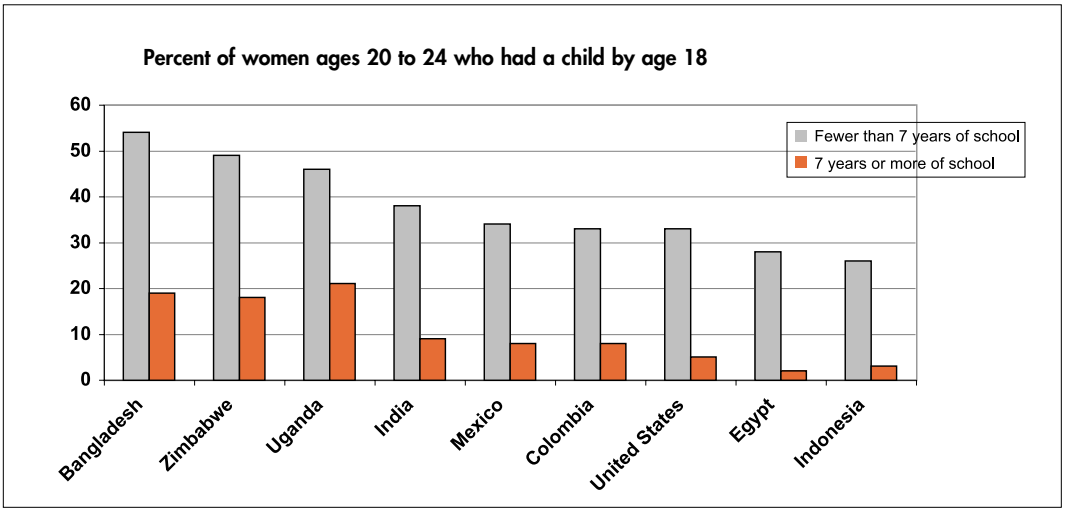
This call for the integration and coordination of multiple resources exposes an essential polarization—if not of intentions, then of mechanisms. Some scientists and clinicians, researchers and opinion leaders energetically promote respect for culture, tradition, family and religion to enhance apparent health benefits.[7] Others are far more ready to value young people's self-assessed needs and their interpretation of personal experience in order to enhance both psychosocial and biomedical aspects of personal well-being.[8]

The youth population is burgeoning in some countries, and in these areas and elsewhere adolescents are confronting new situations and threats to their present health,[9] moving towards a future in which their health status is likely to be compromised. The health, education and social sectors are called upon to devise, test and make wider use of effective new approaches, including operational, social science and community-based research, clinical studies and longitudinal surveys focused on adolescents and youth.[10] Often slow to recognize the essential value of the intersectoral approach in meeting the needs of the population, public health institutions in particular need to provide services and train personnel to ensure that no young person slips through the cracks in health care. There is room for optimism about the health sector's ability to overcome its conservatism and respond to the needs of youth, adapting to new local realities, if for no other reason than cost-effectiveness.

Even with the best of intentions, some health planners and health-care providers persist in making unwarranted choices unfavourable to youth. For example, an international official with limited resources might feel inclined to support safe motherhood programmes over adolescent-focused initiatives or to promote early marriage rather than adolescent participation in society. At the local level, a district medical officer may be busily treating obstetric complications in adolescent mothers, feeling there is no time to visit schools to provide sexual and reproductive health information. Making carefully considered, informed choices at the policy and programme

levels can have profound long-term effects. Figure 4.2 illustrates the impact of investment in education, showing a healthy decrease in childbearing among those who go to school, whether in Egypt, the United States or Zimbabwe. Adolescent development in general, and girls' education in particular, dramatically reduces young people's contribution to fertility, with evident gains in lowering maternal and infant mortality and morbidity.

Figure 4.2
Childbirth among women younger than18 years of age



Source: Population Reference Bureau, *World Youth Data Sheet 2002*.

In every culture and economic setting, a sound evidence base enables policy makers, religious and community leaders, NGOs, and medical and legislative bodies to ensure intersectoral intervention and strong sectoral responses to save young lives and meet the needs of young people. This chapter on health is neither an epidemiological review of the causes of mortality, morbidity and disability among 15- to 24-year-olds, nor a public health policy or programme guide. Instead, it addresses a range of issues of interest to those who need a clear picture of young people's health situation in order to make economic and political decisions favourable to social development. The elements of this picture, each to be examined in a separate section, include the following:

- Monitoring the data
- Special concerns of adolescents and youth
- Access to learning and its influence on health
- Social and economic integration
- Other influences on the health of youth
- Benefits of youth participation

- Adolescent- and youth-friendly health services
- Adolescent and youth health conditions
- The policy environment

A selection of national examples will be used, drawing in general on upper- and lower-quartile samples of phenomena and highlighting the situations in countries from all parts of the world. There are slowly emerging indicators for measuring the effectiveness of adolescent programmes that to some extent make up for the non-existence or unhelpfulness of surveillance systems for monitoring the health status of 15- to 24-year-olds in many parts of the world.

MONITORING THE DATA

Demographic and health data are generally available to planners in each country and region. Such data are not always used to monitor trends and patterns of adolescent and youth health or to ensure equitable attention to this client group.

Adolescence itself is a cultural construct that varies across settings and contexts.[11] In terms of the future health status of countries and regions, however, the period of adolescence can generally be considered the "gateway" and the period of youth the "pathway" to adult health. Attention must be paid to the health of adolescent and youth populations irrespective of their size, yet adolescents (10- to 19-year-olds) remain largely invisible, and youth (15- to 24-year-olds) often disappear from the data screens because of inappropriate or convenience clustering. Even in the referential Global Burden of Disease survey, data on key conditions are aggregated in a cohort comprising 15- to 29-year-olds. National demographic and health surveys, however, are now (more often than previously) structured to pinpoint young people.

In many countries, including India and Senegal, up to a third of the population are between the ages of 10 and 24. In other countries, such as France, the demographic pyramid long ago evolved into a cylinder, with fewer young people supporting an ageing population;[12] this phenomenon is becoming more prevalent in emerging economies such as the Republic of Korea. Some transitional economies, in particular the Russian Federation, are experiencing rapid drops in fertility—even to below replacement levels—but still have a sizeable youth population.

National demographic patterns notwithstanding, youth represent a large global client base with evolving needs in the areas of health services, information and counselling, which has implications not only for the present but also in terms of future requirements for a reformed health sector.[13] Within this context, youth constitute an important resource base for improving their own health and that of society, contributing to global development and intergenerational solidarity.[14]

Data on secondary school enrolment patterns are generally available and offer clear indications of variability within and between countries and regions. This is of some interest from a health perspective. Statistics showing either a slightly or much

higher percentage of boys enrolled than girls often coincide with poorer indicators for the health status of young women.[15] Where a higher percentage of girls are enrolled in secondary and tertiary education, there may be a concomitant increase in levels of substance use, violence and depression among young men.[16]

The average age at first marriage for all women is variable within and between regions but is generally increasing. In spite of national and international legislation relating to minimum ages for marriage,[17] the marriage of adolescent girls (often to older men) is still common. The average age is reportedly as low as 14.2 years in Bangladesh[18] and 17 years in Yemen, but seems to have risen to 29 years in Tunisia.[19]

In the Democratic Republic of the Congo, only 5 per cent of males aged 15-19 years are married, while 12 times as many girls in the same age group are already wed.[20] The contribution of 15- to 19-year-olds to total fertility can be high (11 per cent in the United Arab Emirates) or low (3 per cent in Cyprus). Another way of looking at the phenomenon is that in Chad, one in five girls aged 15-19 years gives birth each year, compared with 1 in 50 in Malaysia and 1 in 100 in Italy.[21] The countries that show the greatest gender discrepancies are also among the poorest and concomitantly exhibit the highest adolescent fertility rates.

