LAWS AND POLICIES AFFECTING ADOLESCENT HEALTH

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WORLD HEALTH ORGANIZATION
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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides and pharmaceuticals; formulating environmental health criteria; recommending international non-proprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO’s work is presented in the Organization’s publications.
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1. Introduction

This book is about that part of life known as youth. This is taken as covering the 10-24-years age group which accounts for nearly a third of the earth's population; more than 75% of these young people live in the developing world. Although the transition between adolescence and adulthood has certain clearly defined characteristics, neither the process nor the problems lend themselves readily to generalizations; they are highly individualized, as is the effect on them of external influences. “For many adolescents and for some youth, their developmental health and social problems are closely entwined with those of their families, peer groups and local communities” (1).

It is thought that one of the common desires of adolescents is to have realistic opportunities and reasonable life experiences, despite the fact that they live in vastly differing situations and an increasingly stressful world. Though health concerns usually rank low on the list of immediate priorities of most young people, such concerns are legitimate and important, and in many instances form an integral part of general adolescent experience.

The major health-related problems of adolescents are wide-ranging, and have been described by WHO as including the following (2):

- Socioeconomic deprivation and disadvantage
- Unemployment and underemployment
- Malnutrition
- Rural/urban migration
- Alcohol abuse and dependence
- Drug abuse and dependence
- Smoking
- Accidents and risk-taking behaviour
- Suicide
- Sexual and reproductive health problems
- Mental disorders
- Mental retardation and other handicaps

The present study, which focuses on some of these health-related needs, has its roots first of all in the recommendation made some years ago by a WHO Expert Committee, in a report entitled Health needs of adolescents (3), that the legal and policy aspects of adolescent health care be explored, and that legislation be used to facilitate “more and better” health services. Then, in 1979, the United Nations, in General Assembly Resolution A/34/151, designated 1985 as International Youth Year. Among the youth-oriented activities advocated in this resolution were those that would lead to the development of “comprehensive measures for intersectoral community-based health care”.

On a global scale, adolescent health care issues continue to be neglected, possibly for two reasons—those who provide health care fail to recognize the special needs of adolescents and adolescents themselves tend not to utilize the services that are available.
This study looks at the way laws and policies throughout the world affect health care programmes for young people. It touches on what are perceived to be their major health problems, from sexual and reproductive to occupational, from mental illness to drug and alcohol abuse, from handicaps to accidents. It therefore aims to be "suggestive", in the sense that it will attempt to analyse the current situation and to suggest an array of legal and policy approaches that may be adopted in attempting to provide health care to adolescents. Not all of the alternatives will please all readers, nor will all be appropriate everywhere. This is only to be expected.

A cautionary note is in order here. There is a danger in preparing a study of this kind, namely that of appearing to glance rapidly at a number of the world's legal systems without being aware of the basic differences, substantive and procedural, as well as philosophical, that exist between them. It is quite possible that a legal approach that seems perfectly adequate in one setting will be wholly inappropriate in another for any number of reasons, not the least of which is that constitutional systems may differ or fundamental laws may exist which cannot be transcended. For example, the importance given to case law in the common law system may have little relevance in other legal systems where legal codes take precedence.

Equally, it may be unwise, indeed impossible, to adopt wholesale any of the legal approaches discussed in these pages. While it is expected that change in one country may prompt changes in others, experience indicates that it serves little purpose merely to copy a given law or regulation, especially where circumstances in the countries concerned differ widely. Nevertheless, the basic idea underlying a change in legislation may be widely applicable. The key is to adapt the approach so that it is woven comfortably into the local fabric. In this way, the change will become more than a mere academic exercise.

If there is a lesson to be learned from this study it is that there is no single legal model that can serve as an answer to all the legal and policy problems described here. Indeed, the word "model" is perhaps itself an unwise choice as it has come to be thought of as synonymous with "ideal". Many alternative legal and policy approaches exist, each of which can probably provide solutions, but the adoption of any particular one will depend on the nature and context of the legal and policy problem involved. Hence, what has been attempted throughout these pages is a description of as many alternative legal and policy approaches and solutions as can be found. It is the general approaches that recommend themselves, not the details of the legislation or regulations; these must be worked out at the national level.

In short, this book is designed to inform the reader, in a general way, about what law and policy have to say about adolescent health care, to look briefly at the ways in which they impose constraints on the development of adolescent health care programmes, to explore the various approaches that have been adopted around the world to
eliminate, overcome, or avoid such constraints, and to examine how law and policy have been utilized to ensure greater access by adolescents to health care. The book essentially views law and policy as facilitating rather than inhibiting such access. Finally, it should be seen as a source book for ideas rather than a definitive treatise.

References and Notes

1. Adolescents and youth health: perspectives, problems, priorities. Unpublished WHO document, MCH/IYY/SG/84.3a, p. 3.
2. Background and General Legal Framework

Before launching into the substance of this study, it is important to dispose of a few technical points that will make it easier to understand the bulk of the material that follows. This chapter therefore contains a brief discussion of three important issues: (1) the definition of adolescence and how it is affected by the legal view of that age group; (2) the legislative framework governing adolescent health care; and (3) how the issue of consent affects the question of access to health care.

Definition of Adolescence

Adolescence is the process whereby an individual makes the gradual transition from childhood to adulthood. The concept is relatively new, and is not without its problems. In many ways, adolescence is a kind of limbo. Most cultures relate the beginning of adolescence to the onset of puberty, though they may differ widely over when it ends. However, the purely biological approach to definition overlooks important social and legal considerations. Because traditions and customs vary so widely from one setting to another, adolescence is difficult to define in specific, universal terms. The following remarks by Chui (1) give some indication why this may be so:

In many developing countries, especially in rural and underdeveloped areas, a girl is often considered to be an adult at the time when menstruation is established regularly. They tend to marry early and do not go to school. The transition from childhood to adulthood in such cases is quick, and the notion of adolescence does not exist. On the other hand, in developed countries and increasingly in urban areas of developing countries where rapid social changes are taking place with modernization, young people go to school and tend to marry late. There is a long transition from childhood to adulthood, and the notion of adolescence emerges. There is thus a continuum between quick and slow transition in different societies.

Even so, attempts at definition have been made that purport to accommodate such variations. Thus, at the WHO Meeting on Pregnancy and Abortion in Adolescence in 1974 (2), adolescence was defined as the period during which:

(a) the individual progresses from the point of the initial appearance of the secondary sex characteristics to that of sexual maturity;
(b) the individual's psychological process and patterns of identification develop from those of a child to those of an adult;
(c) a transition is made from the state of total socioeconomic dependence to one of relative independence.

Despite the difficulty in framing a universal definition, some observations can be made with certainty about adolescents themselves. As the WHO Expert Committee on Health Needs of Adolescents observed: "There is, however, one unvarying factor; though no longer a child, the adolescent is not yet considered by society to be fully adult" (3). It is still true then, as Mr Justice Fortas of the United States Supreme Court wrote more than a decade ago, that the adolescent often "receives the worst of both worlds... he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children" (4).

The chronology of adolescence is often as slippery to grasp as the definition, partly because it varies from culture to culture, and indeed, from individual to individual. Social scientists and medical researchers have found it useful to take as broad a view as possible in establishing age limits, even to the extent of distinguishing the earlier phase of adolescence from the later, e.g., 10–14 years and 15–19 years. Some years ago a WHO Expert Committee (5) proposed that the age limits of 16–20 years be used to identify "adolescence", and this seems to represent the conventional wisdom on the matter. The overlapping notion of "youth", 15–24 years, has been employed by social scientists, and is the vogue in current usage because of the emphasis on 1985 as International Youth Year.

The law attempts, to a certain degree, to take into account the process of individual development called "adolescence", even though the term "adolescent" is not used in legal language. In legal parlance, prior to legal adulthood, a person is considered a "minor", a "juvenile", a "youth", or simply "underaged". The law, however, seeks uniformity and certainty, and rather arbitrarily selects the age at which legal adulthood is reached for some or all purposes. This is commonly referred to as the age of majority. In earlier times, the age limits corresponding to minority and adolescence were more or less identical. Recent developments have changed this situation.

In most countries, the age of majority—the age at which individuals are regarded as competent to handle their own affairs—was traditionally 21. The trend over the past 15 years has been to lower that age somewhat, usually to 18, and the law of various countries reflects this. However, 21 remains the age at which many of the trappings of legal adulthood are assumed in many countries.

No consensus exists, even within countries, with respect to the legal age of majority for all purposes. Minimum ages often vary, not only by sex, but also according to the purpose of the age limit—marriage, civil majority, criminal responsibility, voting rights, military service, access to
alcoholic beverages, consent to medical treatment, consent to sexual intercourse, etc. (6). None the less, the legal limits are important.

**Legislative Framework of Adolescent Health Care**

Health care is a legitimate concern of any nation. Legislation is used not only as a vehicle for expressing this concern but also as a method of creating a system of "rights" and "duties" with regard to health care. At its most simplistic, the right to health is said to be possessed by individuals, while the duty to provide health care in general falls to the state. These rights and duties are elaborated at various levels and take various forms.

**General legislation**

The constitution of a country often establishes the fundamental rights of citizens and the obligations of the state. Most countries have public health codes which establish the administrative machinery for health care, in addition to specifying some of the details concerning health care programmes. These are complemented by health-care-related legislation and regulations drawn from such disparate sources as criminal law, child welfare law, education law, family law, and labour law. In sum, the aim of this legislation is to ensure that health care is available to the population, though what is decreed and what occurs in reality may often differ considerably. It is unfortunate, but nevertheless a fact of life, that the burgeoning rural populations of many countries are virtually without health care of even the most rudimentary sort.

The recently adopted Constitution of Spain recognizes the right of its citizens to health care. Article 43(2) requires the public authorities to "organize and safeguard public health through preventive measures and the necessary benefits and services." In Cuba, the right to health protection and health care is guaranteed by the state, and these are provided in the form of free medical and dental care, plus access to health education, medical examinations, immunizations, and other services that prevent disease. Free health care at state institutions is also guaranteed under the constitution in Albania and the Soviet Union.

Such broad legislative statements apply to adolescents as to all other age groups, but some constitutional provisions are specifically concerned with the health interests of the young. In Greece, in addition to placing the responsibility for health care on the state, Article 21 of the Constitution requires the state to take special measures to protect the health of the young. In Sri Lanka, the state is under the general obligation to "promote with special care the interests of children and youth, so as to ensure their full physical, mental, moral, religious and social development."

The public health codes or their equivalent are central to any rational attempt to organize and regulate the various health care and
promotion services. Such codes exist in virtually every country and are often extensions of the constitutional statement. Thus the Romanian law of 6 July 1978 promotes the creation of conditions that “maintain and enhance the health of the population and . . . prevent diseases”, and one of the main objectives is to protect and enhance the health of young people. To achieve this, health units are required to carry out educational and medical activities within families, at schools and workplaces, to prepare young people for establishing families, and to provide medical supervision for pregnant women and care for children.

Access to health care is often a problem for adolescents because they cannot meet the costs. Certain countries have remedied this situation, at least for some adolescents. For example, Ordinance No. 73-65 of 28 December 1973 in Algeria made public health activities, diagnosis, treatment, and hospitalization free to certain groups of people. Decree No. 74-2 of 16 January 1974 made young people up to the age of 16 years eligible for free medical services.

The problem of cost is less of an issue in countries where health care is typically considered part of the larger social welfare scheme. In these countries, health care is available free or at a minimal cost to the recipient. However, in countries where a larger proportion of health care is provided by the private sector, legislation allowing minors to consent to health care treatment may fail to address directly the question of whether a minor can be held personally liable for the costs.

The provisions of public health codes, as a minimum, establish the general objectives of health care programmes, many of which have an impact on adolescents. These cover such areas as reproductive health, mental health, attempts to regulate tobacco, drug, and alcohol abuse, occupational health, immunization programmes, oral health care and treatment, biomedical research, organ and tissue transplants, and accident prevention.

Legislation on special categories of adolescents

If it is generally true that the state has an obligation to meet the health needs of adolescents, it is equally true that parents also have obligations. Under the General Health Law of Costa Rica, adolescents have a right to expect parents and the state to “safeguard” their health. For the parents, this means, in part, that they must comply with medical advice given them regarding the health of minors. In most legal systems, parents must ensure that their adolescent children are brought up under circumstances that enhance their health, physical as well as mental. While this may be viewed as an implicit feature of parenthood, such obligations are also explicitly imposed in legislation on child welfare. The Child and Youth Welfare Code in the Philippines requires that parents take special care to prevent children from indulging in practices that prejudice their health, such as alcohol or drug addiction, smoking and “other harmful vices”.


However, the state is the ultimate arbiter in deciding when these obligations are being met. In many countries, it has authority to intervene when it can be shown that the interests of the adolescent are being disregarded. For example, when the parents are either unable or unwilling to provide proper care, a court may determine that the adolescent is "neglected". One of the options then open to the state is to take the adolescent into care; another is to order that the adolescent undergo medical treatment, sometimes against the parents' wishes. However, medical treatment is usually ordered only if care is necessary to alleviate a condition that is life-threatening or seriously detrimental to health.

In every state of the USA, statutes have been enacted that authorize courts to intervene to protect neglected children. These statutes, either implicitly or explicitly, authorize courts to order medical treatment for minors where parental consent is withheld and a case for "medical neglect" can be made. Generally speaking, such action has been taken by courts only where the absence of medical treatment seriously endangers the minor, but in a number of states the statutes have been used to order medical treatment in circumstances that fall short of an "emergency". However, in practice, these statutes offer little assistance to minors in need of health care, particularly if the treatment they are seeking relates to drug use or sexual activity, for the simple reason that the parents must be made a party to the judicial proceedings. This runs counter to the desire of minors not to inform their parents about such sensitive health problems.

The customary use of the parens patriae authority to take the place of the parents comes within the area of "neglect" proceedings. Such proceedings should not be confused with delinquency proceedings, since adolescents are taken into care for delinquency, not because their parents have failed to meet their obligations, but because the minor has committed acts that, if done by an adult, would constitute a violation of criminal law, and is, in addition, in need of rehabilitation, supervision, and/or treatment. The delinquent minor's antisocial conduct, however, is frequently combined with problems relating to the minor's health, including drug dependence, alcoholism, mental illness and need for reproductive health care. When and if the state intervenes is largely controlled by local criteria, attitudes, and perceptions. In some countries such intervention aims at assisting and rehabilitating adolescents, in others it is often punitive.

**Consent**

By way of preface here, some space must be devoted to a discussion of the legal capacity of minors and, in particular, of how this affects the issue of consent. The law generally takes a protective view of minors—those under the age of legal majority—designed both to insulate them from the supposed flightiness of their own decisions and from outside
pressure or coercion. The theory is that minors lack the capacity to give
gively valid consent, where such is required, because their physical,
mental, and moral development is incomplete (11), and they are "too
vulnerable to exploitation by the rapacious and too exposed to the
unscrupulous" (12). For this reason, they do not have the same basic
legal rights as adults. Of this essentially paternalistic view, it has been
said (13):

The disabilities are really privileges, which the law gives them, and which they may
exercise for their own benefit, the object of the law being to secure infants from
damaging themselves or their property by their own improvident acts or prevent
them from being imposed on by others.

Privileges perhaps, constraints possibly; the special legal status of
minors cuts two ways. On the one hand, it reflects an attitude that gives
minors special protection that is not available to adults, but on the
other, many of the benefits available to adults through the exercise of
choice are not available to minors without parental consent. Nowhere is
this more evident than in the area of medical treatment, where the
concerns for the welfare of the minor and the standards governing the
tort liability of medical personnel (14) come together generally to bar
medical treatment without parental consent. In the absence of such
consent, the actions of a medical practitioner in treating a minor may, in
fact, constitute assault and battery (15). The vindication of parental
rights, given parents' liabilities for support of, and responsibility for the
child, and the protection of health care providers have thus been
recurring legal themes. To a certain extent, then, minors are held
hostage to the will of adults, either that of their parents or guardians, or
of health care providers.

It is the law concerning consent to medical treatment of minors that
most directly affects the question of whether health care services are, in
fact, available to youth. Consent is the key to access. While requiring
parental or spousal consent arguably tends to safeguard adolescents
from irrational decisions and poor, if not dangerous, care, in the minds
of many observers, it pragmatically limits the options for health care
available to adolescents, particularly where such thorny issues as
reproductive health care or drug abuse are concerned (see Chapters 6
and 10 respectively). It overlooks, as well, the process of intellectual
development which occurs as the adolescent progresses towards
maturity.

Under historic common law, children were considered chattels—
property, possessions—of their parents, and therefore no interference
was countenanced in the way in which the parents dealt with the child's
interests, including deciding what services were made available (14).
Until recently, the near-universal rule has been that minors must have
the consent of their parents, or if married and female, the consent of
their spouse before they receive medical treatment. This historic view was recently reiterated in the USA by Chief Justice Warren Burger (16):

Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments.

Initially, the only exception at common law was made for emergencies (14). Blackstone, the eminent 18th-century English jurist did, however, advance the view, long overlooked, that minors could enter into agreements to acquire “necessary physic”, defined as beneficial medical treatment for themselves that helped to maintain a suitable level of health (17).

Over the years, the traditional strict legal rules have changed. These changes have addressed the issues of “whether a minor has the right to consent to medical treatment over the objection or without the knowledge of his or her parents” (14) and, if so, at what age or under what conditions. This shift has been triggered in large measure by the increased health care needs of teenagers. Various forward-looking legal approaches have been used. First, in the face of problems related to sexually transmitted disease, drug abuse, and teenage sexuality and pregnancy, many countries have enacted “health services to minors” acts or “minor treatment” statutes that permit underaged persons to seek and consent to medical help without parental intervention. These have their origins in the recognition of the fact that many young people do not want their parents to know of their health problems (14), and that “strict adherence to the traditional parental consent rule would create problems for great numbers of young people in need of health care” (18). In the USA, much of the impetus for the passage of these special acts was provided by the rapid growth in the incidence of sexually transmitted disease and by the need for reproductive health care. Second, the courts, particularly in common law countries, have introduced exceptions to the parental consent requirement. We shall explore these inroads into the traditional rules in what follows.

Legislation on consent

In many countries, the rules governing consent to health care are set by statute, rather than by jurisprudence and practice or court decisions. In recent years, many of these rules have been changed by legislation specifically designed to avoid the rigours of the existing law while at the same time reflecting contemporary conditions. While the age of majority in England and Wales for most purposes is 18 years, Section 8 of the Family Law Reform Act, 1969, states that the “consent of a minor who has attained the age of sixteen years to any surgical or medical . . . treatment . . . shall be as effective as it would be if he were of full age”. The Act thus makes it unnecessary for health care personnel to obtain
the parent's consent before providing health care to anyone 16 years of age or older (as long as he or she is mentally competent).

In Quebec (Canada), Alabama (USA), and New South Wales (Australia), the age of consent for medical treatment is as low as 14 years. In Quebec, Section 36 of the Public Health Protection Act divides minors into two distinct categories—infants and adolescents—in matters pertaining to consent. It lays down that:

An establishment or a physician may provide the care and treatment required by the state of health of a minor fourteen years of age or older with his consent without being required to obtain the consent of the person having paternal authority.

For those under the age of 14, the following approach is taken:

Where a minor is under fourteen years of age, the consent of the person having paternal authority must be obtained; however, if that consent cannot be obtained or where refusal by the person having paternal authority is not justified in the child's best interest, a judge of the Superior Court may authorize the care or treatment.

In New South Wales (Australia), the Minors (Property and Contracts) Act 1970 lays down in Section 49 that the consent of a minor aged 14 years or over to medical treatment will preclude a claim for assault and battery. The Act prescribes that: (1) for patients under the age of 14 years the consent of the parent or guardian is required; (2) between the ages of 14 and 16, either the patient or the parent or guardian may consent; and (3) at age 16, only the minor's consent is necessary. Despite the Act, the Hospitals Commission, uneasy as to the desirability of the practice, has recommended that a more cautious policy be followed and has urged hospitals to seek the consent of parents if the minor is under 18 years of age (19). Such a position is not legally required but shows the caution with which health care providers approach the subject.

In South Africa, Act No. 43 of 1976 empowers any person over the age of 18 to consent to medical treatment, laying down that: "Notwithstanding any rule of law to the contrary, any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon, or any medical treatment of, himself" (20).

In every state of the USA and the District of Columbia, legislation has been enacted that alters, in varying degrees, the general legal requirement of parental consent to health care for minors. The scope of such legislation differs markedly from state to state, and to add to the complexity and confusion, a state will often have enacted a number of separate authorizing provisions which may overlap (21).

In general, two basic types of statute exist in the USA. The first allows certain minors to consent to virtually all kinds of "ordinary" medical treatment (14). Statutes in this general group can be divided
into a number of subcategories. Thus, a few statutes authorize the "mature minor" (defined along the same lines as the common law "mature minor" exception, described more fully below) to consent to medical treatment generally. Others have modified the common law emancipation doctrine (see below) and, at times, have defined emancipation quite broadly. Still others have simply lowered the "age of majority" for purposes of medical treatment. This is, as we have seen, the approach adopted in many other countries.

Statutes of the second type focus on specific health problems about which adolescents may be particularly reluctant to inform their parents—sexually transmitted disease, pregnancy, sexual activity, drug or alcohol abuse, or emotional stress. These statutes authorize some or all minors to consent to medical care relating to specific problems or conditions. For example, in every state of the USA and in the District of Columbia, legislation expressly authorizes minors to consent to diagnosis and treatment for sexually transmitted disease. Statutory provisions expressly authorizing minors to consent to care and treatment relating to sexual activity and pregnancy care have also been enacted in many states, but in a number of these, consent to abortion and/or sterilization is expressly excluded. In the light of recent United States Supreme Court decisions, the statutes precluding some minors' consent to abortion are, however, probably unconstitutional (22). (This question will be discussed in greater detail in Chapter 6.) Many statutes explicitly authorize access to contraceptive services for minors without parental consent but some have tried to suggest that parents should be notified of the treatment being given to the adolescent. The federal rule on this practice in the USA—popularly known as the "squeal rule"—has been struck down by the courts (27).

Exemptions from parental consent

Over the years, courts in some countries, but particularly in the United States and others that follow the common law tradition, have developed judicial exemptions from the parental consent requirement. These have been alluded to earlier.

The first exemption, the most traditional one as we have seen, dispenses with the requirement of parental consent when a medical emergency exists. In such cases the physician may begin treatment without waiting to obtain such consent (24). "Emergency" has been variously construed, but typically courts have defined it narrowly, applying it only in cases in which there is imminent danger to life or health unless treatment is promptly provided. As Holder says, speaking of the emergency doctrine, "purely elective treatment of a young child" does not fit the requirements and "should never be undertaken without parental consent" (14).

The second exemption relates to the emancipated minor—"one who is not subject to parental control or regulation" (14). A number of conditions qualify a minor as "emancipated": Minors who live apart
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from their parents and are self-supporting are generally considered emancipated (25). Even a minor who remains at home but is totally or partially self-supporting, and makes many of his or her own decisions, may often be considered "emancipated" (26). Other events that emancipate the minor include marriage (27) and service in the armed forces (28). In addition, Holder suggests that "pregnancy constitutes emancipation in fact" (14).

The recently drafted Model Health Care Consent Act in the USA, which was approved by the National Conference of Commissioners on Uniform State Laws in 1982, takes up the emancipated minor rule. (The Conference recommended that the Act be adopted throughout the United States.) Section 2(2) of the Act authorizes a minor to consent to health care if he or she: (a) is emancipated; (b) has attained the age of 14 years and, regardless of the source of his or her income, is living apart from his or her parents or from an individual in loco parentis and is managing his or her own affairs; (c) is or has been married; (d) is in the military service of the United States; or (e) is authorized to consent to health care by any other law of the state of residence.

Emancipation is, nevertheless, a difficult term to define in some cases and, indeed, a minor may be emancipated for some purposes and not for others. The essence of emancipation is that the minor is no longer totally dependent upon or under the control of his or her parents, whether or not they have voluntarily relinquished control (14). He or she makes decisions that affect important aspects of life, and is therefore deemed competent to consent to medical treatment. The question of emancipation turns on status and behaviour rather than maturity, and relies on objective rather than subjective criteria (18).

The third judicially created exemption permits the mature minor to obtain medical care without parental consent. Holder (14) is of the opinion that, all things being equal, it is "a sensible rule". A "mature minor" is one who is sufficiently mature to understand the nature and consequences of the treatment being offered (27). Whether a minor is "mature" is largely a subjective matter for the physician to determine. In applying this exemption, the courts appear to have looked at a number of factors in addition to the minor's age. As Dickens says, the basis for consent under this rule is the "quality of intellectual and emotional maturity, not dependent upon the achievement of the age of maturity" (29). Thus, experience, intellect, and capacity for responsible decision-making are all factors that help to determine "maturity". While the precise scope of this exemption is determined on a case-by-case basis, the following conditions, according to Wadlington (30), appear to apply:

1. the treatment undertaken is for the benefit of the minor;
2. the minor is near the age of majority (at least in the range of 15 years of age upward);
3. the minor is considered to have sufficient mental capacity to understand fully the nature, importance and consequences of the medical treatment offered; and
4. the medical procedures are characterized as something less than "major" or "serious" in nature.
The American Bar Association (ABA) has endorsed a series of recommendations or "standards" regarding the conditions under which minors may obtain medical care on their own (31). These standards are intended to serve only as guidelines but summarize the gist of the judicial decisions on the subject. The "standards" generally advise that parental consent should be obtained before medical services are provided to a minor. However, they also outline a series of exemptions: when a minor is "emancipated" or "mature"; when the nature of the service is of a sensitive or confidential nature; when emergency conditions exist that jeopardize the life or health of the minor. In these cases, the physician should feel confident in providing services without parental consent.

Parental consent for other categories of minors should be waived for certain services, the Joint Institute of Judicial Administration/American Bar Association Commission recommended (31), particularly when "the social utility in providing medical treatment outweighs the potential negative impact that treatment without parental consent might occasion". With respect to reproductive health care, the Commission stated that "a minor of any age may consent to medical services, therapy or counseling for: (1) treatment of venereal disease; (2) family planning, contraception or birth control other than a procedure which results in sterilization; or (3) treatment related to pregnancy, including abortion". The "standards" also suggest that the physician notify the parent of the treatment only if the minor agrees or if the physician believes that failure to notify the parents would seriously jeopardize the young person's health.

The nature of consent

However well intentioned, necessary, or beneficial health care measures are, the rule is that they "must be authorized by the patient" (18). This is done by consent. The classic statement in American jurisprudence is that by Judge Benjamin Cardozo, who concluded that an individual of the requisite years, status, and sound mind "has the right to determine what shall be done with his own body" (32). However, consent itself, as Christoffel reminds us (18), must meet four established tests. First, "the consent must be for what is actually done"—no more, no less. Second, "the consent must be voluntarily given"—no threats, no coercion, no manipulation. Third, the consent "must be given by a person legally and mentally competent to do so". And last, "a patient can only authorize treatment if he or she is given adequate information about it"—the consent must be informed. It is this last requirement that is receiving much attention of late, as well it should, especially where adolescents are concerned.

To be "informed" an adolescent must receive and understand an explanation of:

- the nature of the medical procedure to be used;
- the risks of the suggested procedure, their seriousness and the probability of their occurrence (33);
the potential benefits of the suggested treatment;
-- the need for any post-treatment supervision or continued treatment; and
-- the alternatives to the treatment suggested and their relative risks and benefits.

To meet the "informed consent" requirement, the minor must have the "capacity to absorb and assimilate information", a capacity that some may lack (12). The test is basically, as Dickens (12) puts it, "the minor's intellectual capacity to comprehend... not his legal capacity as such to consent, although the former conditions the latter". In other, more direct, words: "if you can understand the risks, you can consent to them" (34).

If the minor is not sufficiently intelligent and mature to understand the explanation, informed consent cannot be given. Because of this, the ability to consent may be affected by the nature and seriousness of the treatment. A sliding scale applies: the less serious the treatment the more likely it is that legally effective consent can be given. This can make for problems, but then so does declaring that at age 18 one is an adult, and therefore able to make responsible decisions. As one United States District Court has suggested (35) many young girls may be sufficiently aware to be legally competent to consent to the use of reversible contraceptives, but may lack the knowledge, maturity, and judgement to consent to permanent sterilization.

In recent years it has been suggested that two other pieces of information be given to those who seek health care, namely: that they have the right to refuse treatment, and the probable consequences of such a decision. They should also receive assurance that no punitive action will result from refusal of treatment.

Logic dictates that, if an adolescent can consent, he or she can also refuse to accept recommended treatment, at least where ordinary medical care is concerned (36). Only when the treatment has been characterized as life-saving or required by statute, have courts intervened to override the refusal of minors and parents alike. Under traditional parental consent rules, the right of refusal lies with the parents. With the advent of the newer minor-oriented consent rules, the right of refusal has passed to adolescents, though younger adolescents may still not have the right to consent and hence no right to refuse. Much depends on the age and legal status of the minor. The real problems arise where either the parent refuses and the minor wants or needs the treatment or vice versa. This raises the issue of whether a parent, through a medical practitioner, can compel the minor to undergo treatment or override his or her decision to seek care.

There is still much debate on this point. However, for some kinds of treatment it seems clear that the best interest of an older minor will prevail over the desires of the parents. This is particularly true in the area of reproductive health care, as has been made clear in two cases, one in the USA and one in Canada, both concerned with abortion.
There is, in some quarters, the belief that parents have the authority to veto a minor daughter's decision either to interrupt a pregnancy or not to seek such treatment. This, according to Dickens, is "a misapprehension of parental powers" (29). In both cases, courts in the USA and Canada have intervened on behalf of minors to protect their interests (37). It may well be, as Lord Denning has said, that the parental right of decision-making on behalf of minors is "a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice" (38).

The one area of law where this balance is tipped in favour of parents, or third parties, is that of treatment for mental illness. Here the basic question of mental competence arises from the outset, so that many of the exceptions alluded to throughout this discussion simply do not apply. (More will be said about this in Chapter 12.) The underlying view is that (16):

Simply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or official of the state.

There is one other aspect of consent, alluded to earlier, that merits brief attention here. It arises when minors do, in fact, have the power to consent to health care, whether under statute or common law. This is the question of whether parents should be "notified" that their child is undergoing treatment. Such parental notification raises subtle ethical issues. While it is difficult to deny that parents have a legitimate interest in the health of their children, the advent of the minor consent rules has brought into focus a new type of conflict between the minor and the parent. Health care personnel are caught in the middle.

As patients in their own right adolescents are entitled to the protection of confidentiality. Except where permitted by statute or by case law, parental notification would not be authorized in the case of a minor who can consent to his or her own treatment. The classic exceptions have been, first, when the minor has a contagious disease (39), and secondly, when the minor's health or life is in imminent danger (14). The more serious the health problem, the more reasonable notification becomes.

Of course, if the young patient freely consents to parental notification, the practice is not objectionable. However, if the minor, even if under the age of consent, is adamant that the parents must not be notified, health care personnel are in the difficult position of having to weigh the effects of deterring minors from seeking care against the legal interests of the parents. To some extent, practice, particularly in the area of sexual health care, suggests that it is acceptable to forego parental notification, though this is an area of legitimate debate, and many approaches are being used, as will be described in Chapter 6. As
Dickens says of care of the minor under the age of consent (12): “a physician is in principle entitled to decline to undertake non-emergency treatment, and if he wishes may accordingly make it a condition of rendering treatment that the patient consents to parental notification”.

**Legal alternatives to consent**

The parental or spousal consent requirements essentially rest on the theory that this is the best way to protect the health of minors. Depending on the context in which they operate, the requirements can be either barriers or safeguards. Where they create a barrier for adolescents seeking needed health care, there is perhaps sufficient reason to reassess that approach, otherwise minors will simply be discouraged from seeking the health services they need. In the long run, one of the reasons for the consent rule will then be undermined as minors either fail to seek care or turn to care given outside the law, by unqualified practitioners.

The technical requirements of the law must also be seen in relation to what happens in reality. In many instances, it may be virtually impossible to comply with the requirement of parental/spousal consent. This is particularly true, as is increasingly the case worldwide, where teenagers are drawn to urban centres, far from their parents, in search of better economic and educational opportunities, or where they simply misrepresent their age or marital status, or where young women who are subject to spousal consent requirements do not wish to involve the spouse. While these circumstances alone are not sufficient reason to abandon the rule, their existence has to be faced. Where there is doubt or ambiguity about the applicability of the parental consent rule, there are alternatives that have struck a balance, albeit with some difficulty, between making the services accessible, ensuring that adolescents are well informed and are given care that does not jeopardize their health, protecting the need for confidentiality, and serving the interests of adolescents, parents and health care providers alike.

The following legal approaches have been adopted that diverge from the general rule that, where adolescents are younger than the legal age of majority, parental, guardian or spousal consent is generally required before health care can be given:

1. **Special legislation:** Legislation has been formulated—relating especially, but not solely, to contraception, pregnancy, abortion, sexually transmitted diseases and drug abuse—that expressly permits adolescents of various ages to consent to medical treatment without parental involvement.

2. **Special judicial or administrative hearings:** Where there is either conflict between the parents and the minor or some question as to the minor’s ability to consent, some countries have introduced special screening processes to determine what course of action is in the best interests of the minor. The disadvantage of this approach is that it
takes time to work through the judicial system, so that it is unsuitable if care needs to be given quickly.

3. Ombudsman or child advocate: The task of such officials is to protect the interests of the minor in “emergency” cases, or where the minor is “neglected or abused” or in “moral danger” and hence is at odds with the parents, or where it can be shown that the minor will be harmed if the parents’ views prevail or if they are informed. This approach depends on the existence of the proper judicial or administrative machinery to assess the status of the minor concerned and appoint an appropriate advocate and then take the best possible course of action. Court intervention on behalf of a “medically neglected” adolescent is being increasingly used in some states of the USA, for minors with psychiatric problems.

4. Surrogate parents: Another adult, e.g., aunt, older sister, or teacher, is used as the source of any required consent in cases where the minor chooses not to involve the parents or where there are none. This is largely an experimental approach and has not been enacted into law, except in so far as the concept would apply to legal guardians (40).

5. Mature minor doctrine: Minors who are sufficiently mature to understand the nature and consequences of the medical treatment proposed for their benefit are able to give legally effective consent, even in the absence of a specific statute. This approach has been adopted in special medical treatment statutes for minors.

6. Emancipated or partially emancipated minor doctrine: Where minors are married, live apart from their parents, are self-supporting or already make major decisions affecting various aspects of their lives, they are able in some jurisdictions to give legally effective consent to medical treatment.

7. Parental notification: It has been suggested that a notification requirement, for some types of health care, would be less of a barrier than one calling for parental consent, and that this is one way to alleviate the tension arising from the parental consent requirement. However, it seems clear, from the studies that have been carried out, that many young people who seek treatment for reproductive health matters, for example, do not want their parents to know and will not seek such treatment unless they are assured of confidentiality (41). The notification requirement must then be seen as undesirable; however, it may provide a middle ground and some countries do use this approach.

Conclusions

The three subjects discussed in this chapter set the scene for the chapters that follow. The legal definition of adolescence, the basic framework within which adolescent health programmes function, and the question of access as governed by consent are recurring themes. It
will be noted that their effect on adolescent health care varies depending on the subject under discussion. Many of the legal regimens have their own idiosyncrasies. The survey, though unified by the subject of adolescence, is as much a study in variations and differences as in similarities and consistencies.

References and Notes

15. Ibid. at p. 125. Judge Cardozo framed the correct statement of law: “a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages”. Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92, 93 (1914).


36. The exceptions, all of which are described in the appropriate chapters, are, when the law makes it compulsory for treatment to be given. Treatment for communicable disease, sexually transmitted disease, drug abuse and mental illness are examples.

37. As the court said in *A. L. v. G. R. H.*, 325 N.E. 2d 501 (Indiana CA. 1975) of a parental request to sterilize a 15-year-old retarded son: “the common law does not invest parents with such power over their children even though they sincerely believe the child’s adulthood would benefit therefrom”.


39. Here the rationale is that those with whom the minor may come in contact are entitled to be notified in order to protect themselves.

40. The Model Health Care Consent Act (USA), in Section 4(b)(3), suggests that “consent for health care for a minor may be given by an adult sibling of the minor if a parent or an individual in loco parentis is not reasonably available, declines to act, or his existence is unknown to the health care provider”.

41. Confidentiality is one of the basic tenets of medical ethics. The confidentiality of the doctor/patient relationship is protected. While confidentiality is not to be confused with consent, the rule may be invoked in good faith, to protect the interests of the youthful patient once the issue of consent has been dealt with. The doctor's duty is to the patient and where he perceives that a minor's interests, and these may be health-related, are not served by consulting the parents, he may proceed in good faith to treat him. Very little attention has been given to the question of whether confidentiality can be used to override the normal consent requirements. The role which confidentiality plays remains largely at the ethical margins of the law and medical practice. See the discussions in Holder, A. R. (14) and Dickens, B. M. (12).

**Legislation**

**Albania**

Constitution of the People's Socialist Republic of Albania of 25 December 1976 (Section 45).
Algeria
Ordinance No. 73-65 of 28 December 1973 establishing free medical care in all health sectors [IDHL, 29: 289 (1978)].

Australia
New South Wales

Canada
Québec
Public Health Protection Act [IDHL, 26: 299–301 (1975)].

Costa Rica
General Health Law of 31 July 1973 (Articles 13 and 14) [IDHL, 26: 465 (1975)].

Cuba

Greece

Philippines

Romania
Law of 6 July 1978 on the safeguarding of the health of the population (Sections 2, 6, and 94) [IDHL, 30: 269 (1979)].

South Africa

Spain

Sri Lanka

Union of Soviet Socialist Republics
Constitution (Draft) of 4 June 1977 (Section 42) [IDHL, 28: 644 (1977)].

United Kingdom
England and Wales
3. Health in Schools and Universities

Schools and universities are widely used as focal points for health programmes aimed at adolescents. The approach is a recurrent one and virtually universal. In most countries, responsibility for school and university health programmes, as for other health-related activities, lies largely with the ministry of public health. For example, in Morocco, the Division of Population within the Ministry oversees the work of departments that deal specifically with school and university health and health education. While the legal arrangements governing such programmes vary from country to country, the programmes themselves include essentially the same three major activities: health education, health services, and health-related activities, including in-school physical training and sports.

**Health Education**

A healthy life-style begins with education. The approach in health education “should be one that seeks primarily to prevent disease and promote health” (1). Since the main function of schools and universities is to convey knowledge, it is quite natural for them to take a leading role, as they do in most countries, in educating young people about health matters.

Nowhere else can such a young, impressionable, and more or less captive audience be found than in schools. Thus, as part of the General Health Law in Costa Rica, students are required, in addition to undergoing health examinations, to attend educational programmes on health. This arrangement provides an opportunity to present information of crucial importance to health during adolescence—information on nutrition, infectious diseases, fertility regulation, the biological and psychosocial characteristics of adolescence, etc. Of course, in the best of all circumstances, “health education” begins well before adolescence is reached, and for the most part does so wherever compulsory education is the norm.

Health education should be an essential feature of school curricula. Several subjects lend themselves to the conveying of health information, though in some countries a separate “health” course may be taught in which all matters pertaining to health are covered. Influence over the curriculum is the key to any rational attempt to influence health education. In some countries, such matters are determined largely at the
local level; in other countries, decisions of this nature are the prerogative of national ministries.

Health education activities are unusual in that they often require the cooperation of a number of ministries or agencies. The interests of two fields intersect—health and education. No one institution predominates; coordination is necessary. The legislation on the subject often aims to ensure that collaboration between the health and education authorities is a reality. Thus, the Bulgarian Decree No. 2341 of 2 November 1973 emphasizes this point in Section 45, when it lays down that:

Health agencies shall, jointly with agencies responsible for national education, devote special attention to the protection and improvement of the health of students.

The Algerian Public Health Code stipulates that the Ministry of Public Health must promote health through “health education activities”, going beyond the students themselves and directed at parents and teaching staffs as well, thereby underscoring the importance of a broad health education programme. Section 123 of the Code requires the Minister of Public Health to act jointly with other Ministers in making the regulations governing these activities.

Health Services

Health services at school are a necessary adjunct to health education. Adolescents at school and at universities constitute an important target group for health services, both preventive and curative. Specific school health service programmes are usually overseen at the primary level by school nurses, who pay particular attention to public health matters, focusing on primary health care and acting, in most instances, with medical support.