The issue of gender equality remains relevant, especially where sex preference towards boys is common. Apparent social justification for such discrimination is a tenacious cofactor in provoking serious health (including mental health) and nutritional consequences. The availability of quantitative and qualitative indicators of the health effects of sex discrimination, sex preference and other factors of gender inequality in some regions may be limited by strong cultural, traditional or religious concerns. Gender stereotypes also interfere with the professional judgement of health workers concerning the sexual, reproductive and mental health both of adolescent girls and of young people whose sexual orientation remains uncertain.[22]102 Associated sex-role stereotypes prevent women from even knowing they experience discrimination, sexual coercion, exploitation or abuse. In those countries for which preventing the sexual exploitation of the young is a priority, however, a minimum age for consensual sex has been established.

The rationale for research on adolescents will be more explicit and the effectiveness of interventions greatly enhanced if national experts identify and use appropriate sources of regional and country-specific data on adolescents. Basic indicators of health and social status need to be disaggregated by sex and by single year of age in order to enhance their usefulness in programming. Where this has been done, trends in youth mortality are more readily apparent.

THE SPECIAL CONCERNS OF ADOLESCENTS AND YOUTH

Adolescence is a dynamic concept that is being defined even now within the context of a life-course approach to health and development. In some traditional societies a rite of passage from childhood to adulthood excludes much of the notion of transition. However, social changes in general and the earlier age at which puberty occurs ensure that, irrespective of when adolescents reach biological maturity, there is no easily recognizable standard age at which a young person is no longer a child though not yet an adult.[23]

The markers of international recognition of the importance of adolescent and youth health exist nonetheless. Commitments made by the World Health Assembly in Geneva in 1989 were reinforced by the specific recommendations of the International Conference on Population and Development (Cairo, 1994), which in turn contributed to the gender-specific achievements of the United Nations Fourth World Conference on Women (Beijing, 1995). As a consequence, the international community has become increasingly inclined to identify adolescents as a distinct group for public health attention and as one in need of ad hoc, gender-sensitive reproductive health programmes, education, counselling and services—provided within a framework of respect for their rights and responsibilities as individuals, partners, spouses and parents, as well as members of families, communities and nations.

Young people are participants in the political evolution of society and occasional clients of the health system. They are people in their own right as well as protégés of families and communities. Religious traditions, values and cultures are essential sociological and psychological phenomena that play a role as risk and protective factors for health.[24] However, the moderating influence of a safe and supportive environment and its contribution to sound mental health, the containment of violence and a sense of belonging can easily be lost for individual young people and the youth population cohorts as a whole.

A complete understanding of the stages of development in human life is drawn as much from religious writings, classical literature and philosophical texts as from endocrinology and psychology. Consequently, well-read parents, teachers and health professionals who are inspired by such materials can study, understand, accept and respond to the specific situations of pubescent children, of early, middle and late adolescents, and of youth. Clinical, community and operational research complements this humanistic view and confirms that the needs of, and manner appropriate for dealing with, 16-year-old patients are not the same as those for 6-year-olds or 36-year-olds.[25]

Specific interventions and approaches to adolescent services are indicated to deal with the emergence of risk behaviour during that stage. However, research design, information dissemination, professional skill development and health-care programme implementation are not universally managed according to the principles of user-friendliness and a holistic participatory approach. Where they are, an inter-disciplinary strategy leads to cost-effectiveness.[26]

International agencies have been particularly influenced by the Convention on the Rights of the Child and are beginning to utilize a rights-based programming approach, encouraging the sharing of responsibility between community institutions, parents and adolescents themselves in protecting and promoting the health and development of those under 18.[27] In pursuing this approach, the concept of basic needs as the foundation or motivation for intervention should not be lost. Legal provisions also influence adolescent health and development; policies and laws are in constant need of reform, adoption or enforcement to support medical, psychological and legal definitions and justifications of the fact that adolescents are distinct from children and adults. The socio-legal consideration of adolescence is a work in progress in many countries. Laws and policies affecting adolescent health need to be monitored, both internally and externally, and if necessary updated to remain in the best interests of young people. Health-related areas requiring particular attention are outlined in box 4.1, which lists recommendations made by the Committee on the Rights of the Child to some European countries that are States Parties to the Convention on the Rights of the Child.[28]

Box 4.1

EXAMPLES OF RECOMMENDATIONS OF THE COMMITTEE ON THE RIGHTS OF THE CHILD FOR SOME EUROPEAN COUNTRIES WITH REGARD TO SEXUAL AND REPRODUCTIVE HEALTH

Teenage pregnancy

- Reduce the number of teenage pregnancies;
- Promote adolescent health policies and reproductive health education and counselling services.

Abortion

- Reduce the practice of abortion;
- Strengthen measures to ensure that abortion is not perceived as a method of contraception.

STIs and HIV/AIDS

- Prevent discrimination against children infected by HIV/AIDS;
- Provide counselling to HIV/AIDS-infected mothers about the risk of transmission of HIV/AIDS through breastfeeding;
- Ensure access for adolescents to sex education, including information about contraceptives and STIs;
- Use of the media in relation to awareness raising and education;
- Provide statistical data and other indicators for vulnerable groups (disaggregated data), and multidisciplinary studies on the special situation of children infected by HIV/AIDS.

Teenage marriage

- Increase protection against the harmful effects of early marriage;
- Amend legislation to ensure that boys are treated as equally as girls.

Honour killing

- Review legislation;
- Develop awareness raising and education campaigns to combat discriminatory attitudes and harmful traditions affecting girls;
- Develop special training and resources for law enforcement personnel.

Female genital mutilation

- Undertake strong and effectively targeted information campaigns to combat this phenomenon;
- Adopt legislation with extraterritorial reach to protect children within the State's jurisdiction from female genital mutilation outside its territory.

Age of sexual consent

- No gender discrimination with regard to ages of sexual consent and sexual relations;
- No discrimination based on sexual orientation in regard to the age of sexual consent;
- Enact legislation concerning the minimum legal ages for sexual consent.

Family planning services

- Establish comprehensive family planning programmes;
- Develop youth-sensitive counselling, care and rehabilitation facilities that are accessible without parental consent.
- Allocate adequate human and financial resources to increase the number of social workers and psychologists, to evaluate the effectiveness of training programmes in reproductive health.

Reproductive health education

- Improve the primary health care system regarding the effectiveness of sex education and family planning;
- Strengthen reproductive health education;
- Ensure a programme for the systematic sexual education of adolescents at school;
- Evaluate the effectiveness of training programmes in reproductive health education.

Source: Reproduced from E. Roque, "The Convention on the Rights of the Child and rights to sexual and reproductive health", *EntreNous*, No. 51 (Copenhagen, WHO Regional Office for Europe, 2001), p. 9.

A rights-based approach to the protection and promotion of adolescent and youth health is easily undermined. This occurs, for example, when national or international public health authorities seek to use their positions to influence behaviour by promoting their perceptions of morality or specific religions, cultures or traditions rather than recognizing them as contributory issues in programming. In doing so, they disregard their obligation to assess the conformity of national policy development and legislation with international legal instruments and the application of best practices in public health.[29]