School and university health programmes include medical and dental examinations (see Chapter 15), vaccinations and immunizations, diagnosis and treatment, and preventive measures affecting health and safety. In Spain under Decree No. 2892 of 1975, any accident or illness among students during school hours must be reported to the school physician who must investigate the matter and make a report. As far as prevention is concerned, school authorities in New Zealand are empowered, under the Education Act, 1964, to bar from school any pupil who for “want of cleanliness” or because he is suspected of having a communicable disease might create a health problem for other students (Section 193B).

While the principal focus of these programmes is on the school-enrolled adolescent, they tend to go beyond these narrow confines. The Ministry of Public Health in Algeria, for instance, is charged under the Public Health Code of 1976, with the responsibility of the ‘surveillance
of the health of each pupil and student, teacher, and any other employee in contact with them”.

Medical and dental examinations are a common prerequisite for entrance to school or university. In Alaska, the regulations on education contain sections on the “physical examination” of schoolchildren. Most states in the United States require that medical examinations be given and that proof of vaccination be presented when pupils first enrol in, or change, schools.

The comprehensive regulations in Poland governing medical examinations for children and adolescents were laid down in the Ordinance of 24 June 1976. The Ordinance provides for: (1) routine prophylactic examinations; and (2) examinations that meet the needs of educational institutions, among others. Thus comprehensive examinations of adolescents are conducted at ages 10, 14, and 18, their purpose being to assess the state of health and to determine whether there is a need for preventive, therapeutic or rehabilitation programmes. The regulations also define the procedures for communicating the results to parents or other interested parties and specify the persons responsible for conducting the examinations and for recording the results. The second type of medical examination is designed, inter alia, to provide information on the suitability, from the standpoint of health, of a pupil’s participation in physical education, sports, and various forms of leisure activities. Any pupil who has been absent from school for more than five days on account of illness must also undergo an examination.

In Spain, under Decree No. 2892 of 31 October 1975, pupils are required to undergo medical examinations during the first, fifth, and eighth years of the basic general education course and during the last year of studies for a school leaving certificate. Other examinations may be required by the School Health Authority (Section 9). Teachers and school personnel must also undergo yearly “preventive” medical examinations (Section 20). Periodic health examinations are also required for students in El Salvador, under Decree No. 516 of 8 January 1974, and in Costa Rica under the Public Health Law.

Most vaccination programmes will have been completed before students reach adolescence. As a minimum, the general immunization programme in Sweden, under Order No. 76 of 21 October 1976, includes vaccination against tetanus, diphtheria, whooping cough, poliomyelitis, measles, and German measles (for girls only), as well as against tuberculosis for tuberculin-negative children. Nurses specially trained in school health may perform such vaccinations. Schools are often utilized in ensuring that vaccinations have been performed. Thus, in Alaska (USA), a pupil must have been immunized against the above-mentioned diseases before he can enter, for the first time, any of the school grades 1-12 in that state. The requirement is met by producing either a valid vaccination certificate, or a physician’s certificate stating that the immunization would be harmful to the child’s health.
The prevention and control of tuberculosis is a health priority for many European countries, one of the methods used for this purpose being BCG vaccination. Some antituberculosis programmes focus on what WHO has defined as high-risk groups, such as older adolescents and young adults. Specific regulations exist in the German Democratic Republic, Portugal, and Spain. Thus, in the German Democratic Republic, BCG immunization is compulsory for all schoolchildren in the 10th grade and all apprentices who have reached the age of 16. Although, in Sweden, vaccination has been banned for newborns, it is recommended for schoolchildren aged 13–14 years because experience has shown that there is little risk of complications at that age.

A number of other health-related activities, particularly at school, are also governed by regulations. Many of these establish standards for the school environment while others affect the students themselves. Proper nutrition, for example, is a basic element of good health, and one important feature of school health programmes in many countries is the provision of midday meals or nutritional supplements. Thus, in Costa Rica, the General Health Law and implementing regulations require that both public and private educational institutions provide supplementary nutritional services. Many countries subsidize school meals, and for indigent students meals are often available free of charge. Hygiene standards for school kitchens and dining-halls are in force in many countries.

School safety requirements also contribute to health, since some school activities involve a certain risk; this is particularly true of classes in which dangerous materials are used. Thus, in Denmark, Instruction No. 144 of 18 June 1976 is intended to protect pupils from the potentially harmful effects of enameled containing lead, cadmium, and other dangerous substances, often used in school handicraft classes.

Physical Training and Sports

Physical training and sports are a component of the curricula at many schools and universities, since it is widely believed that these make substantial contributions to adolescent health. The legal basis for such activities is often established at the highest level. The Constitution of Portugal, for example, urges the “promotion of physical and athletic training” at school as well as for the general public. A number of countries have ministerial-level posts for youth and sports, responsible for overseeing such activities. In Bulgaria, the Ministry of Public Health has the authority to “exercise medical surveillance” over physical education and sports. The Ministry also has the power to approve the medical standards and rules pertaining to physical training and education, particularly for students.
The Public Health Code of Algeria contains the following overriding mandate:

Physical training must be regular, balanced, attractive, and suited to the age and physical constitution of young people, taking account of medical contraindications. Persons taking part in intensive and vigorous sports competitions which may endanger their health shall be required to undergo a prior fitness examination and a regular medical examination.

Activities coming under the heading of "physical education" are elective in some countries, compulsory in others. Many secondary schools, and even universities, require students to enrol in such classes. Exemptions are, however, granted where the activities would endanger the health of a particular student.

Conclusions

The role of schools and universities in the education of adolescents in health matters is an important one. Two of the recommendations from a recent report by a WHO Expert Committee (1), referring to the functioning of school-based programmes, seem appropriate as concluding statements.

Health care services for adolescents and school health programmes should be adapted to the needs and resources of each country. Along with medical examinations, the health services should emphasize health education, including preparation for family life, and a positive approach to health promotion.

There should be close collaboration by education and health authorities in the revision of school curricula, and teachers should be specifically prepared to promote a better understanding of the immediate and future health related needs of adolescents.

Finally, whatever the value of school and university health programmes, it must be recognized that large numbers of adolescents do not attend school. Other sections of the book will consider the endeavours of law and policy makers to reach these groups.

Reference


Legislationa

Algeria

Ordinance No. 76-79 of 23 October 1976 promulgating the Public Health Code [Sections 121(1) (2) and 140] [IDHL, 29: 279 (1978)].

aFor the sake of conciseness, International Digest of Health Legislation has been abbreviated throughout to IDHL.
Bulgaria
Decree No. 234 of 2 November 1973 embodying the law on public health (Section 51(1)) [IDHL, 28: 512 (1974)].

Costa Rica

Denmark

El Salvador

German Democratic Republic
Thirteenth Regulations of 2 June 1975 for the implementation of the Ordinance on the prevention and control of tuberculosis (Section 3) [IDHL, 28: 507 (1977)].

Morocco

New Zealand
Education Act 1964 (Section 193B) [IDHL, 29: 179 (1978)].

Poland

Portugal

Spain
Decree No. 2892 of 31 October 1975 approving provisional school health regulations (Sections 9 and 20) [IDHL, 28: 1052 (1977)].

Sweden

United States of America
Alaska
Chapter 06 (Government of schools) of Regulations on education [IDHL, 28: 387 (1977)].
4. Reproductive Health Care: Background and General Legal Framework

Adolescent Sexuality and Fertility

Adolescent sexuality and fertility pose health-related problems of a special kind. Unfortunately, on a global scale, little solid information is available on current patterns of adolescent behaviour in this respect, much less the impact that they have on health. Some cautious generalizations can, however, be made. Three distinct patterns may be observed (1). The first, common in the developing world, is characterized by early age at marriage or consensual union and early and frequent childbearing. In Asia especially, cultural values strictly prohibit premarital sexual activity and premarital pregnancy is infrequent. In other parts of the world (e.g., parts of Africa and Latin America), premarital pregnancy is likely to lead to socially approved consensual union. Fertility is frequently marital, and the proportion of adolescents who are mothers quite high. Contraceptive use is low, but slowly rising. When recourse to abortion is sought, generally by young unmarried girls, it is usually illegal, hence clandestine and highly dangerous. The incidence of sexually transmitted diseases is of increasing concern, principally because, along with unhealthy childbirth practices and abortion, it leads in the long term to infertility.

The second, and perhaps diametrically opposite pattern, exists primarily in the developed countries, and is characterized by the onset of sexual experience, often out of wedlock, in the middle to late teens. Though contraceptives are available, their use is infrequent among the unmarried (except in Western European countries), and non-marital pregnancy and recourse to abortion (largely legal and safe) are both common, accompanied by later age at marriage, very low fertility, and a significant rate of sexually transmitted disease.

The third pattern is intermediate between the other two, a "no-man's land", where life-styles are changing, largely as a result of the process of socioeconomic development. With the growth of urban centres, e.g., in sub-Saharan Africa and Latin America, economic and employment opportunities are expanding, especially for women, and age at marriage and first birth is rising. Some of the types of sexuality and fertility behaviour here resemble the first pattern, some the second. The traditional restraints remain but are less controlling, premarital sexual intercourse and pregnancy among youth are increasing as is recourse to
abortion, and overall fertility is beginning to decline as contraception is increasingly used.

Such statistics as are available shed some further light on the situation. Data, particularly from the USA, indicate that the incidence of premarital sexual intercourse among adolescents is high. This, in turn, creates special health problems. For example, it has been found that many unmarried adolescents visiting family planning clinics for advice and services for the first time have already been sexually active, though unprotected, for about a year. The comparatively low rate of use of contraception among teenagers continues to confound observers. It has been estimated that fewer than 20% of the sexually active teenagers in the USA use effective contraceptives consistently (2, 3). These patterns of behaviour also manifest themselves in other ways.

There are some 29 million young people between the ages of 13 and 19 in the USA. Of these, 12 million (7 million males, 5 million females) are thought to be sexually active. The latest data (1978) show that each year about 1.1 million 15–19-year-olds become pregnant. Of these pregnancies, 38% are terminated by induced abortion, 13% end in miscarriage, and the remainder are carried to term. On average one-fifth of all births in the USA—some 554,800 annually according to the 1978 figures—are to girls still in their teens. Nearly four-fifths of all teenage pregnancies and over one-half of all births are unplanned. One-fifth of all births to teenagers occur out of wedlock (4).

Fertility among adolescents, while it does not constitute the whole picture, is one way to gauge the health needs of the age group. Here the statistics are perhaps more reliable. Jekel & Klerman (5) have observed that, on the one hand, teenage birth rates in the USA have actually declined in the last few years while, on the other, the proportion of all live births accounted for by women under 20 has slowly risen. Similar patterns may be seen in the developing world. Chui (6), using United Nations data, notes “a general unmistakable trend of decrease in the overall fertility rate (births per 1000 women) of women aged 15–19 in selected developing countries having relatively good statistics”. This parallels the present global trend towards lower fertility. For example, the fertility rate among women aged 15–19 declined in Algeria from 122.9 per 1000 (1965) to 97 per 1000 (1977); in Cuba from 146 per 1000 (1965) to 96 per 1000 (1979); in Malaysia from 77 per 1000 (1965) to 37 per 1000 (1979); and in Venezuela from 138 per 1000 (1961) to 92 per 1000 (1970). Fertility rates among adolescents, although declining, are still substantially higher than in most industrialized countries, where the range is from 4 per 1000 (Japan) to 81 per 1000 (Bulgaria) (see Table 1). Nevertheless, as Isaacs (7) points out, the “United Nations data indicate that in many developing countries births to women under 20 represent an increasing proportion of all births, a fact partially explainable by the comparatively greater number of young people in populations of developing countries”. A recent study in Panama (8) showed that mothers between the ages of 15 and 19 accounted for 23% of the births
Table 1. Trends in fertility rates of women under 20 and percentage of total births to women under 20: selected countries

<table>
<thead>
<tr>
<th>Country or area</th>
<th>Latest data (year)</th>
<th>Previous data (year)</th>
<th>Latest data (year)</th>
<th>Previous data (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chile</td>
<td>68 (1951)</td>
<td>64 (1960)</td>
<td>13 (1941)</td>
<td>12 (1956)</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>96 (1979)</td>
<td>146 (1965)</td>
<td>23 (1979)</td>
<td>19 (1965)</td>
</tr>
<tr>
<td>France</td>
<td>18 (1950)</td>
<td>29 (1972)</td>
<td>6 (1980)</td>
<td>7 (1975)</td>
</tr>
</tbody>
</table>

*Adapted from Senderowitz, J. & Paxman, J. M. (1), by permission of the Population Reference Bureau.

in that country in 1978, as compared with 13.2% in 1970 and 19.2% in 1976.

Statistics present only one part of the picture; they cannot explain what factors affect the different patterns. On a global scale, it is well understood that traditional patterns of adolescent sexual behaviour are affected to a greater or lesser degree by cultural mores and values. Some societies have traditionally frowned upon sexual activity among young people, some have accepted it, while others simply prohibit premarital sex because it violates codes of personal morality. Many societies, especially in Africa, Latin America, and Asia have traditionally encouraged early marriage for girls, before or shortly after puberty. Sexual relations and childbearing then occur early, though within marriage, and as a result the incidence of non-marital pregnancy is relatively low. As Chui has said (6), the so-called problem of adolescent
sexuality, as evidenced by fertility, must be "seen as two sides of the same coin: 'mothers too soon' for the married and out-of-wedlock pregnancy for the unmarried adolescent". Even so, as Darabi et al. (9) concluded, "differences in marriage rates, sanctioned consensual unions, attitudes on abortion, and the general acceptance of contraception for women of any age yield very different perceptions of whether teenage fertility is an accepted norm or a problem".

Patterns of sexual behaviour are also affected by biological and socioeconomic factors, among which earlier sexual maturation, changing morals, and increasing age at marriage in many societies figure prominently. Socioeconomic changes, and with them massive urbanization, migration, and the influence of the mass media, have lessened the influence of social control mechanisms which formerly discouraged adolescent sexuality prior to marriage. A WHO meeting (10) convened to look at the issues of pregnancy and abortion in adolescence found that little had been done in the past to address this important health problem:

In the past, many of the health needs of this age group [adolescence] were neglected. Little was known about them and little was done for them. The problems related to pregnancy and abortion, for example, were often ignored or simply included within the larger phenomenon of adult pregnancy and abortion; little attention was paid to the complex legal, social and economic implications of pregnancy and abortion.

This lack of concern has been typical both of developed countries, where the problem has perhaps existed for far longer, and of developing ones, where adolescents are often not even perceived as a distinct group. The health-related consequences of adolescent sexuality or fertility cannot realistically be looked upon, however, as a peculiarly "Western" problem. The fact that by the year 1990 there will be an estimated 1 thousand million young people between the ages of 15 and 29 living in the developing world (11) shows the magnitude of the challenge of providing reproductive health care to adolescents.

Within the past few years, authorities have begun to look at adolescents as a group with special health care needs worthy of special attention. The programmes that have been established rest on two interrelated rationales. Of these, the health rationale draws part of its strength from the fact that sexual activity among adolescents, with its potential risks to health, and especially the high risk of pregnancy, in many instances unwanted, creates unique and sometimes severe health problems.

It is known that pregnancy itself presents a greater threat to the health of younger teenagers than to that of most adult women (12, 13). Adolescent pregnancy often signals high obstetrical risks, partly because many adolescents do not seek care until late in pregnancy. Complications are frequent. As a WHO Expert Committee noted, "in
many developing countries, complications of pregnancy, childbirth, and the puerperium are among the main causes of death in 15-19-year-old females, the death rate from causes related to abortion and delivery being particularly high in girls below 18 years of age"(14).

In the Dominican Republic, Ecuador, and Japan, women under 19 are twice as likely to die from pregnancy-related causes as those in the age group 20-24 years; in Austria, they are nearly five times more likely to die from such causes (15). The offspring of adolescent mothers are also known to suffer (16), the most common problem being premature birth, with accompanying low birth-weight, which in turn may lead to other complications, such as poor childhood nutrition and increased frequency of infectious diseases (13,17).

On a broader front, it is now becoming clear that knowledge about human reproduction and the dynamics of human relationships is an important adjunct to the learning process. Having the correct information increases the chances of making intelligent, responsible choices in matters of reproduction. All of this demonstrates the need for greater efforts to provide adolescents with the types of health and educational services that contribute to their overall well-being, physical as well as mental.

In the past decade a strong link has been forged between human rights and reproductive health care. The human rights rationale rests on the statements in three key international documents: the Teheran Proclamation on Human Rights (1968) and accompanying resolution; the United Nations Declaration on Social Progress and Development (1969); and the Plan of Action of the World Population Conference held in Bucharest in 1974. Taken together, these state that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. The assumption made here is that adolescents are covered by that statement. The Bucharest conference went on to recommend that countries "encourage appropriate education concerning responsible parenthood". It noted that this could be done only if "educational institutions in all countries" changed their curricula to include "where appropriate" educational programmes on "family life" and "responsible parenthood".

More recently, the International Conference on Population, held in Mexico City in August 1984, made several recommendations on the subject of teenage pregnancy and childbearing in three statements. These add to the weight of prior international statements on the human right to family planning (18). One of the recommendations advises that government policies should encourage delay in the commencement of childbearing, and governments concerned should make efforts to raise the age of marriage. Another "encourages community education to change prevailing attitudes which countenance pregnancy and childbearing at young ages, recognizing that pregnancy occurring in adolescent girls, whether married or unmarried, has adverse effects on the morbidity and mortality of both mother and child". A further
REPRODUCTIVE HEALTH CARE

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recommendation urges “governments to ensure that adolescents, both boys and girls, receive adequate education, including family-life and sex education...and suitable family planning information and services”.

In the remainder of this chapter, two essential components of the legal framework, namely the minimum age for marriage and the minimum age for consensual intercourse, will be considered. Chapters 5, 6, and 7 deal with reproductive health education and information, the availability of sexual and reproductive health care services, and sexually transmitted diseases, respectively.

Minimum Age for Marriage

In many societies, sexual relations and pregnancy become socially and legally acceptable only if they occur within marriage. Many individuals, adolescents included, receive their sexual initiation upon marriage. Historically, early age at marriage has been associated with high fertility and its attendant health consequences.

Laws establishing a minimum age for marriage are nearly universal. Ages are usually set at which one can marry with and without parental consent, and these ages differ for males and females. In addition, in multicultural countries, the ages may differ between various ethnic and religious groups; sometimes religious or customary law prevails rather than legislation. The most common minimum ages seem to be 18 for males and 16 for females (19).

European countries generally have the highest legal and actual ages at marriage and the lowest fertility rates. In Asia, legal ages tend to be lower, but fertility patterns vary. The practice of child marriage, with attendant high fertility, is prevalent in Bangladesh and parts of India. In China, Japan, the Republic of Korea, and Sri Lanka, actual age at marriage is high—in the mid- to late-20s—and fertility low. The reasons for this differ from country to country.

In south-west Asia and north Africa, some countries lack a minimum legal age for marriage, choosing to adhere to Muslim law which allows girls to marry at menarche (age 12 or 13). Others have moderately high legal ages. In general, actual age at marriage has risen and fertility has declined somewhat.

In Africa, the legal age for marriage is often high, reflecting the tendency to adopt European legal standards, yet actual age at marriage is low, fertility is high, and contradictions are apparent. Countries with a slightly higher age for marriage have higher fertility rates than those where early marriage is the custom. Latin American countries, on the whole, have the lowest legal ages for marriage in the world, but these are still higher than those at which young women tend to become sexually active and bear children (17).

The effect of a legally established minimum age for marriage on sexuality and hence fertility is not entirely understood, though it is known that minimum age, like other factors, interacts with other social and economic influences. Shifts in the age for marriage have occurred
over time and have usually accompanied, or been a product of, changes in the economic, social, political and religious conditions that have tended to encourage early marriage. A law on age for marriage has sometimes been an aspect of those changes. However, the question remains: will raising the legal age for marriage raise the actual age? Or for that matter, will it lead to reduced adolescent sexuality and fertility?

The answer to both questions seems to be "no". The law has only a symbolic, though reinforcing, role. It is quite clear that age at marriage has risen as a result of other factors. None the less the law does have a role to play in under scoring the official decision to encourage delayed marriage. Equally, law by itself will not effect a change in fertility behaviour, for the simple reason that laws on age for marriage are unenforceable in most countries where the necessary administrative systems are lacking. For example, despite the passage in Pakistan of the Muslim Family Law Ordinance in 1961, raising the minimum age for marriage for females to 16, the estimated age at marriage in 1968 was 13.5 years in Dhaka and 14.9 in the rest of Bangladesh (then East Pakistan) (20).

In the past 20 years no fewer than 54 countries have altered their laws on the minimum age for marriage. The predominant trend in the developing world appears to be the raising of the minimum age. A few countries, principally those in Europe where the age of majority has changed, have lowered the age for marriage. In countries that have raised the age, there is every indication that the actual age at marriage was rising well before the legislation was amended. In these circumstances the law has merely reflected trends rather than being an agent of change.

In Tunisia, eight years before Law No. 615 of 28 February 1964 was passed fixing the minimum age at 17, the mean age at marriage for women was 19.5 years. As of 1975, it had risen to 23.3. Malaysia and Sri Lanka also experienced increases in actual age long before the law was changed. In Sri Lanka, the mean age has been increasing since the turn of the century, and in 1976 was 23.7 for women and 26.9 for men. In 1978 the legal ages were raised to 16 for women and 18 for men. These changes have been affected by such disparate factors as increased education and economic opportunities, rapid urban migration, high emigration and worsening domestic economic circumstances, which make early marriage unfeasible (11). Only in India, which in 1978 raised the minimum ages to 18 years for females and 21 for males, may the law have been in advance of practice.

Minimum Age for Consensual Intercourse

Many countries have set a minimum age at which minors can consent to sexual intercourse. This is very often the same as the age of majority, and is sometimes the same as the age at which a person can marry. At times, the minimum age is specified, inter alia, by the provisions of the criminal law aimed at penalizing those who engage in
sexual acts with minors; this is referred to as, e.g., “statutory rape”, “felonious intercourse”, or “unlawful carnal knowledge”. The position taken by the law is essentially a protective one. The minimum age is intended to prevent the “sexploitation” of young people.

The presumption underlying fixing of a minimum age is that young people lack the maturity to comprehend fully the nature and long-term consequences of sexual intercourse. Hence, legally they are incapable of “consenting” to intercourse. The law may be somewhat arbitrary in the age it selects, but is not concerned with the ability to engage in sex. Indeed, although the age of sexual maturation has fallen over time, the law generally has not taken this into account. It takes more than physical maturity to be able to consent at law.

The concept of the minimum age of consent has been challenged in some quarters. One English judge observed of one prosecution: “There are many girls under sixteen who know full well what it is all about and can properly consent” (22). More recently, English judges have shown little interest in trying cases of statutory rape among adolescents for fear of criminalizing the behaviour of substantial portions of the youthful population of the country. Nevertheless, the law sets the standard, the legal minimum.

The age for consent to intercourse is 13 in Thailand, 16 in the United Kingdom and New South Wales (Australia), 17 in New York, South Australia and Tasmania. In Australia, the Royal Commission on Human Relationships recently recommended that the age of consent be lowered to 15 (23). Many contradictions arise as a result of differences between various laws. In the United Kingdom, for example, cinema advertisements for a do-it-yourself pregnancy test kit are rated “X” and can therefore be seen only by those over the age of 18, yet intercourse is lawful at 16. In New York, contraception is available at age 16, and sometimes before, while the legal age of intercourse is 17; marriage without parental consent is not possible until the person is 18. In many countries, the pregnant teenager, while she cannot legally consent to intercourse, must carry her baby to term and is then legally responsible for its care.

Despite the fact that the theoretical concern of the law is to protect, treat, and rehabilitate minors, thereby minimizing adolescent follies, many sexually active minors are not protected by the law. In many instances, the law treats them as “promiscuous” or “incorrigible” rather than as persons in need of health care and advice. Research findings show that teenagers’ knowledge of contraception and fertility is inaccurate and that considerable legal and practical barriers hinder their access to sorely needed contraceptives.

**Conclusions**

As we have seen, adolescents have unique reproductive health needs that constitute a problem in many countries. The legal framework governing reproductive health care for adolescents is in itself unique and
sometimes neglected. As we have seen, despite the theoretical concern of the law, many sexually active minors fail to obtain protection and assistance in matters of reproductive health. While the role that the law can play must not be overestimated, there is still much it can do with regard to the available options for health care. Laws and policies help to determine whether young people can obtain appropriate information concerning human sexuality, and whether teenagers have access to the necessary reproductive health services. Without such measures, the problems that adolescents face may simply multiply as potential options are foreclosed.

References and Notes

14. WHO Technical Report Series, No. 409, 1977 (Health needs of adolescents: report of a WHO Expert Committee). The whole subject of health care for pregnant adolescents must be put in perspective. WHO has estimated that between 60% and 80% of all births occur without the attention of formally trained health personnel. (See Traditional birth attendants. A field guide to their training, evaluation, and articulation with health services. Geneva, World Health Organization, 1979 (Offset Publication, No. 444).) Thus, systematic health care for pregnant women in many areas is largely non-existent. In these settings the reproductive aspect of health care is often attended to by traditional health practitioners. Most of the populace simply does not have access to a formalized health care system.


Legislation

India
The Child Marriage Restraint (Amendment) Act, Act No. 2 of 1978 (All India Reporter, 65 (174); 45 (1978)).

Pakistan

Tunisia
Law No. 615 of 20 February 1974.
5. Reproductive Health Education and Information

According to a recent survey by the International Planned Parenthood Federation, throughout the world three-quarters of those under 15 (and half of those over 15) have no access to reproductive health information and education (1). For example, in Nairobi, Kenya, despite high rates of sexual activity in the 15-19 years age group, 53.8% of boys and 69.8% of girls knew nothing about contraception (2). Of course, sex education is more than knowledge about contraception, but the figures are startling. While reinforcing the view that few individuals need to be taught the mechanics of sex, they show that greater emphasis is needed on how sex fits into human relationships and what the consequences of human sexuality are. In its fullest sense, sex education seeks to make the individual aware of the social, moral, psychological, and physiological characteristics of human sexuality.

There are essentially two channels through which adolescents can acquire education and information on reproductive health, namely the formal (education) and non-formal (information), or the in-school as opposed to the out-of-school setting. Whether adolescents have access to such information in a formal setting is often determined both by a number of interrelated laws and regulations and by educational policies. The substance of these laws and policies, as might be expected, tends to reflect the cultural, religious and socioeconomic climate in a given country. This being so, health education is far from being a strictly legal matter: indeed, the law may at times appear to be of marginal importance. Nevertheless, law and policy do determine what kinds of information and education can be provided to the public.

**Reproductive Health Education**

The report of the Lane Committee (3), published in the United Kingdom in 1974, contains this trenchant remark:

A public educated to a more mature and responsible attitude towards sexual behaviour and to contraception will be the most sure guarantee [against] unwanted pregnancies.

That same year a WHO Meeting on Education and Treatment in Human Sexuality (4) concluded that:

The provision of appropriate sex education for the general public should receive the highest priority of all the approaches to sexual health care, because of its importance in terms of prevention and its potential for affecting the largest number of people.
Whatever the merit of these observations, they are not shared by all participants in the debate over what has been called, perhaps somewhat euphemistically, by Kellogg et al. (5) "fertility-related education and information" for adolescents. To say that the subject of sex education is controversial is an understatement. The debate is robust, even at times vitriolic. Those who advocate more sex education for youth have been accused of, among other things, brainwashing adolescents into embarking upon sexual careers and of undermining family and parental responsibility. They often reply that they do not encourage permissiveness but do believe that sex education should help young people lead healthy, satisfactory sex lives. As Kellogg & Stepan observe (6), "Opposition to sex education appears to be motivated by fear that [an] understanding of such matters may lead to promiscuity, by old taboos against open talk of sex, or simply by an attitude of intolerance". These attitudes are difficult to overcome. Perhaps an Australian judge made the correct response when he wrote, nearly a century ago: "Ignorance is no more the mother of chastity than of true religion" (7). Studies in the United Kingdom indicate that those who learn about sex from reliable sources—and school is generally thought to be the most reliable—are less likely to rush into early sexual experience.

There is no universal legal approach to reproductive health education, and none can be prescribed in a multicultural world. As far as the law is concerned, the key issues appear to be the following (5):

- Should reproductive health education courses be permitted within the school curriculum?
- If so, should these courses be obligatory or elective?
- What should the content of the courses be?
- Should the courses on fertility-related matters be separate courses or should the material be integrated into existing courses?
- At what age should the courses begin and what should be their duration?
- Should the sexes be separated for instruction or taught together?
- What role should parents have? Is their consent required? Should they be permitted to screen materials used in courses?

There are essentially five different types of legal response to these questions: (1) to make sex education compulsory; (2) to make it elective; (3) to approve of sex education but have no legislation on the matter; (4) neither to prohibit nor to promote it; and (5) to prohibit, in part or totally, some aspects of sex education. Examples of these will be described below.

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"Sex education, education dealing with matters of human reproduction, may be distinguished from what has come to be known as population education, that is, education about the causes, nature, and consequences of population dynamics and related social and economic problems. Here we shall use the term "reproductive health education"."
Compulsory sex education

Only a few, predominantly European, countries utilize laws to make sex education compulsory, of these, many have comprehensive legislation on the subject. Sweden was the first country to introduce sex education into its school system. It was made a compulsory subject in 1956 and has since become an integral part of the curriculum for all students in state schools from ages 7 to 20. Parents must be consulted on the syllabus used and a balanced view of the issues must be presented (8).

Sex education is conducted under the aegis of the National Board of Education, which in 1977 prepared a new manual for the purpose. Information on contraception is given to pupils between the ages of 14 and 16, while the teaching of sex education to the age group 17-19 years is designed to enable the young people to make their own decisions concerning contraception and abortion (9). The teaching also aims to help them to acquire knowledge of sexual and personal relationships in a way that promotes responsibility and consideration. The curriculum puts sex in context: students are taught that sexuality is an integral part of a person's life, one linked to personality development, interpersonal relationships, and the social structure (10, 11).

A similar compulsory arrangement in Denmark, dating from 1970 and establishing integrated sex education in state schools, survived a recent legal challenge before the European Court of Human Rights. In the Kjeldsen, Busk, Madsen and Pedersen case (1976) (12), the Court held that such education did not violate human rights principles. In its opinion, the Court observed that the instruction was "aimed less at instilling knowledge that [students] do not have or cannot acquire by other means than at giving them such knowledge more correctly, precisely, objectively, and scientifically". The Court went on to say that sex education in the Danish context was an attempt to warn students about the disturbing "phenomena" of "excessive frequency of births out of wedlock, induced abortions and venereal diseases". All of these, of course, are health problems of particular importance to adolescents.

Wherever compulsory sex education is introduced, a natural tension arises between the interests of the state and the rights of the parents. This tension figured prominently in a lawsuit in the Federal Republic of Germany which resulted in a ruling that compulsory sex education in schools was not at variance with the Constitution. It was the opinion of the Court that the duty of the state to educate young people takes precedence over parental rights, as long as certain restrictions are observed. Schools must avoid indoctrinating the young, while at the same time remaining open to different sexual value systems and respectful of the parents' religious or ideological convictions. If these principles are followed, sex education does not depend on the consent of parents (13).

In recent years both Iceland and Luxembourg have enacted comprehensive laws on reproductive health which have included
provisions on sex education. The Luxembourg Law of 15 November 1978 states that “sexual information and education” will be given at all levels. It is intended to be “complementary to the sex education given in the family”. In Iceland, Law No. 25 of 22 May 1975 lays down in Section 7 that: “The educational authorities, acting in co-operation with the Chief School Medical Officer, shall provide instruction on sex life and sexual ethics during the compulsory school years. This instruction shall also be given in other school years”.

In Eastern European countries, the subject of sex education is less controversial though the approach to it may be the same. It is given particularly high priority in countries that are attempting to replace abortion by contraception as the method most often used to avoid unwanted pregnancy. In reality, however, the concerns are wider than that as can be seen from the Czechoslovakian experience, which began in the early 1960s. “Family life education” is an integral part of the curriculum from the first year of school (age 6). From grade 6 (age 12) onward, boys and girls are taught separately and the courses stress the wider social and psychological implications of sexual behaviour and the importance of the family, the aim being to create a sense of responsibility towards sexuality and parenthood. In the final compulsory grade (at age 15), instruction is given on contraception (5).

Few countries in the so-called developing world have introduced compulsory sex education but the Philippines has adopted this approach. The Constitution of 1973 placed the responsibility for curbing population growth firmly on the shoulders of the government, and the complementary Republic Act No. 6365, as amended, establishing the Population Commission, made education on contraception a national policy. The Population Commission was instructed “to make family planning a part of the broad educational program”. As a result, schools were ordered to cooperate in disseminating fertility-related information to students. Education on contraception is now given at the secondary school level and is apparently compulsory.

Population and sexuality education form an essential part of China’s attempt to alleviate its population pressures. This apparently stems from a statement of Mao Zedong in 1957 to the effect that the question of population growth “deserves further study”. Education in and out of school is thought to be complete and thorough on matters relating to reproduction, though premarital sexual activity is said to be non-existent. The process begins by inculcating in children the ideal of the small family. This is later reinforced through small study groups that discuss a wide variety of social questions. Membership of these groups is compulsory (6).

Elective sex education

Most of the countries that have comprehensive regulations on sex education make it compulsory. Until 1981, however, a middle course was taken in France, where instruction on contraception and ethical
matters relating to sexuality was provided outside school time in "meetings" of special groups. These were convened at the request of the students and with parental permission. In this way, the parents had a say in the matter and the interests of those who did not favour such forms of education were protected. The decision as to whether to convene such meetings was left to the individual schools. As a preliminary, the "mechanics" or anatomical features of human reproduction were taught as part of the general biology course in the fifth and sixth classes (ages 11-13) of the secondary schools. The teaching of "sexual information" was managed under a Ministry of Education Circular of 23 July 1973, while overall responsibility lay with the High Council on Sex Education, Birth Control and Family Education, which was established in 1974.

Later, the French Minister for Women's Rights made the broad dissemination of information on birth control one of her top priorities. As a result, on 8 December 1981, a circulaire note de service of the Minister of National Education made sex education in French schools compulsory. The text of the note reads in part (14):

In fact, our ministerial department agrees to implement an active policy in the field of sex education. It is necessary to prepare young adolescents for the physiological changes at the age of puberty in order that they can understand and accept them without distress or embarrassment when such changes occur. It is likewise necessary, at an earlier age and more completely than is done now, to ensure that students receive information on reproduction, and on birth control, and its techniques. It is an obligation of the school to supply the students, i.e., the adults of tomorrow, with the means of enabling them to face the choice of attitudes and convictions necessarily implied in a conscious social life. For this purpose, curricula, especially those of the natural sciences, can be revised.

Sex education, including information on contraception, is now provided in French schools, principally in courses on natural sciences.

In the United States, although sex education is generally in the domain of local school districts, 31 states and the District of Columbia have adopted laws or policies to guide local authorities. In the remaining states, whether and how to provide sex education is left to local school districts. Maryland, New Jersey and the District of Columbia make inclusion of sex education in the curriculum compulsory. Delaware, Illinois, Iowa, Kansas, Minnesota, Montana, Pennsylvania, and Utah encourage such instruction. No state prohibits it, though Louisiana bars sex education before the 7th grade (age 12). Most state laws and policies encourage the involvement of parents and community members in planning sex education, and eight states make such involvement compulsory. Most states require or recommend that

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*Arizona (for grade schools only), Idaho, Maryland, Michigan, Nevada, New Jersey, Washington, and Wisconsin.
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pupils be excused from this type of instruction if the parents so request (15).

Many states also provide guidance to local districts on course content. Seven states (Connecticut, Illinois, Maryland, Michigan, Minnesota, New Jersey and North Dakota) and the District of Columbia support the inclusion of family planning in the curriculum; Kansas, Ohio, and Utah restrict it (15). Connecticut, Louisiana, and Michigan restrict the inclusion of abortion in the teaching programme; the District of Columbia alone requires instruction in contraception and abortion (15).

A regulation of the New Jersey State Board of Education requires school boards, as of September 1983, to offer family life education in elementary and secondary school curricula, the content being left to the discretion of the local school districts; community involvement is mandatory. The regulation allows students, at their parents' request, to be excused from segments of the course that conflict with their conscience or religious beliefs. In a unanimous action the United States Supreme Court dismissed the appeal of a group of parents who had challenged the regulation, thus upholding the unanimous decision of the New Jersey Supreme Court that the regulation was constitutional (16).

Prior to 1977, Michigan was one of two states that actually prohibited the mention of contraception in the classroom. Public Act No. 226 of 1977, however, empowers local school boards to provide sex education including instruction on "family planning, human sexuality, and the emotional, physical, psychological, hygienic, economic, and social aspects of family life . . . [and] the subjects of reproductive health and the recognition, prevention, and treatment of venereal disease". The law authorizes detailed sex education but does not make it compulsory. The classes are elective and parents must be notified in advance of the course and given an opportunity to review the materials to be used. The State Board of Education is charged with the responsibility of designing the guidelines for such courses. Of the 527 school districts in the state, only six or so actually provide instruction on all the subjects authorized in the law. One school district in Detroit makes a course on personal health management, with instruction on contraception, a requirement for graduation. Students are excused only if parents so request.

Parental involvement is an important issue. A recent comprehensive review of population education reported research showing that, in India, Kenya, the Philippines, and the Republic of Korea, teachers and parents favour including population education in the curriculum but are concerned about what children will be taught about sex and family planning (17). Because of parental concern, the courses given in Bangladesh, Indonesia, Malaysia, Pakistan, and Sri Lanka avoid the subjects of sex and family planning.

This reluctance to introduce sex education into school curricula is beginning to disappear, at least in developed countries. A recent investigation in the United States provides encouraging data on this point. Based on the findings of two national surveys carried out in 1977
and 1978, the investigators report that, when parents help to develop the curriculum, significantly more topics are included than when parents are not involved. Contrary to the notion that parents are opposed to sex education in school, the report (18) concludes that:

Parental involvement in developing the curriculum has a facilitating effect; involving parents in curriculum development appears to give a boost to the comprehensiveness of such courses. This provides additional validation for public opinion polls [in the United States] that show parents to be more supportive of sex education in the school (including discussion of contraception) than the public at large.

A 1981 public opinion poll in the USA found that 80% of parents, compared with 70% of other adults, approved of state school instruction in sex education (19). Another survey of voters in the same year found that 70% approved of the inclusion of family planning information in sex education (20). In 1982, 82% of the adults in the United States supported sex education in schools (21), whereas in 1977 only 69% did so (22).

In the absence of a comprehensive, somewhat centralized, approach to reproductive health education, a number of countries rely on texts from different sources to provide a legal basis. The result may at times have a patchwork appearance, as fragments from a variety of different items of legislation are pieced together.

An apt example of the "patchwork" approach is found in Mexico, where the Federal Congress has the authority, under Article 25 of the new Constitution, to legislate on educational matters. In addition, Article 4 guarantees the right to information concerning family planning. At the same time the Secretary of the Interior has been authorized by the General Population Law of 1974 to establish and coordinate family planning programmes within the educational and public health services as a way of resolving the country's "demographic problems". Article 34 of the Sanitary Code makes the Secretary of Health, in coordination with the Secretary of Public Education, responsible for establishing family planning educational programmes based on "scientific and ethical principles." Since 1974, therefore, there has been a solid legal basis for sex education, though in practice it may not be widely available because local authorities do not want to provide it. The Director of the National Population Council of Mexico has announced that, on the basis of research concerned with sex education on television, public opposition to such education is a myth (17).

Article 219 of the Health Code of 7 February 1974 in Costa Rica requires that a course on human reproduction, sexuality, and hygiene be taught in all secondary schools. It is the responsibility of the General Advisory and Supervision Commission on Family Planning and Sex Education to ensure that this is done. The Costa Rican programme is based in large measure on the concept of "responsible parenthood".

It is frequently possible to find provisions on sex education in legislation on family planning, thus emphasizing the inevitable link between the two. In Tunisia, the National Office of Family Planning and
Population was created by Law No. 73-17 of 23 March 1973. One of its duties is to "promote a permanent programme of population information and education at the family, school and professional levels." In reality, despite the policy of the Government, which strongly favours limitation of population growth, the introduction of "sexuality" education proceeds slowly and more or less as an experiment because of the sensitivities of the people arising out of a combination of the national culture and Islam.