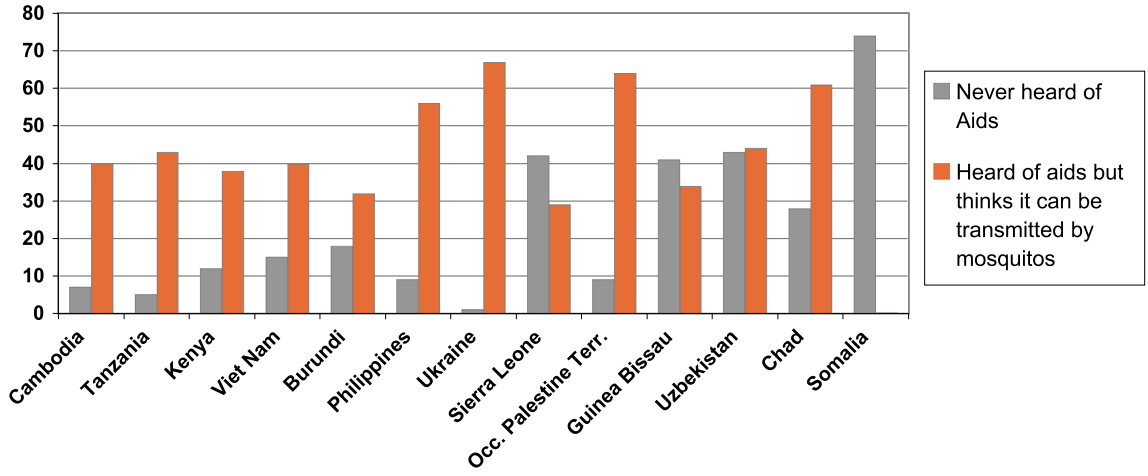
ACCESS TO LEARNING AND ITS INFLUENCE ON HEALTH

Helping adolescents make decisions that will positively affect their health and their prospects for the future is a challenge for communicators and educators. A variety of means must be used to reach young people, a group characterized by great diversity; they have had a wide range of experiences and have different needs and lifestyles.[30] Access to school and higher education, youth programmes and training are critical if young individuals are to acquire self-efficacy, the health asset of social capital. Rates of school attendance, even where high, do not in themselves indicate the economic and social relevance of training programmes or that curricula have been evaluated appropriately to ensure that they are providing both the knowledge and the skills necessary to sustain health. Criteria that can be used by educationalists and health planners to determine whether or not an educational institution promotes health include well-defined staff roles, access to nutrition, water and sanitation on the premises, health education curriculum content, stress management, gender mainstreaming, non-violent conflict resolution and accessibility of counselling.[32]

Health information and knowledge about diseases and about bodily conditions and functions are evident determinants of health status and outcomes.[33] However, as information (learning to know) is only useful if reinforced by positive attitudes (learning to be) and useful skills (learning to do), the ability to recognize a potential problem must be accompanied by the will and the identification of the means necessary to avoid it.[34] "Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life."[35] They include the ability to negotiate and exercise good judgement, maintain self-esteem and handle pressure.

Figure 4.3, drawing on data from Multiple Indicator Cluster Surveys, reveals the considerable variation in the percentages of young people for whom a lack of information could potentially lead to death.

Figure 4.3
Misconceptions about AIDS among adolescent girls



Source: UNICEF, *Adolescence: A Time That Matters* (United Nations publication, Sales No. E.01.XX.13), p. 23.

In the protection and promotion of health,[36] parental consideration is the key and the youth perspective the doorway; the same is true for education in general and for health, reproductive health and sex education in particular.[37] The responsibility of parents to educate their offspring about the personal, physical and social aspects of sexuality, pregnancy, sex roles and sex-related matters, including STD prevention and management, is a major concern in most societies and can be considered an obligation in many traditions.[38] In situations in which both parents and traditional media fail to perform this duty, modern media may fill the gap, but not always in a health-promoting manner. Box 4.2 provides an example of how media misinformation can replace traditional sexual initiation. The nature, timing and content of health education need to be discussed by religious, civic and community leaders and by parents, teachers and health professionals—and with young people themselves.

Box 4.2

SEX (MIS)EDUCATION THROUGH MODERN MEDIA

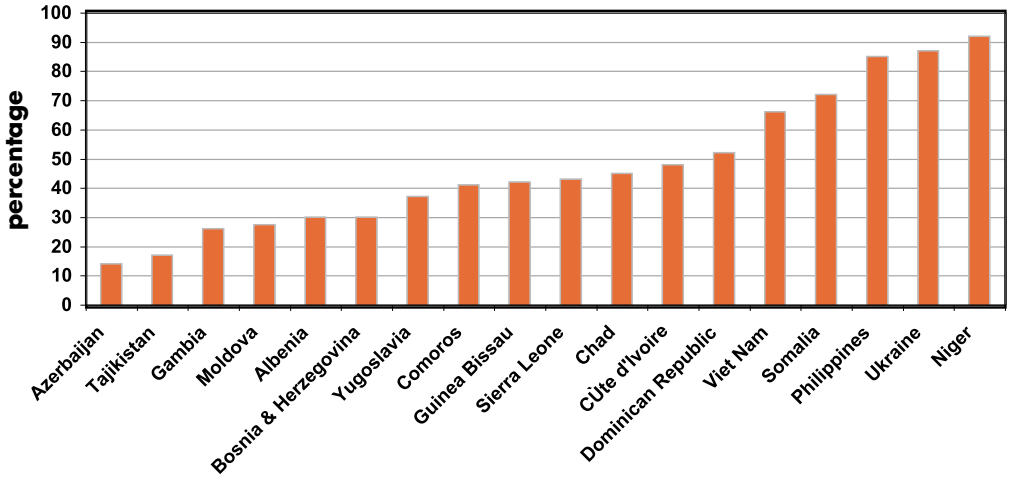
Papua New Guinea's traditions provide fertile ground for (...) reproductive health education. Sex was never a taboo subject. Neither was it shameful. All societies saw it as the mysterious source of life. What was taboo was open sexual discussion between men and women. This distinction is important because, contrary to popular belief, discussions on sex raged within male or female groups. Adolescent males got instructions on manhood and paternal responsibilities in exclusively men's houses, when they were judged ready. Adolescent females were tutored by their mothers or aunts on their roles as wives and parents in women-only houses.

What was and is still missing is that, until they were judged ready, young people were barred from learning about sexual matters in those societies. They were told not to ask questions about how babies were made. In traditional society, that knowledge gap was filled when adolescents reached puberty. In today's modern setting, the ignorance spreads on, with the youth at the mercy of misinformed peers or pornographic and other media.

Source: UNFPA, *Populi*, excerpt (September 2000), p. 15.

Citing 32 projects in more than 20 countries, Johns Hopkins University has demonstrated the cost-effectiveness of utilizing quality media that correctly influence the health behaviour of young people.[39] In some countries, however, the role of the media is still poorly understood and defined with regard to health promotion and communication for sustaining behaviour change.[40] Figure 4.4 illustrates how the failure to match knowledge, skills and attitudes can create or perpetuate misconceptions, often exacting a high cost. Examples are numerous: in Ukraine and the Philippines, around three-quarters of young women, despite having received information about AIDS, still refused to buy from an HIV-positive shopkeeper; and in Azerbaijan and Gambia, a similar proportion believe that a teacher who looks healthy but is HIV-positive should be allowed to continue working.

Figure 4.4
Proportion of young women who have heard of AIDS and have at least one negative attitude towards people living with the disease



Source: UNICEF, Multiple Indicator Cluster Survey, 1999-2001, information available at http://www.childinfo.org/eddb/hiv_aids/young.htm.

School curricula and extra-curricular activities are seen as ideal means to promote health and adolescent development. However, in cases in which multiple sources of resistance with regard to the status of adolescents and to youth participation combine with misconceptions of the objectives of sexual and reproductive health education, the intersectoral policy basis for youth health is undermined.[41]

SOCIAL AND ECONOMIC INTEGRATION

Social and economic integration of the young and their access to and security within the world of work are consequences and determinants of health and development.

The socio-economic integration of both young women and young men follows improved literacy and basic education, founded on and leading to better health.[42] Social health is based upon recognition of individuals and populations and of their diversity (whether in terms of gender, age, disability, ethnicity, race, language, religion or sexual minority status) as social capital needed for growth, development and prosperity. As the size and proportion of the youth population change, youth policies, workplace laws, occupational health practices and placement mechanisms need to be revised to ensure that youth are provided access to training opportunities and the labour market. All such efforts contribute to reducing the harmful physical, social and mental health consequences associated with child labour, underemployment of the qualified young and youth unemployment in both developed and developing countries, inappropriate academic choices, unrealistic parental attainment expectations, and poor or tardy integration of the disabled.