Absence of laws or regulations

Not surprisingly, many countries have no laws or regulations on sex education. Kellogg et al. attribute the absence of specific legal texts to two "mutually exclusive causes" (5). First, interest in issues relating to human sexuality and family planning is of such recent origin that the subjects have yet to be dealt with in law. The leader in this field, Sweden, introduced sex education in schools just under 30 years ago. To the extent that such education goes beyond health education and is linked with family planning and hence population reduction, many countries reject the need for such an approach. Second, even where countries have an expressed interest in promoting reproductive health care, its prerequisite, public education on matters of human sexuality, may simply be too controversial to be approved in legislation or regulations. The absence of an authoritative text yields two quite different results: either sex education is pursued quietly as a matter of policy or it is not pursued at all.

These contrasting patterns may be seen the world over. In the Netherlands and the United Kingdom, fairly thorough sex education is officially approved but does not enjoy legislative protection. In many other countries, nothing is done because the law provides neither guidance nor authority.

The absence of legislation, regulations, or court decisions on the issue of reproductive health education for adolescents can prove either a blessing or a burden. While it may be comforting to know that no legal barriers exist, experience shows that, without other compelling reasons—such as population pressures or increases in sexuality- and fertility-related health problems among adolescents—governments are unlikely to make any bold moves to extend reproductive health education to individuals through the school system. Nevertheless, where no specific legal barriers exist, it is often possible for new initiatives to flourish without interference from the law. In that sense, no law is sometimes good law.

Prohibition or restriction of sex education

Laws in many countries prohibit or limit sex education. Some of them do so by prohibiting the flow of sex-related information to the public, some by limiting the flow of family planning information, some
by restraining the dissemination of what are considered to be obscene materials. Few of them deal directly with sex education but, by their nature, they have an impact on the availability of such education. Such laws also affect the dissemination of reproductive health information to the public, through channels other than school. To avoid repetition, we shall discuss these laws, and their impact on reproductive health education and information, more fully in the following section.

A few observations may be made here none the less, in particular regarding the interaction between law, culture, and religion. Public sensitivity to sex education is often shaped by cultural and religious perceptions. In Pakistan, for example, where under Article 2 of the Constitution Islam is declared the state religion, nothing which is offensive to Islamic religious principles can be taught in the schools. While there are many schools of thought within Islam that take the position that nothing in the faith conflicts with family planning and contraception (2), there is no general agreement on the part of Islamic scholars or political leaders as to the compatibility of sex education for adolescents with the tenets of the religion. In such a situation, the teaching of anything to do with reproductive health, for example, may have to be undertaken with caution.

In Pakistan, various laws, together with public opinion, act to restrain attempts to introduce sex education. For example, Section 293 of the Penal Code forbids the distribution, exhibition, or circulation of any "obscene object" to persons under the age of 20, and the Indecent Advertisement Prohibition Act (1963) defines "indecent" as anything which "has the tendency to . . . corrupt those whose minds are open to such immoral influence". In Pakistan, sex education offends public opinion, and also to a certain extent the law, and has therefore never been offered.

It is no surprise then that, as a matter of policy, a strong antipathy towards sex education in school persists in other Moslem countries. Only Egypt and Tunisia are slowly introducing the subject into the school curricula, and then only on an experimental basis (6). The stigma of "sex education" is avoided in Indonesia, where efforts to educate students on population and sexual matters take the less controversial form of "family life education" (5). The presentation is not as thorough as the courses given in European countries. As with many other things, sex education must be culturally adapted.

Some predominantly Catholic countries have the most restrictive laws and policies on reproductive health education, though the reasons are often related as much to pronatalism as to religion. This often says more about the origins of the laws than of the countries in which they are in force. In Argentina and Ireland for example, sex education that

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4This covers family relationships, including in some cases sexuality, but also child development, nutrition and social and economic welfare.
REPRODUCTIVE HEALTH EDUCATION

includes information on contraception, is banned, indeed is considered a
criminal offence, particularly if it takes the form of "propaganda", where
this term is very broadly defined to include less than advocacy. The
Argentine decree of 28 February 1974 goes so far as to prohibit any
"dissemination of information on fertility regulation to the public".
Essentially the same situation exists in French-speaking Africa, where
remnants of the 1920 French anti-contraception legislation still
remain in force. In Senegal, however, the 1933 decree, prohibiting
propaganda in favour of contraception, has been repealed, although the
ban on "incitement to abortion" by public speeches or the public
display, advertisement, or sale of abortifacients, has been retained. (See
the discussion in the next section for further details.)

To the extent that generalization is possible, two somewhat
contradictory features are apparent. First, while governments may in
fact favour family planning as a reproductive health strategy, and seek
to inform adults about the consequences of human sexuality, they resist
instructing the young on the subject. This makes sex education, in its
fullest sense, impossible. Second, where religious precepts are threatened
by sex education, the political rather than the legal process is used to
suffice its acceptance. In many Latin American countries instruction on
"responsible parenthood" is acceptable as long as it conforms to the
doctrinal position of the church on reproductive matters. Since church
doctrine proscribes "artificial" forms of contraception, only the
rudiments of reproductive health may be taught, with nothing said of
modern methods for controlling fertility. (See Table 2 for a summary of
the legal status of education about sex and family life for adolescents in
various countries.)

Reproductive Health Information

While it may be obvious that one way to influence patterns of
adolescent fertility is to provide young people with information
concerning sexuality and fertility as part of their education, it is equally
obvious that not all adolescents go to school. In Mexico, where primary
education is mandatory, one-fifth of the school-age population do not
attend school, and of those who do, only 44% complete the primary
grades (23). In Egypt, only 55% of Egyptian girls of primary school age
are reported to be in school (24). Other ways of reaching adolescents
must therefore be sought, and other channels found. Unfortunately,
numerous laws and regulations restrict the kinds of information on
sexual health care that can be disseminated to the public in general and
to adolescents in particular, and also affect the educational process.

The impact of criminal law

Legislation of various types—criminal as well as drug regulatory—
sometimes hinders efforts to disseminate accurate, up-to-date informa-
<table>
<thead>
<tr>
<th>Country</th>
<th>In school (education)</th>
<th>Out of school (information)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Permitted, except for</td>
<td>Permitted, except for</td>
<td>1974 decree severely limited information and programmes because of pro-natalist policy.</td>
</tr>
<tr>
<td></td>
<td>information on contraception</td>
<td>contraception</td>
<td></td>
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<td></td>
<td>Information on</td>
<td>Information on contraception prohibited</td>
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<tr>
<td></td>
<td>contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>Mandatory (1966a)</td>
<td>Permitted and actively</td>
<td>&quot;Family life education&quot; from first year of school. From age 12, separate classes by sex. Institute of Health Education develops materials. Material linked to family planning programme.</td>
</tr>
<tr>
<td></td>
<td>information on</td>
<td>promoted</td>
<td></td>
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<tr>
<td></td>
<td>contraception at age</td>
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</tr>
<tr>
<td></td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>including information on contraception</td>
<td></td>
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</tr>
<tr>
<td>Indonesia</td>
<td>Permitted Information on contraception prohibited for those under age 17</td>
<td>Permitted Information on contraception prohibited for those under age 17</td>
<td>Reproductive biology part of school curriculum. Law makes it illegal to give information on contraceptives to those under age 17.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Restricted</td>
<td>Restrict</td>
<td>Restricted by statutory laws plus religious principles.</td>
</tr>
<tr>
<td>Philippines</td>
<td>Mandatory (1972),</td>
<td>Permitted (1972) and actively promoted</td>
<td>Family planning counselling prerequisite for marriage license (1978). National Population Commission has explicit policy to disseminate contraception information.</td>
</tr>
<tr>
<td></td>
<td>including information on contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>Mandatory (1956),</td>
<td>Permitted and actively</td>
<td>Sex education begins when school starts. Parents consulted on syllabus. Under aegis of National Board of Education.</td>
</tr>
<tr>
<td></td>
<td>including information on contraception for ages 14-16 plus information on abortion for ages 17-18</td>
<td>promoted</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Permitted</td>
<td>Permitted</td>
<td>&quot;Sexuality education&quot; takes place in secondary school.</td>
</tr>
</tbody>
</table>

tion about reproductive health. This is particularly true of contraception. Fortunately, such restrictive legislation is becoming less common, but it still exists. One of the vestiges of the French legal system illustrates this point well. In Chad, Article 98 of Law No. 28 of 29 December 1965 draws its inspiration from the French anti-contraception law of 31 July 1920 (no longer in force in France) and makes it a criminal offence to disseminate "contraceptive or anti-natalist propaganda" through speeches in public places, or by placing books, written material, drawings, pictures, or posters in "public channels". In theory, violation of this law is punished by heavy fines or even by imprisonment.

Until 1979, in Ireland, the Censorship of Publications Acts of 1929 and 1946 prohibited the advocacy or advertising of all forms of "unnatural" contraception. In addition, the Criminal Law Amendment Act No. 6 of 1935 made it an offence "to sell, or expose, offer, advertise or keep for sale or to import or attempt to import . . . for sale any contraceptive". (These Acts were repealed by the Health (Family Planning) Act of 1979.) Two Irish family planning groups were acquitted of violating these laws in 1974, the charges stemming from the mailing of a booklet on family planning and free contraceptives (condoms) to two underaged girls who had requested them (they had been used by their parents as agents provocateurs). A Dublin court found that the mailings were not "sales", and therefore ruled that they did not come within the 1935 law, and further said that the booklet "did not advocate the unnatural prevention of conception" as prohibited by the Censorship of Publications Acts.

Public morality and obscenity

Quite frequently certain provisions of the penal code, particularly in civil law jurisdictions, are designed to protect public morality. The theory is that discussions about certain subjects are not only offensive to, but actually undermine, public morality. Taken literally, these, too, have an impact on the dissemination of reproductive health information. Some are directed specifically at contraception. Spain and Italy had such laws, and their experience is instructive. In 1977, the editor of El País, a leading Madrid newspaper, was threatened with prosecution under Section 416 of the Penal Code for reprinting a factual article on contraception which referred in some detail to the various methods available for regulating human fertility. The case inspired a vigorous debate. In the end, the prosecution was dropped and the Spanish Government promised to change the law to permit the dissemination of information and services having to do with contraception. When the

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*Just to show how convoluted matters may become, the full title of the law was "An Act to Make Further and Better Provisions for the Prosecution of Young Girls and the Suppression of Brothels and Prostitution, and for Those and Other Purposes to Amend the Law Relating to Sexual Offences."
Penal Code was amended in 1978, the restrictive provisions were eliminated and public discussion of contraception made legal.

The Spanish controversy was strikingly similar to the de Marchi case, which caused such a stir in Italy in 1971. De Marchi was an advocate of family planning whose efforts were frustrated by Section 533 of the Penal Code, which blocked the flow of all family planning information to the public. When de Marchi challenged the law, the Italian Supreme Court simply declared it to be unconstitutional (25), ruling that:

\begin{quote}
The problem of family planning has, in the present period of history, become so important socially and concerns such a wide range of interests that, in light of the public awareness and of the gradual widening of health education, it can no longer be considered an offence to public morals to discuss various aspects of the problem publicly, to disseminate information concerning it, or to promote contraceptive practices.
\end{quote}

Both of these examples demonstrate dramatically how “out of step” the law can become in relation to modern thought and practice on reproductive health. Yet similar laws exist elsewhere and, where they go unchallenged, have an adverse effect on attempts to educate and inform.

Laws in a few countries treat information on reproduction or family planning as either immoral or obscene per se. This is the case in Malta, where the somewhat out-dated 1933 ordinance says that “any printed matter that, under any pretext whatever, directly or indirectly divulges the means or explains the ways of preventing impregnation ... shall be deemed to offend against the public morality”.

The types of laws described above are broadly drafted in such a way as to make them applicable to everybody. Some laws, however, are deliberately framed to protect the interests of younger people who, it is feared, will be corrupted in some way if reproductive information reaches them. This is the case in Indonesia, where Article 283 of the Penal Code (patterned on the former law of the Netherlands) flatly prohibits the presentation of “information on contraception” as well as the “display and distribution of writing, photographs or articles which conflict with morality” to a person “known” or “assumed” to be under 17. Moreover, where the contents are known to conflict with morality, the mere reading aloud of the information is a crime. A lesser penalty is applied where it can merely “be reasonably assumed” that the writing, photographs or article conflict with accepted norms or morality.

A number of interesting lessons can be drawn from the Indonesian situation. First, the law is not viewed as being in conflict with the Government’s avowed policy of providing what is called “family life education” to adolescents; this does not “conflict with morality”, but is seen as an attempt to inform and educate rather than corrupt. Second, it highlights the fact that legislation is often not an impediment to education. While it appears at first sight to conflict with government policy, it is really irrelevant since it is not enforced. Reality has outstripped what were once strict legal restrictions.
What is thought to be a threat to public morality in one legal system may be obscenity in another. The availability of reproductive health information and education may therefore also be affected by the rules relating to obscenity. The battle over public access to information on reproductive health, particularly contraception, dates from the late nineteenth century, when proponents of family planning, such as Annie Besant, in England, appeared on the scene. At the same time in the United States, the retrograde “Comstock laws” were enacted. The debate then, as later, focused on whether advocacy in print of the methods of contraception was acceptable. Publication and dissemination of such materials, in fact, were often banned because they were thought to promote immorality.

One of Annie Besant’s books survived a challenge in an Australian court, but the opinion of the one dissenting judge still reflects the sentiments of many people. In his view, the book “suggested impure thought, [was] offensive to chastity and delicacy, [and] expressed or represented to the mind something which delicacy, purity and decency forbid to be expressed” (7). Such views continue to determine many official attitudes on these matters. In the United Republic of Tanzania in 1980, a book that could have been used as an instructional aid on human reproduction and family planning was banned on what appeared to be obscenity grounds; that decision is now being challenged.

Elsewhere, more flexible views are taken in interpreting and applying the law. Section 181 of the Kenyan Penal Code makes it an offence “to trade, possess or distribute” materials that are obscene or tend to corrupt morals. This could be interpreted as prohibiting the publication and distribution of sex education literature, but the Section has never been applied to fertility-related materials, probably because of the importance of family planning to the country and the fact that the Public Health Act makes exceptions for persons who, either with the permission of the Minister of Health or in good faith, seek to publish materials that advance the cause of medical science and education. Information on health care relating to reproduction would appear to fall within the provisions of that Act and outside those on obscenity.

According to Kellogg & Stepan (6), of 19 countries surveyed up to 1976, only three (Indonesia, the Islamic Republic of Iran, and Pakistan— all Moslem) had obscenity laws that would be an obstacle to sex-related education and information. Only in Pakistan were the legal obstacles considered substantial.

The view taken here is that reproductive health information and education are not obscene and do not seek to promote immorality. They are the antithesis of obscenity and pornography, seeking merely to inform individuals of the facts relating to their sexuality and, in some

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*The actual title of the law was “An Act for the Suppression of Trade in and Circulation of Obscene Literature and Articles for Immoral Use”.*
instances, of the methods available for regulating their fertility. This seems also to represent the line of reasoning put forward in countries that have instituted thorough education programmes for adolescents.

Counselling

Roemer & Paxman (26) observe that “Family planning clinics and counselling centres are an important source of information on contraception for adolescents. The number and distribution of such facilities, and their announced availability to young people, play an obvious role in determining how much information and advice adolescents get. Counselling is an integral part of any effort to provide contraceptive services. It can add immeasurably to the knowledge and decision-making abilities of the young.” In France, the legislation encourages the use of family information and counselling centres by university students. In Hungary, the legislation calls for “intensification of educational measures directed to the public, particularly young persons,” on human relationships and family planning. Other examples of this type of legislation are to be found in Iceland, Luxembourg, the United States, and Yugoslavia.

In Iceland, Law No. 25 of 22 May 1975 on counselling and education concerning sex and childbirth and on termination of pregnancy and sterilization is “a model of comprehensiveness” (26). The Law provides that:

1. Everyone shall have the right to counselling and education on sex and childbirth. The Chief Medical Officer shall be responsible for the general supervision of the provision and preparation of such counselling and education.

2. Depending on the circumstances, assistance shall be provided as follows:
   (a) education and counselling on the use of contraceptives and the means of obtaining them;
   (b) counselling for persons intending to undergo a pregnancy termination or sterilization;
   (c) sex education, and counselling and education on the responsibilities of parenthood;
   (d) counselling and education concerning the assistance available to women in connection with pregnancy and childbirth.

3. The above counselling services shall be provided in health centres and hospitals, where appropriate in conjunction with maternity aid committees, gynaecology departments, psychiatric care centres, counselling services for large families, and social counselling services.

4. The counselling services shall be provided by physicians, social counsellors, midwives, nurses, and teachers, as required.

In Luxembourg, the Law of 15 November 1978 concerning sexual information, prevention of clandestine abortion, and regulation of the voluntary interruption of pregnancy requires the Ministry of the Family,
in conjunction with the Ministries of Education and Public Health, to prepare a booklet and make it available free of charge in appropriate public places. Local authorities are now required to provide this booklet to all applicants for a marriage licence, and school authorities to provide it to all students who have completed primary school. The legislation creates regional centres, which are available free of charge to everyone, for consultation and information on contraception, sterilization, and abortion.

Two republics of Yugoslavia have enacted legislation with a strong emphasis on counselling on contraception. The Law of 20 April 1977 in the Republic of Slovenia provides that men and women have the right both to advice on how to prevent conception and to have a physician personally advise them on, and prescribe for them, the most suitable method of contraception. The Law of 21 April 1978 in the Republic of Croatia prescribes the establishment of counselling centres and other forms of assistance as a way of implementing the rights of citizens to information regarding the methods and advantages of family planning.

Advertising

Laws and policies on advertising often impinge on the availability of information, even in countries that enthusiastically embrace the concept of individual choice in matters of fertility regulation. Space permits only a brief account here of such legal provisions, which affect access to information in at least three ways (2, 26).

First, legislation on drugs in many countries permits the advertising of contraceptives only if this is directed solely to the medical and pharmaceutical professions in professional journals. Advertisements for, e.g., a specific brand of oral contraceptives, cannot then be addressed to the general public. Where legal distinctions are made, the most common is to restrict the advertisement of prescription contraceptives to physicians while allowing that for non-prescription contraceptives to the general public.

Second, access to information on specific family planning methods may be blocked by the views of public or private authorities who control the media. Public advertisement of specific brands of contraceptives is prohibited altogether in some countries, although advertisements informing the public where family planning services in general are available are permitted.

Third, rules controlling the display of contraceptives, particularly condoms, often require that they be hidden away from public view. In this way the advantages of self-advertisement are precluded. "No display" requirements are often only a matter of aesthetics; they serve no legitimate health purpose.

All these restrictions, in varying degrees, reduce the chances of the public obtaining information on the various aspects of reproductive health.
Conclusions

There exists a wide array of laws and policies that hinder attempts to educate young people on matters relating to their sexuality and fertility. Irrespective of whether adolescents are or are not sexually active, it is important that they should be given such education, if only for health reasons.

In the past, where laws and policies have restricted the scope of reproductive health education and information, it has nevertheless sometimes been possible to avoid their effects by arguing that a factual presentation of sexual matters, including contraception and other health-related subjects, is neither advocacy nor propaganda nor an excursion into the obscene but simply an honest attempt to provide young people with essential information. However, sex education should be more than just telling people the facts; it should provide a basis for intelligent, informed decision-making. As the Australian Royal Commission on Human Relationships pointed out (27):

There is widespread ignorance on sexual matters that points to the need for comprehensive education. Surveys in Australia and overseas on the sources of sexual knowledge show the influence of peers and their role in perpetuating misinformation, due mainly to lack of any reliable source. There is need for early and continuous sex education and for an education programme which will help young people to be responsible to themselves and to each other and to decide to act within knowledge, not in fear and ignorance.

One of the difficulties to be faced in the context of reproductive health is that of persuading the authorities to change their policies regulating the curriculum content. This is often where the real problem lies. Once the legality of sex education has been established, the law itself has only a tangential role to play as it is the educational authorities that determine what is taught. The content of the courses is always influenced by the local mores and culture.

Not all adolescents are sexually active. Not all those who are active are married. Not all adolescents are informed about the health consequences of human sexuality. There are, of course, no easy solutions to the problems created by this situation, but little can be achieved by overly emotional debate. Attempts to provide adolescents with information on fertility regulation should not be regarded as an effort to subvert public morals or as an excursion into the obscene. They are, in fact, a forthright attempt to resolve what is becoming a major health problem. Ignoring the fact that many young people are sexually active and that patterns of adolescent fertility are changing will not make the difficulties disappear. Unfortunately, many of the laws and policies still in force throughout the world, whatever their basis, inhibit efforts to educate and inform adolescents. Briefly, if persons are deprived of information on such matters they are unlikely to act "responsibly" in their decisions on reproductive matters. One way of dealing with the situation, at least in part, has been found in the Philippines where all...
applicants for a marriage licence are required to receive "instruction and information on family planning and responsible parenthood" before the licence is issued. The information can be in the form either of personal instruction or of brochures, pamphlets or handbooks. In this way at least those who are entering into marriage acquire some information on reproductive health. Nevertheless, in reality more people need this type of instruction. As the WHO Consultation on Contraception in Adolescence pointed out (28):

Not only children, but parents and other family members, health workers, teachers and religious counsellors, have a need for accurate information on reproductive life since it is often the older friends and relatives and social institutions that perpetuate the misinformation, ignorance and fear surrounding this subject.

References and Notes

7. Ex parte Collins, (1888) 9 NSW 497.
23. CORNEJO, G. ET AL. Ley y poblacion en Mexico. Mexico City, Fundacion para Estudios de la Poblacion, 1974, p. 84.

### Legislation*

**Argentina**

Decree No. 659 of 28 February 1974 providing for the conduct of a study on demographic problems [IDHL, 26: 717 (1975)].

**Chad**

Law No. 28 of 29 December 1965 organizing the practice of pharmacy (Article 98) [IDHL, 29: 316–217 (1968)].

**Costa Rica**


**Denmark**


**France**


Decree No. 74–1 of 3 January 1974 for the implementation of Law No. 73–639 [IDHL, 25: 314 (1974)].

Circular of 23 July 1973 of the Ministry of Education.

Circular No. 52 of 24 August 1976 of the Minister of Health [IDHL, 28: 504 (1977)].

Circular of 8 December 1981 of the Minister of National Education.

**Hungary**


**Iceland**

Law No. 25 of 22 May 1975 on counselling and education concerning sex and childbirth and on termination of pregnancy and sterilization (Sections 7, 9(2), and 15(3)) [IDHL, 28: 615–617 (1977)].

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*For the sake of concision, International Digest of Health Legislation has been abbreviated throughout to IDHL.*
REPRODUCTIVE HEALTH EDUCATION

Indonesia
Penal Code (Article 283).

Ireland
Censorship of Publications Act, 1929.
Criminal Law Amendment Act, 1935.
Censorship of Publications Act, 1946.
Health (Family Planning) Act, 1979 [IDHL, 30: 807–811 (1979)].

Kenya
Penal Code (Section 181).

Luxembourg
Law of 15 November 1978 concerning sexual information, prevention of clandestine abortion and regulation of the voluntary interruption of pregnancy (Sections 2 and 3) [IDHL, 30: 253 (1979)].

Malta
Ordinance V of 1933.

Mexico
Constitution, as amended 1975 [Articles 2, 3(2), and 25].

Pakistan
Constitution (Article 2).
The Penal Code (Section 293).

Philippines
Constitution, 1973 (Article XV, Section 10).
Republic Act 6365 as revised by Presidential Decree of 8 December 1972 [IDHL, 24: 897 (1973)].
Presidential Decree No. 965 of 20 July 1976 requiring applicants for a marriage licence to receive instructions on family planning and responsible parenthood [IDHL, 29: 417 (1978)].

Senegal
Law No. 80-49 of 24 December 1980 inserting a new Section 295 bis into the Penal Code and repealing the Decree of 30 May 1933 for the implementation of the Law of 31 July 1920 on the prevention of propaganda in favour of contraception and incitement to abortion [IDHL, 34: 77 (1983)].

Spain
Law No. 45 of 7 October 1978 amending Sections 416 and 343 bis of the Penal Code [IDHL, 31: 372 (1980)].

Tunisia
Law No. 73–17 of 23 March 1973 establishing and organizing the National Office for Family Planning and Population (Section 2(C)) [IDHL, 28: 180 (1974)].
**United States of America**  
**Michigan**  
*Michigan Compiled Laws Annotated* [Section 380. 1507 (1)] (establishment of sex education curriculum).

**New Jersey**  

**Yugoslavia**  
**Croatia**  
Law of 21 April 1978 on health measures to implement the right to a free decision regarding the birth of children (Sections 11, 28, and 121) [*IDHL, 30* 329 (1979)].

**Slovenia**  
Law of 20 April 1977 on medical measures to implement the right to a free decision regarding the birth of children (Sections 10 and 18) [*IDHL, 28* 1112 (1977)].
6. Availability of Reproductive Health Care Services

Education and information on reproductive health and health care itself are, of necessity, complementary. However, this unitary approach is not pursued everywhere. In some countries, health education and information are promoted but little is done to give adolescents, particularly if unmarried, access to reproductive health services. In others, the educational programmes are inadequate but services are available to adolescents, particularly if married. One survey of the availability of family-planning-related health programmes specifically directed to teenagers (1) revealed the following: (a) of 23 Asian countries, nine had programmes providing education for teenagers but only three actively provided services; (b) of 36 African countries, 11 had communication or education programmes, but none provided services; (c) of 32 Latin American countries, 21 had communication and education programmes for teenagers, but only four provided services specifically to adolescents. There is none the less a degree of correlation between the availability of education and information and that of health care in the industrialized countries, where those that offer a comprehensive programme of reproductive health education to adolescents also tend to offer reproductive health services.

To a large degree, the laws and regulations governing reproductive health services affect adolescents and adults alike. Service delivery schemes that focus on adolescents are subject initially to the general legal rules that regulate the availability of such services—contraception, sterilization, abortion, pregnancy-related care and the treatment of sexually transmitted diseases (see Chapter 7). Beyond that, special legal requirements often affect access by adolescents to the services as described below.

**Contraception**

If sexually active adolescents, whether married or unmarried, are to control their fertility, it is essential that they have access to contraceptives. The laws, regulations and policies affecting such access are nevertheless in a state of disarray. The differences both between and within countries are telling. The advertisement and sale of contraceptives are prohibited in Saudi Arabia, while in Sweden contraceptives are aggressively advertised and widely available. In some countries, contraceptives are not available as such but may be prescribed for other
medical reasons: the contraceptive pill as a cycle regulator, the intrauterine device (IUD) for treatment of uterine adhesions and the condom as protection against sexually transmitted disease.

In Japan, the contraceptive pill is not yet available as a contraceptive but the IUD is (though it may not be suitable for nulliparous adolescents). In Hungary, oral contraceptives are prohibited for girls under 16, as are IUDs for those under 18 or who have never given birth. In contrast, termination of pregnancy is allowed on request for unmarried teenagers. In Papua New Guinea, though the low-estrogen pill is available without prescription, it can be sold only to married women and only if they have proof that their husbands consent. In Indonesia, it is technically a criminal offence to distribute the "instruments of contraception" to anyone under 17, despite the fact that the permitted age for marriage is 16. There appear to be no legal exemptions for married women but in practice contraception is available to married women irrespective of age.

Many of the laws and regulations on contraception affect adults and adolescents alike because they relate generally to the availability of specific methods but some are aimed at adolescents alone, as will be seen in what follows.

**Acquisition of contraceptives**

The acquisition of contraceptives is governed essentially by provisions of two types: the requirement for a doctor's prescription and the requirement that contraceptives can be sold only in pharmacies.

**Doctor's prescription requirement**

One of the legally protected functions of a doctor is to “prescribe” medications for the treatment of human diseases and disorders. Because the contraceptive pill, contraceptive injections, and IUDs are normally listed as "potentially harmful drugs and devices", they tend to be available only on prescription. Doctors thus control their distribution to the public. The prescription requirement is based on the assumption that doctors are available to write prescriptions. In countries where doctor/population ratios are relatively high, such a requirement may have little inhibiting effect on the availability of contraceptives. However, in those where doctor/population ratios are low, it has a major effect in stalling contraceptive programmes (2).

Other approaches have therefore been developed, as follows. Either appropriately trained health workers and auxiliary personnel have been authorized to prescribe and distribute contraceptives or the prescription requirement for oral contraceptives has been eliminated altogether. The current situation is summarized below (2):
1. No prescription required for oral contraceptives: Antigua, Bangladesh, Grenada, Hong Kong, Iraq, Jamaica, Nepal, Pakistan, Papua New Guinea.

2. Prescription for oral contraceptives required and available either from trained health workers or auxiliary personnel, such as midwives and nurses, or from government-authorized personnel, such as field staff workers: Chile, Malaysia, Morocco, the Philippines, Republic of Korea, South Africa, Sri Lanka, Sweden, and Thailand.

3. Initial doctor's prescription or subsequent screening by doctor required for oral contraceptives but contraceptive pills provided on a continuing basis by a dispenser at the request of the consumer: Barbados, Fiji, India, and Indonesia.

4. Initial doctor's prescription for 12 months or more, interim supplies available from other health workers: Brazil, France, Tunisia.

Regulation of place of sale or distribution

The restrictions on place of sale and distribution of drugs and devices, found in so many laws governing pharmaceutical products, affect access to both prescription and non-prescription contraceptives (e.g., contraceptive pills, condoms, foams, and jellies). The Health (Family Planning) Act of 1979 in Ireland imposes such restrictions, limiting sales of all contraceptives to the shops of pharmaceutical chemists or dispensing chemists and druggists, and only on prescription (3). In France, similar provisions have now been abandoned. Prior to 1974 sales of contraceptives had to take place "exclusively in pharmacies"; however, in 1974 the law was amended to permit the sale of non-prescription contraceptives at other locations (2). Where pharmacies are few and far between, restrictions on the place of sale of contraceptives seriously affect access to contraception. Since many potential users are persons of rather modest means and limited mobility, they tend to make frequent purchases of small amounts of needed commodities (e.g., food or medicine) at shops very near their homes. The usual restrictions, i.e., sale only in pharmacies under a registered pharmacist's supervision, therefore have their greatest adverse impact in the rural areas where some 75% of the world's population lives (2). For this reason, among others, any restrictions that reduce the accessibility of contraceptive outlets can greatly hinder the task of providing continuing contraceptive services to the population.

Insertion of IUDs

The legal requirements concerning the insertion of intrauterine devices differ somewhat from those governing the prescription or distribution of other contraceptives for the simple reason that IUDs cannot be self-administered. They must be inserted by trained personnel
with special skills and knowledge; this does not necessarily mean that only doctors can insert them. As with some of the other forms of contraception, the basic problem is the shortage of personnel trained to provide the service. Three legal approaches have been adopted in dealing with this problem.

First, as a general rule, laws and regulations do not specifically regulate IUD insertion. Even so, the predominant approach has been to treat such insertion as part of medical practice. Therefore, in the absence of any rule to the contrary, insertion has often been restricted to doctors.

Second, a few countries have specifically restricted the insertion of IUDs to doctors and have even specified where it may be performed. France and Hungary are among the few countries with detailed legislation on the subject of IUD insertion.

Third, there is a growing trend, principally—though not entirely—in parts of the world where there are shortages of doctors, to authorize other health personnel to insert IUDs. Chile, China, the Philippines, the Republic of Korea, Sweden, and Thailand have adopted this approach (2).

Access to contraception and consent

Contraceptives are still strictly regulated or even prohibited in several countries, though such countries are becoming fewer in number. In Gabon, for example, contraceptives may be prescribed only for "therapeutic" purposes, not for family planning, though in exceptional cases they may be prescribed, by a "commission" of three physicians, where further pregnancy would endanger the woman's health or when the well-being of the family requires such a measure. Only in a case of absolute necessity may contraceptives be prescribed for a woman under 25 years of age. These are fairly stringent requirements, but the most stringent position is that taken in Saudi Arabia where contraception has been banned altogether. (See Table 3 for an overview of availability of contraceptives for adolescents in several countries.)

Access

Many of the inroads into the general ban on contraception are relatively recent: the sale of contraceptives was legalized in France in 1967, in Spain in 1978 and in Ireland in 1979. In the USA, the last state law to prohibit the use of contraceptives, even by married women, that of Connecticut, survived until 1965 (4). In France, under Decree No. 69-765 of 3 February 1969, a minor (an unmarried woman under 21) could not obtain contraceptives unless one of the parents or a legal representative consented in writing. This requirement was later eliminated, principally because of the high incidence of pregnancy and illegal abortions among teenagers, and Law No. 74-1026 of 4 December
Table 3. Laws and policies on provision of contraceptives to adolescents

<table>
<thead>
<tr>
<th>Country</th>
<th>Condom</th>
<th>Pill</th>
<th>IUD</th>
<th>Other</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Ministry of Health supplies contraceptives to needy adolescents under age 20 (high-risk group).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Copper intrauterine device (IUD) approved (1983).</td>
</tr>
<tr>
<td>France</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Unmarried minors may get contraceptives at family planning centres (1974).</td>
</tr>
<tr>
<td>Gabon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives for therapeutic reasons only, on advice of three doctors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives to those under age 25 only if &quot;absolutely&quot; necessary (1985).</td>
</tr>
<tr>
<td>Hungary</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>15-19 year olds must be dealt with by specialists in obstetrics and gynaecology (1974).</td>
</tr>
<tr>
<td>Indonesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Providing contraceptives to adolescents under age 17 technically a crime.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives to married people only.</td>
</tr>
<tr>
<td>Mexico</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives technically unavailable to unmarried minors (1974).</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Consent at age 16.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adolescents under age 16 may get contraceptives at family planning centres (1977).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives available to minors only if married (1979).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spouse’s consent required.</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Consent at age 15.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doctor forbidden to inform parents.</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Contraception banned (1979).</td>
</tr>
<tr>
<td>Sweden</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Consent at age 15.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doctor forbidden to inform parents.</td>
</tr>
<tr>
<td>Thailand</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Contraceptives available to all adolescents (1979).</td>
</tr>
</tbody>
</table>

1974 authorized the distribution of contraceptives free of charge at family planning centres.

Italy has a similar history. As already mentioned on p. 50, section 553 of the Penal Code, which forbade the promotion of contraception,
and hence the sale and distribution of contraceptives, was declared unconstitutional in the de Marchi case in 1971 (5). In 1975, a network of family and maternity assistance centres was established by Law No. 405 of 29 July to provide, among other things, contraceptive advice and services. This was partially in response to the fact that 1% of births in Italy were to girls aged 10–14 years and 22%, to those aged 15–19 (6).

Where contraception for adolescents is accepted, a line is often drawn between those who are married and those who are not. In 1976, a report on adolescent fertility pointed out that, as a matter of official policy, family planning programmes in China, Indonesia, Malaysia, and the Philippines, distributed contraceptives only to married couples (7). This was also the case in Mexico, though as a WHO survey indicated, this was largely a reflection of the negative attitude of medical personnel towards contraception in general (6).

Such policies in population-conscious countries are somewhat puzzling, though they may reflect a well thought out approach based on national priorities and cultural values; for instance, it has been said that premarital sexual activity in China is virtually non-existent. However, in countries where the level of sexual activity among unmarried adolescents is relatively high, such policies leave large numbers of adolescents virtually unprotected and, moral issues aside, simply make reproductive health more difficult to achieve.

Statistics from Indonesia are somewhat contradictory. It has been reported that 41% of Indonesian women have their first child before age 17, but at the same time it is said that only 4% of all births are to adolescents (6). It will be recalled that, in Indonesia, providing contraception to those under 17 is technically a crime. Under such conditions, programmes that offer counselling and assistance regarding contraception to teenagers, particularly if unmarried, will be difficult to find.

Matters are quite different in other countries with similar backgrounds. In Thailand where, in 1975, 7.6% of all births were to adolescents, all forms of contraception are available to adolescents of both sexes regardless of marital status (6). In Hong Kong, where the contraceptive pill is available without prescription, contraceptive services are extended to all regardless of age, sex, or marital status, although public opinion seems to be against the provision of such services to unmarried minors (6).

In Czechoslovakia, opinion appears to be divided on the question of whether to provide contraception to younger girls, and the matter is essentially left to the discretion of the doctor (6). The type of contraceptive that may be provided to a minor is restricted by Methodological Directive No.14 of 10 June 1977, which lays down that, in the case of a woman who has never been pregnant, contraceptive vaginal suppositories and spermicidal jellies, if necessary in combination with male contraception, or diaphragms should be recommended initially, and that hormonal contraceptives are to be prescribed for minors only in exceptionally justified cases.
The Ministry of Health in Hungary has taken a more formal approach. By virtue of Instruction No. 13 of 1974, hormonal contraceptives may be prescribed for any woman who is at least 16 years of age. Only medical specialists in obstetrics and gynaecology may prescribe for women between the ages of 16 and 18. Similarly Instruction No. 22 of 1973 contains detailed regulations on the insertion of IUDs. They may be inserted in any woman who has already been pregnant, irrespective of age, or in any woman of at least 18 years of age for whom pregnancy may involve undesirable health consequences.

In England and Wales, the National Health Service (Family Planning) Act 1967 authorized local authorities to give contraceptive advice to "social" as well as "medical" cases, without regard to marital status. In 1970 it became mandatory for family planning clinics to offer services to unmarried clients. Family planning was officially incorporated into the National Health Service in 1973 and was then made available free of charge to all who requested it, irrespective of age or marital status.

The Contraception, Sterilization and Abortion Act of 1977 in New Zealand contains a provision relating to those under 16, that is quite unlike any other on the subject. Section 3 of the Law makes it an offence for a person to sell, give, or "otherwise dispose" of any contraceptives to anyone under 16 or to offer to do the same unless that person is: (a) the parent or guardian of the child; (b) a medical practitioner or someone acting under his supervision and authority; (c) an authorized representative of a family planning clinic or other authorized organization approved by the Minister of Justice; or (d) a pharmacist or someone acting under his supervision and authority if he sells or offers to sell on the receipt of a prescription signed by a medical practitioner.

The 1977 Law replaces a statute which made it a crime not only for anyone to provide contraception to under-16s but also for under-16s to attempt to procure contraceptives. At best, the purpose of the legal restrictions listed above would seem to be to keep contraceptive distribution to younger minors in the hands of the few individuals who are ostensibly either prepared to provide adequate information to the recipient about contraception or have a vested legal interest in the "child", as the law calls the under-16s. On the other hand, particularly in the case of condoms and spermicidal foams and jellys, the restrictions seem somewhat excessive and eliminate a number of possible sources of contraceptives. Criminalizing such behavior seems inappropriate when looked at from the point of view of health, though the 1977 Law is an improvement on the previous one, which made contraception for under-16s completely illegal.

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*In New Zealand anyone 16 years of age or over may give the consent necessary to acquire contraceptives.*
In the USA, one of the stated purposes of the Adolescent Pregnancies Act (8) is “to expand and improve the availability of, and access to, needed comprehensive community services, which assist in preventing unwanted initial and repeat pregnancies among adolescents”. The Act was introduced because adolescents in the USA are at high risk of unwanted pregnancy. Under the Act, special funding is made available to programmes that provide, among other things, contraception to adolescents. Regulations require that services be made available to eligible adolescents free of charge if they are unable to pay, irrespective of the income of the parents or guardians.

Providing free contraceptive services to those “most in need” (and adolescents may often be described as such) is becoming an increasingly common feature of national contraceptive programmes, in countries where the national health service or insurance scheme provides the contraceptives, this is not usually a problem. For example, in France, under Law No. 74–1026, contraceptives are distributed free of charge at family planning centres. In contrast, in the Federal Republic of Germany, contraceptives are not covered by the health insurance system, an exclusion that has been criticized as irrational. The law in Luxembourg makes all services and medications for minors free. In Brazil, the approach is more limited. Contraceptives, including contraceptive pills, are distributed free of charge to economically needy women in “high-risk” pregnancy groups, that is, those below 20 or above 40 years of age (3).

Recent experience in the United States may shed some light on the pros and cons of contraception for adolescents. In mid-1977 the United States Supreme Court decision regarding Carey v. Population Services International (11) struck down a New York statute that made it a crime: (1) for anyone to sell or distribute non-prescription contraceptives to a minor under the age of 16; (2) for anyone other than a licensed pharmacist to distribute contraceptives to persons over 16; and (3) for anyone, including pharmacists, to advertise or display contraceptives. The controversy had arisen over the mail-order sales of non-prescription contraceptives (condoms and the like) to minors in New York.