Urbanization creates a particular set of conditions requiring both psychosocial and logistical competence on the part of youth living in huge metropolitan areas or drifting between rural origins and new peri-urban habitats. When young people about to enter into adult life perceive that their standard of living will never be as high as that of their parents or grandparents, the social and personal health cost is high. The ability of the health sector to absorb those youth who suffer from increased stress or frustration or clinical depression is limited. The exposure through media to images of unobtainable consumer lifestyles that contrast sharply with real living conditions is likely to contribute to higher levels of anxiety, compulsive behaviours, poor nutritional and exercise habits, and a consequent deterioration in mental and physical health.[43]

Where gender-based differences in the distribution of the workload between home and the place of employment exist, or where, because of discrepancies within the place of employment, society expects women to bear the double burden of housekeeping and lower remuneration for identical work, poorer occupational health for young women must be taken into account. Unpaid or extremely poorly paid domestic work for adolescent girls, many of whom will be at higher risk of sexual coercion as a result, and school drop-out related to pregnancy are the most flagrant examples of conditions that undermine young women's health and development.[44]

OTHER FACTORS INFLUENCING THE HEALTH OF YOUTH

Adult family members, community leaders, religious and faith groups, institutions and peers all influence young people and their health and development

The sources of influence on young people's health and development—for good or ill—include but are not limited to internal psychological mechanisms, external educational institutions, the media, peer pressure and individual expectations for the future. Adults of both sexes from within the family and from extended family communities influence adolescents through dialogue or example, providing both positive and negative reinforcement. Role modelling and solicitation of favours in exchange for rewards also play a role in shaping behaviour, including sexual behaviour. The leaders of religious communities and institutions often encourage and sometimes demonstrate how individuals, families and communities can promote and protect health and provide a safe and supportive environment.[45] At the same time, abuse by adults in positions of responsibility and influence over the lives of others, especially the young, is recognized as particularly compromising for personal development, sexual integrity and social stability.

The social and economic integration of adolescents and youth will be enhanced through legislation that provides appropriate protection for members of this group with regard to their preparation and training for entry into the world of work. Much of the common gender discrimination affecting adolescents and youth in their daily lives and work is easily recognizable. However, there are social constructs so

strong that women in general, and mothers in particular—but also young men—are prevented from seeing where and when they are each victims and perpetrators of life-threatening and health-compromising gender prejudices.

UNAIDS offers helpful suggestions for countering harmful gender norms (*see box 4.3*). The cost of gender-sensitivity training for those involved in youth health work is low in comparison with the cost of treatment for those who are return visitors suffering the physical and mental health effects of gender-based violence.

Box 4.3
UNAIDS RECOMMENDATIONS ON CHALLENGING HARMFUL GENDER NORMS

Programmes should seek to counter harmful gender norms that lead to the sexual coercion and exploitation of women and girls. Through the use of media, public information campaigns, the arts, schools and community discussion groups, such programmes should:

- Encourage discussion of the ways in which boys and girls are brought up and expected to behave;
- Challenge concepts of masculinity and femininity based on inequality and aggressive and passive stereotypes;
- Encourage men and boys to talk about sex, violence, drug use and AIDS with each other and their partners;
- Teach female assertiveness and negotiation skills in relationships, sex and reproduction;
- Teach and encourage male sexual and reproductive responsibility;
- Teach and promote respect for, and responsibility towards, women and children;
- Teach and promote equality in relationships and in the domestic and public spheres;
- Support actions to reduce male violence, including domestic and sexual violence;
- Encourage men to be providers of care and support in the family and community;
- Encourage understanding and acceptance of men who have sex with men.

Source: Reproduced from UNAIDS, "Report on the global HIV/AIDS epidemic 2002", p. 84.

The social cost of the poor health of adolescents "on the street" is often assessed by institutions such as the Naga Youth Centre in Cambodia.[46] However, the cost of measures appropriate for the health sector to ensure that a safe and supportive environment is created to prevent delinquency is less often calculated. An ongoing survey of homeless adolescents in the mid-western United States reveals the prevalence of abuse and violence in the lives of vulnerable youth. At least three out of every four runaways report being struck by some hard object, and 23 per cent of boys and 43 per cent of girls show signs of post-traumatic stress disorder. Associated health problems are predetermining factors in living away from the parental home.[47]

Protection from abuse is provided to some young people by legal systems that prohibit sexual advances from those who bear responsibility towards the young. Such laws protect youth from sexual coercion or constraint in a relationship with an older person while giving them the right and responsibility to manage sexual relationships

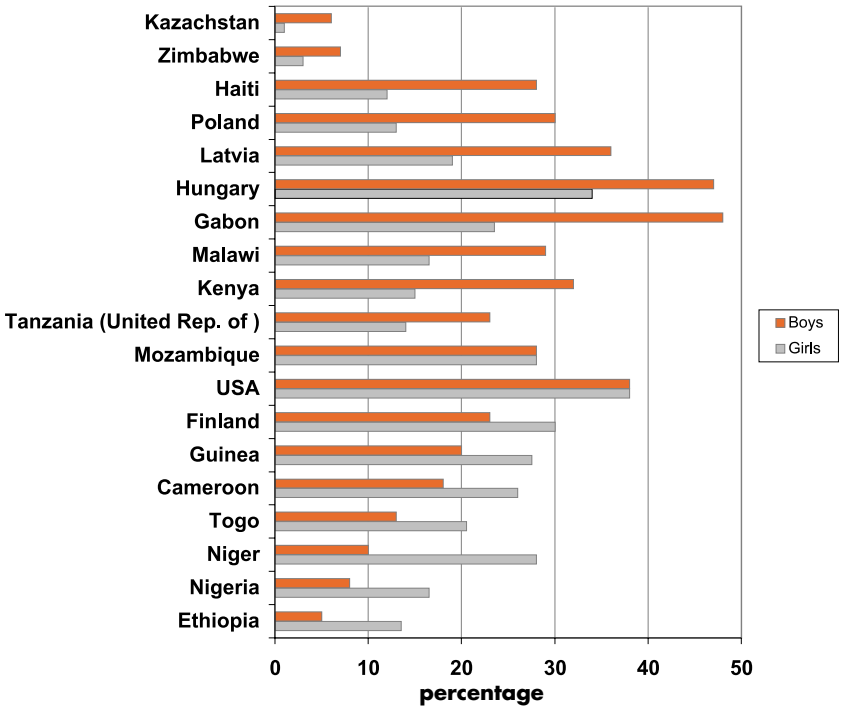
with people of similar age. In some legislation an age limit is strictly applied, with the perverse effect of turning a stable relationship between two young people into an zillegal, punishable act when the older one passes the age limit.

The influence of friends and others in the same age group plays an increasing role in shaping behaviour in middle and late adolescence before tapering off in young adulthood. Peer influence complements, and at times contrasts or conflicts with, the influence of parents and families, faith principles and community expectations. Structured youth and student groups help to channel and shape influence[48] using a cascade of peer-based methodologies starting with peer information sharing and motivation and continuing through peer education to peer counselling and service delivery or commodity dissemination. Dialogue and partnership between the generations, stimulated by active advocacy to support self-expression by adolescents and understanding on the part of elders, are of essential importance for social harmony and mental health.[49] Dialogue is of special relevance because the changes of adolescence are often lived as though they were unique to the young person experiencing them. When, almost inevitably, self-doubt overwhelms the adolescent, leading to mood changes and the questioning of prevailing socio-cultural values, parental expectations and religious principles, it is imperative that a skilled and caring older person shows the adolescent that he or she is not alone, not abnormal to be thinking in this way and can feel confident that someone is there to listen and share in their reflections.

There are data available on the sexual activity of adolescents and unmarried young people from most parts of the world.[50] A significant absence of data is noted for regions in which strong taboos exist with regard to sexual matters. In these areas researchers are prohibited from administering questionnaires addressing sexuality outside of marriage.[51] As a result, data about sexual activity cannot be collected from unmarried persons, making interregional comparisons and evidence-based health programming difficult. The prevailing principles, values and expectations about adolescents and their personal situation extend to sexuality.

Figure 4.5 shows that the percentage of those who report having had sex before their fifteenth birthday varies widely, ranging from 2 per cent of girls and 6 per cent of boys in Kazakhstan to around 45 per cent of boys in Gabon and Hungary (and half and two-thirds of that proportion of girls in each country respectively).[52]

Figure 4.5
Percentage of young men and women who have had sex before age 15, 1998-2001



Source: UNAIDS, "Report on the global HIV/AIDS epidemic" (Geneva, 2002), p. 71.

The skills required for sustaining abstinence and other manifestations of sexual responsibility have to be learned. In this respect, health-care providers can support parents, community opinion leaders and others who bear responsibility towards the young. In particular, mental health professionals such as counsellors can help adolescents acquire important life skills, providing guidance in managing emotions and feelings, building and maintaining self-esteem, and applying negotiation skills that will enable them to refuse unwanted, unplanned and unprotected sex.

In order to communicate effectively in addressing sensitive issues raised by their adolescents, parents need to overcome social taboos, personal discomfort and a lack of relevant information and skills. Primary health-care workers can use their place on the front lines of family practice to assist youth in acquiring and sustaining good social, sexual, mental and spiritual health.

Parents are among those who play an important role in the life of an adolescent and continue to have a significant influence. This may not always be beneficial, as indicated by the persistently high proportion of mothers who say they intend to subject their daughters to the traditional practice of genital mutilation.[53] For others, the family is the institution that has sent them to become child brides, soldiers or labourers. Where beneficial influences within the family setting are demonstrated, the health and social sectors can support them. For many youth, however, the influence of external institutions and individuals on health-related behaviour is increasing. Clearly, additional measures and supportive actions must be provided to adolescents who do not have a nurturing family environment or for whom the family is the setting for abuse or

neglect. Youth-serving institutions have been shown capable of providing additional support to health promotion including creative peer-based approaches that underpin social values and norms while at the same time making health information, counselling and services available.[54]

BENEFITS OF YOUTH PARTICIPATION

Youth participation in community, political and social affairs puts them at the centre of development and allows them to exercise their right to be involved in decision-making on matters that concern them. Young people can and should be part of the solution to global and local health problems affecting themselves and the community at large. Their role as agents of change in promoting health and development enhances their competence.[55]

Participation also diversifies the settings in which adolescent and youth health can be promoted. Results of a 54-country survey indicate that young people wish to be treated with respect and have their voices heard, and to be provided with health services in a professional and respectful manner—not just in traditional settings but in all the places that young people frequent.[56] A major limitation in centrally directed programmes targeting high-risk behaviour can be overcome with youth participation in health promotion. Often risk behaviour is defined according to the perceptions of epidemiologists or other specialists. This means that some vulnerable young people will be overlooked, including those who may be only occasionally or sporadically involved in the risk behaviour. This is increasingly important, as some young people may not identify themselves as injecting drug users, commercial sex workers or homosexuals, but may occasionally consume substances, sell sex or have intercourse with those of the same sex.[57] Using peer-based but anonymous methods for the identification of young subjects makes it possible to extend coverage more widely.

The UNICEF Voices of Youth web site provides a clear example of how to elicit and assemble the views of youth in order to structure their contribution to decision-making.[58] It should be noted, of course, that market research shows how access to the Internet as a health education resource varies widely between the regions of the world.[59] As mentioned earlier, a cascade of methodologies relevant to peer approaches is emerging, ranging from peer motivation, social mobilization and information sharing to peer education and counselling, peer-based services, and youth-to-youth commodity distribution. These approaches enhance the work of health, educational and social services.

In most parts of the world, young people consider health a low to medium priority. A recent review of expectations of young Arabs indicates that while economic issues such as job opportunities are important to 45 per cent of 15- to 20-year-olds, health care is a top priority for only 4 per cent of them.[60] Health ranks below education, the environment, wealth and income distribution, and political participation. There are some young people, however, for whom health is articulated as an issue. Box 4.4 offers a summary of a focus group discussion with some medical students in Lebanon.

Box 4.4

FOCUS GROUP DISCUSSION WITH MEDICAL STUDENTS AT THE AMERICAN UNIVERSITY OF BEIRUT

The country started changing rapidly as a society in 1990 after 15 years of civil war. A post-war wave of modernization and globalization took place, facilitated by the availability of cable TV and satellite dishes mostly broadcasting programmes made up of or inspired by perceived Western attitudes, values and behaviour. At the same time, many Lebanese who had emigrated to Western countries during the war returned with a lifestyle that had been adapted to their adopted home.

All this had a clear impact on youth, leading to a sharp departure from the norms of the older generation, along with a rise in the age of first marriage owing largely to the deterioration of the economic situation. A combination of both factors resulted in a widely reported increase in premarital sex. Large parts of society from various local, religious, ethnic and migrational backgrounds refuse to believe that young people do in fact have boyfriends or girlfriends, engage in premarital sex with multiple partners, have same-sex relations and do not emphasize the importance of virginity. This dichotomy in perception and behaviour constitutes one of the major problems facing the implementation of adolescent sexual and reproductive health programmes in Lebanon—in fact, probably in the region as a whole.

Policy-making and real life stare at each other and drift further apart. Promoting reproductive health and safe sex is impossible in a society that thinks it is immune to sexual and reproductive problems, feeling itself free of extramarital sex. "Society would rather nurture a perverse fear that a national reproductive health programme for young people is a secret means for promoting premarital sex. This misguided adult view remains the challenge. So far, we are put at greater risk, living a risky lifestyle with little guidance and education, and absolutely no services and supplies."

Source: Focus group discussion with Hossam Mahmoud and others, April 2002, American University of Beirut.

Health can also be given low priority in industrialized countries with a strong tradition of public health care. The 2000 Shell Study on Youth[61] reveals that few German young people consider health a high priority, perceiving it as something that is being taken care of. Increasing unemployment rates, disappointing educational options and a pessimistic view of their own future obscure the value of health. Young Germans fear unemployment most, followed by drug problems, lack of apprenticeships, and irregularities in school and in education in general. Health problems are denied and rank lowest on the issue scale. Paradoxically, fitness and a healthy appearance are considered the most effective signs of establishing one's identity; young people feel that there is pressure on them to measure up to the ideal of youth being beautiful, fit, strong, lean and healthy. To address their needs effectively, the health concerns of adolescents need to be understood from their perspective and not only from mortality and morbidity trends.[62] Box 4.5 summarizes a focus group discussion with some economics students in Germany.

Box 4.5

FOCUS GROUP DISCUSSION WITH ECONOMICS STUDENTS IN GERMANY

Health planners should be placing more emphasis on certain global tendencies. Being young no longer means simply being healthy. Young peoples' health is getting worse, not better, because they remain a neglected part of society. The young are poorer than general society, and it is no consolation to say, "One day you'll be as old and wealthy as the mainstream today."

One solution is to stopping seeing children first of all as property of their parents. Value the specificity of young people—not as a lack of lifetime experience but as a resourceful skill that should be used before being lost.

Source: Focus group discussion, reported by Aron Mir Haschemi and others, spring 2001, University of Cologne, Germany.