This was one in a series of cases on the subject of contraception that had been heard since 1965, but the first to explore thoroughly the advisability of making contraceptives available to minors. One of the key arguments used by New York to justify the statute was its interest in deterring sexual activity among minors. It was argued that, if contraceptives were widely available to minors, this would act as an inducement to illicit sexual conduct. The Court challenged the validity of this argument by observing initially that “there is no evidence that teenage extramarital activity increases in proportion to the availability of contraception”. In addition, it expressed the opinion that “it would be plainly unreasonable to assume that [the state] has prescribed pregnancy and birth of an unwanted child (or the physical and psychological dangers of abortion) as punishment for fornication”.

As Justice Stevens wryly observed: "It is as though the state decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets". This view reflects those taken in other countries that provide contraceptive services to minors and focuses on one of the consequences of denying sexually active teenagers the benefit of contraception.

Consent

The issues of who should give consent—the adolescent or the parent—and whether the parents should be notified of the fact that a "minor" is using contraceptives have been addressed in various ways. Law and practice on the subject seem to diverge in some instances. The most heated debates have taken place in the USA and the United Kingdom.

In the United Kingdom the age of consent for medical services is 16, but the practice has been to give contraceptive advice and services to those under that age without first obtaining parental consent. This was accepted by the Department of Health and Social Security, which took the position in its 1974 guidelines that the prevention of unwanted pregnancies among the young should be given priority. This followed the view expressed by some of the members of the Lane Committee (the Committee on the Working of the Abortion Act) that providing contraception is a "lesser evil than allowing the girl to run the risk of pregnancy" (12).

The 1974 guidelines advised that, if done in "good faith" and with the best interests of the adolescent in mind, it was acceptable to provide contraceptives to under-16s without parental consent and without informing the parents. In addition, the Director of Public Prosecutions indicated, via a case brought to test the legality of the practice, that there would be no case to answer.

Because of pressure from parents, however, revised guidelines, issued in February 1981, recommend that, whenever a doctor or other health professional is approached by someone under 16 for advice concerning contraception, he or she should try at the earliest stage of the consultation to persuade the child to involve the parents or guardian in the decision-making process. It is pointed out, however, that it is

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1 The question does arise of the criminal liability of those who either consent to, or give contraceptive advice or services to, those under the age of 16, the age at which one can also consent to intercourse in the United Kingdom. Kloss & Raisbeck (13) record the following: "In 1971, the Attorney-General was asked in Parliament to prosecute a gynaecologist who had prescribed contraceptive pills to a girl of 12 who had had an abortion. The girl's parents had consented. It was suggested that the gynaecologist and the girl's parents were guilty of aiding and abetting or counselling and procuring unlawful intercourse. The Attorney-General replied that he thought no crime had been established, and this is probably correct. The mere provision of contraceptive protection in case the girl should again have intercourse does not amount to advising, or helping her to do so." However, in 1980, the Minister of Health declared that "sexual relations with a girl under 16 are illegal, and to supply her with contraceptives is condoning an illegal act."
widely accepted, as a principle of medico-legal ethics, that consultations between doctors and patients are confidential, and to abandon this principle for children under 16 might deter some from seeking professional advice and hence expose them to the risks of pregnancy, sexually transmitted diseases, and psychological threats to a stable family life. In such cases, the protection of the young person concerned is left to the clinical judgement of the doctor (14).

The guidelines were challenged in court by Mrs Victoria Gillick, mother of five daughters under 16 years of age. Mrs Gillick contended that the circular of the Department of Health and Social Security was unlawful because (1) it authorized doctors to give advice and treatment to girls under 16 without parental consent, and (2) it advised doctors to commit a crime in causing or encouraging unlawful sexual intercourse with a girl under age 16. She sought affirmation that no advice or treatment would be given to her daughters without her involvement. In December 1984, the Court of Appeal found unlawful the 1981 Department of Health and Social Security guidelines permitting a doctor to provide confidential contraceptive advice to girls under 16 years of age. Reversing the decision of a lower court that had upheld the guidelines, had specifically approved the doctrines of the "mature minor" and of doctor-patient privacy, and had emphasized the need to help young girls avoid pregnancy, the appellate court held that physicians are not authorized to prescribe contraceptives or give advice or treatment for abortion to a young person under 16 without parental consent, thus reasserting the supremacy of parental rights in such matters, as guaranteed historically in law. The only exception made by the court was for emergencies.

However, on review, the House of Lords reinstated the lower court decision, Lord Fraser observing: “I am not disposed to hold now, for the first time, that a girl aged less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age” (72).

In Denmark, the Pregnancy Hygiene Law of 1966 gave to every person over the age of 15 years the right to seek contraceptive advice from a physician without parental consent. A recent article in a Danish newspaper has raised the issue of whether physicians may supply contraceptives to girls under 15 without parental consent. The article suggested that family doctors inform young girls at an early age, perhaps even at the time of their first menstruation, that they may safely ask for contraceptives when the need arises (15). The Danish National Board of Health approves of informing young teenagers about contraception in order to avoid unwanted pregnancies, but it plans to take legal advice on the question of whether doctors should be allowed to supply contraceptives to young persons under 15 without parental consent (10).
Contraceptive advice may also be given without parental consent in Sweden to any person who has reached the age of 15 years. Physicians in Sweden are forbidden to inform parents that a young person has approached them for advice. This guarantee of confidentiality is thought to be essential in dealing with adolescents.

The issue of parental involvement in contraceptive decision-making is more complicated in the USA, where no state has a statute that specifically requires parental consent for contraception, though consent requirements are found in other items of legislation (or have been developed from judicial decisions). As of late 1976, a "mature minor" could obtain contraceptives without parental consent in 30 states and the District of Columbia. Some states, among them New York and California, have statutes that require that family planning services be made available, at public expense, to all needy persons, irrespective of age and with no requirement for parental consent.

These provisions are similar to those of Title XIX of the Social Security Act (Medicaid) under which the Federal Government provides funds to states to provide family planning services to "categorically needy" or "medically needy" persons, including sexually active minors. Title XX of the Social Security Act (Social Services) authorizes contraception for eligible "minors who can be considered sexually active", without regard to age or marital status. The mere request for family planning services is evidence of "need" under the law. And the Supreme Court has reaffirmed that parental consent is not required for programmes that receive federal assistance under the Social Security Act (16).

The debate in the USA has since moved on to the issue of whether parents must be "notified" of their children's use of contraceptives. A United States Court of Appeals, in *Doe v. Irwin*, held that parents do not have a constitutional right to be informed that contraceptives are being supplied to their minor children (17). Minors, the court concluded, possess a constitutional right to privacy, which includes the right to obtain contraceptives. This right is buttressed by the independent interest of the state in the well-being of its youth, an interest that was being asserted through the establishment of family planning clinics, as an attempt to avoid the physical and emotional hazards of unwanted pregnancies.

Kenny et al. (18), reviewing the legislative history of the principal federal law on the funding of family planning services in the USA (Title X of the Public Health Service Act), point out that the original purpose of the legislation, passed in 1970, was to make "comprehensive and voluntary family planning services available to all persons desiring such service". In 1974, a Congressional report stressed the importance of serving adolescents (19), and in 1978 Congress passed an amendment to Title X requiring that services be provided to them. In 1978, the House of Representatives defeated a proposal to require
parental notification before provision of prescription contraceptives to any unemancipated child under 16 (20). In 1981, Title X was amended to require entities receiving grants and contracts to encourage family participation to the extent practical.

Despite this background, and against a storm of protest, in 1982 the United States Government, under the Reagan administration, proposed new regulations requiring federally funded family planning clinics to notify the parents of any patient under 18 to whom they had prescribed contraceptives within ten days of having done so. This regulation was made final early in 1983 (21). It became known as the “squeal rule”. In February 1983, two separate federal judges declared the regulations to be invalid on the grounds that they violated the intent of the federal law authorizing funds for family planning (22, 23). The injunctions against use of the regulations were made permanent the following month. On 8 July 1983 the United States Court of Appeals for the District of Columbia declared the regulations “unlawful”. Writing for the court, Judge Skelley Wright (24) said:

Congress ... has long recognized not only the importance of family involvement, but the crucial importance as well of preserving patient confidentiality. ... Congress was fully aware of this consistent administrative practice and, in particular, recognized the critical role played by assurance of confidentiality in attracting adolescents to the clinics.

Pregnancy Termination

The fact that women the world over rely on abortion as one of the principal methods of averting unwanted pregnancies, as well as for other health reasons, is well recognized. A survey conducted in 1974 by the International Planned Parenthood Federation concluded that some 55 million abortions were carried out annually throughout the world. More recently, in 1979, the Population Crisis Committee estimated that 20 million “illegal” abortions are performed in the world each year. Evidence abounds to show that abortion has been practiced in almost all communities throughout history and that women will seek out abortion services, whether legal or illegal, if they deem it necessary. Adolescents behave in exactly the same way. In 1978, in the United States alone, 356,602 young women aged 19 or under faced unwanted pregnancy and were able to obtain a legal termination; of these, 12,735 were 14 years old or younger (25).

That abortion is an important health problem for adolescents has been demonstrated by Tietze in his 1983 study of induced abortions (26), though the rates vary from country to country (see Table 4). The percentage of all legal abortions to women under 20 years of age is highest in countries in the industrialized world where the procedure is
### Table 4. Legal abortions obtained by women under 20 years of age

<table>
<thead>
<tr>
<th>Country or area</th>
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<th>14 years</th>
<th>14.17 years</th>
<th>18.19 years</th>
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<td>0.8</td>
<td>12.3</td>
<td>15.2</td>
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<td>1980</td>
<td>0.5</td>
<td>7.4</td>
<td>9.9</td>
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<tr>
<td>England and Wales</td>
<td>1980</td>
<td>0.7</td>
<td>13.4</td>
<td>13.5</td>
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<tr>
<td>Finland</td>
<td>1980</td>
<td>0.3</td>
<td>10.3</td>
<td>13.5</td>
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<tr>
<td>France</td>
<td>1979</td>
<td>0.1</td>
<td>3.9</td>
<td>8.9</td>
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<tr>
<td>German Democratic Republic</td>
<td>1979</td>
<td>0.1</td>
<td>6.4</td>
<td>7.9</td>
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<tr>
<td>Germany, Federal Republic</td>
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<td>5.9</td>
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<td>8.3</td>
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<tr>
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<td>11.1</td>
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<td>B. Abortion rates per 1000 women</td>
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<td>C. Abortion ratios per 100 known pregnancies</td>
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<td>46.5</td>
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<td>England and Wales</td>
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<td>United States of America</td>
<td>1980</td>
<td>41.7</td>
<td>41.7</td>
<td>39.6</td>
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*Residents only.

*Rates for abortions at 14 years or less were computed per 1000 women aged 15-14 years.

*Legal abortions plus live births six months later.*

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Legal and widely available. Overall, the rate ranges from about 2.5% to just below 30%, as follows:

- **Tunisia**: 2.5%
- **Japan**: 3.2%
- **Czechoslovakia**: 6.1%
- **India**: 6.3%
- **Singapore**: 8.8%
- **Denmark**: 17.8%
- **Sweden**: 19.1%
- **England and Wales**: 27.3%
- **Canada**: 28.3%
- **USA**: 29.6%
- **Scotland**: 29.7%
In most of these countries, abortion rates among the under-20s have been rising for a long time and have only recently begun to decline. Tietze, in 1979, (27) attributed this initial increase to a number of factors, among them "earlier maturation, changing patterns of sexual behavior, growing acceptance of abortion as an alternative to forced marriage of out-of-wedlock birth, liberalization of abortion laws and of the attitudes and practices of the medical profession". Little is known about the hidden impact of "illegal" abortion. One survey in Bangladesh—where abortion is legally available only to save a woman's life—concluded that 87% of deaths among unmarried women could be defined as "abortion-related" (28).

The availability of pregnancy termination is largely determined by national legislation. The grounds that have been accepted in various countries as justification for pregnancy termination have been listed by Cook & Dickens (29) as follows:

(a) there is a risk to the life or a grave and immediate risk to the health of the woman (the strict necessity indication);
(b) there is a risk to the woman's health (either physical or mental or both) from the continuation of the pregnancy beyond that normally associated with pregnancy (the health or therapeutic indication);
(c) the child is likely to suffer from some degree of physical or mental impairment (the fetal or eugenic indication);
(d) the pregnancy is the result of incest, rape (including statutory rape), or other forms of criminal intercourse (the juridical indication);
(e) childbirth is likely to have an adverse effect upon the health and welfare of the woman and her existing children and family (the social, sociomedical or socioeconomic indication);
(/) the social position of the woman or her family will be jeopardized (the family indication);
(g) a routinely employed contraceptive method has failed (the contraceptive indication);
(h) the pregnancy is that of an adolescent girl or a legal minor (the adolescent indication); and
(i) the woman does not wish to continue with the pregnancy (abortion on request, usually permitted only during the first trimester).

In any country, an adolescent seeking an abortion must meet the general requirements of the law (30). These requirements take two different forms: those that establish the grounds on which a pregnancy may be interrupted and those that establish the formal procedural conditions to be met in order to gain access to abortion services. The procedural conditions affect such disparate matters as the approval procedures required, the persons authorized to perform an abortion and the places where abortions may be performed. None of the laws surveyed here focus solely on the subject of adolescent abortion and, as a general
Abortion on medical grounds

Little purpose would be served here by describing in detail the different types of abortion law since this has been done admirably elsewhere (26, 31, 32). The more important question is how these affect access by adolescents to pregnancy termination services; this must, however, be viewed, at least initially, from the broader legal perspective. While it is true that all countries impose restrictions on abortion of one form or another, it is equally true that few countries prohibit abortion in all circumstances and for all women. Tietze (26) calculated that only 10% of the world's population live in such countries.

Almost invariably, exceptions to the general prohibition of abortion are made, even if only in narrowly defined circumstances. For example, in the Philippines, Section 256 of the Penal Code makes abortion a criminal offense without exception; however, the general principles of criminal law can be applied to abortion and these would permit the termination of pregnancy where it is necessary to save the life of the mother. A handful of countries, predominantly in Africa and Latin America, permit abortion only when the life of the mother is threatened.

Countries that follow the legal traditions of either the United Kingdom or France tend to have abortion statutes that may be characterized as essentially restrictive, some of these countries failing to legitimize abortion for any reason. This underscores the need to look to other sources of law, such as case law, to determine when abortion can be legally performed.

Many statutes permit intervention where the woman's health is threatened. Few make any attempt to define what is meant by "health", though the statutes in force in the Republic of Korea and Zimbabwe specify that it relates only to physical health. Under most legislation, determining when an adolescent's "health" is endangered by pregnancy is left to the doctor concerned. Each case is therefore judged on its unique health-related merits.

In the main, laws that authorize abortion only where the life or health of the woman is threatened are on the restrictive side of the spectrum of abortion legislation. The position taken in many countries is that termination of pregnancy on health grounds encompasses only certifiable "medical" indications. (For a summary of the status of the world's abortion laws, see Table 5).
Abortion for reasons particularly relevant to adolescents

Social and economic factors, age, marital status

Social environment, economic circumstances, age, and marital status can have a bearing on the decision to terminate pregnancy, provided that the legislation permits them to be taken into account. An increasing number of countries are enacting laws to make this possible.

While many eastern European countries have tried of late to curb their reliance on abortion as a means of regulating fertility, they have also been leaders in addressing the reproductive health needs of young women. In Hungary, for example, under Ordinance No. 4 of 1 December 1973, abortion is available for a wide variety of social reasons. If the woman is unmarried she has the right to an abortion; abortion may also be permitted where there are "other social grounds of an imperative nature". The emphasis, however, is on early abortion. For example, if the pregnant woman is a minor, the termination may not be authorized if the duration of the pregnancy exceeds eight weeks, unless

Table 5. Legal status of abortion in various jurisdictions (mid-1982)

<table>
<thead>
<tr>
<th>Country or area</th>
<th>Legal on specified grounds*</th>
<th>Medical</th>
<th>Narrow (life)</th>
<th>Broad (health)</th>
<th>Eugenic (fetal)</th>
<th>Juridical (rape, incest, etc.)</th>
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Legal on specified grounds:
- **Medical**
  - Narrow (life)
  - Broad (health)
  - Eugenic (fetal)
  - Juridical (rap, socio-medical)
  - Social and medical
  - Legal (grounds not specified)

1. Adapted from: FISHER, C. Induced abortion: A world view. 1983, 5th ed. New York: The Population Council, 1983, pp. 16-17. The table does not include most areas with fewer than one million inhabitants or those for which information on legal status of abortion was not available. Countries applying Islamic law appear under "Medical/narrow (life)."
2. Abortion to save woman's life may be authorized under general principles of criminal law (status of necessity).
3. Abortion on medical and eugenic grounds is generally permitted prior to viability of fetus. Abortion on juridical grounds is generally permitted up to the same gestational limit as abortion on social or sociomedical grounds.
4. In Northern Territory and South Australia.
5. Prior to viability of fetus.
6. On request for unmarried women, married women with two living children, and married women over age 40 with one living child.
7. During first 10 weeks of pregnancy.
8. No legal limit but most abortions performed during first trimester.
9. On request for women over age 40.
10. On request for unmarried women, for married women with three living children or those who have experienced three spontaneous abortions, for certain categories of women with two living children, for married women over age 40, and for women without a home or apartment of their own.
11. During first 12 weeks of pregnancy.
12. No formal authorization required and abortion permitted in doctor's office, abortion de facto available on request.
13. During first 24 weeks of pregnancy.
14. On request for women over age 40 and for those with four or more living children.
15. During first 18 weeks of pregnancy.
17. Penalty may be waived when abortion performed during first three months of pregnancy because of serious economic difficulty.

The delay in seeking the abortion is not the woman's fault. All abortions in Hungary must be approved by special committees. The law in Czechoslovakia is similar in many respects, but also permits termination of pregnancy if the woman was under 15 years of age when conception took place. The Bulgarian Law of 1973 permits abortion for women under 18 with no living children.

In Denmark, abortion is available on request during the first 12 weeks of pregnancy. After that, abortion may be authorized in cases where, because of age (16 or less) or immaturity, the woman would be incapable of caring properly for the child or the care of the child would become an undue burden. Other social and economic factors affecting the woman's personal circumstances may also be considered. The same social considerations apply in Iceland.

In Austria, after the first three months of pregnancy, during which abortion is available on request, socioeconomic indications are not acceptable as a basis for abortion. However, a pregnancy may be
terminated if the woman became pregnant when she was less than 14 years of age. Abortion on request is not available in Finland, but during the first 12 weeks of pregnancy, socioeconomic indications may be taken into account by the screening committee. However, the law does permit abortion for women under 17 years of age. In Hong Kong, legislation passed in 1981 makes abortion legal for women under the age of 16 if performed by a physician.

Social factors of a different sort affect abortion for adolescents in at least two countries. In Cyprus, the law allows abortion where the pregnancy would jeopardize the social status of the family. The law in Colombia, where abortion is prohibited, serves another function, since a reduction in the sentence imposed for a violation or a pardon is possible if the abortion was sought to protect the honour of a mother, spouse, daughter or sister.

In some countries, social indications by themselves are not enough to justify terminating a pregnancy but must be linked to the health of the woman. The Abortion Act of 1967, which regulates abortion practice in the United Kingdom (except Northern Ireland), permits two registered medical practitioners to determine whether the continuation of the pregnancy would involve a greater risk to the life of the pregnant woman, or to the physical or mental health of the woman or any existing children of her family, than would its termination. The risk to life or health is thus the basic legal indication for an abortion to be authorized. Even so, the Act allows consideration of the pregnant woman's "actual or reasonably foreseeable environment". This does not create a "social" indication for termination, since health considerations clearly predominate. Nevertheless, factors of a social or economic nature, including the woman's age, marital status, and family situation, may be taken into account in reaching the decision.

This same formula has been followed in Hong Kong, India, and Zambia. Age is specifically cited as a factor to be considered in the Zambian Termination of Pregnancy Act of 1972. In New Zealand, the fact that the woman is near the beginning of the child-bearing years is not an indication "in itself" for abortion but may be a factor in determining the medical need for the procedure.

A few laws have unique features found nowhere else. Explanation III to Section 3(2) of the Medical Termination of Pregnancy Act, 1971 in India, for example, authorizes abortion if continued pregnancy would involve a risk of grave injury to the mental health of the woman. Explanation II to that Section states that:

> Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

Although the legislative explanation apparently applies only to married women, it is of importance to adolescents in India because early
marriage is still prevalent there. The provision can thus be applied to youthful couples who are attempting to postpone childbearing. In fact, only 6.3% of all recorded legal abortions in India in 1979 were performed on women aged 19 or less (27).

Rape, incest, illegal intercourse

No fewer than 35 countries, predominantly in Europe, Latin America, and Scandinavia, have laws that permit abortion where the pregnancy is the result of rape, incest, or other illegal intercourse (31). This is often referred to as the “juridical indication”, though it may equally be called “humanitarian”. The rape justification, at least, is founded on a predominantly moral view. In the words of one writer, it is simply “intolerable that a woman who has been the victim of . . . assault should be compelled to bear the child of her ravisher” (33).

Frequently, legislation requires that, before an abortion can be carried out on the grounds of rape, criminal proceedings against the assailant must be initiated. This is the case in Argentina, while Bulgarian law, like that in Cameroon, insists that the rape be verified by the law-enforcement agencies. This often constitutes an additional procedural impediment.

In several countries, the fact that a pregnancy was the result of rape serves as a defence to the crime of abortion. In others, it is only a mitigating factor in the sentencing of an accused abortionist. In Ethiopia, the fact that the pregnancy resulted from rape, or incest, is treated as an extenuating circumstance in sentencing (37); in Uruguay, punishment may be waived altogether in these circumstances (31).

There are other forms of sexual intercourse that are regarded as criminal but do not carry the stigma of rape. Pregnancy as the result of incest is essentially an adolescent predicament. Incest is a criminal offence in most countries but, curiously, not all countries permit the termination of a pregnancy resulting from an incestuous relationship. In New Zealand, however, Section 187A of the Crimes Act 1961 (as amended in 1977), allows termination of pregnancy “resulting from sexual intercourse between the closest relations”. Many other countries simply permit abortion generally whenever the pregnancy results from rape or other “forms of sexual misconduct” prohibited by law, as is the case in the German Democratic Republic. In Israel, this includes extramarital sexual relations, but not necessarily all premarital ones.

By definition, intercourse with a minor is a criminal offence in many jurisdictions, and is often referred to as “statutory rape”. In theory, any woman below a specified minimum age is, because of her immaturity, incapable in the legal sense of giving a valid consent to intercourse. Abortion law sometimes reflects this kind of paternalism. Greek law, for example, speaks of the “seduction” of a woman under the age of 16 and permits abortion of any resulting pregnancy. In Liberia, intercourse with
a girl under 16 constitutes a criminal offence and forms a ground for a justifiable abortion. Israeli law permits abortion where the woman is under the minimum age for marriage. As noted above, in a number of other countries age is the sole determining factor. Such laws are sometimes linked to the legal age for consent to intercourse (see the discussion of this subject on pp. 34–35).

Consent as a prerequisite to abortion

Most abortion legislation fails to state explicitly that the consent of the woman seeking the termination of pregnancy is required. Of the legislation that does deal explicitly with consent, the Mexican Federal Criminal Code, Section 370, is perhaps typical in requiring the consent of the woman. The Abortion Act 1974 of Singapore grants access to abortion on the “request of a pregnant woman and with her written consent”, but no provision is made for third party consent. These formulas do little to determine who can give legally effective consent if the woman happens to be under the age of majority. While the usual way to clarify the position is to look to the rules governing consent for minors in other legal sources, a number of abortion laws do address themselves specifically to the issue of minors and consent. One or more of three basic patterns is then followed: (1) consent of parent, and sometimes spouse or guardian, is required; (2) alternatives to parental consent are established; or (3) minors themselves are permitted to consent.

Consent of parent, spouse, or guardian

The predominant rule requires the parent, spouse or guardian to consent to an abortion if the woman is underage; this is the pattern in the laws of Bulgaria, the German Democratic Republic, Honduras, Japan, the Libyan Arab Jamahiriya, Switzerland and all six republics of Yugoslavia (34). The age below which a third party’s consent is required is usually specified. The provisions governing consent for termination of pregnancy in the recently enacted Population Planning Law (No. 2827 of 1983) in Turkey require parental consent for the unmarried minor, and spousal consent if the minor is married. There is the additional requirement that, if the minor has a guardian, the consent of that person plus “the permission of the justice of the peace” is also needed.

In India, a pregnancy cannot be terminated “except with the consent in writing of her guardian” if the woman is under 18. In France, only if the minor is unmarried must a parent or guardian consent. Moroccan law requires the consent of the spouse or, in his absence, a notice from the chief medical officer of the province or prefecture before an abortion can be performed on a married woman, but has no specific mention of consent requirements for an unmarried woman. In
Czechoslovakia, when the woman is under 18, the abortion commission may, if necessary, seek parental involvement in the decision, as well as that of the male who "is responsible for her becoming pregnant".

In their survey of abortion laws in Commonwealth countries, Cook & Dickens (32) present another point of view on the rationality of the parental consent requirement:

This barrier to lawful termination of pregnancy following a medical finding justifying the procedure may provide parents with a mechanism for controlling not merely their child's health but also her educational and social future. This is all the more oppressive in those jurisdictions where the age of majority is relatively high.

**Alternatives to parental consent**

As abortion laws have changed over the last decade, a new feature has been the creation of alternatives to the parental consent requirement. This is the result, no doubt, of the recognition that the parents' views do not always reflect what will serve best the interests of the pregnant minor. At least two countries, by statute or regulation, permit parental consent or refusal to be overridden by a committee decision. In Hungary, though the consent of the legal representative of a minor is generally required, it can be replaced by the decision of a screening committee. In Denmark, if the woman is under 18, parental consent is required except in an emergency, or where the abortion committee authorizes termination despite parental refusal. This latter provision is unique.

In Italy, a slightly different approach has been adopted. The abortion law requires initially that either a parent or a guardian consent to pregnancy termination for a woman under 18. However, if during the first 90 days of pregnancy it is "impossible or inadvisable" to consult these individuals or if they refuse to consent or "express conflicting opinions", the case may be submitted to a magistrate, who must decide within five days whether to grant approval. Moreover, where a doctor finds that the pregnancy poses a "serious threat to the health" of a woman under 18, he need not request the consent of parents or guardian. The law in Iceland requires parents to make application for an abortion jointly with the woman if she is under 16 years of age, "unless special circumstances render this inadvisable".

Some countries require only that the parents be notified of an impending abortion. In Norway, if the woman is under 16 years of age, the law requires only that the parents be "given an opportunity to express their opinion". In Slovenia (Yugoslavia), the parents need only be notified of an impending termination; they cannot participate in the decision-making process. Even this notification requirement can be dispensed with if the minor is earning her own living and is therefore emancipated.
Right of minors to consent

A few countries have legislation that has eliminated the parental consent requirement for all or some minors. In Czechoslovakia, for example, minors do not need parental consent prior to abortion. In the United States, the right of some minors to consent to abortions has been elevated to constitutional status as a result of two recent Supreme Court cases: Planned Parenthood of Central Missouri v. Danforth (35) and Bellotti v. Baird (36), both of which analysed state legislation against a constitutional background.

In the Danforth case, the Court declared unconstitutional a provision in the Missouri abortion statute which required parental consent and which, in the words of the Court, gave parents of unmarried adolescents "an absolute, and possibly arbitrary veto over the decision" to seek an abortion. The Court emphasized, however, that in striking down the parental consent requirement, it was not suggesting that "every minor, regardless of age or maturity, may give effective consent for termination of pregnancy" but that, where the physician was satisfied that the minor was sufficiently mature to consent, that consent was sufficient. This decision affected the law then in effect in 14 states.

The Court dealt with the Bellotti case on two different occasions, in 1976 and 1979. In the later case, known as Bellotti II, a Massachusetts law, in some respects similar to that recently introduced in Italy, was ruled unconstitutional. Two different views were taken by the Court as to why this should be so. The first was that the statute gave the judge a veto over the minor's decision to ask for an abortion, no matter how mature or well informed the minor might be. That, in the view of some of the Justices, was just as burdensome as the parental consent requirement.

The other view was that the law was unconstitutional because it interfered with the right of a mature minor to decide to have an abortion and imposed a parental notification requirement. Justice Powell, speaking for this view, went on to suggest an alternative procedure that would be appropriate under the Constitution: if a minor did not want to seek parental consent, she should be given a chance to explain to a court: (a) that she possessed sufficient maturity to make the decision in consultation with her doctor; or (b) even if she were not capable of making a mature decision, that the court could authorize the abortion because it was in her best interests.

Several states of the USA have followed this reasoning and enacted statutes that permit a minor who is unwilling to seek parental involvement to apply to a judge. She may then be permitted to consent to, or authorize the abortion if she can show it to be in her best interests (37).

The notification requirement, first addressed in the Bellotti case, has since been held to be valid in some specific instances. Utah has a statute requiring parental notification before an abortion can be performed on an immature, unemancipated minor. The Supreme Court upheld that

The most recent cases have confirmed the position taken in *Danforth, Bellotti II* and *Matheson* (39).

Courts in the USA have also had to struggle with issues that have arisen when statutes say nothing about a minor's consent or where they conflict with other legal principles. One case, decided over a decade ago by the California Supreme Court, shows how questions concerning a minor's ability to consent to reproductive health services were resolved at that time and helped to mould the development of the law in the USA. Though therapeutic abortion legislation was passed in 1967 in California, in the absence of specific provisions governing the matter, it took four years to settle the question of whether a minor could consent to pregnancy termination. In *Ballard v. Anderson* (40), the Court finally held that another statute—which authorized minors of any age to consent to care and treatment relating to pregnancy—provided the basis for an unmarried minor who was “of sufficient maturity to give an informed consent” legally to consent to a therapeutic abortion. That statute (41) laid down that:

> An unmarried pregnant minor may give consent to the furnishing of hospital, medical or surgical care related to her pregnancy, and such consent shall not be subject to disaffirmance because of minority.

The opinion in *Ballard* did emphasize nevertheless that the burden of convincing medical authorities that the consent was “informed” fell on the minor. If the teenager failed to convince them that she had the required “understanding and maturity”, they could refuse to perform the therapeutic abortion until parental consent was obtained.

The same ideas are emerging outside the USA. Thus Woods, after examining the laws in the various states of Australia, concluded (42):

> Taking into account current social conditions and ideas, it would seem reasonable advice that if a girl is 16 or over and not obviously mentally defective or otherwise incapacitated, a termination of pregnancy could lawfully be effected without reference to a parent. If she is 14 or 15, the doctor must make a careful assessment of the girl to judge whether or not she is capable of giving, and does give, a free consent. Pressure from another person would need to be considered. The girl's intelligence would be relevant as would her knowledge about sexuality in general and about the implications and risks of a termination operation. Whether she was living at home with her parents, or by herself, or in a welfare institution might be relevant to her state of mind and might say something about her “independence”: but the test ought not to be whether she is an “emancipated infant” in terms of living at her parents' home or away from there. A school girl living at home may, in fact, be more sensible and mature than a girl of equivalent age who, because of family strain and difficulty, has left home to live by herself. It depends on the individual case ...

What if the girl is under 14 years? There should not be an absolute rule that a girl under 14 cannot consent to a termination of pregnancy.
In short, Woods underscores the view that legally effective consent of a minor of any age "depends on his capacity to understand and come to a decision on the procedure in question" (43).

The McMullin Commission in New Zealand (44) expressed the view that "the minor's wishes should prevail if proper grounds for her abortion have been established". To deny any abortion simply because of the woman's age would, in the words of the Commission "be harsh as well as illogical". These views did not, however, find their way into the law when it was amended in 1977. The age of consent for abortion remains 16.

Counselling on abortion

The pregnant adolescent needs to know about the availability of options other than abortion, as well as about the risks and consequences of the procedure before she can provide an "informed" consent.

The French legislation (Law No. 75-17 of 17 January 1975) requires a woman seeking an abortion to:

... consult a family information, counselling, or advisory establishment, a family planning or education centre, a social welfare service, or any other approved institution ... This consultation shall consist of a private interview during which the woman shall be provided with assistance and advice appropriate to her situation, as well as the necessary means to resolve the problems posed.

This provision was amended by Law No. 79-1204 of 31 December 1979, to add, after the word "posed", the following: "especially with a view to enabling her to keep her child".

Having access to adequate counselling, whatever the outcome of the personal decision-making process, is of immense importance. Some countries have recognized this and have established, through legislation, special centres for the purpose. Among those that have done so, the predominant pattern seems to be for counselling on abortion to take place within the context of family planning programmes.

In Italy, the family counselling centres, established in 1975, are obliged to assist "any pregnant woman", including minors, with the advice and means necessary "for achieving freely chosen objectives, with regard to responsible parenthood".

Procedural requirements

Abortion laws often establish a number of procedural requirements relating to such matters as the approval procedures to be followed prior to an abortion, where abortion may be performed and at what stage of pregnancy. Of these, the time limits for abortion are perhaps the most important. It is widely believed that adolescents, particularly those who are unmarried and pregnant for the first time, are slow to reach a
decision as to whether to terminate the pregnancy. This may make abortion for such adolescents an impossibility because the later the abortion is requested, the more stringent the legal requirements for approval. In addition, the later the termination takes place, the greater the risks to health.

Stage of pregnancy

The predominant legislative pattern is for the time limits to be related to the accepted indications for legal abortion. The most obvious of these is one that permits abortions essentially on request during the earliest possible stage of pregnancy. (Abortion on request is perhaps a misnomer as access to abortion is rarely available in this way. Other criteria must often also be met, such as the approval of a doctor or, as in France, the existence of a “situation of distress”.)

The rather liberal indications for abortion in Italy are applicable only during the first 90 days of pregnancy. After that time, a pregnancy may be interrupted only if it creates a risk to the woman’s life or health (physical as well as mental) or if there is evidence of fetal malformation. In Denmark, abortion is available on request during the first 12 weeks of pregnancy measured from the beginning of the last menstrual period. After that time, special criteria must be met and the decision is made by a committee. In France and Slovenia (Yugoslavia), the limit for “on request” termination is ten weeks. Applications after that time in Slovenia can be approved only if there is a substantial risk to life or health that is greater than that associated with continuation of the pregnancy. In France, abortion is possible at any stage of gestation if pregnancy “seriously” endangers the woman’s health or if there is a “strong possibility” that the fetus is suffering from a “disease or condition” that is incurable.

The law on abortion in Norway specifies three distinct periods during which different criteria apply. Abortion is available on request, if there is no serious medical reason against it, during the first 12 weeks of pregnancy. During the next six weeks the pregnancy may be terminated only if: (1) the pregnancy, childbirth, and care of the child would place an unreasonable strain on the physical or mental health of the woman; (2) it they create “difficult circumstances” for the woman; (3) there is evidence that the child will be deformed or diseased; (4) the pregnancy is the result of a criminal act; or (5) the woman suffers from a “severe mental illness or retardation”. After the 18th week of pregnancy, termination is not allowed unless there are “particularly important reasons” for it. In no case can pregnancy be terminated if there is reason to believe that the fetus is viable.

In Singapore, a pregnancy may not be terminated after 24 weeks unless it is “immediately” necessary to save the life of the woman or to “prevent grave permanent injury” to her mental or physical health.
Screening

The purpose of screening procedures is to ensure that the legal criteria are met before abortion is authorized. A variety of mechanisms are used for this purpose, ranging from the approval of a single doctor (USA), or of two (United Kingdom) or three (Zambia), to that of a committee or commission (Czechoslovakia, Finland, and Hungary). The delays caused by the use of a committee have led at least one country, Sweden, to abandon this approach during the first 18 weeks of pregnancy. Experience in Singapore with a committee system was similar, and after five years the procedure was abandoned, not only because it caused delays but because it also reduced privacy and was unduly humiliating (32). A request for an abortion can, of course, be denied when, in the judgement of those who decide such matters, the legal requirements are not met. Under the earlier system in Sweden, fully 60% of applications were turned down. Many of those rejected in this way had recourse to illegal abortionists at added risk to their own health (45). The report of the Lane Committee in the United Kingdom (12) observed that “evidence indicates that a woman determined to obtain an abortion is not easily deflected from her purpose, particularly if she is unmarried”. Though at the time no accurate national survey had been carried out, the Committee estimated that as many as 30% of “those at first refused may eventually obtain an abortion, and a substantial proportion (perhaps a fifth) of those do so within the National Health Service”.

Financing pregnancy termination

As Roemer has observed (10), a coherent “system of financing abortions is a crucial determinant of access, particularly for adolescents” who cannot usually afford the procedure. Many countries have national health systems in which reproductive health care is financed out of public funds in the same way as other forms of medical care. The cost of legally obtained abortions is usually covered in this way. In Luxembourg, the cost of an abortion is reimbursed from the health insurance funds. In France, as the law on abortion has developed, so have the corresponding financial measures. Initially, under the 1975 law, only abortions performed to save a woman’s life or safeguard her health, or those performed for eugenic reasons were financed from public funds. Those carried out essentially “on request” during the first ten weeks of pregnancy had to be paid for by the woman herself. Law No. 82-1172 of 31 December 1982 abolished this difference and made the cost of early abortion “reimbursable” by the social security system. Developments in the United States have been in the opposite direction: federal funds for abortion have virtually been eliminated. Under the now famous “Hyde Amendment”, enacted first in 1976, and subsequently an annual event surrounding the budget appropriation for the Medicaid programme (which attends to the medical needs of certain
categories of the poor and needy), the use of federal funds for abortion is forbidden except: (1) where the life of the mother is placed in jeopardy by the continuing pregnancy, or (2) where the pregnancy is the result of rape or incest, reported within 48 hours of the incident (46). The Supreme Court, in spite of strong dissenting opinions, upheld the constitutionality of the budgetary amendment in *Harris v. McRae* (47) by saying:

> It simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.

Courts in two states, California and Massachusetts, have taken the opposite point of view where state funds were involved (48).

**Concluding remarks**

This section has focused on the relationship between the law and the problem of abortion among adolescents, but it is impossible to speak of abortion in isolation. To a great extent, abortion is needed when there is a failure to prevent pregnancy. Reliance on abortion as an aspect of reproductive health care could certainly be lessened if effective contraceptives were more widely available.

Contraception is generally preferable to abortion. Nevertheless, no modern method of contraception is 100% reliable, and no single contraceptive is appropriate for everyone. Hence, it is likely that abortion will always be required. In fact, in the short run, a desire for effective contraception is likely to lead to an increase in abortion rates, because of the failure rate associated with every method of contraception. Because of this interrelationship, contraception and abortion services need to be linked.

While much headway has been made in the past decade in providing a legal basis for the interruption of pregnancy among adolescents, there are still areas that are unsettled. The fact that the law has been liberalized in many countries does not necessarily mean that services for adolescents are, in practice, more widely available. The major problem is often one of implementation.

In many respects the present legislative measures regarding adolescent abortion deal with only a small part of the overall problem. A much greater threat to health is posed by the practice of illegal abortion. Experience has clearly shown that women will turn to abortion as a method of coping with unwanted pregnancy whether or not it is legally available, and for various reasons, adolescents may be even more apt than adults to seek illegal abortions. Equally, it is evident that clandestine abortions pose an immense health risk to those who undergo them.
As one would expect, many illegal abortions are performed in countries where the laws on abortion are restrictive. Surprisingly, though, in countries with so-called liberal laws, the practice may also flourish because of the numerous impediments created by the law—screening procedures, parental consent requirements, and requirements as to where the abortion may take place, who may perform it, and how many doctors must approve of the procedure. Moreover, the cost of a legal abortion may affect the incidence of illegal abortion. In such instances, a liberal law may benefit only the more well-off in the community.

Voluntary Surgical Contraception

Voluntary sterilization is becoming an even more popular aspect of reproductive health care, especially when the desired family size has been reached (2), and it is one of the more striking trends in contraceptive practice since the early 1970s. An estimated 90 million couples worldwide have chosen sterilization as the method of regulating their fertility—a figure that represents a threefold increase since 1970, and accounts for fully one-third of all couples practicing contraception (49).

As sterilization must be considered irreversible, it is not generally a realistic option for most adolescents, unless there are substantial, overriding medical reasons. Nevertheless, under certain circumstances it may be a desirable alternative. For instance, a decade ago over 70% of females between the ages of 15 and 20 in Bangladesh, Chad, India, Mali, Nepal, Niger, Pakistan, and the United Republic of Tanzania were married (50). Many women in these countries have three or more children before the age of 21. Similarly, the families of many men of the same age may have reached their desired size. Voluntary sterilization for these people may not be entirely out of the question.

Sterilization is also available for medical reasons other than those linked solely to fertility. Whether or not sterilization is available depends on the interpretation given to the applicable law. The relationship between law and sterilization in general will first be briefly discussed, followed by a discussion of how the law affects adolescents.