Adolescents look at the world without prejudice through a window of opportunity to create peace and tolerance. Young people are often the first promoters of social reconciliation despite the stereotype of the clash of generations. Their natural desire for justice and truth and their unique capability to teach the world of adults can help abolish the hatred and mistaken belief that friends and neighbours are enemies. Openness and tolerance shown in childhood and early adolescence can be nurtured to the point that the physically disabled or mentally ill in a young person's entourage are not perceived as handicapped or considered incompetent or incapable of assuming a place in society. With their enthusiasm for surprise and novelty, young people show that marginalized racial, ethnic, linguistic, religious and sexual minorities are part of the rich diversity of life that contributes to social health. The publication *Scenarios from the Sahel* relates how young media professionals produced short films and television spots to successfully communicate health-promotion messages to young and old alike.[63] Not all nations and regions are able to provide adolescent programming on the basis of such active listening to young people. A pervasive paternalism in public health remains a major limitation despite clear provisions in the ICPD Programme of Action calling for young people to be involved in needs assessment, policy development and programme design, intervention delivery and evaluation.[64]

ADOLESCENT- AND YOUTH-FRIENDLY HEALTH SERVICES

Adolescent- and youth-friendly health services help enhance accessibility and acceptability.

It is becoming widely recognized in both developed and developing countries that friendliness towards clients enhances clinic accessibility and acceptability, though such quality-related criteria are difficult to measure. The United Kingdom health service makes it a priority to ensure that all potential users of services, including young people, are able to exercise their right to health care.[65] Throughout Africa, a friendly approach towards young clients involves giving them a say in decisions regarding working hours, staffing, decoration and the attractiveness of the premises, ensuring the presence of younger health professionals at least at the reception and initial screening interview, and/or providing a separate entrance for adolescent clients.[66] Once standards and criteria are clearly specified, it is possible to measure them. An example is the "quality assurance framework for young people's sexual health and contraceptive services" developed by the Brook Advisory Centres in the United Kingdom. The WHO technical report on programming for adolescent health and development describes the different models in place for delivering health services to adolescents and outlines a wide range of characteristics of "adolescent friendliness" that corresponds to the World Health Organization's wider definition of quality health care, highlighting the need for the following:

- Adolescent-friendly policies that advocate for the provision of services to honour the rights and fulfil the needs of adolescents, that are sensitive to gender-related factors hindering equitable provision and experience of care, that do not restrict the provision of health services on any terms, regardless of status, that guarantee privacy and confidentiality and promote autonomy, and that ensure that the special needs of different population segments/groups are taken into account;
- Adolescent-friendly procedures that ensure easy registration and record retrieval, short waiting times, free care or affordable charges, and consultations with or without an appointment;
- Adolescent-friendly health-care providers who are technically competent and act in the best interests of their clients/patients, who are interested and concerned, non-judgmental and considerate, easy to relate to and trustworthy, who treat all their clients/patients with equal care and respect (regardless of status) and are willing and able to devote adequate time to each, and who can be contacted at repeat visits;
- Adolescent-friendly support staff (such as reception clerks) who are understanding and considerate and treat adolescent clients with equal care and respect, regardless of their status;
- Adolescent-friendly health facilities that carry no stigma, are situated in an appealing milieu at a convenient and safe location, offer convenient hours of operation, afford privacy, and provide informational and educational materials;
- Adolescent involvement, whereby they are well informed about the services on offer and their rights to partake of them, and are actively involved in the provision of health services;
- Community involvement, whereby communities are engaged in positive dialogue to promote the value of health services and encourage parental and wider support for the provision of quality services to adolescents.

Interdisciplinarity and complementarity in health service provision for adolescents are primary considerations.[67] Even when an adolescent focus is ensured, there is no guarantee that they will present themselves, especially not to multiple sites of service delivery. One-stop health care is how adolescents themselves might describe what they are looking for, although this means in practice that a variety of types of health facilities might be called for, ranging from stand-alone adolescent reference centres, through private general practices with a solid reputation for attending to adolescent interests, to public primary health-care facilities integrating reproductive health and family planning where adolescents can receive special attention.

While competence and expertise are readily accepted as marks of quality in health care, the attitudes and practices of health service providers and associated staff often stand out in the minds of adolescent clients and can be strong indicators of whether or not a follow-up visit will be made. The orientation and training of health workers to build competence in handling adolescent patients is an area covering a

range of considerations that is constantly evolving. An introduction to, or orientation on, the meaning of adolescence and its implications for public health is urgently needed in medical and nursing curricula. An orientation would need to cover the development and mental, sexual and reproductive health of adolescents, including the prevention, testing and clinical management of pregnancy, STDs and HIV/AIDS, and management of the consequences of abortion. Health professionals also require training to learn how to deal with substance use among young people, adolescent aspects of vaccination and nutrition, chronic conditions, trauma, and health problems that begin in adolescence with manifestation in adulthood.[68] Senior service providers and programme managers need to know how to identify the ongoing training needs of service providers, including those of youth peer workers operating alongside professionals.

An optimum package of services for each level of facility is essential for each national or subnational context. The main considerations in setting up and maintaining a service programme should be sustainability, cost recovery within the limits of adolescents' ability to pay, prevailing health conditions, and the range of essential medications and commodities needed. A decline in self-medication and an increase in adolescent use of services can thereafter be expected; however, the responsibility is shared between adolescents and the health sector.

In certain countries, other sectors play a complementary role in health care and promotion through the services provided by military, school and university health departments, juvenile justice facilities, those engaged in sports medicine, and prenuptial counsellors. Counselling can also enhance the value and appropriate use of services and can prepare young people to lead healthy lives.[69] Non-directive, values-based, client-centred one-to-one and family counselling all have a place in enhancing the ability of young people to solve their own problems.[70]

Whatever the physical setting for service delivery, international best practice shows that when it comes to commodity provision, sexually active adolescents need the double protection of a barrier method to prevent STDs combined with an effective, long-lasting hormonal method to enhance pregnancy prevention.[71]

As they grow older, adolescents increase and diversify their risk behaviours,[72] but they also have an increasing ability to recognize their need for health care and the consequences of negligence, self-medication, recourse to unqualified practitioners and the failure to discuss relevant issues with significant adult mentors including parents. Special attention is required to enhance the use of services by the disadvantaged, displaced, disabled and indigenous populations and by marginalized ethnic, racial, religious and sexual minorities. Adolescents in especially difficult circumstances include those who live on the street, sell sex, use substances, live without families or are incarcerated. Adolescents who are fleeing conflict or have become refugees, or who have been internally displaced within their home countries, are in need of special attention. In some countries, military conscripts and career soldiers can be both young and vulnerable. All young people, including those facing particular challenges, merit and require positive outreach to ensure their access to health services and to stimulate beneficial reflection on what constitutes a suitable alternative approach, structure or type of staffing to bring health care to the young. Many health-

care professionals are ill-prepared to address the social and behavioural causes that underlie adolescent health problems. Some remain unwilling to recognize the need to reconsider their attitudes and prescribing practices with regard to young patients,[73] especially the marginalized.

Guidelines, indicators of quality service provision, additional procedures and protocols exist for adolescent-friendly primary care and appropriate secondary and tertiary referral. Medical and nursing education and training (both pre- and in-service), including the development of interpersonal communication and counselling skills, can enable health professionals to confidently meet the needs of the young in an adolescent-friendly environment.[74] However, these elements are far from universally integrated into capacity-building for service providers.

ADOLESCENT AND YOUTH HEALTH CONDITIONS

Thanks to the good start in life for which immunization and breastfeeding are largely responsible, adolescents and youth who have survived childhood illnesses are generally considered the healthiest members of society. However, accidental death and death by natural causes continue to take a toll, seen when calculating the burden of disability-adjusted life years lost through events occurring in adolescence. Health planners and service providers are thus obliged to rethink their views regarding youth, seeing them first as people and then as people with problems, rather than treating their health conditions in isolation from community-based pre-adolescent development.