Stepan et al., in their recent survey of the legal trends in voluntary sterilization (49), have discerned four basic categories, namely:

- voluntary sterilization for contraceptive or other purposes is specifically permitted by special provision of law, regulations, or policy;
- voluntary sterilization is legal because the law does not prohibit it;
- it is unclear whether sterilization for contraceptive purposes is legal, even if an individual gives informed consent; and
- voluntary sterilization is a criminal offence.

We shall treat these briefly in reverse order.
Legal background

Voluntary sterilization purely for family planning purposes is a relatively recent innovation. Hence, only a minority of countries, though a growing one, have laws that apply specifically to it. Of these, a handful of countries make sterilization unlawful for any reason, most of the legislation concerned being a remnant of earlier legal eras. In Spain, before 1983, the sterilization of a person, even with his or her consent, constituted a crime under the Penal Code (51). However, Law No. 8/1983 of 25 June 1983 added a new paragraph to Article 428 of the Code, whereby sterilization was decriminalized, provided that the person sterilized has duly consented and that the operation is performed by a medically qualified person. Portugal also prohibited the use of "methods which lead to sterility" (52). Argentina punishes any act that interferes with the ability "to engender or conceive" (53). Similar provisions are found in the laws of Costa Rica and El Salvador but are not applied to voluntary sterilization (51), and the same is true for Thailand, where Section 297(2) of the Criminal Code includes, under the category of aggravated bodily harm, any injury that results in an "inability to reproduce" with the exception of voluntary sterilization. The section of the Penal Code in Italy that made sterilization a crime was repealed only in 1978 (54).

In some countries the question arises as to whether various general provisions of the criminal law could be applied in a way that makes sterilization illegal. The fear is that it may be considered a form of "grievous bodily harm", "assault", or "mayhem", as expressed in common law systems, or of coups et blessures volontaires (intentional wounds and injuries), as in the Civil Law Codes modelled on that of France.

Such apprehensions generally have an adverse effect on attempts to offer sterilization services. For example, Section 360 of the Penal Code of Nicaragua punishes anyone who "maliciously castrates or renders the reproductive organs of another person useless" with or without that person's consent. Similar laws are found in Paraguay and Peru, though they are not applied to sterilization carried out by a doctor (51).

Some countries have interpreted their restrictive penal provisions in a way that excludes their application to voluntary sterilization. For example, Article 262 of the Revised Penal Code of the Philippines imposes penalties "upon any person who shall intentionally mutilate another by depriving him, either totally or partially, of some organ essential for reproduction". But in an opinion dated 17 September 1973, Secretary of Justice Vicente Abad Santos stated that, since certain methods of sterilization (tubal ligation and vasectomy) "do not involve lopping or clipping off the organs of reproduction of both sexes", as may be the case with castration, but "are effected by the closing of a pair of small tubes in either the man or the woman so that the sperm and ovum cannot meet", they should not be regarded as "mutilation within the contemplation of Article 262". Similar interpretations have
been adopted in other countries, e.g., the Mexican law that punishes acts that cause "permanent disablement of sexual functions" is not applied to voluntary sterilization (51).

There is little doubt as to the application of the criminal law to sterilization in France. Articles 309 and 310 of the Penal Code, which originated in the Napoleonic Code, punish any act that results in the "mutilation, amputation and privation of the use of a limb... or other permanent injury". Sterilization for purely therapeutic reasons is allowed in France, but is subject to narrowly specified conditions. According to the Academy of Medicine, sterilization may be performed only when a woman suffers from an "incurable disease" which in the event of pregnancy would expose her to serious complications and could lead to her death. This view may change now that the Council of Europe has recommended that sterilization services be made available in accordance with the right to family planning (55).

The Napoleonic Code is the basis of laws that would appear to apply to sterilization in a number of former Belgian and French colonies, among them Burkina Faso, Burundi, Chad, Côte d'Ivoire, Gabon, Guinea-Bissau, Haiti, Madagascar, Mali, Mauritania, Rwanda, Senegal, and Togo (51). The prevailing legal view is that sterilization for any non-therapeutic reason is illegal even with the consent of the person sterilized.

The degree of confusion over the legal status of voluntary sterilization is indicated by the fact that the laws that are thought to be applicable to it are the criminal laws on assault and severe bodily injury. If strictly applied, they would equate the work of a skilled physician on a willing patient under clinical conditions to a brutal assault. Such a view has been rejected in many countries. In some countries that have inherited the English common law system, a voluntary sterilization is simply considered "a surgical operation" which, if done in "good faith" for the intended "benefit" of the patient, is not a criminal act.

In other countries, legal uncertainties about voluntary sterilization have been resolved by enacting new statutes clarifying the legal position. In Singapore, for example, the Voluntary Sterilization Act, 1974, contains a provision that states that "sexual sterilization by a registered medical practitioner (under the Act) shall not constitute a 'grievous hurt' within the meaning of the Penal Code". In 1977 a new section was inserted in the Crimes Act 1961 of New Zealand, which protects anyone who performs with "reasonable care and skill" a surgical operation "for the purpose of rendering the patient sterile".

Legislation affecting sterilization of adolescents

On the whole, there is a trend towards liberalizing the laws affecting the availability of voluntary sterilization. According to Stepan et al. no
fewer than 25 countries have either laws or regulations that expressly govern voluntary sterilization (49). In many instances changes have been made in the laws applying to the whole range of sterilization services, therapeutic and eugenic as well as contraceptive, either through reinterpretation of existing legislation or enactment of new statutes. Where laws specifically authorize voluntary sterilization, they generally prescribe certain preconditions for the performance of the operation. Examples of legal requirements affecting access by adolescents to voluntary sterilization services are given below (see Table 6 for examples of laws and policies in force).

Consent

In order for sterilization to be truly voluntary, those who ask to be sterilized should be adequately informed and give their consent, free of outside pressure. Since the furore over India’s proposed programme of compulsory sterilization, the issue of informed consent has received close attention internationally and guidelines have been worked out. It is felt that in all instances information must precede consent. (See Chapter 2, pp. 14–15 for the types of information that should be provided).

Stepan et al. emphasized that “while it is easy to write legal requirements and procedures for informed consent, it is more difficult to be sure that the procedures lead to meaningful informed consent” (49). Nevertheless, in some countries, rules have been established, such as the Guidelines on Medical Ethics on Sterilization of the Swiss Academy of Medical Sciences. These require the physician to assess the psychological and physical indications for sterilization and obtain the valid, informed consent of the applicant, free of duress (14). The Guidelines impose higher ethical standards on the physician when he is dealing with mentally handicapped individuals.

In fact, adolescents will rarely seek sterilization. Nevertheless, it is of interest to see in what way laws or practice determine how the issue of consent is dealt with. The general presumption seems to be that those seeking sterilization will be married, and spousal consent is required by law in Japan (51) and in several predominantly Moslem countries. In Japan, the consent is even required of any person who, though “not legally married, possesses marital status” in respect of the person applying for sterilization.

The law aside, spousal consent is sought as a matter of medical practice in many countries. This is often as much a reflection of the cautiousness of doctors as of the prevailing cultural and religious attitudes or of the legal system and its attribution of special rights to spouses. For example, in the Republic of Korea nothing is said in the

"Austria, Chile, Cuba, Czechoslovakia, Denmark, El Salvador, Dominican Republic, Finland, Federal Republic of Germany, Iceland, Islamic Republic of Iran, Japan, Luxembourg, New Zealand, Norway, Panama, Philippines, Singapore, South Africa, Sweden, Tunisia, Turkey, United Kingdom (vasectomy), United States (44 states), Yugoslavia (Croatia and Slovenia). Ecuador enacted such legislation in 1982.


<table>
<thead>
<tr>
<th>Country</th>
<th>Eutectic Medical</th>
<th>Sterilization by Adolescents</th>
<th>On request</th>
<th>Remarks</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>After 25 sterilization with consent before age 25 legal if &quot;not contrary to good morals&quot;</td>
<td>Criminal Code of 23 January 1974, Section 90(2)</td>
</tr>
<tr>
<td>Chile</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Sterilization &quot;not to be considered a method of family regulation&quot;; hence can be performed only on medical grounds</td>
<td>Ministry of Health Resolution No. 202 of 8 September 1975</td>
</tr>
<tr>
<td>Indonesia</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Not to be part of national programme but possible in private sector, where couple request at designated institutions</td>
<td>Instruction No. 316 of Ministry of Health of 11 August 1980</td>
</tr>
<tr>
<td>Mozambique</td>
<td>x</td>
<td></td>
<td></td>
<td>Included in national family planning programme for women over 35</td>
<td>Decree law No. 40,451 of 1980</td>
</tr>
<tr>
<td>New Zealand</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Surgical operation intended to sterilize is authorized if done for lawful purpose and consent given; no person can consent to sterilization of underaged individuals (minors)</td>
<td>Crimes (Amendment) Act (Act No. 6) adding Section 614 to Crimes Act 1961 (1975); Contraception, Sterilization and Abortion Act (Act No. 112), Section 7 (1977)</td>
</tr>
<tr>
<td>Philippines</td>
<td>x</td>
<td></td>
<td></td>
<td>Criminal law on mutilation not applied to voluntary sterilization</td>
<td>Secretary of Justice Opinion No. 731 of 27 September 1973; Presidential Decree No. 1014 of 22 September 1976</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>x</td>
<td></td>
<td></td>
<td>All contraception, including sterilization, banned</td>
<td>Royal Decree of 28 April 1976</td>
</tr>
<tr>
<td>Singapore</td>
<td>x</td>
<td>x</td>
<td></td>
<td>Sterilization now available on request for all married persons; those under 21 need consent of spouse, parent or guardian</td>
<td>Voluntary Sterilization Act (Act No. 25) 1974, Section 3 (2)</td>
</tr>
<tr>
<td>Sweden</td>
<td>x</td>
<td></td>
<td>x</td>
<td>After 25 persons aged 18-25 may be sterilized for eugenic or medical reasons; under 188 cannot be sterilized</td>
<td>Law No. 580 of 12 June 1975, Sections 1-3</td>
</tr>
</tbody>
</table>


law about spousal consent, yet it is always sought. In Pakistan, spousal consent is required only if it is a woman who is to be sterilized. In most countries, spousal consent is not required (61). As far as consent for minors is concerned, fewer countries define the position in the law governing sterilization. In Norway, for a person under 20, the consent of a parent or guardian is needed before
sterilization may be undertaken, and only at age 25 can sterilization be requested without specific medical criteria being satisfied (51). The law in Singapore requires parental or guardian consent only if the person is under 21 and unmarried. The 1977 Act in New Zealand is unusual in that consent to sterilization must be "personal and voluntary" (51) so that no person can consent to sterilization on behalf of a minor. This provision may have been introduced as a consequence of recent attempts on the part of parents to have minor children sterilized. Sweden and Switzerland also bar "third party" consent. Courts in the United States and England have ruled that parental consent alone is not enough to ensure that the interests of the minor are being protected (56), but the statute in North Carolina precludes a doctor from sterilizing an "unemancipated" minor even though he or she consents; a parent or guardian or whoever is in loco parentis must concur (3).

Minimum age

Minimum age requirements in this context are designed to inhibit individuals from making a decision, with irreversible consequences, that they may regret later in life. This requirement not only affects a person's right to request the operation, but may also relate to the circumstances under which sterilization is available. Most statutes that have set a minimum age for sterilization on request have set it somewhat higher than the age of majority.

In Denmark, for example, sterilization is available "on request" at age 25. Between the ages of 18 and 25, careful screening is required before sterilization is permitted. Among the reasons for which sterilization may be approved for persons in that age group are that future pregnancy would pose a risk to the woman's life or lead to a deterioration in her physical or mental health, that there are adverse eugenic factors, or that the individuals concerned, because of physical or mental handicaps, would be unable to care for a child. Sterilization of anyone under the age of 18 is not permitted unless there are "very special reasons" for it (51). Similar provisions exist in Finland, Iceland, Norway, and Sweden (2, 51). In Sweden, however, the rules totally preclude the sterilization of anyone under the age of 18.

Under federal regulations in the USA, no one under the age of 21 can be sterilized in programmes subsidized by federal funds (57). In most states of the USA the age of consent to sterilization is 18 — the age of majority. In Singapore, the age requirement has been eliminated altogether. Austria, like the Scandinavian countries, has set the age at 25. In Cuba, the minimum age is 32; in Uganda it is 40 (51). In two Yugoslav republics, sterilization on request is available only to those over 35. Anyone younger than that must seek the approval of a commission which decides as to the validity of the "health reasons" for which the sterilization is being sought (Slovenia) or the existence of therapeutic or eugenic grounds (Croatia) (51, 58).
Minimum number of living children

Laws and policies in various countries require that, before an applicant can be authorized to undergo voluntary sterilization, evidence must be presented to show that he or she has living children. In Japan, the requirement is for "several"; in Tunisia, the requirement is for 4 (51). Age and number of offspring are often combined as minimum requirements in a way that would preclude the sterilization of adolescent parents. This approach has been used worldwide and has given rise to the "rule of 100" (i.e., age multiplied by number of living children must equal 100 or more). Application of this "rule" seems to be decreasing. The Ministry of Health guidelines in India call for the man to be at least 25 and the woman 20 before either member of a couple can be sterilized (49). They must also have at least two living children, the youngest being more than two years old (hence outside the age group where infant mortality takes its heaviest toll).

In Panama, a woman must be 26 and have five living children. In Czechoslovakia, the requirements are for three children, if over age 35, otherwise four (51). In Ecuador, it is 25 years and three children; Egypt, 35 years and three children. In the Dominican Republic the requirements are graded, i.e., the older the person the fewer the number of children necessary; 46 years and one child, 35 years and three children, 30 years and five children, 25 years and six children (51). The trend in Singapore has been downward. In 1972, the law required applicants to have two children, and in some cases one; by 1974, the requirement had been eliminated altogether from the statute.

At least two states in the USA — California and New Hampshire— have enacted laws forbidding health facilities that provide contraceptive-related sterilization services from imposing any non-medical eligibility requirements (e.g., age, number of children, marital status) if they differ from those imposed on individuals seeking other surgical procedures at the institution.

Medical indications for voluntary sterilization

Where specific laws and regulations exist they often make sterilization contingent on the existence of specific medical indications. For example, Ministry of Health policy in Chile specifically requires that voluntary sterilization be practised "only for medical reasons". Chile and Peru, as a matter of policy, forbid sterilization for purely family planning reasons (51).

Sterilization in Turkey was, until recently, permitted for "therapeutic" reasons only, i.e., where the woman needed to avoid pregnancy because of a physical defect or disease or where the person suffered from a hereditary disease. The latter condition is akin to the commonly accepted eugenic grounds for sterilization. Now, however, sterilization is
available on request. Medical reasons are the only basis for sterilization in the USSR (57).

**Sterilization of mentally ill or retarded adolescents**

A number of other problems are worthy of consideration, one being that of the criteria for the sterilization of a sexually active but mentally incompetent minor. This procedure, though now probably used less frequently, is still being carried out. In Canada (Ontario), the provincial government banned, for a time, the sterilization of mentally retarded individuals under 16, while it worked out legal and ethical guidelines (46). The action was prompted by a report that 308 individuals under 18, some possibly without their consent, had been sterilized in 1976. Another important issue is whether parental consent to sterilization of a minor—whether mentally competent or not—is sufficient to protect the interests of everyone concerned. As Roemer has pointed out (personal communication), the request for sterilization “is usually motivated by the parents’ desire to enable the handicapped minor to have as full a life as possible in society . . . but not be burdened by responsibilities for children beyond their capacities”.

As far as the first problem is concerned, at least for programmes in the USA that receive federal funds, a relatively straightforward solution has been found. The Department of Health, Education, and Welfare, after a long discussion, issued its regulations of 30 October 1978 (59). These prohibit the use of federal funds for the sterilization of individuals who are:

- under 21 years of age;
- mentally incompetent; or
- institutionalized (57).

The regulations were in large measure the product of a controversy that arose following the sterilization in Alabama of the Relf sisters—two young girls of allegedly subnormal intelligence, both sexually active, who were sterilized without their knowledge on the authority of welfare officials (60).

Views on such matters vary greatly from country to country. In some countries, either the parents or a specially appointed guardian is completely free to apply for the sterilization of a mentally or physically handicapped minor. In Denmark, Law No. 318 of 13 June 1973 contains two separate provisions on this subject:

If the said person, on account of a mental disease, mental deficiency, or other reason, is unable, permanently or for a long period, to understand the significance of the operation, the committee may authorize sterilization on the basis of an application submitted by a guardian specially designated for the purpose, where this is justified by the circumstances. [Section 6(2)]

If the person on whom the operation is to be performed is a minor or suffers from a mental disease or it is to be considered doubtful, on account of the applicant’s mental state, which may include feeblemindedness, that he himself will apply for
sterilization, the committee may authorize sterilization on the basis of an application of the person concerned and of the person exercising parental authority or of the guardian, or possibly a guardian specially designated for the purpose. (Section 7)

Of course, each case must be decided on its own merits if the person is a minor, but the statute clearly specifies the persons who may represent the minor.

Law No. 25 of 22 May 1975 in Iceland also allows a specially appointed legal guardian to submit an application for the sterilization of a person who is "incapable of comprehending the consequences of the procedure". Under Norwegian legislation, Law No. 57 of 16 June 1977, an application may be submitted by a guardian if the person concerned suffers from a mental illness or mental handicap or retardation which is of such "severity that he is incapable of expressing any personal opinion regarding the operation and recovery or significant improvement cannot be anticipated".

The Abortion and Sterilization Act, 1975, in South Africa contains a special provision which attempts to define the "circumstances in which... a person who is incompetent to consent to sterilization may be sterilized". It permits, in sweeping terms, the sterilization of "any person who for any reason is incapable of consenting or incompetent to consent" if his or her legal representatives apply to the Minister of Health and the application is approved. The application is subject, under Section 4(1), to certification by two physicians, one of them a psychiatrist, that such a person either:

(i) is suffering from a hereditary condition of such a nature that if he or she were to procreate a child, such child would suffer from a physical or mental defect of such a nature that it would be seriously handicapped, or

(ii) due to a permanent mental handicap or defect is unable to comprehend the consequential implications of, or bear the parental responsibility for, the fruit of coitus.

In New Zealand, the Royal Commission of Inquiry recommended "that Courts be vested with power to make an order for the sterilization of intellectually handicapped persons" (44). The recommendation was accepted in a slightly modified form by the legislators submitting the bill on contraception, sterilization and abortion. In addition, it forbade any third party from "consenting" to the sterilization of minors or mentally handicapped (44).

The statute in the Commonwealth of Virginia (USA) takes a less restrictive position by authorizing, in certain cases, the sterilization of minors between the ages of 14 and 18. But the procedural requirements are said to be "stringent" and include: (1) a petition requesting sterilization filed by the parents or guardians in a court in the area where the minor resides; (2) a court determination that the minor, parents (or guardian) and spouse, if applicable, have been fully informed...
of the “means, consequences and risks” of the procedure plus the availability of alternative temporary methods of contraception; (3) a court finding that the minor is so mentally impaired that he or she cannot, now or in the foreseeable future, make a personal decision about sterilization; (4) a finding that the minor is sexually active, needs contraception and would not want a pregnancy if “mentally competent”; (5) a finding that no other reasonable method of contraception will meet the need; and finally (6) a finding that the severity of the disability is so great that it makes it permanently impossible for the minor to care for or raise a child.

Several cases during recent years show the need for restraint in allowing minors to be sterilized since some parents, social workers, and even physicians may too easily accept the responsibility for a decision that will leave another person sterile for life. In the United Kingdom, in an important case, *In Re D (a minor)*, the English High Court held that non-therapeutic sterilization performed without competent consent of the person sterilized would be a violation of a basic human right and refused to authorize the sterilization, requested by the mother, of an 11-year-old girl. The girl suffered from a condition diagnosed as Sotos’ syndrome, and was somewhat retarded mentally (IQ 80) but, as commonly accepted, had sufficient intellectual capacity to enable her to marry in due course. When the girl reached puberty at the age of ten, the mother was worried that her daughter might be seduced and give birth to an abnormal child. The consulting paediatrician was ready to perform the operation but the court intervened to stop it (61).

The courts in the United States are divided on the question whether, in the absence of a statute authorizing the sterilization of mentally retarded minors, they have the authority to order the procedure (62).

**Concluding remarks**

Voluntary sterilization is widely accepted as a reproductive health measure. This acceptance has been accompanied by attempts to clarify the laws on the subject. The legislation that does exist has sought to regulate the practice in the interests of freedom of choice for the patient by addressing itself to such matters as minimum age, mental competence, informed consent, waiting periods, and screening procedures and criteria.

Except where special therapeutic or eugenic reasons exist, sterilization is not normally available to adolescents. The most pressing legal issue today is that of ensuring that sterilization is “voluntary” in the sense that a person’s decision to be sterilized is informed and unpressured. Of particular interest in this regard are the criteria applicable in the case of the proposed sterilization of a sexually active but mentally incompetent minor.

Stepan et al. recommended that the capacity of a mentally incompetent person to offer consent be decided on an individual basis,
with some provision for a third-party review (49). This represents one of the current enlightened alternatives. Rigid, one-dimensional rules tend not to work. To this can be added the conclusion of the Law Reform Commission of Canada (67):

"Unless safeguards to avoid differential application of the law (which must include on-going evaluation of the application of medical procedures and law) are built in, the victimization of mentally handicapped persons may continue. The state—through criminal law as well as civil proceedings—should try to strike a fine balance in this regard. It must both protect such persons and still give adequate scope for individual choices to be expressed and to prevail. Persons who are mentally handicapped simply constitute a group with special needs. Self-respect, dignity, and self-determination must be guaranteed for each individual, including those with limitation. The law should not only uphold but also enhance these essential human qualities."

Health Care for Pregnant Adolescents

A congressional report in the United States indicated that 40% of all females in the USA become pregnant while still in their teens (64). In the United Kingdom, each year, over 12000 schoolgirls under 16 become pregnant (65). In Portugal, of the 35000 adolescents who become pregnant each year, 22% are unmarried at the time of the birth and the crude birth rate for women under 20 increased from around 26 per 1000 in 1960–65 (66) to 43.37 per 1000 in 1976. Fertility among adolescents varies from country to country. In Mexico, most women marry before the age of 20 and have their first child while between the ages of 18 and 20. In Turkey, births to women under 20 account for 11% of all births. In Thailand, in 1972, the figure was 9.6%, and in Indonesia it is about 2%. Illegitimacy is a factor in some settings. Fully 40% of births to women under 20 in Hong Kong are illegitimate (6).

Adolescent pregnancies are often associated with high obstetrical risks because adolescents tend not to seek care, even when it is easily available, until late in pregnancy. Complications resulting from adolescent pregnancy are frequent and include anaemia, toxaemia, hypertension, and premature labour. A recent survey in the United Republic of Tanzania found that, as observed elsewhere, antenatal complications were much higher in a group of first-time mothers aged 15 and under than for women aged 21–25 (67).

Toxaemia is one of the major causes of maternal death and is most often seen in very young mothers. In the developed countries it accounts for 25–35% of all maternal deaths; the rates are probably higher in the developing world (68). As a WHO Expert Committee pointed out, pregnancy-related complications “are among the main causes of death in 15–19 year-old females” in many developing countries and the “death rate from causes related to abortion and delivery [is] particularly high in girls below 18 years of age” (69). Nortman has calculated that the
average maternal mortality rate for women under 20 in 11 high-mortality developing countries is 50% higher than the rate for women in the age group 20–24 (70).

General legislative schemes

There is every reason to believe that most pregnant adolescents, whether married or not, carry their pregnancies to term. The general policy pursued in all countries is one that encourages motherhood and seeks to protect the health of pregnant women. This type of health care is usually provided by the maternal and child health programmes which are part of the reproductive health care network, but it has also been made available in some countries by “family-oriented centres”.

The measures adopted in Denmark and Mongolia are perhaps typical of the former approach. When the Pregnancy Hygiene Law of 1966 was amended, antenatal and postnatal health care were made available free of charge as part of the Danish national health care system. In addition, specialized homes have been established as part of the social assistance scheme for pregnant women and mothers who find themselves in difficult circumstances during the period surrounding childbirth. In Mongolia, maternal health is protected through a network of consulting rooms, maternity homes, sanatoria, and rest homes for pregnant women.

In Luxembourg, more detailed legislation on the subject exists. Under the Law of 15 November 1978, special centres were established to provide counseling and services connected with sexual matters. Among the duties of these centres is that of providing information on the “rights, assistance, and benefits guaranteed by law to families and to married and unmarried mothers” (Article 5). The centres may provide medical care that does not require hospitalization (Article 6), and both services and medication are free of charge to minors (Article 8).

In Italy, family counselling and service centres were established by Law No. 405 of 29 July 1975. This brought maternal and child health and family planning services under one roof. The recent change in the abortion law curiously reinforces the role of these centres in assisting pregnant women and underscores the overriding policy in favour of motherhood. Law No. 194 of 22 May 1978 speaks of “the social protection of motherhood” and specifies that the centres are required to: (1) inform pregnant women, including minors, of their legal rights to social, health, and welfare services; (2) inform them of the ways in which they can take advantage of “labour legislation designed to protect the pregnant woman”; (3) take special action or suggest that other agencies do so whenever pregnancy or motherhood create problems of a special nature; and (4) eliminate those “factors which might lead the woman to terminate her pregnancy” (Section 2). Similar arrangements exist in France and Iceland.
Legislation on care in pregnancy

Legislation on the health care of pregnant women may be characterized by its lack of any specific reference to the problems of adolescents. The legislation, in the main, deals with the broader aspects of maternal health, irrespective of age or marital status. Hence, the care made available to minors is automatically subsumed by the larger programme catering to the health needs of all pregnant women. There are, however, a few exceptions to this general approach. These take two basic forms, one aiming at the development of special programmes for adolescent women and the other at making it easier for adolescents to gain access to existing services during pregnancy. Both forms may be illustrated by reference to the situation in the United States.

The Federal Adolescent Health Services Pregnancy Prevention and Care Act of 1978 begins with a statement to the effect that “pregnancy and childbirth among adolescents, particularly young adolescents, often result in severe adverse health, social, and economic consequences”. The Act created a grant programme for the establishment of a network of community-based agencies to provide such “core” services as pregnancy testing, ante- and postnatal care, family planning and specialized counselling. According to the legislation, one of the purposes of such a programme is to “enable pregnant adolescents to obtain proper care and assist pregnant adolescents and adolescent parents to become productive independent contributors to family and community life”. The scheme provided remedial health and social services to pregnant adolescents and adolescent parents, but focused primarily on people 17 years of age and under. In 1981, the Public Health Services Act was amended, in Title X, to accommodate what were called Adolescent Family Life Demonstration Projects. Among other things, it prohibited agencies receiving federal funds from providing information concerning pregnancy termination or from referring the adolescent concerned or her parents to programmes that could supply such information and services. Under the programme, funds were made available so that counselling could be given to the adolescent to encourage her to carry the pregnancy to term, including information on adoption, should the adolescent mother not want to care for the child herself.

A number of states have enacted statutes that permit all or some minors to consent to health care relating to pregnancy. This eliminates the problem that health care providers often have to face as to whether to seek parental consent. The usual patterns have been either to permit adolescents to consent to medical care only for problems endemic to adolescence, including pregnancy-related care, or to permit them to consent to all types of medical care. Where the age limits for consent have been specified, they vary from 12 to 18 years. Some legislation focuses particularly on the “unmarried”: the California Civil Code, Section 34.6, permits “an unmarried pregnant minor” to consent to all types of care related to the pregnancy. If pregnant teenagers have the right to consent to treatment, it is easier for them to gain access to existing health care services, public as well as private.
The whole subject of health care for pregnant adolescents must be put in perspective. WHO has estimated that between 60% and 80% of all births take place in the absence of formally trained health personnel (71); systematic health care for pregnant women in many parts of the world is thus largely non-existent. In these situations, the reproductive aspects of health care are attended to, if at all, by traditional health care providers, such as the traditional birth attendant.

In countries where health facilities are available, legislation has tended not to focus on the special needs of adolescents; by and large, services are aimed at all women without distinction of age, and few are geared specifically to young people.

Conclusions

The diversity of laws and policies relating to adolescent sexual behaviour is so great that it is difficult to make generalized statements that are universally applicable. However, a few points may be noted.

First, ready access to reproductive health services is a basic need of adults and adolescents alike. Any programme providing such services to adolescents should endeavour to fulfil two specific requirements: (1) to provide care to adolescents who need it, ensuring that they are fully informed of all the foreseeable consequences of such care; and (2) to clarify the position of health care personnel providing treatment to minors, through appropriate legal and educational processes. Often, health care providers refuse to treat minors without parental consent, unless the law clearly allows it. When faced with unclear laws, health personnel will tend to interpret them in a way that minimizes or eliminates the risk of legal proceedings, a situation which may not serve the best interests of the adolescent.

Second, the problem of who can consent to health care of a minor is important. The competing interests are difficult to balance and vary from country to country. In many cases, adolescents may be sufficiently mature to consent to health care related to fertility regulation. Nevertheless, it would be foolish to disregard totally the role of adults. In many areas of the world, it may be impossible to confer on minors full powers of decision in matters of sexuality and fertility. Nothing can be gained by isolating parents and spouses from such decisions, as they also may have a positive contribution to make. While adolescents must be provided with education on responsible sexuality, parents must also be educated as to appropriate roles they may play.

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40. 4 California reporter 3d 873 (1971).
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47. 448 U.S. 297, at 316 (1980).
52. Statute of Physicians, Section 81 (see 51). There is some question as to whether this provision still applies, for the following two reasons: first, Article 150 of the Penal Code, as amended in 1982, appears to approve therapeutic sterilization (Decree Law No. 401/82 of 23 September 1982); second, resolution of the Committee of Ministers of the Council of Europe No. (75) 29, which Portugal supported, approves sterilization as a means of family planning.
53. Criminal Code, Section 91 (see 51).
54. Section 22. A question did arise as to whether sterilization had, in fact, ceased to be a crime. A Dr Concini was prosecuted, and acquitted, in a case brought to test whether continuation to be a crime under other sections of the criminal law.
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7. Health Care for Sexually Transmitted Disease

Despite advances in therapy and prophylaxis, sexually transmitted diseases remain endemic in many parts of the world, and many strains of pathogens resistant to antibiotics are emerging. While the full extent of the problem of sexually transmitted disease, particularly syphilis and gonorrhoea, is unknown, increases in the incidence of gonorrhoea, some quite dramatic, have been observed in all continents (7, 2).

Data available from the industrialized countries point to adolescents and young adults as a high-risk group (3). In Italy, where the law requires that cases of sexually transmitted disease be reported, 16% of all cases reported during 1973 were in males between the ages of 14 and 26; 18% were in females in the same age group. By 1976, 14% were males of that age—a slight decrease—but fully 25% were young females (4). In Colorado (USA), 92% of the individuals treated for gonorrhoea are between the ages of 17 and 26 (4). In Mexico, during 1972, fully 30% of those aged 15–19 treated in hospitals had sexually transmitted disease (4).

Evidence from a few countries where reporting procedures are reliable indicates that, between 1966 and 1972, the incidence of gonorrhoea doubled for males and tripled for females in the age groups 15 years and under and 16–17 years. The incidence in the 16–17-year age group was between 50 and 80 times greater than in the under-15s (5).

Two recent WHO reports note that the prevention and treatment of sexually transmitted disease is an adolescent health problem worthy of special attention. The first, Health needs of adolescents (6), noted that the health aspects of sexually transmitted diseases, among other things, are of concern to adolescents as they embark on sexual experience, and recommended that adequate services be established to cope with what has become a major adolescent health problem. The second, a report of a ten-country WHO survey designed to ascertain the health problems associated with adolescent sexual and reproductive behaviour, noted that in countries as disparate as Czechoslovakia, Mexico, and Thailand, the high incidence of sexually transmitted disease among adolescents represented a particularly important problem for the health services (4).

Over a 20-year period three studies have been published on the subject of legislation on the control of "venereal disease": the first in 1956 (7), the second in 1964 (8), and the third in 1975 (9). The latest survey noted that "in contrast to numerous other communicable diseases, venereal diseases continue to be covered by specific legislation". In addition to
provisions prescribing general prophylactic and therapeutic measures, reference is also made to such diseases in other items of legislation dealing with, for example, the control of prostitution, premarital and antenatal examinations, blood donors, and wet-nurses.

**General Legislative Framework**

Legislation on sexually transmitted disease control does not usually focus specifically on any particular age group or sex, but tends to apply to all persons who are to undergo or carry out diagnosis or treatment. Before the provisions specifically affecting minors are considered, a brief word is necessary on the general provisions as they affect patients and doctors.

**Obligation to undergo treatment and disclose contacts**

The obligation to undergo treatment is fundamental to the control of sexually transmitted diseases. Legislation always reflects this fact by making it compulsory for any person who is aware or believes that he is suffering from such a disease to seek treatment. This is buttressed by a requirement that the treating physician inform the patient of his duty to comply with treatment.

As one of the aims of legislation in this field is prevention, many countries require patients found to be suffering from a sexually transmitted disease to disclose, if possible, the source of the infection and the names of any sexual contacts who might have transmitted the disease or been exposed. Such a requirement may lead to some degree of personal embarrassment, but is essential if control activities are to be effective.

**Notification**

In most countries, another important feature of the legislation is the requirement that confirmed cases be notified or reported to the health authorities. The usual pattern is to keep the notification anonymous, but in Colombia the name of the patient must be given. The general view seems to be that, by keeping the notification anonymous, some of the stigma is removed and individuals are more likely to seek treatment, though some of this advantage may be lost when the person is also required to disclose the possible source of the infection. A few countries, including the Netherlands, New Zealand and the United Kingdom, have dispensed with the notification requirement. Where a person refuses to undergo examination or treatment, however, it is usually required that his name be reported to the health authorities and at that point anonymity is lost (9).
Premarital examinations

A number of countries require individuals who are about to enter into marriage to undergo an examination designed to confirm the absence of specific diseases, including those transmitted sexually. In the main, individuals are tested for syphilis. If evidence of the disease is found, the marriage cannot be contracted until the patient has undergone treatment and is no longer infective.

Criminal sanctions

The transmission of sexually transmitted disease intentionally, or in some cases through negligence, is a penal offence in many countries. It may be punished by either a fine or imprisonment. Hence, anyone who knows or has reason to suspect that he has such a disease and who willfully exposes others to it, can be prosecuted. Laws of this type are in force in many countries, including Costa Rica, France, Greece, Guatemala, New Zealand, and Sweden (9).

Access to Treatment

Faced by the growing incidence of sexually transmitted disease, especially among young people, a number of countries have enacted legislation that expressly authorizes treatment for minors. Some of these predate recent concerns about what has been called the “VD epidemic”. These laws are of three types.

First, some laws enable all minors, irrespective of age, to consent to treatment for sexually transmitted disease. In the United States, for example, though the minimum age for consent for medical care is usually 18, special legislation in at least 40 states has made it possible for minors of any age to consent to health care for such disease (10).

Second, some laws establish a minimum age at which minors can seek out and consent to treatment. In Minnesota, for example, minors aged 12 years or older may consent to care and counseling related to the diagnosis and treatment of sexually transmitted disease. The same age has been chosen in California, Illinois, Oregon, and Vermont, whereas 14 is the minimum age in Alabama, Hawaii, Idaho, New Hampshire, North Dakota, and Washington (11).

Third, laws in many countries require parental approval before minors can receive treatment for sexually transmitted diseases. Where this is the legal position, it is usually part and parcel of the general rules on medical care and treatment, whereby treatment of anyone below the age of majority is subject to parental consent. Some laws, however, do contain special provisions that require parental consent for minors. In Ontario (Canada), parental consent is required for anyone under the age of 16. As has been pointed out above, treatment for sexually transmitted
disease is usually compulsory. This raises the question of whether parental consent is necessary if the state prescribes that those concerned must be treated.

Responsibility for Ensuring that Minors Obtain Treatment

Once sexually transmitted disease has been diagnosed in a minor, legislation frequently sets out certain duties for both the physician and the patient's parents or legal representative, some discretionary, some compulsory. For example, in France, if a physician diagnoses or treats a minor for such a disease, he must inform the patient of the treatment to be followed; it is left to his discretion whether to inform the parents or other individuals. The physician must decide which course of action is in the best interests of the minor. In Hawai'i, parental notification, if possible, is required. In the German Democratic Republic, the parents or legal representatives must be informed, and treatment is compulsory. In Romania, if a minor is suffering from sexually transmitted disease, either the parents, guardians or the individuals with whom he dwells must ensure that treatment is pursued until the cure is complete. If the minor is in an institution, the physician employed in that establishment must ensure that the necessary care is provided. In Liberia, too, those having parental responsibility for persons under 18 must ensure that they are examined and treated for sexually transmitted disease when necessary.

In Sweden, under the Communicable Disease Law of 1968 (as amended), if the patient is under 18, the doctor may inform the patient's legal representative of the situation, if he feels it to be necessary. If the patient, because of some physical or mental disability, is unable to comply with the treatment required, it is the duty of the physician to inform the legal representative of the measures to be taken.

Some laws also contain special provisions affecting minors and young adults, aimed principally at preventing and detecting sexually transmitted disease. In Romania, the law requires medical examinations for students in their last year of secondary school, as well as prior to admission to higher education. Special efforts are also made at polyclinics and dispensaries that serve students. In communities having a high incidence of sexually transmitted disease, special testing is required for individuals in the age group 15–30 years, for whom the risk is greatest.

Conclusions

Although many countries have legislation on the control of sexually transmitted disease, this is rarely concerned specifically with adolescents. In those countries where the subject has been dealt with, two diametrically opposed approaches have been adopted, the first being designed to make it easier for adolescents to gain access, on a confidential basis, to the necessary health care. Such legislation has
HEALTH CARE FOR SEXUALLY TRANSMITTED DISEASE

typically granted minors below the age of majority the power to consent to such treatment without the necessity of parental intervention. The second approach requires parents or guardians to ensure that adolescents suffering from venereal disease undergo treatment.

Many of the summarizing comments found in the previous three chapters are applicable here. The threat to health constituted by sexually transmitted diseases is a significant one, and the recent increase in herpesviral infections and the emergence of acquired immunodeficiency syndrome (AIDS) have recaptured the attention of public health officials in many parts of the world. There is a need for preventive education and care for sexually transmitted diseases, especially for adolescents. Developments in the pattern of diseases may be outstripping the arrangements made for their prevention and treatment, and the laws and policies relating to this topic could benefit from review and updating.

References and Notes

10. See, e.g., Texas Family Code Annotated, Title 2, Section 35.03 (pregnancy, venereal disease and drug addiction) (Vernon, 1978).

Legislation

Canada

Ontario

An Act to amend The Venereal Diseases Prevention Act (Dated 9 July 1971) [IDHL, 24: 87 (1973)].

"For the sake of concision, international digest of health legislation is abbreviated throughout to IDHL."
France

German Democratic Republic
Ordinance of 23 February 1961 on the prevention and control of venereal diseases [Section 4(3)] [JDHL, 13: 688 (1962)].

Greece
Law No. 3370 of 13 July 1955 on control of venereal disease [Section 2(2)] [JDHL, 9: 511 (1958)].

Liberia
Liberian Code of Laws, Title 33 (Public Health) (Section 16.4) [JDHL, 31: 49–64 (1980)].

Romania
Instructions No. XII/Cl.2758 of 24 July 1970 (Section 1) [JDHL, 23: 318 (1972)].

Sweden

Uganda
The Venereal Diseases Decree, 1977 [JDHL, 29: 482 (1978)].

United States of America
Minnesota
Minnesota Statutes Annotated (Section 144.345).

Texas
Texas Family Code Annotated, Title 2 (Section 35.03).
8. Smoking

Cigarette smoking has been repeatedly characterized as one of the greatest health hazards of modern times (7), albeit an avoidable one. It has been known for some time that long-term, heavy smoking plays a major role in the development of a number of life-threatening, disabling diseases in adults, including lung cancer, emphysema, chronic bronchitis and coronary heart disease (1, 2). A WHO Expert Committee recently estimated that cigarette smoking is in some way linked to more than a million premature deaths each year worldwide (3).

According to the WHO Expert Committee on Smoking Control (4), there is increasing evidence that smoking in childhood and early youth:

... results at a very early stage in an increase of cough and sputum, more complications from infections of the upper respiratory tract, and a greater degree of ventilatory impairment. At least in the early stages the lung damage is reversible. If smoking persists, the damage is likely to progress and chronic bronchitis in the familiar adult form may manifest itself. The earlier the age at which a child starts to smoke, the greater is his or her chance of having a less healthy life and of dying prematurely.

The data from the United States shown in Table 7 confirm that the earlier a person begins smoking, the greater the risk of dying from lung cancer. Evidence is also accumulating that "passive smoking"—mere exposure to cigarette smoke—is a factor in the development of lung cancer and other health problems among non-smokers, including children whose parents habitually smoke (3).

The relationship between smoking and increased risks to health has served as the basis, theoretical as well as practical, for the efforts to "combat the world smoking epidemic" (5), particularly among young

| Table 7. Lung cancer mortality ratios for males by duration of cigarette smoking |
|---------------------------------|-----------------|
| Age began cigarette smoking (years) | Relative risk |
| Non-smoker                      | 1.00           |
| >= 25                           | 3.21           |
| 20-24                           | 9.72           |
| 15-19                           | 12.51          |
| < 14                            | 15.10          |

people. As one WHO Expert Committee declared (1): "the encouragement of young people not to take up smoking—as the one certain protection against the health hazards of cigarettes—is of vital importance". Another Expert Committee (2) pointed out that “action to prevent smoking is aimed at all people, but is especially an expression of concern for the health and wellbeing of children and young people", and that the measures recommended were “designed primarily to protect children". The report pointed out that “many of them will, unless action is taken, take up the habit while they are still young, uninformed and unable to understand its dangers”. The importance of the adolescent population in any serious, widespread effort to combat smoking is shown by the statistics on youth and tobacco use in a number of countries (see Fig. 1), though the patterns vary and in some countries are changing. More is known about the situation in the developed than in the developing world.

In Denmark, in 1972, 40% of 14-year-olds smoked daily. Though this percentage has since declined for boys, the percentage of girls and young women who smoke had increased by 1981 (6). Denmark is one of several developed countries showing a crossover pattern in prevalence for boys and girls. Between the ages of 12 and 13 the rate for girls is higher; between ages 15 and 16 that for boys becomes higher. Figures for the Federal Republic of Germany indicate that nearly half of all young people who smoke begin between 12 and 14 years of age, with boys starting earlier than girls. This situation has changed very little since 1976. Though there has been a slight drop overall in smokers in the age group 14-25 years since 1973, the proportion of habitual smokers in the 18-30-year-old bracket has gone up (6).

**Fig. 1. Approximate percentage of smokers in selected countries by age and sex.**

In Italy, consumption surveys reveal that the age at which the first cigarette is smoked continues to fall, so much so that most boys and girls of 15 can be considered habitual smokers (6). Italy is an example of a developed country in which the problem of smoking among young people—indeed, among the whole population—continues to worsen; not only are young people beginning to smoke earlier, but consumption of tobacco in Italy has risen steadily over the years (6).

A report issued by the Surgeon General of the United States (2) indicated that, although there was a decline of about 25% in the number of teenage smokers between 1974 and 1979, an increasing proportion of all smokers were young people, many of whom had begun smoking by age 12 (8). The 1979 figures show a decrease in the number of teenage smokers but an increase among young women aged 17–18 years (Fig. 2). Among boys of 15–18, the prevalence of smoking in 1979 was lower than in 1969 (9) and for the age group 17–19 a greater percentage of women than men were smokers (10). Moreover, studies show that 75% of all smokers in the USA have acquired the habit by the time they reach the age of 21 (8).

Also alarming are recent statistics from Belgium and France. In the former, a survey of young people between the ages of 11 and 15 showed an increase in the percentage of smokers from 11% at age 11 to 50% at age 15 (11). In the latter, statistics show that 30% of young people between the ages of 10 and 17 smoke (12). Of the French smokers who took part in one study, 43% said that they acquired the habit between the ages of 10 and 12 (12).

On the whole, though, developed countries have at least begun to address the problem of smoking among young people. Some recent data are encouraging. The Swedish National Board of Education has conducted surveys that indicate a constant decrease from 1974 to 1980, in the proportion of schoolchildren who smoke (9) (Fig. 3). Figures from the Netherlands and Norway show an inconsistent series of small

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**Fig. 2. Trends in prevalence of cigarette smoking for boys and girls in the USA**

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reductions in the numbers of children who smoke. And, as one recent publication points out (11):

Norway and Sweden are noted for vigorous anti-smoking campaigns, the former attacking the problem in a comprehensive fashion and the latter, of course, mounting the world-renowned programme "Generation of Non-smokers".

The effects of smoking on health, have, until recently, been mainly a concern of developed countries (13). A message to the Fifth World Conference on Smoking and Health of July 1983 from Dr H. Mahler, Director-General of the World Health Organization, pointed out that smokers are now a minority in many industrialized countries, and that there has been a significant decrease in the number of young smokers. In contrast, a marked increase in smoking seems to be occurring in developing countries, where tobacco companies have employed aggressive marketing techniques (3, 34).

The WHO Expert Committee on Smoking Control warned as early as 1979 that, if forceful government action was not taken promptly in developing countries, the smoking epidemic would spread to affect their populations with the numerous smoking-related diseases even before communicable diseases and malnutrition had been brought under adequate control (4).

It is particularly in the developing countries that the habit of smoking is acquired at a very young age. In China, one quarter of males
SMOKING

Data from India, based on samples sufficiently large to offer stability, show an average of 11.7 years for beginning to smoke. Nigeria reports the habit as beginning between 12 and 16 years of age. In Argentina, data from a large sample of differing social classes in La Plata gave the age of initiation for boys as 11-12 with girls beginning two years later. Thus sizeable percentages of children around the world are becoming regular smokers by the time they reach early adolescence with a high probability of remaining smokers for life.

Masironi & Roy of the WHO International Clearinghouse on Smoking and Health Information have put together other data that describe the prevalence of smoking among youth in developing countries. As a general rule, rates are higher for males than females. The highest rates are found in Senegal where, among the school-going population between ages 10 and 21, 71% of the males and 52% of the females smoke; of youths aged 12-21, fully 87% smoke. In Ethiopia, 22% of males aged 12-18 smoke, as do 35.7% of those aged 18-21 years. In Jamaica, 21.7% of the males polled in Kingston smoked. The rates in Egypt are lower: 8.7% of urban youth between 10 and 20 years of age smoke as compared with 6.3% of their rural counterparts. Data gathered on schoolchildren in India, particularly males, show an increase in rates with age: at age 13 years 4.1% smoke; by age 20, 26.7% admit to smoking. Papua New Guinea is the only country where data indicate that prevalence among females (11.0%) is greater than among males (6.0%) in the age group 15-20 years (13).

Child smokers have consistently demonstrated less knowledge about the health hazards of smoking than non-smokers. For a variety of complex sociological and psychological reasons, it is quite difficult to convince young people of the seriousness of either the short- or long-term risks associated with cigarette smoking (1). Part of the difficulty lies in the fact that certain modes of behaviour are endemic to adolescence (experimentation, rebellion, etc.); there are also other factors that induce the young to smoke. Three significant factors, according to the literature, are peer pressures, sibling exposure, and employment outside the home.

According to Wake et al. (7), peer pressures — subtle or direct — are often successful in inducing smoking:

... since the young person, involved in an effort to establish independence (by breaking away from the authority of parents) feels a strong need for support somewhere and thus is willing to submit to group wishes simply to maintain the group's backing for independence. (It is one of the great paradoxes of childhood that the individual child or youth will, in an effort to establish independence from the family become very dependent on the group—and not even recognize the paradox.)
In some settings peer pressures combine with the notion of "machismo", characterized by independent, risk-taking behaviour, to induce smoking. "Machismo" is thought to be a very important factor in promoting smoking among boys in South America. Smoking itself is considered a symbol of modernity in Africa, and is taken up as a deliberate imitation of film stars in India.

Siblings and parents are not in the strictest sense peers, yet evidence is emerging that they exert considerable influence on the behaviour of the young in the family. The Surgeon General's Report in 1979 (2) observed, for example, that in the USA at least two major surveys point to "the smoking behavior of older siblings as a possible influence on younger children". The report goes on to support that inference by noting that, for the USA, the data suggest that if "an older sibling and both parents smoke, the child is four times as likely to smoke as a child who has no smoking model in the family".

Employment outside the home also appears to have a direct influence on smoking behaviour. Though the reason for this is at present somewhat speculative—the literature suggests that socioeconomic factors as well as educational status may have something to do with it—it is known that in the USA teenagers who work outside the home are twice as likely to smoke as those who are not engaged, despite the fact that some employers have begun to exclude smokers from their work-forces (2). The relationship between employment and smoking is not limited to the so-called industrialized countries. Wake et al. (7) state that:

One very direct pressure to smoke comes from employers in some parts of the world (e.g. Africa) who will smoke half a cigarette and reward the employed youth with the other half. Or offer a 'bidi' (a cigarette made of local tobacco, rolled in a "cannabis" tree leaf) to attract a youth to work (e.g., India).

The question that remains is: what can be done to address the issues raised by the points detailed above? It has been recognized that a variety of legislative measures aimed at combating smoking, if combined with vigorous and widespread health education activities, may significantly reduce the incidence of cigarette smoking (14). The WHO Expert Committee on Smoking and its Effects on Health in 1975 (1) reiterated the conclusion of a report on smoking and health to the Twenty-third World Health Assembly in 1970, that measures aimed at the "control of cigarette smoking could do more to improve health and prolong life... than any other single action in the whole field of preventive medicine". However, somewhat surprisingly (especially in view of the medical evidence concerning the health risks related to smoking), the same Committee found that at that time most countries had not enacted any legislation on the subject. Thus, most of the legislation that now exists is comparatively recent. There now appears to be a trend towards introducing anti-smoking legislation. Roemer (14) summarized the strategies that may be followed in enacting legislation, and noted that,
as of 1982, at least 57 countries had promulgated either legislation or regulations that addressed, *inter alia*, the problems of cigarette advertising, sales, information, and/or education. The different regulatory measures that can be found in such legislation include:

- control of advertising and sales promotion;
- health warnings and statement of tar and nicotine contents of cigarettes;
- control of harmful substances in tobacco;
- restrictions on sales;
- restrictions on smoking in public places;
- restrictions on smoking in the workplace;
- preventing young people from smoking;
- mandatory health education on smoking; and
- fiscal and economic measures.

Many of these regulatory measures have an impact, in one way or another, on the problem of adolescent smoking but we shall concentrate here on those measures that most directly influence smoking habits among the young. Roemer (14) notes the following five adolescent-oriented measures:

(a) prohibition of sale of tobacco products to minors;
(b) restrictions on sale of cigarettes from automatic vending machines;
(c) prohibition of smoking in schools or other places frequented by young people;
(d) prohibition of smoking in public by children and adolescents; and
(e) prohibition of cigarette advertising at times and in places that are likely to have an influence on children and adolescents. To this list may be added mandatory health education on smoking and mandatory health warnings on cigarette packages. We shall briefly examine all of these.

**Prohibition of Sales to Minors**

Any effort to reduce the incidence, and hence the harmful effects, of cigarette smoking must include a component directed to young people. The prohibition of the sale of tobacco products to some or all minors seems to be one of the more potent weapons in any anti-smoking arsenal. The most recent WHO Expert Committee to look into the matter stated unequivocally that "there should be legislation to prohibit all sales of tobacco products to minors" (3). Despite the fact that such a prohibition was one of two basic rationales for anti-smoking legislation in the period 1890–1960 (together with fire prevention), as of 1982 only a few countries—15 according to the information available—had banned cigarette sales to persons under 16 (14).

Of this type of legislation with its long, if not entirely successful, history, Roemer writes (14):
Illustrative of the early legislation to ban sale of cigarettes to minors is the District of Columbia Ordinance of 1890 prohibiting sales to minors in the capital city of the United States. In 1899, Norway prohibited the sale of tobacco to children under 15 years of age. In Canada, the Act to restrain the use of tobacco by young persons was passed in 1908, prohibiting the sale or furnishing of cigarettes to persons under 16. New Zealand, under the Police Offences Act of 1927, imposed a fine for selling cigarettes to persons under 15. In Italy, Article 730 of the Penal Code prohibited the sale of cigarettes to persons under 16. In the United Kingdom, the Children and Young Persons Act of 1933 contains a stringent provision against selling tobacco products to persons apparently under the age of 16. A similar provision in Scotland, now incorporated in the Children and Young Persons (Scotland) Act of 1937, was first enacted in the Children Act of 1908. The motivation for these measures was probably the wish to protect both health and morals. In fact, an interesting law enacted in Japan in 1900 banned smoking by persons under the age of 20—a measure designed to uplift the morals of young people.

Minimum age

In those few countries that do impose a ban on the sale of cigarettes to the young, there is considerable variation in the age at which such a ban is applied. In a number of countries, including Bulgaria and Switzerland, the legislative provisions simply refer to "minors" or to "children and minors". The age of majority is still 21 in many countries, although there is a trend to lower it to 18. Other statutes, by contrast, specifically set an age, which is often below the age of majority. In Norway (which, in 1899, was the first country to pass legislation prohibiting the sale of tobacco to children) and in Finland, the ban on the sale of tobacco products applies to persons under the age of 16 (15); in New Zealand, the applicable prohibition applies "to any youths under 15 years of age" (1) (see Table 8).

Table 8. Legislation prohibiting the sale of tobacco to adolescents

<table>
<thead>
<tr>
<th>Country or territory</th>
<th>Minimum age</th>
<th>Products whose sale is prohibited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>16</td>
<td>Cigarettes</td>
</tr>
<tr>
<td>Bophuthatswana</td>
<td>16</td>
<td>Cigarettes, tobacco or its products</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>16</td>
<td>Tobacco products, cigarette papers, and tobacco in any form</td>
</tr>
<tr>
<td>Canada</td>
<td>16</td>
<td>Tobacco products, cigarette papers, and tobacco in any form</td>
</tr>
<tr>
<td>Finland</td>
<td>16</td>
<td>Tobacco</td>
</tr>
<tr>
<td>Italy</td>
<td>16</td>
<td>Tobacco</td>
</tr>
<tr>
<td>Japan</td>
<td>20</td>
<td>Tobacco or appurtenances</td>
</tr>
<tr>
<td>New Zealand</td>
<td>15</td>
<td>Cigarettes, cigar or tobacco in any form</td>
</tr>
<tr>
<td>Norway</td>
<td>16</td>
<td>Tobacco products, cigarettes, cigar or tobacco in any form</td>
</tr>
<tr>
<td>Poland</td>
<td>16</td>
<td>Nicotine products</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>16</td>
<td>Cigarettes</td>
</tr>
<tr>
<td>Switzerland</td>
<td>16</td>
<td>Tobacco</td>
</tr>
<tr>
<td>USSR</td>
<td>16</td>
<td>Tobacco</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>16</td>
<td>Tobacco (in cigarette form) or tobacco products</td>
</tr>
<tr>
<td>United States</td>
<td>16</td>
<td>Cigars, cigarettes or tobacco</td>
</tr>
<tr>
<td>Utah</td>
<td>16</td>
<td>Cigars, cigarettes or tobacco in any form</td>
</tr>
</tbody>
</table>

In the United States, there is no national law on this subject and hence no uniformity in the minimum age. However, in most of the states, legislation has been enacted that prohibits the sale (and in some cases the furnishing) of tobacco products to persons below a specified age (16). Many of these state statutes set the minimum age at 18, or simply prohibit sales to “minors” who, in most states, are defined as persons below the age of 18. The lowest minimum age for tobacco sales established by any of the states is 15 (Hawaii and Maryland); the highest is 19 (Utah and Washington) (16).

An interesting and apparently unique provision is that in Michigan, where a general minimum age of 18 is set, but tobacco products may be sold to minors with parental consent at age 17.

Sale, distribution and supply

Differences also exist between countries in the rules governing the circumstances surrounding distribution. The least restrictive statutes prohibit only the sale of tobacco products to those below a specified age. This “sale only” legislative model is found, for example, in Bulgaria and in several states in the USA. Much more restrictive are the statutes that prohibit not only the sale of tobacco products but also, as in Finland and New Zealand, the supply of tobacco products to underaged people. Under the Norwegian legislation of 1973 “it is prohibited to sell or hand over tobacco products or imitations which may prove an encouragement to the use thereof to persons under 16 years of age”. Similarly, a statute enacted in the state of Alaska in 1978, as part of the Criminal Law, provides that a person aged 19 or older who “knowingly sells, exchanges or gives cigarettes, cigars, or tobacco to anyone under sixteen years of age” commits a criminal offence. Where legislation covers the “furnishing”, “exchanging”, “supplying”, “giving”, etc. of tobacco products, non-commercial as well as commercial transactions are, of course, within the scope of the prohibition.

Questions may arise from time to time as to whether the law prohibits the sale of cigarettes or other tobacco products to a minor for use by an adult. Most of the existing legislation does not address this question, although in a particular country, existing judicial or administrative interpretations may be relevant to this issue. In the United States, for example, the New York Penal Code, which prohibits the sale of tobacco to persons under 18 years of age, specifically states that “it is no defense to a prosecution pursuant to this section... that the child acted as the agent or representative of another person or that the defendant dealt with the child as such”.

Place of sale

Some countries have begun to prohibit the sale of tobacco in places likely to be frequented by young people. In Bulgaria, the sale of tobacco products is prohibited in educational and health establishments and in
shops within 200 metres of them. Similarly, in the USSR, the establishment of kiosks and shops selling tobacco in the vicinity of schools is prohibited and the legislation is designed progressively to restrict and ultimately to abolish the sale of tobacco in all such commercial undertakings.

One of the major obstacles to the effective enforcement of these bans is the existence of automatic cigarette vending machines. The seriousness of this obstacle to enforcement is compounded, moreover, by the fact that legal sanctions are not generally imposed on the minor who possesses or smokes tobacco products except, perhaps, pursuant to a broad definition of juvenile delinquency or incorrigibility that may exist in some countries.

Where vending machines are common, the age restrictions are simply unenforceable unless the location and operation of vending machines are also regulated. In Finland, where this practical problem has been recognized, Law No. 693 of 13 August 1976 prohibits the sale of tobacco products from automatic vending machines except in catering establishments holding a licence to sell spirits (from which premises, presumably, unaccompanied minors can be excluded) or in other sales establishments in which vending machine sales are made under supervision. Further “bite” has been given to this statutory provision by the implementing regulations, under which automatic vending machines must display a notice that those under 16 are prohibited from using the machine, and such machines may be located in places other than licensed premises mentioned in the statute, only if their use is kept under constant surveillance (see Table 9).

Table 9. Regulation of sales of cigarettes from vending machines

<table>
<thead>
<tr>
<th>Country or territory</th>
<th>Restrictions on sales from vending machines</th>
<th>Responsibility for supervision</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Banned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bophuthatswana</td>
<td>Permitted to those 16 and over</td>
<td>Proprietor of premises</td>
<td></td>
</tr>
<tr>
<td>(South Africa)</td>
<td></td>
<td>where machines kept</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>Permitted to those 16 and over</td>
<td>Proprietor of premises</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>where machines kept</td>
<td></td>
</tr>
<tr>
<td>Cyprus</td>
<td>Banned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>Permitted to those 15 and over</td>
<td>Proprietor of premises</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>where machines kept</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>Permitted to those 15 and over</td>
<td>Proprietor of premises</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>where machines kept</td>
<td></td>
</tr>
</tbody>
</table>

In Cyprus, the use of cigarette vending machines has been banned entirely, making it apparently the first country to do so, and the scope of the Health Protection (Smoking Control) Law of 1980 is extremely broad. It makes any or all of the following an offence: to possess, to have under one's supervision, to allow to be installed or used on premises under one's supervision, to use, operate, import or manufacture any automatic tobacco vending machine (14). In Belgium, a different approach has been adopted and the use of vending machines is prohibited except in places where tobacco products are customarily sold.

Countries in which cigarettes are commonly sold from automatic machines may find it difficult to control their use by children. The problem of surveillance and enforcement has been simplified in France by permitting the sale of cigarettes from automatic vending machines only on a very limited basis.

In Canada, the Tobacco Restraint Act of 1970 makes it an offence to sell cigarettes, cigarette papers or tobacco to persons under 16. The Act also provides that a court may order the person on whose premises a vending machine is being kept to ensure that it is not used by the underaged or to remove the machine if it is being used by underaged persons.

It seems clear, then, that from an enforcement standpoint, an important adjunct to any age restriction on the sale or provision of tobacco products is legislation regulating automatic vending machines. It has been suggested that the sale of tobacco products from vending machines should be prohibited near schools and other places that are regularly frequented by adolescents (1), and should at all times be under the supervision of an individual able to ensure that they are not used by persons who are below the specified minimum age.

Enforcement

It is almost always easier to lay down legal requirements than to enforce them. Although there appears to be a modest trend towards the enactment of legislation prohibiting the sale of cigarettes to young persons, and although such legislation has existed in some countries for nearly a century, basic questions remain as to its practical utility (1,14). As the WHO Expert Committee on Smoking Control (4) pointed out, "if not properly implemented, legislation and other restrictions ... lose much of their value". Roemer (14) also emphasizes this point:

The penalties provided for conviction are often nominal, e.g. $20 in Australia and a maximum of $50 in Canada. Moreover, enforcement is often lax. In the United Kingdom, according to the 1977 report by the Royal College of Physicians of London, a survey in 1975 revealed that out of a random sample of 50 tobacconists' shops in England and Wales, 43 sold cigarettes to children who were obviously under age 16. In a recent five-year period, however, prosecutions for breach of this law averaged only 20 a year.
In truth, not much seems to be known about **how** the young acquire cigarettes; what is known is that they do. A report of the Task Force on Smoking in Ontario, Canada (17), has recommended that studies be conducted on how children acquire cigarettes, and on the effects of enforcing existing or stricter restrictions on cigarette sales to minors. The report assumes that enforcing restrictions on access by young people can reduce their consumption, as has been shown with alcohol. Though it is not known how, exactly, they acquire cigarettes, the report cites evidence to the effect that up to 80% of the cigarettes that children smoke are purchased by the children themselves. If research were to confirm this, enforcement of restrictions on cigarette sales to minors would obviously gain in importance. The Minors' Protection Act, administered by the Attorney General of Ontario, provides that no person may sell cigarettes to a child under 18 (unless it can be determined that the cigarettes are for a parent's use). Fines for this offence range from $2 to $50. Although this legislation has been in effect for many years, the Task Force noted that prosecutions or convictions under the Act are virtually nonexistent. The question remains: What can be done? This will be discussed in detail below, but for the moment it may be sufficient to observe, as do others (7), "that while legislation on, for example, sales of cigarettes to young people may be difficult to enforce, it is also difficult to oppose, and may be a useful first step in committing a government to an anti-smoking stance".

**Prohibition of Smoking in Places Frequented by Young People**

Legislatively imposed bans on smoking in specified premises are one example of the kind of provisions that may help to reduce the exposure of minors to smoking outside the home.

Among the countries that have statutes banning smoking on school premises are Finland, France and Italy. A number of states in the United States have laws restricting smoking in a variety of public places (18), and public (state) schools are often included. The state of Kentucky has enacted legislation on this subject (19) which lays down that:

Any person, except adult employees of the school system who smoke in a room on the school premises designated by the superintendent or principal for the purpose, who smokes a cigarette in any school building or any part of the buildings used for school purposes, or upon school grounds, while children are assembled there for lawful purposes shall be fined . . .

The Federal Republic of Germany prohibits smoking in classrooms and in the Netherlands smoking is banned during lessons at primary and secondary schools and pre-university establishments (16).

Such bans, of course, mean that students are not exposed to the presence of smoking adults, and that students themselves may not smoke. Schools are thought to present a situation in which the presence of teachers as non-smoking adult role models can have considerable influence on young people. One of the issues involved in the control of
smoking in schools is whether teachers should smoke on school premises. Grey & Daube point out that setting aside special smoking areas for teachers leads to similar requests being made for pupils (20).

Smoking in school classrooms is prohibited in Italy, and in Jamaica smoking in schools below university level is prohibited. In Belgium, under a special circular from the Ministry of National Education, teachers cannot smoke while carrying out their duties; smoking is also forbidden in the dormitories of boarding schools (6,14) (see Table 10).

Table 10. Prohibition of smoking in schools and public places frequented by the young

<table>
<thead>
<tr>
<th>Country</th>
<th>Educational institutions</th>
<th>Leisure and recreational facilities</th>
<th>Public places and events</th>
<th>Adolescents in public places</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
<td>Banned</td>
<td>No smoking in public or way to school</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Banned</td>
<td>Banned</td>
<td>—</td>
<td>Banned</td>
<td>Banned in places within 200 metres of schools</td>
</tr>
<tr>
<td>China</td>
<td>—</td>
<td>Banned</td>
<td>Banned</td>
<td>Banned</td>
<td>Students forbidden to smoke</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Finland</td>
<td>Banned</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>50% of space in vehicles for transport of students/youth people reserved for non-smokers</td>
</tr>
<tr>
<td>France</td>
<td>Banned</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Germany, Federal Republic of</td>
<td>Banned</td>
<td>Banned</td>
<td>—</td>
<td>Banned</td>
<td>Banned for those under 16</td>
</tr>
<tr>
<td>India</td>
<td>—</td>
<td>Banned</td>
<td>Banned</td>
<td>Banned</td>
<td>Banned for juveniles in same ages</td>
</tr>
<tr>
<td>Iraq</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>No smoking on buses</td>
</tr>
<tr>
<td>Jamaica</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>Does not apply to university level</td>
</tr>
<tr>
<td>Japan</td>
<td>—</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>Banned for those under 20</td>
</tr>
<tr>
<td>Kenya</td>
<td>—</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Pakistan</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
<td>Ban applies to cinemas only</td>
</tr>
<tr>
<td>Poland</td>
<td>—</td>
<td>—</td>
<td>Banned</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>—</td>
<td>Banned</td>
<td>Banned</td>
<td>—</td>
<td>Bans apply to cinemas and transport</td>
</tr>
</tbody>
</table>
Table 10 (continued)

<table>
<thead>
<tr>
<th>Country</th>
<th>Educational institutions</th>
<th>Leisure and recreational facilities</th>
<th>Public places and events</th>
<th>Adolescents in public places</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>Banned in some schools</td>
<td></td>
<td></td>
<td></td>
<td>In others, special areas set aside for smokers</td>
</tr>
<tr>
<td>Thailand</td>
<td></td>
<td>Banned</td>
<td>Banned</td>
<td></td>
<td>Bans apply to cinemas and public transport</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td>Banned for those under 16</td>
<td></td>
</tr>
<tr>
<td>United States of America</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adult school employees may smoke in designated areas</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Banned while school in session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td></td>
<td></td>
<td></td>
<td>Banned for those under 18</td>
<td></td>
</tr>
</tbody>
</table>


a Depending on national rules, may include such places as nurseries, schools (public and private), day care centers, nurseries, Italy, Portugal, Romania and Turkey also ban smoking in schools.

b Depending on national rules, may include such places as theaters, youth camps, holiday centers, hostels, swimming pools, and other sports facilities.

c Depending on national rules, may include such places as cinemas, public transport, and public byways.

The national legislation restricting smoking in schools, for all its range and variety, forms only a part of the controls imposed on this activity; smoking in schools is often governed by local policy determined on a regional or community basis or by individual schools (14).

The Finnish and French statutes contain a number of additional "premises bans" which also specifically refer to minors. In France, there is a prohibition on smoking not only on school premises but also on premises that are used for leisure or holiday accommodation for anyone under the age of 16; in public road transportation vehicles, a smoking area may be set aside for those over 16 if measures to prevent the spread of smoke are taken. In Finland, an additional "premises ban" extends to "indoor public entertainments for children or young people . . . to which children of school age or younger have access", except that smoking may be permitted in a designated part of such premises.

Bulgarian Ordinance No. 2 of 1980 specifies a large number of public places where smoking is prohibited, including educational establishments, sports premises, hostels and youth establishments.
Prohibition of Smoking by Young People in Public Places

In some jurisdictions, all or most public smoking is forbidden to youth. In the Federal Republic of Germany, the law on the protection of juveniles prohibits persons under the age of 16 from smoking in public (6). The state of Michigan in the United States makes it a criminal offense for a young person under the age of 18 to smoke or use cigarettes, in any form, in "public" places, that is, on public highways and streets, in alleys, parks, and on other lands used for public purposes, or in a public business or amusement place (14). Other jurisdictions restrict smoking in public for the whole population, youth and adult. In Kenya, for example, the Minister for Health announced in 1980 that smoking in public places was prohibited since it created a "nuisance" as defined in the Public Health Act (6).

Restrictions on Advertising and Promotion of Tobacco Products

The youthful population is generally thought to be particularly susceptible to advertising. The portrayal of smoking as a way of achieving success, glamour or popularity has immense appeal and can, many specialists argue, act as an inducement to smoke. Legislation restricting or prohibiting advertisements that, directly or indirectly, promote smoking has become increasingly common in recent years (21). Although its actual effect on behaviour—especially the behaviour of those who already smoke—is somewhat unclear, such legislation is, at the very least, an expression of society's concern for health and tends to diminish the social sanction accorded to smoking (1). The decision to ban tobacco promotion, in the words of one WHO Expert Committee (3), "helps to create a climate in which smoking is no longer seen by young people as a socially desirable activity, and in which health education can flourish, free of sophisticated, expensive, and misleading opposition". Moreover, it is supposed that these bans probably have their greatest effect on the behaviour of young people who have not yet begun to smoke, and who, by virtue of the restrictions, are no longer bombarded by advertising promoting smoking (22).

Recent analysis of the relationship between advertising and the consumption of cigarettes has led, unsurprisingly, to the conclusion that advertising is one of the strongest weapons available to the tobacco industry in its fight to promote smoking (23). Not only the volume but also the character of advertising persuades people to smoke. As a Federal Trade Commission report on cigarette advertising in the United States concludes (24): "the dominant themes of cigarette advertising are that smoking is associated with youthful vigor, good health, good looks and personal, social and professional acceptance and success, and that it is compatible with a wide range of athletic and healthful activities".

Some analysts have emphasized that cigarette consumption has risen in some developing countries that have banned advertising (25).
However recent evidence from France supports the notion that where advertising is banned—as part of an overall anti-smoking campaign—there is both a reduction in consumption and a change in the attitude towards smoking on the part of young people (12, 26). Making time available in the media for anti-smoking messages can be quite effective in discouraging smoking in the general population, if events in the United States are any indication (14):

[Applying the “fairness doctrine” of the Communications Act, radio and television] stations carrying cigarette advertising were required to make significant amounts of broadcasting time available to responsible anti-smoking groups—$150 000 000 equivalent of free time in the years 1968–70—in order to balance the time devoted to both sides of a controversial issue. During the period that anti-smoking messages were carried on the air as a public service, the number of smokers in the country declined. When Congress banned cigarette advertising on radio and television and stations were no longer required to grant “equal time” for anti-smoking messages, however, cigarette sales increased by 2.5% per year.

The fact that cigarette smoking decreased when the “equal time” anti-smoking campaigns were broadcast, but not when the later ban on television and radio advertising went into effect, shows that partial bans often leave the tobacco industry free to use other powerful media avenues, such as magazines, newspapers, and billboards. This suggests that substantial restrictions on advertising, combined with vigorous educational anti-smoking programmes, may provide the environment most likely to discourage smoking among young people.

The enactments relating to advertising fall into three broad categories: (1) legislation banning all advertising that promotes smoking in some or all media; (2) legislation banning all advertising (and thus necessarily banning advertising that promotes smoking) that is directed at children; and (3) legislation banning all advertising that promotes smoking when such advertising is—because of time, place or other circumstances—especially likely to be seen or heard by, and/or to exert an influence upon children and adolescents.

Banning of all advertising

Where the advertising of cigarettes is banned, by legislative enactment or by other governmental action, in all or some media, there may be no need for additional legislation directed specially to the young. Whether or not a legislative enactment “covers the field” depends, among other things, on what media are covered by the ban, and on whether direct as well as indirect advertising is—or could be—covered by a given enactment.

The following 13 countries have banned all cigarette advertising: Afghanistan, Bulgaria, Czechoslovakia, Finland, Hungary, Iceland, Italy, Mozambique, Norway, Poland, Romania, Singapore, and the USSR (7).
Bans on television and radio advertising of cigarettes are the most common. For example, in Ireland and Switzerland (1) the ban applies to television advertising; in the United States, national legislation enacted in 1969 makes it unlawful to advertise cigarettes on radio and television. The Maltese Act of 1970 goes a step further, and bans the advertising of tobacco products in cinemas as well as on radio and television. These statutes do not, of course, cover other media and, as has been pointed out, the "outdoor advertising, [which] has been left ... reaches large numbers of children" (1).

To date, in terms of the media affected, the most comprehensive ban on advertisements promoting smoking appears to be that enacted in Singapore in 1970. Virtually all forms of advertising and all media fall within the ban because the word "advertisement" is defined broadly to include "any notice, circular, pamphlet, brochure, programme, price list, label, wrapper or other document, and any announcement, notification or intimation to the public or any section thereof or to any person or persons, made: (a) orally or in writing; (b) by means of any poster, placard, notice or other document affixed, posted up or displayed on any wall, billboard or hoarding or on any other object or thing; (c) by any means of producing or transmitting sound or light and whether for aural or visual reception or both; or (d) in any other manner whatsoever".

In Bulgaria, Finland and Poland, the general bans on advertisements promoting smoking attack in various ways some of the difficult problems posed by "indirect" and other subtle forms of advertising. The Polish Ordinance of 14 June 1974, taking cognizance of a form of "sneak" advertising — the presentation on television or in films of public figures who are "casually" smoking — limits smoking on television shows. In Bulgaria, Ordinance 2 of 1980 states that "it shall be prohibited to issue any form of advertising or publicity in which beneficial properties are attributed to alcoholic beverages and tobacco products". The Federal Republic of Germany prohibits all advertising that might give the impression that indulgence in tobacco products can improve performance or well-being, especially at young people. In Finland, Law No. 692 of 13 August 1976 addresses very specifically the problem of indirect advertising and "prohibits the advertising of tobacco, tobacco products and imitations and smokers' accessories, as well as all other sales promotion activities directed to consumers in respect of such products, and the inclusion of such products in advertisements for other products, services or in other sales promotion activities". An exemption is made in the case of advertisements in foreign publications whose chief purpose is not the advertising of these materials. French Polynesia, too, prohibits advertising in publications produced in the country, and restricts indirect advertising in that it prohibits tobacco manufacturers and dealers from sponsoring all public meetings, as well as entertainment, and cultural or charitable events. (See Table 11 for examples of the types of restrictions in force in a number of countries.)
### Table 11. Restrictions on tobacco advertising specifically affecting adolescents

<table>
<thead>
<tr>
<th>Country</th>
<th>Total ban on advertising</th>
<th>Ban on adolescent-oriented advertising</th>
<th>Ban on advertising in selected media</th>
<th>Ban on advertising at places frequented by young people</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
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<tr>
<td>Belgium</td>
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<tr>
<td>France</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany, Federal Republic of</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
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<td></td>
<td></td>
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<tr>
<td>Peru</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venezuela</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Remarks**
- Voluntary agreement with industry not to target advertising to young people.
- No advertising on television prior to 15:00.
- No advertising before 19:00.
- No advertising before 20:00; no advertising during functions suitable for minors before 19:00.
- No advertising on programmes intended for young; none before 21:30; ban on use of adolescents in advertisements.


### Special restrictions affecting adolescents

Rather than ban all cigarette and/or tobacco advertising in specified media, a number of countries have addressed the problem of such advertising as it relates to young people. As is true of the more general advertising bans, the legislation differs from country to country in terms of the media covered, and the inclusion of indirect as well as direct advertising.
Ecuador has one of the most comprehensive tobacco advertising regulatory schemes in existence. Under the Supreme Decree of 24 August 1973 (which restricts advertising and publicity aimed at promoting the use and consumption of alcoholic beverages as well as cigarettes) the following activities—most of which relate solely to promotional efforts directed at young people—are prohibited:

1. Directing cigarette advertisements at minors.
2. Broadcasting television commercials for cigarettes before 19 h 30.
3. Inserting advertisements and publicity for cigarettes in radio and television programmes intended exclusively for children.
4. Using minors as models in advertising or publicity for cigarettes.
5. Advertising or publicizing cigarettes at or near schools and colleges.
6. Exploiting, through posters, films or records, the name or picture of a juvenile sporting star or performer for publicity aimed at promoting the use or consumption of cigarettes.
7. Advertising cigarettes in comics and comic supplements to newspapers.
8. Recommending smoking as a means of achieving concentration, efficiency, or relaxation.
9. Giving away cigarettes to minors as samples or as a means of promoting sales; and
10. Representing as consumers of cigarettes persons who have made a major contribution to Ecuador’s history or literature.

Much less sweeping than that of Ecuador is the Peruvian Decree of 1970 whose purpose is, inter alia, to shield minors from exposure to advertising that promotes smoking. This prohibits cigarette advertising on radio and television before 20 h 00. In addition, all such advertising is prohibited in places of public entertainment during functions or shows suitable for minors that take place before 19 h 00. Similar provisions are in force in Malaysia and Spain.

In Spain, under the Crown Decree of 1978, advertising of tobacco is prohibited in radio or television programmes intended for young people. None may appear in any case before 21 h 30. In addition, under provisions somewhat similar to those of Ecuador, the use of messages directed specifically at minors, that refer to the social advantages of smoking and that use persons under 18 in the presentation, is prohibited. In Mexico, the advertising of tobacco is not permitted if it depicts children or adolescents or is directed at adolescents.

Some alterations in the patterns of advertising result from voluntary agreements. The tobacco industry in Malaysia voluntarily refrains from advertising cigarettes in magazines directed to adolescents. There is an agreement between the Belgian Ministry of Health and The Federation of Tobacco Industries in Belgium and Luxembourg that the tobacco industries will not seek to appeal to young people within the limited
advertising they are permitted, but no penalties for infringements have been established (6).

In some countries, for example, Switzerland, a general ban on television advertising of tobacco products is supplemented by legislation restricting cigarette advertising directed at minors in other media. Singled out for specific regulation in the Swiss Ordinance are advertisements that would appear in places frequented by minors, advertising in which the material itself is intended for minors, advertisements in which sports clothing, articles, and vehicles are presented, as well as advertising in the form of the free supply of tobacco products to minors.

The partial ban on advertising in Sweden includes a prohibition of advertisements in places principally intended for or frequented by young people. Though this partial ban is quite effective, the National Board of Health and Welfare has called for a total ban on all advertising of tobacco products. In Belgium, competitions or sporting events may not be organized in association with tobacco advertising. France allows no advertisements on radio or television, no publicity or posters in public places, and no free distribution of tobacco. In Iceland, as in France, advertising of tobacco in newspapers is restricted merely to a reproduction of what is on the packet and is totally prohibited in publications aimed at young people. Advertising at sporting events, moreover, is limited and will eventually be eliminated. Lastly, tobacco manufacturers and dealers cannot sponsor events intended for children and minors.

Health warnings (negative advertising)

The discussion of cigarette advertising would not be complete without some mention of "negative advertising"—in the form of warnings to the consumer—which is mandatory under the legislation in a number of countries, including Australia, Belgium, Malaysia, the Netherlands, Nicaragua, Sweden and the United States (27). Such legislation usually contains nothing specifically relevant to minors; it simply imposes a requirement that all cigarette packages carry a warning to the effect that smoking is hazardous to health. One exception is Sweden, the country that has "what is generally acknowledged to be the toughest anti-smoking programme in the world" (11). Norway and the USA now also have alternative warnings. In Sweden, where a warning label is required, the Board of Health and Welfare has authorized some 16 alternative warning labels for cigarette packages, some of which, in effect, dispense advice to smokers. At least one of these permissible alternatives is clearly directed to young people. It reads: "Young people! The earlier you start smoking, the more dangerous it is. Damage can quickly occur in young smokers." The rationale for the alternative labels is apparently that smokers are more likely to read the labels if they vary. Whatever the rationale, however, the overall toughness of Sweden's anti-smoking programme, of which the warnings are part, appears to be
showing results. A study of 13- and 16-year-old students showed a definite downward trend, during the period between 1971 and 1980, in the percentage who smoke (see Fig. 3, p. 120).

Promotion of Anti-smoking Health Education

In the course of a discussion of cigarette advertising and promotion, Fletcher & Horn (28) made the following observation:

It is unfortunately difficult to assess the effect of restricting advertising. Advertisers of cigarettes claim that their purpose is competitive, to win a larger share of the market among those who already smoke rather than to recruit smokers among young people. Whatever the truth of this, if restrictions on advertising are to have any effect on the taking up of smoking by young people, it is essential that they should be accompanied by effective health education programmes for youth and by a visible reduction in smoking by the adult population that sets an example to youth, such as parents, health workers, teachers and popular idols.