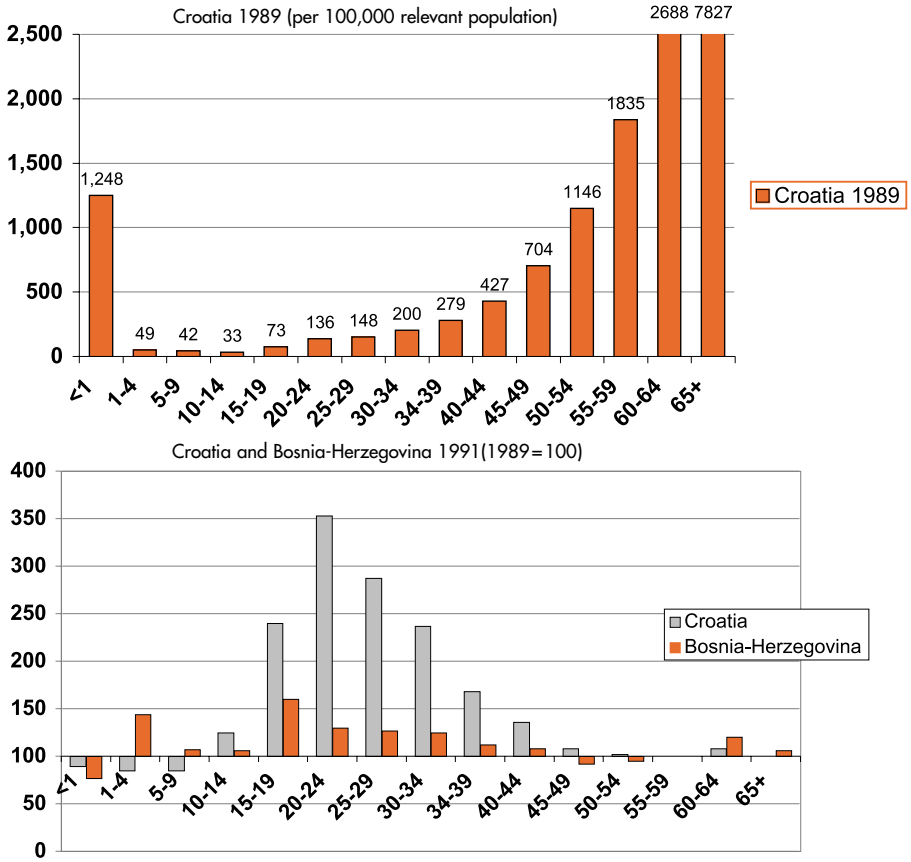
Diseases and health conditions that burden adolescents require particular attention even to be documented as such, much less to be benchmarked for assessing progress.

Epidemiological procedures that unnecessarily aggregate data to mask age by year of birth or even sex contribute to the invisibility of adolescents and youth. Reporting on pregnancy by five-year cohorts unhelpfully amalgamates 15-year-old primiparae at evident high risk of complications with the lower biomedically at-risk 19-year-old expectant mothers.

Accidents and injuries are major causes of youth morbidity, mortality and disability. Anxiety and depression, stress and post-traumatic stress disorders combine with suicide, self-inflicted injury or other forms of violence (including homicide and the effects of self-administered abortion) to present one of the most disturbing faces of youth health. This situation is aggravated in countries ravaged by war, occupation, sanctions or embargoes. Figure 4.6 presents two scenarios, one for Croatia and the other for Bosnia and Herzegovina. The first graph shows male mortality rates across the lifespan at a time of peace. The U-shaped pattern is typical of industrialized countries: infant mortality is relatively contained, and children and adolescents have the lowest probability of death; mortality then rises for young people and increases steadily with age. The second graph shows the inversion of the U shape during a time of war,

with mortality cresting among 15- to 24-year-olds, many of whom are bearing arms. Beyond the male mortality impact of war lies the profound effect on children and young people subjected to a culture of violence, with young women in particular being victims of rape and sexual assault.[75]

Figure 4.6
Male mortality by age in Croatia and Bosnia and Herzegovina
Source: UNICEF, "Young people in changing societies: the MONEE project, CEE/CIS/Baltics", Regional Monitoring Report No. 7 (Florence, UNICEF Innocenti Research Centre, 2000), p. 20.



Note: The infant mortality rate is usually calculated per 1,000 live births instead of the rate per 100,000 children aged 0-1 used in the panel on Croatia, 1989.

Source: UNICEF, "Young people in changing societies: the MONEE project, CEE/CIS/Baltics" ,Regional Monitoring Report No. 7 (Florence, UNICEF Innocenti Research Centre, 2000), p. 20.

War is typically followed by an attempt to return to economic stability, perversely increasing sexual coercion and pressure on young women to assume a reproductive role, leading to earlier pregnancy both within and outside of marriage. This phenomenon has been seen in the course of the Great Lakes War in Central Africa.[76]

The establishment of sexual identity is one of the developmental tasks of adolescence. The State and the family have a duty to care for and support young people during this period of confusion and uncertainty, in particular by preventing sexual abuse.[77] Violence and abuse, including self-inflicted harm and suicidal behaviour, can also be related to sexuality, sexual orientation and gender-based discrimination.[78] Young people are often victims—though they can also be perpetrators—of such abuse and exploitation.

Social, cultural, religious and traditional attitudes towards adolescent sexuality and experimentation vary. There are those who believe that the criminalization or medicalization of young peoples' experimentation with sexuality constitute an obstacle to their personal development and an infringement of their rights. As illustrated earlier in this chapter, legislation in some countries allows for sexual experimentation without State interference.

The improvement of adolescent health worldwide depends on a myriad of interventions, happily some no more complex than washing hands and brushing teeth. Basic hygiene conditions in homes, schools and workplaces around the world have a profound effect on adolescent and youth health, as well as on the health of children born to young mothers. Water, sanitation and hygiene is, in reality, measured at the household rather than the individual level, so in some sense there is no way or need to isolate any age group on the exposure side. The proportion of households with access to clean water and sanitation shows what access adolescent household members have. However, it is not unlikely that adolescent-headed households, like female-headed households, suffer disproportionately from poverty and therefore tend to have more limited access to water and sanitation.

Health education has traditionally focused on basic and oral hygiene, but generally just for those under age five and schoolchildren. There is a well-indicated need to focus on young mothers-to-be and probably on medical students,[79] as this has the potential to dramatically reduce mortality and morbidity by associating manufacturers with health authorities in marketing soap and toothpaste to the young.[80] This is a reminder that behaviours and perceptions are acquired in childhood and, when rehearsed or reinforced in adolescence, have health consequences in adulthood.

Perhaps the most striking example of harmful traditional repetitive behaviour is female genital mutilation—a form of gender-based violence. The age of mutilation varies between countries and cultures, potentially taking place shortly after birth, during early childhood or adolescence, right before marriage or in the seventh month of pregnancy. Whatever the age at which mutilation occurs, psychosocial and biomedical consequences and complications are often manifest during late adolescence in the forms of diminished self-esteem, depression and anxiety, and chronic genito-urinary disorders including abscesses, urinary tract infections, obstructed labour, infertility, and the formation of vesico-vaginal fistulae. While opinion leaders and health professionals are generally aware of these consequences, too few adolescents receive information about the problems associated with this practice.[81] Health professionals brazenly violate young women's rights and their own professional ethics by conducting the procedure.

Other cultural practices harmful to sexual and reproductive health have been adopted by a significant number of adolescents, leading to pregnancy and the transmission of STDs including HIV/AIDS. Data from the Inter-Agency Group's Safe Motherhood Initiative show that pregnancy at age 15 is inevitably characterized by high risk, while at least the corresponding physical biomedical risks for a healthy 19-year-old are reduced. The risk of dying from pregnancy-related causes is twice as high for 15- to 19-year-olds as for 20- to 24-year-olds.[82] Young women aged 15-19 years give birth to approximately 17 million of the 131 million children born every year. In

sub-Saharan Africa around one in five girls in this age group gives birth each year, while in Japan, the Republic of Korea, the Netherlands and Switzerland fewer than one in 100 girls ever gives birth under the age of 20.[83]

In many developed countries immunization in adolescence is recommended, particularly for tetanus and hepatitis A and B prevention.[84] In a number of other countries, high levels of endemic hepatitis affect all population groups, including adolescents, and measles and tetanus continue to complicate adolescent pregnancies. In areas in which poor sanitation is combined with professional neglect of universal precautions for the prevention of infection in hospitals, nosocomial infection is not uncommon. In developing countries in particular, these added health risks and threats, combined with the physical, mental and emotional burdens provoked by female genital mutilation and various initiation rites, weigh greatly on adolescents in their interaction with health facilities.