Similar observations could also be made with respect to the effectiveness of laws prohibiting the sale of tobacco products to young persons. Indeed, as a WHO Expert Committee has said: “it may be necessary to make health education on smoking mandatory before starting legislation programmes so that both the public and the decision-makers are suitably alerted to the dangers of smoking and the need for action” (3).

All of the legislation bearing upon smoking and adolescent health that has been considered thus far has been “negative” in the sense that it concentrates on prohibition and regulation. In contrast, legislation that makes health education relating to smoking compulsory is affirmative in nature—that is, such legislation encourages anti-smoking activities or even makes them compulsory. Of special interest here are those enactments that state explicitly that health education programmes for young people should or must include education about the dangers of smoking.

In Finland, where a vigorous effort is being made to curb tobacco smoking, Law No. 693 of 13 August 1976 places national educational efforts to avoid and reduce smoking (including specifically the efforts of those working with children and young people) under the jurisdiction of the National Board of Health. Also of interest is the Bulgarian Ordinance aimed at combating smoking as well as alcoholism and drug dependence, which states:

Within the framework of their activity state agencies shall, in collaboration with social organizations, be required to participate in the prevention of drunkenness and alcoholism, drug dependence and smoking, and to promote temperance in the younger generation and all workers... The Ministry of Public Health and its agencies shall actively participate in the prevention of alcoholism, smoking and other forms of drug dependence by means of therapeutic and prophylactic measures and health education.
In 1980 Bulgaria issued a General Plan for the Organization of Large-scale Public State Activities against Smoking. The plan, adopted by the heads of ministries, agencies, mass organizations and public movements that helped to draft it, is designed to mobilize the various organizations and agencies in activities to combat smoking.

In the USSR, a Resolution of 12 June 1980 directs the Ministry of Education, the Ministry of Higher and Secondary Specialized Education, and the State Committee on Vocational Technical Training to strengthen their health education and organizational activities to prevent smoking by teachers and students (29). It also urges close cooperation among schools, families, and the general public in carrying out anti-smoking activities directed towards children and youth.

In the United States, several states have enacted laws requiring that health education on smoking be included in the basic school curriculum. Roemer (14) reports that:

- The California law requires a comprehensive health education programme in kindergarten and schools from first to twelfth grade on “misuse of tobacco and alcohol”. In Michigan, the Critical Health Problems Education Act requires a systematic and integrated programme and allocates resources to carry it out. The New York statute directs school authorities to provide the needed facilities, time, and place for instruction regarding alcohol, tobacco, and other drugs, as well as learning aids and resource materials, and requires proper preparation of teachers for this instruction.

- In Belgium, educational measures are directed at young persons as part of general health education, and include audiovisual and poster campaigns and lectures. In Denmark, information on the harmful effects of tobacco is included in the compulsory hygiene course in public schools (6) and a booklet distributed to pregnant women provides detailed information on the harmful effects that their smoking can have on the fetus.

- The Federal Republic of Germany aims its educational programme not only at students, but also at teachers and parents, in an effort to make them aware of the health damage caused by smoking and of their importance as role models (6). In France, school programmes are combined with a weekly series of cartoons shown on the main French television channel at peak viewing time. These have an anti-smoking message designed particularly for children between 6 and 10 years old (6).

- The Government of Luxembourg publishes Groggi, a magazine distributed free to all young people between the ages of 10 and 19, which deals with all aspects of health education, including the problems of smoking, alcohol and use and abuse of drugs (6). In the United Kingdom, the Health Education Council and the Schools Council have jointly developed a health education programme for persons aged 5–18, which includes information on the dangers of smoking to health. The material for 5–13-year-olds is used by at least 30% of primary schools.
in the country. In addition, the Health Education Council has carried out a television campaign featuring Superman to discourage young people from smoking (6).

One of the best known comprehensive anti-smoking programmes is found in Sweden. It was begun by the Swedish National Smoking and Health Association (NTS) in 1965 (30), and by 1973, at the suggestion of an ad hoc governmental committee, was transformed into an official long-range (25-year) effort. The part directed towards young people was given the sobriquet "A Non-Smoking Generation". The outstanding feature of the programme is the rejection of an intense but flash-in-the-pan approach to the problem, in favour of a plan that recognized that any serious effort toward eradicating smoking would take many years of consistent effort (7).

The Swedish programme emphasizes the attractions of non-smoking rather than concentrating solely on the ill-effects of smoking. The programme is comprehensive in the sense that "no single activity should be considered to have any definite, major impact, while at the same time, every single activity should be considered to contribute to the strength of the programme as a whole" (30).

Educational campaigns, indeed anti-smoking programmes in general, cost money. Roemer (14) has reported on the ways in which a few countries are marshalling resources to sustain the campaigns:

In at least two countries, the smoking control legislation requires allocation of a certain percentage of tobacco sales or revenues to anti-smoking education. In Iceland, the State Agency for Trade in Alcoholic Beverages and Tobacco must allocate 2% of gross sales to finance advertising and health education warning against the dangers of smoking. In Finland, 0.5% of the tobacco tax revenue must be set aside each year in the national budget for development of health-oriented tobacco policy, that is, health education, research and evaluation.

Other countries have chosen to increase their national budgets for anti-smoking education without enacting legislation. Sweden [tripled] its budget for anti-smoking activities over a four-year period. In France, the Minister of Health and Social Security stated in the National Assembly on 16 June 1980 that implementation of the rights of non-smokers under the 1976 legislation is being sought through public education rather than through convictions under the law. In 1980, a budget of 5.5 million francs was set aside for public information on the effects of smoking on health, and this level of informational activity will be maintained for several years.

In French Polynesia, in addition to many of the measures provided for in the French law of 1976 concerning measures to combat smoking, it is laid down that 1% of the revenue from tobacco taxes be used for a health campaign.

In Norway, influence on youth is the primary goal of the comprehensive anti-smoking legislation. In the words of the chairman of the Norwegian National Council on Smoking and Health (31):

no one expected the Norwegian to change their smoking habits overnight. It is anticipated, rather, that the legislation will influence young people and that changes in tobacco consumption will appear gradually over time.
In France, too, the legislation places strong emphasis on discouraging smoking by young people. The enactment of legislation has been combined with a media campaign utilizing television, posters and the press, supplemented by a national programme of anti-smoking education in the schools. The campaign relied on highly motivated individuals (32):

In one school in each Department of France, a particularly motivated teacher was selected who, with the aid of materials and suggestions, organized a pilot round table on the abuse of tobacco. From this activity educational materials were developed for distribution to all schools in the country.

This strategy seems to have proved fairly successful; in 1976, for the first time in ten years, the sales of tobacco products fell, the total number of smokers decreased by 3%, consumption by adults who continued to smoke dropped by 15% and by 16% among young smokers, and young people began to find the image of the smoker less glamorous (6). Roemer (14) concludes that:

The French experience seems to point to the importance of a comprehensive approach. It is not sufficient to restrict smoking in schools and in places frequented by young people if advertising of tobacco products is all around and smoking is commonly allowed in public places.

Although it is as yet too early to tell whether legislation aimed at discouraging adolescent smoking has achieved its aim, the statistics from Sweden and France are encouraging.

Conclusions

Legislation that seeks to discourage young people from smoking has, according to Roemer (14), three basic *raisons d'être*: (1) to decrease the morbidity and mortality arising from diseases caused by smoking among young people for whom the risk increases the longer they continue to smoke; (2) since the smoking of tobacco is addictive, to discourage the development of tobacco dependence among young people; and (3) to prevent the onset of smoking among adolescent women in order to avoid the damaging effects on the fetus of smoking during pregnancy and on young infants of smoking in the home. There are also other complementary reasons for anti-smoking legislation (7):

1. To demonstrate government commitment to the eradication of the smoking-induced public health problems;
2. To influence public perceptions and attitudes on smoking behaviour; and
3. To underwrite in a complementary way, anti-smoking public education activities.

The positive results of recent experiments with anti-smoking legislation, at least in some developed countries, have partially overcome the concerns about the effectiveness of such an approach. It has also yielded some useful insights into what can realistically be expected from such programmes. As Wake et al. put it, it should be stressed from the
outset that “any legislation to control smoking should be seen not in isolation as a miracle community cure, but as part of a comprehensive programme, and that it must complement—or be complemented by—a variety of other measures and activities”.

Earlier, a WHO Expert Committee (4) had pointed out that “smoking control activities are traditionally—and wrongly—judged by the short-term impact of specific measures rather than by the long-term effect of a comprehensive programme”. In short, expectations must be realistic, as must programmes.

Two major obstacles loom in the path of efforts to enact and enforce anti-smoking legislation. One is the argument that such legislation improperly infringes on personal freedom. The argument in favour of keeping the state out of such decisions as whether to smoke or not carries some weight, but it has not been accepted in recent public health debates such as those relating to use of seat-belts (see the discussion in Chapter 14, pp. 275–277). The legislative task of governments wishing to discourage young people from smoking is also made more difficult by the tobacco industry itself.

As Roemer (14) has pointed out:

The tobacco industry has large stakes in defeating efforts to control the smoking epidemic. The tremendous concentration of economic power in the seven transnational tobacco conglomerates presents a formidable obstacle to governments struggling to discourage their young people from taking up smoking and to persuade smokers to free themselves from tobacco dependence.

The industry usually fiercely opposes smoking control legislation. However, there are economic incentives that should prod governments into action (14):

Against the much-vaunted economic benefits of tobacco production must be weighed the high costs of smoking. In the United States, the economic consequences of smoking were estimated in 1976 to total $27,500 million, of which $8,200 million represented direct health care costs.

The time may well have arrived when, as one author has suggested, it is necessary to move away from tobacco policies “serving predominantly commercial and fiscal interests towards an explicit health-oriented smoking control policy” (33).

A WHO Expert Committee (3) has urged that tobacco advertising in developing countries be “ended as soon as possible”. It has been suggested that public health officials should seek cooperation from the tobacco industry itself, and that voluntary arrangements be worked out to turn the attention of the industry away from young people. However, experience so far is not encouraging (4):

[Experience] has shown that the tobacco industry has invariably sought to reduce the impact of virtually all smoking control measures and, in general, does not willingly agree to any legislation or voluntary codes likely to have an adverse effect on tobacco sales. It would be surprising commercial practice if it did.
The WHO Expert Committee on Smoking Control (4) bluntly stated that "the international tobacco industry's irresponsible behaviour and its massive advertising and promotional campaigns are, in the opinion of the Committee, direct causes of a substantial number of unnecessary deaths".

Youth is certainly one of the most difficult groups to persuade of the harms of smoking. As Roemer (14) explains:

It is difficult to motivate young people to avoid a risk to whose effects they will be vulnerable only many years later. Rational arguments have not been sufficiently effective in discouraging young people from smoking. A combination of various strategies is called for, and legislation may be an essential means of prohibiting smoking in schools and other places where young people gather, of banning sales to minors, and of creating a non-smoking environment.

Beyond legislation, the effect of strict enforcement of, for instance, bans on sales to minors cannot be forgotten. Such enforcement requires public support: that is the lesson of anti-smoking experience. However, legislation is a valuable starting point for, as Wake et al. conclude (7): "it is inconceivable that true primary prevention can be implemented unless educational activities are complemented by comprehensive legislation". The reverse is also true, as a WHO Expert Committee noted (3): "No legislation could be expected to succeed without educational activity".

References and Notes

5. The phrase is taken from Roemer, R., Legislative action to combat the world smoking epidemic, Geneva, World Health Organization, 1982.
10. US Department of Health and Human Services. The health consequences of smoking for women: a report of the Surgeon General. Rockville, MD, Office on Smoking and Health, Office of the Assistant Secretary for Health, 1980. Increased smoking among girls in the over-15 age group may carry an extra hazard: with the increasing use of oral contraceptives in that age group, the harmful effects of smoking as a risk factor for circulatory disorders are amplified. The risk of myocardial
infarction for smokers who use oral contraceptives is 22 times that for nonsmokers (STEINFELD, J. L. Report presented at the Fifth World Conference on Smoking and Health, Winnipeg, Canada, 10-15 July 1973 (see ref. 34)).


15. Norway, Law No. 14 of 3 March 1973 (on restrictive measures governing the marketing of tobacco products, etc.). The Law also prohibits any offer of tobacco to those under 16, the age at which young people in Norway finish their compulsory schooling.

16. SUSSMAN, A. N. The rights of young people: the basic ACLU guide to a young persons rights. New York, Avon, 1977. Some states (Kansas, Kentucky, Louisiana, New Mexico, Oklahoma and Wisconsin) have no applicable law.


19. Kentucky, Chapter 438, Section 438.050 (1976 Supplement) (Offenses Against Public Health & Safety); International digest of health legislation, 28: 394-395 (1977). The fines are at best modest, from $1 to $5, but the effect of the legislation is thought not to be diminished by this fact.


21. That this group must be a prime target audience for the tobacco industry in its advertising is obvious because therein lies its economic future. As Wake et al. (7) point out:

it is also worth noting that despite their publicly expressed concern to prevent sales to young people, the tobacco manufacturers appear specifically to devise strategies to attract young "stayers" to smoking. A report prepared for the Brown and Williamson Company (US subsidiary of the British American Tobacco Company) sets out "the . . . major parameters" on which "an attempt to reach young smokers, stayers, should be based."


26. The French Legislation, coupled with anti-smoking campaigns, brought about a 5% drop in the total number of smokers, a 15% decline in the cigarette consumption rate, and a 16% decrease in the number of young people who viewed the "smoker's image" as an attractive one.

27. In fact, 37 countries worldwide (33 by legislation) require health warnings on packages (14). As Wake et al. (7) observe:

Many health educators are of the opinion that the most important feature of the health warning on the packet of cigarettes is not that it warns, but that it is a statement that the government recognizes the hazard.


29. The Resolution appears also to look at the question of how to increase chewing gum production as an alternative to smoking.


Legislation

Belgium

Bulgaria
Decree No. 2431 of 2 November 1973, promulgating the Law on public health (Section 55) [IDHL, 26: 513 (1974)].
Ordinance No. 2 on health requirements in connection with smoking (Sections 3 and 4) [IDHL, 31: 752-753 (1980)].

Canada

Ontario
Minors' Protection Act, Revised Ontario Statutes, VII, Chapter 293, 1980.

\textsuperscript{a}For the sake of concision, \textit{International Digest of Health Legislation} has been abbreviated throughout to \textit{IDHL}.\textsuperscript{a}
Cyprus
Health Protection (Smoking Control) Law (No. 5) of 1980 [IDHL, 32: 731 (1981)].

Ecuador
Supreme Decree No. 956 of 24 August 1973, promulgating regulations governing the manufacturing, sales and advertising activities associated with the use and consumption of cigarettes and alcoholic beverages [IDHL, 28: 64 (1978)].

Finland
Law No. 693 of August 1976 on measures to restrict smoking (Sections 10, 11 and 13) [IDHL, 28: 466, 487 (1977)].
Ordinance No. 225 of 25 February 1977 on measures to restrict smoking (Section 11) [IDHL, 28: 489 (1977)].

France
Law No. 76–616 of 9 July 1976 concerning measures to combat smoking (Articles 2, 3, 4, 5 and 7) [IDHL, 27: 735 (1976)].
Decree No. 77-1042 of 12 September 1977 prohibiting smoking in certain places intended for use of groups of people where this practice may have harmful effects on health [IDHL, 27: 352 (1978)].
Decree No. 77-1273 of 17 November 1977 (for the implementation of Law No. 76-616) [IDHL, 29: 361 (1978)].

French Polynesia
Deliberation No. 82-11 of 18 February 1982 on tobacco abuse and dependence (Sections 7 and 10) [IDHL, 33: 283 (1982)].

Germany, Federal Republic of
Foodstuffs and Commodities Law of 15 August 1974 [Section 22(2)].
Law of 27 July 1952 on the protection of adolescents in public as amended (Section 9).

Ireland
Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) Act, 1978, Act No. 21 (Section 2) [IDHL, 36: 806 (1979)].
Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) Regulations [IDHL, 31: 537 (1980)].

Italy

Kenya
Public Health Act, Chapter 242 (Section 118), Laws of Kenya, Vol. 5, Revised 1962.

Malta
Tobacco (Control of Advertisement) Act, 1970 [IDHL, 24: 183 (1973)].

Mexico

New Zealand
Police Offences Act 1927 (Section 27) [IDHL, 26: 399 (1977)].

Norway
Law No. 14 of 9 March 1973 (restrictions on the marketing of tobacco products).
Laws and Policies Affecting Adolescent Health

Peru
Supreme Decree No. DS-0079-70-SA of 29 April 1979 (on cigarette advertising) [IDHL, 28: 689 (1977)].

Poland
Ordinance of 14 June 1974 of the Ministry of Health and Social Welfare, concerning restrictions on smoking based on health grounds [IDHL, 26: 280 (1975)].

Singapore

Spain
Crown Decree No. 1106 of 12 May 1978, regulating the advertising of tobacco and alcoholic beverages by state broadcasting media [IDHL, 29: 817 (1978)].

Sweden


Switzerland
Ordinance on Foodstuffs, Amendments of 18 October 1978 [IDHL, 30: 327 (1979)].

Union of Soviet Socialist Republics
Resolution No. 796 of 12 June 1980 of the Central Committee of the Communist Party of the Soviet Union and the USSR Council of Ministers on measures to intensify campaigns against smoking (Section 3) [IDHL, 32: 87-91 (1981)].

United States of America

Alaska
Alaska Statutes Title I: Criminal Law (Section 116.110) as enacted in Chapter 166, Section 1, Session Laws of Alaska.

Kentucky
Chapter 418 (Section 438.050) (1976 Supplement) (Offenses against public health and safety) [IDHL, 28: 394-395 (1977)].

Michigan
Michigan Compiled Laws Annotated (Section 722.651).

New York
New York Penal Law (Section 260.20).
9. Alcohol Use and Abuse

The patterns of non-medical use of alcohol and other dependence-producing drugs—especially by pre-adolescents, adolescents, and young adults—are both complex and changing. The situation varies from country to country, as well as in different areas within a particular country, and the available data are often either unclear or inconclusive.

Information about alcohol use among young people is scattered and often unreliable; on a worldwide level, surveys are rarely repeated so that there is no clear indication of trends (1). Information about consumption levels among young people is scanty and must generally be obtained indirectly. However, we do know that in 26 countries with fairly reliable statistics, “the amounts of 100% ethanol available per person in the total populations varied from 1.2 to 17.2 litres in 1950. Over the following 26 years, these rates increased by more than 50% in all but 4 countries; in about half of the countries the rates doubled and in four they more than tripled” (1).

Though few reliable or long-term studies have been carried out, there are indications that “the proportions of young people drinking alcoholic beverages have increased over the last 30 years; that they are drinking increasing amounts and more often; and that the habit is starting at increasingly younger ages” (1). (For a few examples, see Table 12.)

As Moser (1) reports:

In Switzerland ... among a 1978 national sample of schoolchildren, 30% had been drunk before the age of 12 years. Among Canadian high school students in three cities, 40% had been drunk in the month preceding the survey. A questionnaire survey of schoolchildren aged 13–18 years in urban and rural areas in England revealed increasing experience of drunkenness with age. By the age of 18 years, 87% of the males reported having been drunk, over half of them more than once in the past year.

A survey conducted in the United States (2) revealed that:

Consumption of alcohol—particularly beer—is common among teenagers. Approximately 42 percent of 12th grade males and 15 percent of 12th grade females drink beer once a week or more, according to a 1974 nationwide survey of over 13,000 junior and senior high students. The same survey found 27.8 percent of the students were problem drinkers. (Because dropouts were not included, these figures are probably underestimates.)
Table 12. Drinking patterns and alcohol-related problems among young people: selected survey findings

<table>
<thead>
<tr>
<th>Place, date, and size and nature of sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong></td>
<td>Percentage using alcohol increased with age from 30.5% in 1973 to 52.4% of boys and 37.6% to 71.9% of girls</td>
</tr>
<tr>
<td>Canberra: samples of pupils in forms 1-6 (aged about 11-17 years) in 37% of secular schools (1973 and 1974); N = 4952; self-rating questionnaire</td>
<td>Alcoholic most widely used drug; never tasted alcohol: males 12.5% in 1974, 8% in 1977; females 19% in 1974, 12% in 1977. Drinking once a week or more often: males aged over 15 years, 43% in 1974, 51% in 1977; males aged 14 years and under, 26% in 1974, 19% in 1977. Felt very drunk or &quot;passed out&quot; more than once a month: males aged 14-16 years, 32% in 1974, 40% in 1977; females aged 14-16 years, 14% in 1974, 26% in 1977.</td>
</tr>
<tr>
<td>New South Wales: studies of samples of pupils aged 14-16 and 12-17 from urban and rural schools</td>
<td>In 1974, 71% indicated use of alcohol at least once compared to 78% in 1978; in 1970, 9% reported using alcohol more than once a week compared to 14% in 1978</td>
</tr>
<tr>
<td>Canada</td>
<td>32% of elementary-school and 72% of high-school students reported drinking one or more alcoholic beverages once or more often during previous six-month period; 8% of elementary-school and 27% of high-school students reported drinking at least once a week, and 17% of elementary-school and 44% of high-school students claimed to have consumed five or more drinks on at least one occasion in past six months</td>
</tr>
<tr>
<td>British Columbia: surveys of representative samples of Vancouver students in 1970, 1974 and 1978</td>
<td>3.3% &quot;heavy use&quot;: 5.7% of males, 0.9% of females; 75.9% &quot;use&quot;: 78.5% of males, 72.2% of females</td>
</tr>
<tr>
<td>Ontario, 1978: survey of representative sample of students, grades 7-13 (N = 8938)</td>
<td>California</td>
</tr>
<tr>
<td>Colombia</td>
<td>32% of elementary-school and 72% of high-school students reported drinking one or more alcoholic beverages once or more often during previous six-month period; 8% of elementary-school and 27% of high-school students reported drinking at least once a week, and 17% of elementary-school and 44% of high-school students claimed to have consumed five or more drinks on at least one occasion in past six months</td>
</tr>
<tr>
<td>Bogota, 1974: sample of 4840 students from all high schools</td>
<td>3.3% &quot;heavy use&quot;: 5.7% of males, 0.9% of females; 75.9% &quot;use&quot;: 78.5% of males, 72.2% of females</td>
</tr>
<tr>
<td>Finland</td>
<td>Alcohol and tobacco most frequently used drugs; 36% of males and 11% of females used alcohol; of these, 52% of males and 100% of females used it once a month or less often</td>
</tr>
<tr>
<td>Helsinki, 1972: unmarried males aged 14, 16, and 18 years in 1960, 1964, 1973</td>
<td>For those aged 18 years, the percentage having had alcohol at least 5 times in the previous 4 weeks increased from 3% to nearly 50%. 43% of those aged 14 years and 73% aged 18 years had had alcohol in the preceding week in 1973. Overall, the amounts consumed at one time tripled for the group aged 14 years and doubled for the other two groups, who consumed large average amounts per occasion than urban adult males, although total consumption was lower for the groups aged 14 and 16 years than for adults</td>
</tr>
<tr>
<td>India</td>
<td>286 male, 246 female university students</td>
</tr>
<tr>
<td>Delhi, 1975: systematic sample of 266 male, 246 female university students</td>
<td>Alcohol and tobacco most frequently used drugs; 36% of males and 11% of females used alcohol; of these, 52% of males and 100% of females used it once a month or less often</td>
</tr>
</tbody>
</table>
Table 12 (continued)

<table>
<thead>
<tr>
<th>Place, date, and size and nature of sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>Percentage abstinent: G, 22.2% (31.6% aged 12 years); F, 16.3% (20.4% aged 12); I, 22.7% (27.7% aged 12). Percentage drinking daily: G, 1.1% (0.8% aged 12); F, 2.5% (2.0%); I, 6.7% (6.5%). Percentage who have been drunk at least once in last 2 months: G, 12.2% (urban), 16.9% (rural); F, 20.9% (urban), 28.8% (rural); I, 19.8% (urban), 26.8% (rural)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Pilot project 1975: 160 females and 160 males aged 13-16 years</td>
</tr>
<tr>
<td>USA</td>
<td>47 States, 1974: 13,122 students aged 12-17 years. Nationwide stratified sample of school classrooms. Self-report</td>
</tr>
<tr>
<td>Zambia</td>
<td>University students</td>
</tr>
</tbody>
</table>

74% used alcohol, 39% drank regularly, 86% preferred beer, 12% spirits


Another indicator of changes in the prevalence of alcohol-related problems is the number of admissions to treatment facilities, although as Moser (7) has pointed out:

... it must be realized that changes in admission rates may be due to increase in facilities or in willingness to admit for care. A few reports have appeared showing increased admissions for young people to individual facilities, although levels still seem to be low. For example, persons aged under 21 years accounted for 3.5% of admissions to a Toronto detoxification center in 1973/74, compared with almost none prior to 1972. Ahlström-Laakso reports that the number of young people with alcohol and drug problems (the latter being rare) treated on the basis of the Child Welfare Act increased fourfold between 1960 and 1975 in Finland and the number of visits of juveniles to [alcohol] clinics increased more than 150% between 1970 and 1974.

The significance of drinking habits among young people, however, is unclear. In the United States, although teenage alcoholism has been characterized as a "national health problem reaching epidemic proportions" (3), a recent study of the literature on adolescent drinking practices from 1940 to 1975, conducted by the National Council on Alcoholism, concluded that no such epidemic exists (4). What did emerge
from the study was evidence of a number of trends meriting serious consideration. According to this study:

There is a trend for increasing numbers of adolescents to experiment with alcohol use. Approximately 90% of the teenagers today have tried alcohol as compared to an average of 54% in the 40's and 50's. There is also a trend, however slight, for teenagers to start this experimentation at a younger age.

By themselves, these trends might be unimportant, but in conjunction with the trend toward increased frequency of intoxication, they suggest that more youths are drinking at an earlier age, and experiencing intoxication. In addition, although it is not clear-cut, there is an indication that females' drinking may be starting to approximate that of males.

Adolescents are thus more prone to develop acute alcohol-use related problems as opposed to chronic alcohol-use related problems. These acute problems ranging from traffic fatalities to alcohol-involved injuries are a cause of grave concern.

(For further information on the role of alcohol in accidents, see Chapter 14, pp. 278--285.) In the future, developing countries will surely be wrestling with these same problems. As Moser (1) writes:

The greatest threat of increasing alcohol problems among children and adolescents is perhaps to be found in areas of the world undergoing rapid sociocultural and economic change. A review of findings in such areas gives examples of the destructive impact of alcohol on societies in a state of rapid transition ... A number of reports refer to the explosive increase in alcohol problems that have reached epidemic proportion.

This burgeoning market encourages the alcohol industry (1). Between 1975 and 1980, beer production increased more than 50% in 46 countries—all but three being developing countries, and more than 100% in 17—16 being developing countries. Over most of the 1970s, the total world alcoholic beverage trade increased by more than 15% a year.

Many factors contribute to the phenomena now being observed in developing countries, most of them accompanying the process of “modernization”. These include, among others, the breakdown of the “formerly effective cultural and social controls” (1) and the frustrations caused by the tension between improved educational facilities and shrinking employment opportunities.

Ritson (5) provides a realistic explanation of alcohol use among adolescents:

Adolescence is a time of transition and experiment. The young person tries out various forms of identity and is strongly influenced by his peers and the images around him. He or she naturally experiments with alcohol because it is part of the adult world. He brings to this early drinking behaviour a metabolism which is unused to coping with alcohol and is himself unused to adapting to the psychological and physical effects of alcohol. This inexperience makes the adolescent vulnerable to its effects at an age when risk-taking is an important part of proving himself in the eyes of his friends. He is also inexperienced in other skills whether this be driving a car or forming a relationship. It is therefore hardly surprising that crises such as accidents, violence or unwanted pregnancies are commonly associated with excessive drinking.
Alcohol abuse can also have long-term effects. A survey carried out in the United States by the Institute of Medicine (2) listed some of these effects which can easily develop into lifelong problems and may eventually lead to premature death:

As the disease [alcoholism] becomes manifest it has many pernicious effects: biological, psychological, and social consequences for the alcohol abuser; psychological and social effects on family members; endangerment of the physical well-being of family members and others (especially by accidents or violence); and social and economic consequences for society at large, which must pay for the problem drinker's maintenance—either indirectly because of decreased productivity, or outright through welfare.

Long-term heavy use of alcohol is associated also with a number of diseases, including "cirrhosis of the liver, some cancers, chronic malnutrition leading to diminished resistance to infection, brain damage, and in the case of pregnant women, damage to the fetus" (6) (see Table 13).

However, on a more optimistic note, Ritson (5) writes:

How concerned should we be about alcohol problems amongst the young? Does it presage a headlong decline into alcoholism? Most evidence suggests that for the majority it does not and that the process of maturing out, which occurs with other drug problems, also applies here.

A recent WHO Task Force report (7) notes that most "problem drinkers" find their way out of the difficulties that prompted alcohol abuse by their middle or late twenties, although alcohol use by adolescents is also seen as a possible "gateway" to other forms of substance abuse. Serious alcohol-related health problems exist among adolescents the world over and it has also been found that adolescents with alcohol-related problems tend to have other health-related problems as well, linked especially to mental health (7). In addition, alcohol consumption interferes with the normal progress of the adolescent through the "developmental" stages leading to maturity.

Table 13. Health and the problems of heavy drinkers 8

<table>
<thead>
<tr>
<th>Consequences of acute episodes of heavy drinking:</th>
<th>Consequences of prolonged heavy drinking:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term impairment of functioning and control; aggressiveness; accidents; exposure to climatic conditions; physical disorders; arrest for drunkenness</td>
<td>Liver cirrhosis; aggravation of other physical disorders; malnutrition; prolonged impairment of functioning and control; accidents; impairment of working capacity; alcohol dependence syndrome; alcoholic psychosis</td>
</tr>
</tbody>
</table>

Possible concomitant problems:
- Loss of friends, family, health, self-esteem, job, means of support, liberty

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8 Source: MOSER, J. Prevention of alcohol-related problems: an international review of preventive measures, policies and programmes. Toronto, Alcoholism and Drug Addiction Research Foundation, 1980. The individual may be affected by a whole series of problems related to his alcohol consumption while not necessarily suffering from the alcohol dependence syndrome.
The purpose of this chapter is to review what law and policy have to say about alcohol use in adolescence. There are various difficulties inherent in this type of analysis. As Fluss (8) said, “One of the difficulties is the multiplicity of legal instruments that are, directly or indirectly, likely to influence drinking behaviour in minors...Another difficulty stems from the complex and interrelated factors that influence alcohol consumption in minors.”

Although legislation relating to alcohol use and abuse often overlaps with legislation relating to the use and abuse of other dependence-producing drugs, there are points of significant difference. More specifically, in most countries, the moderate use of alcoholic beverages by adults is viewed as legally and socially acceptable; in contrast, the non-medical distribution, sale, and use of other dependence-producing drugs is generally either prohibited or very strictly regulated, irrespective of the age of the user. It is for this reason that legislation relating to alcohol is considered here separately from that affecting drugs.

The various methods used in attempting to control alcohol use and abuse are discussed below.

### Control of Production and Trade

#### Prohibition

The current situation with respect to prohibition has been summarized by Moser as follows (9):

> The outstanding examples of national efforts to limit production of alcoholic beverages have occurred, of course, during times of prohibition...There can be little doubt that in the early years of prohibition in several countries where it is no longer in force (Canada, Finland, Norway, USA) all indicators of alcohol problems reached the lowest level yet achieved in any period for which there are relevant data. Prohibition is still officially enforced in Libya, Saudi Arabia, the Yemen Arab Republic, Kuwait, Qatar and parts of India, as well as in Egypt, Jordan and Iraq during Ramadan. In Bahrain, local production and use are prohibited but importation and use by foreigners is permitted. Some additional countries are now attempting to enforce prohibition.

#### Control of purchase and minimum drinking age

In a great many countries, legislation prohibits the sale or other provision of alcoholic beverages to persons below a certain age. Although this legislation—to the extent that it deters excessive alcohol use and/or dependence—may be viewed as a health measure, it should be noted that promotion of adolescent health is not necessarily its sole or even its primary purpose.

Some idea of the various purposes intended to be served by these age restrictions may be gleaned from the recent debates in the United States concerning a number of state legislative proposals to alter the drinking age. According to one American legal commentator, Mnookin
the following arguments are usually prominent among those put forward by opponents of legislation lowering the drinking age:

- Drinking by minors will lead to an increase in juvenile crime and other antisocial behaviour.
- If the drinking age is lowered, still younger underage children will experiment with alcohol, and this, in turn, will lead to a still greater incidence of adult alcoholism.
- If the drinking age is lowered, the problems of teenagers driving under the influence of alcohol will become even more acute.
- Drinking by adults is immoral and undesirable, and a decrease in the legal drinking age will serve to legitimize such activity for the young.

To the above may be added the argument that young people may not have sufficient judgement to anticipate or appreciate the acute effects of excessive alcohol consumption upon their mental and physiological functions. Thus, they may unwittingly endanger themselves or others as a result of misjudging the amount of alcohol that can be consumed without undue adverse effects (5).

Many states have lowered the age limit:

... partly as a result of the national movement to establish adult status at that age [age 18], and partly in the hope that widespread alcohol use problems among youth would be ameliorated if drinking lost the attractiveness associated with its illegality.

For reasons that are yet unclear, this strategy has apparently not worked (perhaps because so many teenage drinkers are still below the legal age limit). Automobile accidents involving youthful drinkers have increased and at least some states are considering rescinding their lower drinking age laws (2).

The national trend is now to raise the age, with emphasis on the link between the legal age for drinking and automobile safety among the teenage population. The Presidential Commission on Drunk Driving (1984) took the position that all states should raise the drinking age to 21 years. This was made a requirement for obtaining the full allotment of federal highway funds authorized by federal legislation to be disbursed in 1985 (11).

As the Chairman of the Commission said, "nothing will change until society accepts the fact that drinking and driving is socially unacceptable" (12). There is now evidence that changes are occurring in states that have raised the drinking age. A recent survey of nine states that did so between late 1976 and early 1980 indicated that the increase in age did result in a decrease in the number of fatal accidents among the young drivers affected by the change (13, 14). (For a full discussion of this interrelationship see Chapter 14, pp. 278-285.)

The precise relationship between any particular minimum age for access to alcohol and alcohol-related health problems, such as alcohol dependence, episodic alcohol abuse, and/or disease caused or aggravated by alcohol, is not clear. In the USA one survey (2) has said that:
highly restrictive laws may have some effect on the number of drinkers... Areas with tight local laws had triple the number of abstaining men (21 percent versus seven percent in unrestricted areas), although those who did drink in "dry" jurisdictions had more problems associated with their drinking. This pattern echoes the national experience under Prohibition.

Statutes barring alcohol sales to young people appear to be more common than restrictions on tobacco sales. The age restrictions relating to alcohol sale and use vary widely in their scope as well as their enforceability. Moser (9) has pointed out that

Probably all countries that have legislation aimed at alcohol control include clauses concerning the age below which persons are not permitted to buy or consume alcoholic beverages. The age limit for purchase and consumption in a licensed place is generally higher than for purchase in a retail shop. There may be an age limit for entry to a place licensed to sell alcoholic beverages.

The statutes relating to alcohol sale and use vary greatly in how they define the specific age group that is covered by the legislative prohibition. Bulgaria and Hungary are among the countries in which the legislation in question simply refers to "minors" or to "children and minors". More common is legislation that sets a specific age. This may or may not coincide with the general age of majority in the particular country. Thus, in Czechoslovakia, Colombia, Liberia, Poland and Singapore, the specified age is 18. In Malawi, the sale of liquor is prohibited to any person who is "or appears to be" under 18 years of age. In New Zealand and Sweden, the age varies: for most purposes it is 20, although in some circumstances it is 18. In Algeria (15), the restriction applies until age 21 (see Table 14 for further information on minimum ages).

The scope of the legislative provisions restricting minors' access to alcoholic beverages varies not only with respect to the precise minimum age that is set, but also with regard to the methods of distribution that are proscribed. For example, the legislation in Algeria and Bulgaria appears to prohibit only the sale of alcoholic beverages to persons below the specified age. Other legislation, by contrast, is broader in scope. Thus, in Liberia, it is an offence to sell or serve alcoholic beverages to persons under 18; in Singapore, no person under 18 may buy or attempt to buy any intoxicating liquor for consumption in any licensed premises and no person may buy from any licensed premises intoxicating liquor for consumption, on the premises, by a person under the age of 18; in Colombia and Hungary, "supplying" minors with alcoholic beverages is forbidden. The Czechoslovak Law of 19 December 1962 is even more comprehensive, since it lays down that:

It shall be prohibited... to sell or supply alcoholic beverages, even in a sealed container, to persons less than 18 years of age, [and] to persons over 18 years of age who, in case of doubt as to their age, cannot produce an identity card... likewise to encourage, facilitate or in any other way make possible the use of said beverages by such persons.
### Table 14. Age limits for purchase and consumption of alcoholic beverages

<table>
<thead>
<tr>
<th>Country</th>
<th>Purchase for consumption elsewhere</th>
<th>Consumption on premises</th>
<th>Entering licensed premises</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>18</td>
<td>18</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Brazil</td>
<td>18</td>
<td>18</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>France</td>
<td>14 (fermented drink) 18 (spirits)</td>
<td>14.16 (may consume fermented drink if accompanied by adult); 18-18 (may consume fermented drink); 18 (spirits)</td>
<td>15 (unless accompanied by adult in change, aged over 18)</td>
<td>Code on (alcoholic) beverage culture and measures to control alcoholism</td>
</tr>
<tr>
<td>Germany, Federal Republic of</td>
<td>16</td>
<td>16 (beer, wine) 18 (spirits)</td>
<td>16 (unless accompanied by adult; some other exceptions)</td>
<td>Law for protection of youth in public</td>
</tr>
<tr>
<td>Iceland</td>
<td>21</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>India</td>
<td>21</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Indonesia</td>
<td>15</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Japan</td>
<td>20</td>
<td>20</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Mexico</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Philippines</td>
<td>21</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>15</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>


Some legal restrictions exempt from their operation the provision of alcoholic beverages to minors by their parents or guardians. This is the case in New York where the Penal Law, Section 260.20(4) lays down that:

A person is guilty of unlawfully dealing with a child when... he gives or sells or causes to be given or sold any alcoholic beverage... to a child less than 15 years old; except that this provision... does not apply to the parent or guardian of such a child.

In the same manner, the Liberian Penal Law does not apply “to a parent or guardian who serves an alcoholic beverage to his child or ward”. A very different approach, in terms of parental discretion, is taken in Czechoslovakia, where Law No. 120 of 19 December 1962 expressly provides that:

The relatives or guardians of children and adolescents and persons responsible for the care or education of children or adolescents, either permanently or temporarily, must see that the prohibition of the supply of alcoholic beverages to such children and adolescents is observed.
The issue of parental discretion is at the heart of the New Zealand Sale of Liquor Act of 1976, which takes a very liberal approach to alcohol consumption and, according to one commentary on the law, attempts to make it "an adjunct of everyday life rather than as an end in itself" (17). The commentary goes on to point out that:

Perhaps the most noteworthy features of the Act are those which allow for young people to be gradually introduced to the moderate use of liquor in a controlled social environment. Although the minimum drinking age of 20 years was retained... the law will now allow liquor to be supplied in hotels, Taverns and clubs to persons 18 years and over where accompanied by an adult spouse or parent. Children of all ages may accompany their parents into designated family lounge bars and be supplied with liquor.

France is a country in which the minimum age for access to alcoholic drinks varies according to the type of beverage (8):

Beverages are classified into five groups, and there are differentiated provisions limiting access to all but group 1 beverages (i.e. non-alcoholic drinks) for: persons under 14 years of age (may not purchase or consume alcohol in public); persons under 16 years of age (may purchase and consume fermented beverages—wine and beer); and persons under 18 years of age (may not purchase or consume spirits in public). These provisions have been consolidated in what is known as the Code des Debits de Boissons et des Mesures contre l’Alcoolisme.

Recent experience in the USA is notable for the fluctuations in the age requirements that have occurred over the past decade. There is no uniform national legislation on this subject. Prior to 1974, 21 was the age of majority as well as the minimum drinking age in the overwhelming majority of the states. In 1974, the Twenty-sixth Amendment to the United States Constitution was passed, lowering the voting age to 18, which then became the general age of majority in almost all states; in about half of the states, the minimum drinking age was also lowered to 18. However, a number of states that, in the wake of the Twenty-sixth Amendment, had lowered the drinking age to 18, subsequently raised it again to 19, 20 or 21 (10). At present, the minimum drinking age in the United States varies from 18 to 21 years, depending on the state.