Poor nutritional practices, cardiovascular diseases, obesity, anaemia, eating disorders, and conditions associated with affluence add to the burdens on today's youth and the adults they will become. The early onset of type 2 diabetes, normally associated with the excess weight that comes with ageing and poor nutrition,[85] and the increasing prevalence of eating disorders such as anorexia and bulimia are part of an emerging trend that is placing a strain on health services[86] and causing pain for adolescents and those who care about them. Other lifestyle diseases are associated with inactivity or excessive consumption, particularly in developed countries, parts of the Arab world and the economies in transition, and also among young people from ethnic minorities.[87]

The influence exercised by cigarette manufacturers on the health behaviour of young people is disturbing. The use of tobacco is a major public health concern, yet because of clever advertising and misinformation in the media and tobacco company sponsorship of sports and cultural events, young people fail to perceive themselves as being at high risk of the entirely avoidable burdens of disease, death and disability linked to the use of this substance.

The emergence or continued existence of eye problems related to computer use, refractive errors and poor vision, and even blinding trachoma in some poverty pockets, indicates that there is still much to be done for the prevention and control of conditions ranging from imperfect vision to blindness in adolescents and youth.[88]

Creative use of whatever leisure time is available to young people can increase—even marginally—the amount of physical activity they undertake. Promoting fitness will have a beneficial impact on their current and future health.

THE POLICY ENVIRONMENT FOR YOUNG PEOPLE'S HEALTH

While every country has some policy basis for action to promote adolescent and youth health, too few national health policies give specific attention to young people. Nonetheless, most United Nations specialized agencies are working to ensure that regional strategies and national plans for adolescent and youth health are being developed, published and acted upon. The Millennium Development Goals underpin such plans.

A successful adolescent and youth health policy, strategy, service, programme or project will almost certainly be interdisciplinary and extend beyond the health sector. The role of various social actors is already known and the effectiveness of youth participation acknowledged. The planning and policy frameworks exist at the international level and are to a large extent nationally adopted, though so far this has not guaranteed that community responses are appropriate, effective or efficient.

In a variety of policy development processes, it is becoming more clearly recognized that adolescents and youth have specific needs. The means to ensure replicability, reliability, quality and cost-effectiveness in adolescent health programming are becoming more widely known and available to policy makers, health professionals, legislators and community leaders.[89] Models of health services reflecting the principles of health sector reform need to ensure that counselling, other services and health commodities are accessible to adolescents if such models are to go to scale.

A focus on the young during health sector reform contributes to the establishment of a relationship between individuals and a system that will take care of them throughout their lives. Attention to adolescents at the start of their self-managed interaction with the health system will ensure more effective recourse to health care, limited by spontaneous preference for lower-cost prophylactic measures over high-cost curative services.

Frameworks, statements, guidelines and policies already touch upon adolescent and youth health in general and often cover the health and development concerns of adolescent girls and young women. Adolescent and youth concerns receive brief mention in assessments of mental health, violence and injury prevention, and HIV/AIDS prevention and care. Adolescent sexual and reproductive health is as yet largely underprotected by effective laws and policies.

The systematic documentation, evaluation and dissemination of projects and initiatives in which young women and young men act as agents of change will influence and if necessary reorient how youth health projects are managed. Norms, standards and indicators for evaluation, as well as technical guidelines, are still being developed as part of the overall effort to achieve large-scale adolescent and youth health programming in which young people are fully involved alongside clinicians, technicians and politicians.

The relative absence of a mid- to long-term economic evidence base for investing in youth health as part of health sector reform is being compensated for by the emergence of more accurate and appropriate measurement mechanisms and indicators for the design, delivery and evaluation of interventions.

As indicated in the outcomes of the third and fourth sessions of the World Youth Forum, respectively held in Braga, Portugal, in 1998 and in Dakar, Senegal, in 2001, young people are calling for increased access to national and international resources in order to establish formal and informal educational programmes on HIV/AIDS, substance abuse, sexual and reproductive health, and mental health. Young people clearly want their Governments to facilitate improved access for youth to health information, health services and sexual and reproductive health services.

Young people have advocated the implementation of the recommendations adopted by the United Nations General Assembly Special Session on HIV/AIDS (New York, 2001), especially those pertaining directly to youth issues. They have priority concerns they hope to see incorporated in national policies addressing youth health and want to contribute to efforts to make counselling and information available (especially on sexual and reproductive health), to promote youth-friendly health services, and to foster progress through research on relevant issues that have been characterized by distinct change since the International Youth Year in 1985.

Global policy concerns reported by youth include adolescent fertility and teenage pregnancy, female genital mutilation, abortion and family planning. Region-specific issues include HIV/AIDS, malaria, tuberculosis, malnutrition, and bilharzia (schistosomiasis) in Africa, violence and injury in the Americas, conflict, occupation and displacement in the Middle East, HIV/AIDS and tuberculosis among young injecting drug users in Europe, suicide and gender-based discrimination in Asia, obesity and eating disorders in wealthy countries, traffic accidents in cities and on highways running through villages, and health and safety in the workplace in transitional and emerging economies.

CONCLUSIONS AND RECOMMENDATIONS

It is hoped that this chapter will stimulate action to build on existing experience in adolescent and youth policy and to help accelerate programming in order to ensure the physical, mental, emotional and social health and overall well-being of young people. Efforts to achieve these objectives should focus on the following:

- Creating a positive environment for promoting the right of young people to participation, development and peace as milestones on their road to better health;
- Equipping young people with adequate knowledge, self-esteem and life skills to ensure their healthy development and to advocate for their provision at the family, school and community levels;
- Enhancing the concept of gender equality between young men and young women and redressing the imbalance in the provision of opportunities—particularly for adolescent girls at risk of early marriage and consequent high-risk pregnancy;

- Providing care and protection for all young people—whatever their health, disability, vulnerability or risk status, their age, gender, sexual orientation or class, or their ethnic, racial, religious or linguistic background—through a safe and supportive environment created and supported by appropriate legislation, clinical procedures and health services including counselling.

Although young people generally constitute one of the healthiest population groups, poor health resulting from disease, accidents or injury is not insignificant for them. Factors that influence the health of young people are numerous and interrelated. Consequently, successful health policies for this group must be interdisciplinary and intersectoral, taking into account not only their physical condition, but also their personal, social, emotional and mental development. It is therefore imperative that national youth health policies and strategies extend beyond the health sector.

Health professionals can contribute to the nurturing environment that should be provided by parents, community leaders and others who bear responsibility for the health of young people. Equally or even more important, however, is young people's participation in all stages of health provision—including needs assessment, design, delivery and evaluation—to ensure that health responses are appropriate, effective and efficient. Promoting good health for young people depends a great deal on providing appropriate information and on facilitating the development of life skills through which youth acquire the ability to deal with sexuality in a mature manner, to exercise good judgement, to build and maintain healthy self-esteem, to manage emotions and feelings, and to handle pressure.

There is an urgent and ongoing need to address young people's sexual and reproductive health using a preventive, rights-based, gender-responsive and empowering approach. Relevant efforts should build on the creative energies of youth and respect their rights and capacities for participation and leadership in decisions that affect their lives. Sexual and reproductive health—tied to emotional, mental and physical health as part of the holistic concept of overall well-being—is an essential component of young people's ability to become well-adjusted, responsible and productive members of society. ■

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