Restrictions on Access to Alcohol

In a number of countries, statutes exist restricting minors’ employment or presence on premises selling alcoholic beverages, as well as prohibiting the sale of alcoholic beverages from certain premises or machines to which minors have access. These statutes—which may be viewed as supplementary to the general age restrictions on the sale or distribution of alcoholic beverages—take a variety of forms. For example, Hungarian legislation prohibits the sale of alcoholic beverages, inter alia, in establishments frequented by young persons, and during sports events, as well as by means of automatic vending machines. Switzerland, too, prohibits sale of alcohol from vending machines.
In Nicaragua, sale of alcoholic beverages is prohibited to persons under 18 in bars, nightclubs, markets, supermarkets, and sports and recreation centres. In restaurants, alcoholic beverages cannot be sold to children under 14. Nicaragua also prohibits the establishment of premises for the supply of alcoholic beverages within 400 metres of schools, hospitals, and sports centres.

In Bulgaria, the Public Health Law, Decree No. 24318 of 2 November 1973, prohibits the sale of alcoholic beverages, inter alia, at entertainment, sports, and other events intended for young persons, and in educational establishments. Liberia prohibits the employment of a person under the age of 18 in the sale of alcoholic beverages. Decree No. 1188 of 25 June 1978 in Colombia is even broader, since it prohibits persons under the age of 18 “from working or being present in establishments where alcoholic beverages are supplied”. Similar concerns are expressed in Algerian Ordinance No. 75–26 of 29 April 1975 which provides that persons under 18, unless accompanied by a parent, guardian, or other person over 21 “responsible for their surveillance”, may not be admitted to bars. And in Czechoslovakia, Law No. 120 of 19 December 1962 prohibits persons under 15 from having “access after 8 p.m. to public places in which alcoholic drinks are supplied unless they are accompanied by adults who assume responsibility for them”.

Council of Europe Recommendation No. R(82)4 of the Committee of Ministers on the prevention of alcohol-related problems, especially among young people, suggests that the sale of alcoholic beverages be prohibited in recreational or sporting clubs during events, in petrol stations and near highways, in secondary schools (where alternatives to alcoholic beverages should be offered), in bars on university premises, and from machines. The Committee recommends that alcohol sale and access to public houses be banned to young people under 16. It also recommends banning the employment of minors in public houses, and banning sales from shops near teaching establishments for the young (18).

In France, the spirit of this Recommendation has been anticipated and one unique further step taken. The Code on (alcoholic) beverage outlets and measures to control alcoholism empowers Prefects to establish so-called protected areas (notably around schools and premises used for leisure and sporting activities) in which bars may not be established (8, 19).

**Enforcement**

Penal sanctions are the principal tools of enforcement of the age restrictions on access to alcoholic beverages. In addition, in many jurisdictions, civil liability and regulatory sanctions imposed by licensing boards or other administrative bodies supplement the criminal penalties. The actual patterns of enforcement, as is to be expected, vary greatly from country to country as well as from place to place.
Since examination of these patterns is far beyond the scope of this discussion, only a brief summary of some of the kinds of existing provisions will be included here. As the commentary of the French Working Group on alcohol legislation notes (19):

The body of law for the protection of young persons from alcoholism is well thought out, appropriate and reasonable, as such, it would be adequate if it were properly enforced. However, it is clear that its enforcement is only partial. This is always the case where the law fails to reflect generally accepted views. The measures will be much better complied with only when the great majority of the population is convinced that they are necessary. This is why it is imperative that educators at all levels should try to provide young persons with complete and balanced information. Better education will mean that there is less need for repressive measures.

The criminal penalties to be imposed on the adult supplier of alcoholic beverages are usually laid down in the legislation on drinking age. This may distinguish between sellers and other suppliers, the harshest penalties being customarily reserved for the former. As indicated earlier, parents or other adults who provide minor children with alcoholic beverages may be exempted from these penalties. Parental exemptions are still fairly common in the United States, although the legislative trend in the twentieth century has been to narrow the discretionary authority of parents in this area (10).

The penalties authorized for violation of these statutes vary from jurisdiction to jurisdiction and may be more severe if aggravating circumstances exist. For example, in Algeria, a fine is the penalty for any violation of the age-restriction legislation; however, it is expressly provided that the maximum fine is to be imposed upon persons who cause anyone under 21 to drink to the point of drunkenness.

The young person who obtains alcohol in violation of these statutes may also be liable to criminal sanctions or to sanctions imposed by a juvenile court.

Of late, a small, but perceptible, move is being made in some jurisdictions to “decriminalize” violations of the drinking-age laws. In Wisconsin (USA), for example, a law passed in 1979 provides only for civil penalties—forfeiture of liquor licence for adults who furnish alcohol and revocation of driving licence for minors who possess it (20). The rationale for this comes in part from the feeling that criminal penalties are an “inappropriate social response to the use of alcohol” (21) because they excessively stigmatize both the provider and the user. The exception to this trend is in the area of drunk driving. In 1983 alone, 40 states introduced more severe penalties into their drunk-driving statutes (22) (see discussion in Chapter 14, pp. 278–285).

In some countries, including the United States, there is extensive government regulation of the sale and distribution of alcohol, and violation of the age restrictions may result in loss or revocation of a liquor licence and/or the imposition of a fine by a regulatory agency.

In the light of the fact that, despite the existence of such legislation, there is widespread experimentation by teenagers with alcohol, the
effectiveness of the laws as a deterrent for either the minor consumer or the adult supplier of alcohol is a subject of much discussion. In all likelihood, such legislation is enforced with greatest vigour when the minor who has been drinking also becomes involved in either criminal activity or in a traffic violation or accident. Many states in the USA have begun to use another approach to enforcement by applying the principle of “dram shop liability”, i.e., the seller is held responsible for the consequences of the individual’s drunkenness if he was underaged or manifestly drunk at the time that he purchased the alcohol. The age-restrictive legislation is, none the less, well established, and such debate as does take place is not in terms of total repeal of age-restrictive provisions but centres around the question of the most appropriate minimum age and the other methods of deterrence that can be provided by the law.

By way of summary, the following comments by Moser (9) on experience in the USA may be quoted:

Attention has been drawn to the fact that regulations concerning age limits are difficult to enforce. In some areas, however, not only the purchaser but also the seller may be punishable and production of an identity card may be requested. The purpose of the regulations is presumably to protect what are considered the most vulnerable age groups. In recent years a tendency has been noted towards lowering these permissible age levels for several reasons: that the regulation is difficult to enforce; that a high percentage of young persons below the legal age level are in any case purchasing and consuming alcoholic beverages, and the prohibition may only exacerbate the situation; it is considered by some that, where the voting age is lowered, so should be the drinking age.

Restrictions on Advertising

The all-pervasive message of alcohol advertising is that drink will make you glamorous, sexually desirable, socially acceptable, successful, less stress-ridden and more lively. There is little hard evidence regarding the effects of advertising on adolescents; Pittman & Lambert (23) have stated categorically that “no evidence has been presented in the literature that supports the contention that alcohol advertisements induce young people to drink”. This view is endorsed by Hawker (24) who says that “there is not a great deal of evidence that advertising alcoholic drink starts anyone drinking”. The issue, however, quite complex; advertising is not the only influencing factor. The fact that the drinking attitudes and practices of young people can be influenced, for good or ill, by many factors, is borne out by research. Thus a study carried out at the University of Strathclyde in Glasgow, Scotland (25) to examine whether the young are influenced in their attitudes towards alcohol by factors from their environment found that they were, but with qualifications:

Social and environmental factors are known to be important in the development of drinking behaviour amongst the young. However, research has sometimes ignored
the fact that the effect of a stimulus/situation upon a person depends on what that person perceives the situation to be. The differing constructions used by different people, or by different sections of a given population, are revealed in a number of broad attitudes or 'views of the world' which they hold.

Alcohol consumption, as Strickland points out in his report on a study in which a distinction was made between consumption and abuse (26), is "inadequately explained by advertising exposure". He concludes that "advertising was shown to have meagre effects on the level of consumption, and these effects rarely translated into effects on alcohol problems'.

Fluss (8) more specifically observed that "there appears to be little solid evidence to demonstrate the effectiveness of restrictions on advertising in reducing alcohol consumption, but the fact remains that many authoritative persons and bodies have called for such controls in recent years'.

Even so, legislation has been enacted in a number of countries that prohibits or restricts some or all advertising of alcoholic beverages; this is the case in Bulgaria, Canada, Ecuador, Finland, France, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the USSR (see Table 15 for some examples). These provisions appear, however, to be less common than those discussed in Chapter 8 in connection with tobacco products. As was true for tobacco advertising, there is in some countries a ban on all alcohol advertising, whether or not it is directed at young people. This is the case, for example, in Finland. In other countries, e.g., Ecuador, only advertising directed at minors is banned. In some instances, a single item of legislation restricts the advertising of both alcoholic beverages and tobacco products. For example, in Bulgaria, the broad statutory ban covers any form of advertising or publicity in which beneficial properties are attributed to either alcoholic beverages or tobacco products. In the same vein, in Ecuador, the relevant regulations strictly limit direct and indirect advertising of both cigarettes and alcoholic beverages aimed at minors. In Finland, tobacco advertising and alcohol advertising are regulated by statute. Switzerland prohibits advertising, inter alia, during events principally attended by, or organized for, children and adolescents.

Grant, in his survey of 15 western European countries (27), notes that restrictions on the advertising of spirits are more common than those on beer and wine, on the basis that the higher the alcohol content the greater the potential for harm. He also notes a trend towards self-regulation and voluntary codes. In the United Kingdom, for example, the Code of Advertising Practices states that advertisements, "should not be directed at young people or in any way encourage them to start drinking", neither should they depict anyone under 21 drinking, nor contain youngsters (except as crowd background). The code regulating television advertising is similar, but with an age limit of 25 years; it also advises that "no liquor advertisement may feature any personality who commands the loyalty of the young" (e.g., pop stars, actors/actresses, and sports personalities).
### Table 15. Restrictions on advertising of alcohol

<table>
<thead>
<tr>
<th>Country</th>
<th>Restrictions and comments</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Apart from regulations against advertising during peak viewing times for children, there are no legislative provisions or other measures aimed at limiting advertising of alcoholic beverages. There have recently been abortive attempts by private members in parliament to introduce them. However, a Voluntary Code of Advertising has been produced. This specifies that advertisements shall not link success and drinking, represent drinking in association with potentially dangerous activities, encourage overindulgence, or feature young people. The Australian Department of Health has primary responsibility for the external monitoring of adherence to the Code.</td>
<td>-</td>
</tr>
<tr>
<td>Canada</td>
<td>Federal regulations permit advertising of beer and wine, but not spirits, on television and radio. Each province passes its own legislation on advertising but must act within the federal regulations governing television and radio advertising. Several provinces allow no advertising and in most others it is subject to a strict code. In Quebec, the regulations state that publicity must be true, aesthetic, and moderate; it should not use star personalities or give the idea that alcohol has nutritive or curative value. Currently, discussions are taking place between the Government and the alcohol industry regarding restrictions on advertising. Advertising of alcoholic beverages: a) is prohibited in daily newspapers, radio and television on Sundays and public holidays; b) may not appear on pages in periodicals or in radio and television programmes directed to children or related to sports activities; c) is forbidden on sports grounds and during sporting activities. No commercial advertising of alcoholic beverages is allowed on radio or television just before and after programmes addressed to minors. Publicity on these products must be limited to factual information. It is prohibited to associate alcoholic beverages with moral and physical well-being, to relate them to sports, intellectual and professional activities or any particular qualities, or to national symbols or folklore music. Minors may not appear in publicity for alcoholic beverages, nor may publicity for these products be directed to minors.</td>
<td>-</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Advertising of alcoholic beverages: (a) is prohibited in daily newspapers, radio on television on Sundays and public holidays, (b) may not appear on pages in periodicals or in radio and television programmes directed to children or related to sports activities, (c) is forbidden on sports grounds and during sporting activities. No commercial advertising of alcoholic beverages is allowed on radio or television just before and after programmes directed to minors. Publicity on these products must be limited to factual information. It is prohibited to associate alcoholic beverages with moral and physical well-being, to relate them to sports, intellectual and professional activities or any particular qualities, or to national symbols or folklore music. Minors may not appear in publicity for alcoholic beverages, nor may publicity for these products be directed to minors.</td>
<td>Law No. 5489 of 8 March 1974</td>
</tr>
<tr>
<td>Egypt</td>
<td>Advertising of alcoholic beverages is prohibited by law. Advertising of alcoholic beverages, including beer, is on the whole prohibited. Exceptions: in professional restaurant trade publications, restaurants themselves, stores that sell alcohol and foreign magazines. To prevent hidden advertising, the directive on applying the law has been made extremely strict. The ban extends to textual advertising and, for instance, newspaper pictures must not show bottle labels or advertisements.</td>
<td>Law No. 63 of 1976</td>
</tr>
<tr>
<td>Finland</td>
<td>Advertising of alcoholic beverages, including beer, is on the whole prohibited. Exceptions: in professional restaurant trade publications, restaurants themselves, stores that sell alcohol and foreign magazines. To prevent hidden advertising, the directive on applying the law has been made extremely strict. The ban extends to textual advertising and, for instance, newspaper pictures must not show bottle labels or advertisements.</td>
<td>Law of 1976</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Advertising of beverages with more than 20% alcohol is forbidden.</td>
<td>Decree of 29 April 1977</td>
</tr>
<tr>
<td>Sweden</td>
<td>All commercial publicity on radio and television is prohibited. A special commission studied other advertising and in November 1977, the parliament passed a bill to come into force on 1 July 1979, including a total ban on all advertisements for spirits, wine and strong beer in newspapers and in most magazines.</td>
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</tbody>
</table>

*Adapted with permission from Mose, J. Prevention of alcohol-related problems: an international review of preventive measures, policies and programmes. Toronto, Alcoholism and Drug Addiction Research Foundation, 1980, Table 15, pp. 122-125.*
The Council of Europe Recommendation suggests that countries should avoid aiming advertising at the young and should avoid glamorizing alcohol. An awareness should be created in the media of the influence of alcohol on the young, and the advertising of non-alcoholic beverages should be supported to deflect attention away from alcohol as a beverage (28).

Countries that choose to restrict or prohibit the advertising of alcoholic beverages appear to base these restrictions on the belief that young people are especially susceptible to such advertising. Despite the lack of proof of the impact of alcohol advertising on youth, Grant (27) concludes that “it would be a callous and irresponsible society which permitted an unfettered exploitation of the youth market by alcohol advertisers”.

Health Education

That it takes more than prohibition to deal with alcohol abuse is a recurring, common-sense theme. Globetti (29) observed that “one truism gleaned from evaluation research is that treatment efforts alone are hardly adequate to meet the magnitude of alcohol problems in society”. Attempts to solve the problem of alcohol abuse appear to require, as a minimum, a broadly based education programme accompanied by governmental action at a societal level (25).

The history and present status of preventive, educational programmes around the world have been summarized by Fluss (8):

No less than 72 years have passed since Venezuela enacted a comprehensive law on anti-alcohol education (Ley sobre enseñanza antialcohólica; dated 25 June 1918). This established a compulsory course on alcohol and its effects in all the country’s schools and colleges. Today, many countries have established educational programmes designed to educate children on alcohol and the problems and hazards to health associated with its consumption. In Czechoslovakia, Law No. 120 of 19 December 1962 specifically refers to the need to educate adolescents attending school and young workers against the use of alcohol. The people’s councils are made responsible for promoting and organizing the rational use of leisure time, especially that of children and adolescents, and protecting the latter from the influence of alcohol by various means. Activities directed to children and young persons are among those assigned to the commissions to combat drunkenness in the Russian Soviet Federated Socialist Republic, the largest constituent republic of the USSR (Decree of 21 August 1972 of the President of the Supreme Soviet of the Russian Soviet Federated Socialist Republic). In the USA, alcohol education in public schools is mandated by law in almost all of the states... In Michigan, the statutory functions of the State Board of Alcoholics include cooperating with and assisting the Department of Public Instruction in promoting and encouraging in a more energetic way the teaching, in the schools of the state, of factual information relating to the use of alcoholic beverages. Under the terms of the Comprehensive Alcohol and Drug Treatment Act of 1973 of Tennessee, the declared policy of the state with reference to alcoholism and drug addiction contains the following statement:

“Prevention of alcoholism and drug addiction is to be accomplished by public education as to the causes, symptoms, and nature of alcoholism and drug
addiction. The department of mental health and mental retardation will prepare and distribute suitable educational material to the schools and interested members of the public and in addition will render assistance to suitable local agencies and activities promoting public interest in and information about alcoholism and drug addictions."

... Also in the USA, provision is made at the federal level for the funding of alcohol abuse education programmes in the Education Consolidation and Improvement Act of 1981, as well as for grants and contracts for the demonstration of new and more effective alcohol abuse and alcoholism prevention, treatment, and rehabilitation programmes in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as last amended by the Omnibus Budget Reconciliation Act of 1981. The latter act also amended the Public Health Service Act by the insertion of provisions enabling grants to be made to states to fund (inter alia) comprehensive programmes designed to deter the use of alcoholic beverages among children and adolescents."

Mention may also be made of the Trinidad and Tobago National Council on Alcoholism (Incorporation) Act of 1977, which creates a council whose aims and objectives are: (1) to stimulate public understanding of alcoholism as a disease that can be successfully treated; (2) to organize a campaign of education on alcoholism through all known media; and (3) to sustain widespread public awareness about the problems of alcoholism, and establish one or more Alcoholism Information and Referral Centres.

In Sweden, where alcoholism is a serious problem and concern considerable, the Social Service Law (No. 620) of 19 June 1980 requires each commune to establish a social welfare board, with responsibility for preventing and combating abuse of alcohol and other dependence-producing substances, particularly among young children and young people.

Conclusions

Legislation and health policy, in combination, form only one element of any coherent programme aimed at alleviating alcohol-related problems amongst adolescents. As Fluss pointed out (8), some of the factors that contribute to such problems "are scarcely, if at all, amenable to legal intervention".

In the first place, many of the root causes of alcohol consumption are beyond the reach of the law. Peer pressures, familial and parental conflicts, sociocultural imperatives, individual personality and behaviour are, in the main, impervious to its influence.

Secondly, even with the best intentions, laws and policies do not always achieve the desired effect and cannot always be enforced, particularly if societal attitudes are not in harmony with the legal requirements. As a WHO Expert Committee has concluded (31):

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* See also note 30, page 163
“Despite the multiplicity of programmes for the prevention of alcohol problems, adequate evidence of their efficacy in the various contexts in which they have been applied is still lacking.”

Finally, laws and policies themselves are often contradictory in terms of the objectives pursued or the messages conveyed to the public. This has led to increases in alcohol production, sale and consumption, at a time when alcohol-related health problems are coming to be recognized as of major importance.

While the role of law and policy is thus admittedly limited, it would be equally erroneous to think that legal measures are futile or unnecessary. The options available are vast, and there is no single universally applicable course of action. Past experience with unenforceable, irrelevant laws has led to the following conclusion: “the arena surrounding legal control of alcoholic beverages and consumption is a controversial one” (32), and must be approached cautiously and thoughtfully; nevertheless, “a series of restrictions, established after careful consideration of local sociocultural and economic factors, and imposed after widespread public education and discussion and investigation of public attitudes, are likely to result in measurable improvement” (9).

In all of this, health, as opposed to raising of revenue, is beginning to appear as a dominant determinant of policy. In Ontario (Canada), a call for a moratorium on measures to relax alcohol marketing and distribution policies has been accompanied by a plea that future measures be gauged by their health objectives, that is, their ability to contribute to the prevention of alcohol-related health problems (9).

References and Notes

15. Algeria, Ordinance No. 75-26 of 29 April 1975, concerning the prevention of drunkenness in public and the protection of minors against alcoholism, Title II; International digest of health legislation, 27: 4 (1976). The law prohibits the sale of alcoholic beverages to persons under 21 years of age in bars and other establishments, irrespective of whether the beverages are to be taken away or consumed on the premises; persons under 18 years of age may not be admitted to bars, unless they are accompanied by a parent, guardian, or other person (above 21 years of age) responsible for their surveillance.
16. Section 9(2) lays down, however, that this prohibition "shall not apply to the sale of beer to persons under 18 years of age provided that they are taking it off the premises for the use of an adult."
20. Wisconsin Statutes Annotated, Sections 48.344, 66.054(20), and 125.07(1) (West's 1979).
30. The United States' programme has established specific goals. These include the following:
- by 1990, the proportion of adolescents between 12 and 17 years of age who abstain from using alcohol should not fall below 1977 levels (in 1977 the proportion of abstinence was 45%);
- by 1990, the proportion of adolescents between 14 and 17 years of age who report acute drinking-related problems should be reduced to below 17% (in 1978, it was estimated to be 19% based on 1974 survey data); the term "acute drinking-related problems" is defined here as "problems such as episodes of drunkenness, driving while intoxicated, or drinking-related problems with school authorities".
Laws and Policies Affecting Adolescent Health


Legislation

Algeria
Ordinance No. 75-26 of 29 April 1975 concerning the prevention of drunkenness in public and the protection of minors against alcoholism (Title II) [IDHL, 27: 9 (1976)].

Bulgaria
Decree No. 2431 of 2 November 1973 embodying the law on public health (Sections 55 and 56) [IDHL, 26: 513 (1975)].

Colombia
Decree No. 1188 of 25 June 1978 promulgating the National Statute on narcotics (Section 13) [IDHL, 29: 23 (1978)].

Costa Rica
Law No. 5469 of 6 March 1974.

Czechoslovakia
Law No. 120 of 19 December 1962 on the control of alcoholism (Sections 9, 9(1) and 11(2)] [IDHL, 15: 78 (1964)].

Ecuador
Supreme Decree No. 965 of 24 August 1973, promulgating regulations governing manufacturing, sales, and advertising activities associated with the use and consumption of cigarettes and alcoholic beverages [IDHL, 29: 64 (1978)].

Egypt
Law No. 63 of 1976.

Finland
Law No. 678 of 13 August 1976 amending the Alcohol Law (Section 59a) [IDHL, 28: 485 (1977)].

France
Code on [alcoholic] beverage outlets and measures to control alcoholism.

German Democratic Republic
Ordinance of 26 March 1969 on the protection of children and adolescents.

Germany, Federal Republic of
Law of 27 July 1952 on the protection of adolescents in public, as amended.

Hungary
Ordinance No. 19 of 20 July 1977 of the Minister of Internal Trade concerning restrictions on trade in alcoholic beverages (Section 8) [IDHL, 29: 147 (1978)].

Indonesia
Decree of 29 April 1977.

*For the sake of concision, International digest of health legislation has been abbreviated throughout to IDHL.
Liberia
Penal Law, Chapter 16 of Title 26 (Section 16.6) (1976).

Malawi
The Liquor Act, 1979 [IDHL, 30: 820 (1979)].

New Zealand

Nicaragua
Decree No. 163 of 17 November 1976 on the opening of premises for the supply of alcoholic beverages (Section 1) [IDHL, 33: 284 (1982)].
Decree No. 596 of 12 December 1980 prohibiting the sale of alcoholic beverages to children under 18 years of age (Section 1) [IDHL, 33: 284 (1982)].

Poland
Law No. 434 of 10 December 1959 on control of alcoholism.

Singapore
Liquors Licensing (Amendment No. 2) Regulations No. 5183 [IDHL, 28: 117 (1977)].

Sweden
Law No. 293 of 12 May 1977 on trade in beverages (Section 1) [IDHL, 28: 451 (1978)].

Switzerland
Federal Law on alcohol (Amendment of 19 December 1980) (Section 41) [IDHL, 33: 739 (1982)].

Trinidad and Tobago
Trinidad and Tobago National Council on Alcoholism (Incorporation) Act, 1977 [IDHL, 32: 259 (1981)].

Union of Soviet Socialist Republics
Russian Soviet Federal Socialist Republic

United States of America
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, 1978, as amended by the Omnibus Budget Reconciliation Act, 1991.
Education Consolidation and Improvement Act, 1981.

New York
Penal Law (Section 260.20(4), as amended 1982).

Tennessee

Wisconsin
Wisconsin Statutes Annotated (Sections 48.344, 66.054(20), 125.07(1), 176.28 and 176.30(2)).
10. Drug Dependence

The increase in concern over teenage drug use and abuse (1) dates essentially from the late 1960s when, in various countries, rapid changes were observed in patterns of drug use, and addicts under the age of 18 were first seen. In the words of Boyd (2), this "reflected the incubation of an epidemic of general drug abuse which had been developing during the previous decade" in many countries. Boyd went on: "The tips of this malignant iceberg manifested itself as a fresh and virulent culture of narcotic drug taking", having its greatest impact on young people. Where previously the onset of addiction had generally occurred when the person was in his 30s, the young were becoming the "new addicts" (3, 4).

Data from other countries seemed to confirm the existence of an "epidemic" of drug use in the late 1960s (5). In the Netherlands, 11.15% of secondary schoolchildren had experimented with drugs at least once (2.5% more than 20 times): in Sweden, 8% of 9th-grade students and 6% of university students had used drugs once (4% and 5% more than 10 times); in Switzerland, 19.6% of a representative sample of young people aged 13–20 in Basel had used drugs at least once (4.7% had used them "often").

Though other drugs—hallucinogens, amphetamines, barbiturates, morphine derivatives, cocaine and solvents—had their place in the patterns of use, the most popular drug was cannabis, or "pot" as it is popularly called (6). As Moser noted (5), it was in the late 1960s that cannabis emerged in most countries of the world as "the drug most widely used for non-medical purposes, and . . . its use has spread rapidly in recent years, particularly among younger age groups" (7).

The most recent statistics available provide some basis for Moser's generalizations as well as the general concern among health care providers and policy-makers over drug use. A recent multicountry study of drug use by non-student youth by Smart and his colleagues (8) shows the range (see Tables 16 and 17). The age at which a person begins to use drugs is important; various experts have pointed out the link between early use, rapid escalation in the rate of use, and the development of dependence (9), as well as the fact that age of first use can be an effective indicator of changes in patterns of drug use (8). This information (see Table 18 for data from six cities in developing countries) is also important in designing preventive programmes because it readily identifies the most vulnerable age groups. In Mexico City, for example, in addition to the data reported in Table 18, research has indicated that use of glues and other volatile
Table 16. Persons ever having used specific drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Chandigarh (N = 393)</th>
<th>Islamabad (N = 360)</th>
<th>Penang (N = 90)</th>
<th>Toronto (N = 430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>3.4</td>
<td>84.4</td>
<td>2.2</td>
<td>51.2</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1.0</td>
<td>0.3</td>
<td>2.3</td>
<td>9.5</td>
</tr>
<tr>
<td>Barbiturates/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sedatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens</td>
<td></td>
<td>0.3</td>
<td></td>
<td>15.4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3.6</td>
<td>13.1</td>
<td>9.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Opium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Table 17. Persons using specific drugs in previous 12 months

<table>
<thead>
<tr>
<th>Drug</th>
<th>Chandigarh (N = 393)</th>
<th>Islamabad (N = 360)</th>
<th>Penang (N = 90)</th>
<th>Toronto (N = 430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>2.0</td>
<td>83.9</td>
<td>6.0</td>
<td>35.1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.3</td>
<td>0.3</td>
<td>1.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Barbiturates/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sedatives</td>
<td></td>
<td>6.4</td>
<td>1.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td></td>
<td>0.0</td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>Opium</td>
<td>2.3</td>
<td>12.2</td>
<td>0.6</td>
<td>1.9</td>
</tr>
</tbody>
</table>


Table 18. Mean age of first drug use

<table>
<thead>
<tr>
<th>Drug</th>
<th>Bangkok</th>
<th>Islamabad</th>
<th>Jakarta</th>
<th>Mexico City</th>
<th>Penang</th>
<th>Rangoon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opium</td>
<td>24.1</td>
<td>29.0</td>
<td>15.5</td>
<td>16.8</td>
<td>23.3</td>
<td>24.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>20.8</td>
<td>18.6</td>
<td>23.3</td>
<td>21.1</td>
<td>20.4</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>17.6</td>
<td>22.0</td>
<td>16.5</td>
<td>16.0</td>
<td>18.3</td>
<td>18.1</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>17.5</td>
<td>16.0</td>
<td>19.3</td>
<td>23.9</td>
<td>29.5</td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td>15.0</td>
<td>16.9</td>
<td>21.3</td>
<td>18.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>20.0</td>
<td>20.9</td>
<td>11.5</td>
<td>12.3</td>
<td>15.2</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>20.1</td>
<td>17.8</td>
<td>17.7</td>
<td>20.4</td>
<td>17.5</td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>18.2</td>
<td>16.3</td>
<td>16.0</td>
<td></td>
<td>19.0</td>
<td></td>
</tr>
</tbody>
</table>


The light of these figures, solvents begins at a very early age and has reached a new peak (10); indeed, mean age of first use is 14.7 years, while 12% had used inhaled substances by age 9, and 53% at age 10–14. In the light of these figures,
it is not surprising that there is a specific legal provision on this subject (see p. 179). In Bangkok, Penang, Rangoon, and Jakarta the group most vulnerable to heroin use is aged between 15 and 21; for cannabis it is the 16-18-year age group.

As Tables 16-18 show, the drugs used vary from country to country, from age group to age group, and from culture to culture. Of the array of drugs available, five groups create "problems" among the young: cannabis, amphetamines, barbiturates, opiates (including synthetic opiates and cocaine) and hallucinogens (mescaline and LSD).

There is little information on current use of hallucinogenic drugs such as LSD, but a decade ago it was reported to be considerable in the United Kingdom, where LSD had become part of the general drug scene. Most of the users were probably under 25 years of age. The survey of non-student youth undertaken by Smart et al. (8) reported that in Toronto 15.4 % of the sample had used hallucinogens. Young people also abuse amphetamines, the first big wave of use among them having begun in Japan in 1946. By 1954, there were about 200 000 amphetamine-dependent persons, mostly male and largely in the age group 21-25 years. Medical treatment for them was provided for by law and the "epidemic" was brought under control fairly quickly (5).

Later, the fashion for oral and intravenous use of amphetamines spread to several European countries, but a rapid increase in numbers of dependent persons was not noted until the mid-1960s. In Sweden, about 1-2% of young people surveyed in 1967 and 1968 had had experience of intravenous drug injection, mostly of amphetamines. Such use, however, was found to be most prevalent in asocial and criminal subcultures. The use of amphetamine-type drugs worldwide appears now to have declined, as Table 16 indicates, but recently, in Toronto, as high a proportion as 9.5% of those surveyed said that they used them (8).

Dependence on barbiturates seems to have developed as a result of over-prescribing. In Australia, in 1974, barbiturates accounted for about 10% of all prescribed drugs. In the United Kingdom, dependence on barbiturates accounted for the most widespread dependence on any drug, except perhaps cigarettes, in the mid-1970s; one in five users were regarded as "dependent". In Thailand, barbiturates can be obtained without medical prescription and dependence on these drugs is said to be frequent among prostitutes and young women working in bars (5). More recently, the prevalence of barbiturate use among youth in Canada, Malaysia, and Pakistan was put at 6.3%, 3.3%, and 6.7%, respectively (8).

Drug-dependence problems arising from the abuse of morphine-type drugs are prevalent in Thailand, where a considerable number of adolescents and young people have become dependent on heroin over the last ten years. Opium is produced in Yugoslavia, though dependence on that drug is not regarded as significant; its use may nevertheless be an
increasingly serious problem among young people. Opium was eaten, smoked or injected by 7% of drug-using secondary-school pupils studied some 15 years ago by Buikhuisen & Timmermans (11) in the Netherlands. Some youthful drug users in Canada (4.4%), India (3.6%), and Pakistan (13.1%) also currently use opium (8).

The use of cocaine was not much reported by most countries at the time of the Moser study (1974) (5), though in the Netherlands, 3% of drug users in a school survey admitted such use. Worldwide, the use of cocaine by teenagers appears low—perhaps a function of the high cost—but in Toronto, 6.3% of young drug users said that they had tried cocaine (8).

In countries with long experience of heavy drug use, the tendency is towards use of a single drug, perhaps because continuous supply is then less problematic (5). Multiple drug use may, however, be the norm for many young drug users in countries where drug use is a relatively recent development.

Moser (5) noted in 1974 that, in France, for example, cannabis, LSD, amphetamines, heroin, opiates, barbiturates, tranquilizers, and even solvents are consumed either together or successively according to the more or less transitory fashion of the moment and the supplies available. Liquor, heroin and hypnotics are used either together or alternately in Thailand. In Yugoslavia, drug-dependants often use various ‘cocktails’ (alcohol-meprobamate-barbiturate, preludin-codein, etc.) which they make themselves, mixing various easily obtained medicaments (5). Many countries report a link between the use of alcohol and that of other drugs. Studies in the United Kingdom indicate two patterns in this regard: (1) the young person who becomes involved with other drugs may have been a heavy drinker, and (2) older people treated for alcoholism had habitually taken other drugs to excess (5).

In recent years, some progress has been made towards describing the profiles of young people likely to use drugs, and gradually, more is becoming known about the causes of drug abuse. In teenagers, the ‘triad of the development of drug dependence’—personality, social milieu, and drug type—as suggested by Kielholz (9) a decade ago, combine to explain drug use (see Fig. 4). In this triad, the personal reactions to the social milieu predominate as ‘triggering’ factors.

However, the ‘causes of drug dependence are always multiple’ (9). Research has shown that feelings of isolation, hypersensitivity and lack of self-confidence are characteristic products of the strain under which many young people operate and, when combined with family history, produce a measurable predisposition to drug dependence. (Kielholz & Battegay (12) found that 60% of drug abusers come from a social or familial milieu that demonstrated a predictable predisposition towards drug abuse.) Yet a large number of young people obviously become drug-dependent without any familial predisposition (see Table 19 for factors and environments associated with drug abuse).
Adolescence is a time of stress; use of drugs, at least initially, may be an attempt to relieve that stress. Kielholz (9) writes that:

Drug dependence is always related to the general human desire to prevent, correct or forget temporarily such unpleasant elements of human experience as conflicts, tension, anxiety, unhappiness, stressful situations, as well as the desire to repeat and intensify pleasures which have once been experienced.

Table 19. Factors and environments associated with high risk for drug abuse

<table>
<thead>
<tr>
<th>Factors</th>
<th>Environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- unemployment</td>
<td>- large urban environments</td>
</tr>
<tr>
<td>- migration to city</td>
<td>- areas where drugs are sold, traded, or produced</td>
</tr>
<tr>
<td>- alienation from family</td>
<td>- areas with high rate of crime or vice</td>
</tr>
<tr>
<td>- leaving school early</td>
<td>- areas where there are drug-using gangs</td>
</tr>
<tr>
<td>- broken home; one-parent family</td>
<td>- areas where delinquency is common</td>
</tr>
</tbody>
</table>

Recent experience in Ireland underscores what has been said and shows how quickly drug abuse can reach "epidemic" proportions when all the necessary factors are present. Up to 1980, Ireland had no drug problem to speak of, save for middle-class youth dabbling with cannabis, LSD, and amphetamines. In 1980, an estimated 100 heroin addicts were being treated at the Jervis Street Hospital, Dublin's main drug-treatment centre; in early 1984 there were between 1500 and 2000 such addicts, mainly between the ages of 16 and 24. Most were jobless and working class. The rapid rise in heroin use, without any identifiable drug culture associated with it, has taken everyone by surprise. According to the specialists, the problem has its origins in "the stress of living in poor, substandard housing, without work or the prospects of it" (13).

While there is much variation in patterns of drug use and abuse among young people the world over, some generalizations can be made. Firstly, as Smart and his colleagues note (8), most of the studies point to a fairly clear profile of young chronic drug abusers. They "are more likely [than their non-drug-using peers] to be alienated from families, out of school, and away from home, or in situations where parental controls are relaxed and their peers are using drugs".

However, to put things in their proper perspective, the majority of young people appear not to use drugs. Data from India suggest that a high percentage of young people have never tried drugs, including tobacco and alcohol (14). Similar findings have been made elsewhere (see Table 20). The situation in Pakistan (Islamabad), where only a small percentage are non-users, appears to be an aberration.

### Table 20. Types of drug use*  

<table>
<thead>
<tr>
<th>Type</th>
<th>Chandigarh (N=303)</th>
<th>Islamabad (N=360)</th>
<th>Penang (N=50)</th>
<th>Toronto (Y=430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-users</td>
<td>94.1</td>
<td>8.1</td>
<td>76.9</td>
<td>44.2</td>
</tr>
<tr>
<td>Light users</td>
<td>5.1</td>
<td>6.4</td>
<td>13.3</td>
<td>44.4</td>
</tr>
<tr>
<td>(Have used one or more substances but none as frequently as once a week in the past year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate users</td>
<td>0.5</td>
<td>14.4</td>
<td>1.1</td>
<td>9.3</td>
</tr>
<tr>
<td>(Have used one or more substances once a week, but none as frequently as once a day in the past year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy users</td>
<td>0.5</td>
<td>71.1</td>
<td>1.1</td>
<td>2.1</td>
</tr>
<tr>
<td>(Have used one or more substances at least once a day in the past year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It should also be remembered that not all young drug users continue the practice. Experimentation, one of the hallmarks of the youth experience, figures prominently among the reasons for which drugs are used. Research on the reasons for drug use among university students in India yielded, *inter alia*, the following results: 61.6% used drugs on an experimental basis out of curiosity; 35.1% used them for “kicks”; and 32.4% to help deal with problems, stresses and failures (15). This does not, however, lessen the seriousness of the drug-abuse problem.

The problem of drug use among youth presents a daunting challenge (16). It cannot be dealt with in isolation—the causes and patterns of drug use and abuse are simply too complex. Rather, as Jayasuriya writes in his recent survey (17) “the issues and problems involved are so inextricably interwoven that, in order to identify and appreciate the nature of any one of them, one has to consider all the relevant matters from a very broad perspective”. The legal and policy perspective that will be presented in this chapter is necessarily narrow, representing only one aspect of programmes to deal with the effects of drug use among youth. One must be careful, as Jayasuriya warns, not to overlook the social, economic, medical, cultural and psychological factors that impinge, in one way or another, on the problem. Nevertheless, law and policy have their role to play in deterring drug use and establishing comprehensive programmes to combat the effects of such use and dependence among young people. It is from this perspective that the present chapter has been prepared, and it will therefore look specifically at how law and policy have been used to address the problem of drug abuse among young people. It is based largely on the report by Jayasuriya (17) and a recent survey by Porter et al. on *The law and the treatment of drug- and alcohol-dependent persons* (18), together with additional original research.

**Prevention of Drug Use and Abuse**

The history of drug control *per se* is an interesting one. Jayasuriya (17) notes that “quite apart from legislation, there have been other forms of social control since time immemorial to regulate the use and consumption of certain types of dependence-producing drugs”. Historically, the use of drugs such as opium and cannabis carried no stigma in many societies; indeed, they have been freely used for what were thought to be culturally acceptable and beneficial purposes—therapeutic as well as domestic and religious. In other societies—the Islamic communities, for example—the use of mind-influencing drugs is subject to an absolute taboo, sometimes enforced by penal sanctions. While it is true that drugs can have a number of important beneficial uses, they also have the potential, when abused, to cause immense damage.

The earliest drug control legislation, with few exceptions, appears to have been introduced for economic or political, rather than health.
reasons. In the past, control over drug production generated prestige and wealth for the governments of countries where the drugs were grown and processed. Little, if any, attention was given to the effects that drugs had on users.

The use of criminal law to punish users, possessors and addicts is largely a 19th century innovation, at which time drug abuse became labelled as unacceptable. The vast majority of drug abuse laws, however, have come into being in the 20th century (17), and are now found throughout the world. Most, based as they were on criminal law, rest on the premise that individuals who abuse drugs should be punished rather than treated and rehabilitated; that they are criminals rather than ill people. This pattern has a long, if not altogether glorious history, going back more than 600 years in Thailand where, during the reign of King Rama Tibodi I (Ayutthaya Period), a “Criminal Behaviour Law” was enacted which contained a provision that sought to punish drug addicts (19). Another centuries-old legal tradition has also built up around drugs, namely that of using laws and policies to impose sanctions on the producers and sellers, as well as the users, of illicit, dependence-producing drugs. More recent legislation, as we shall see later, has moved on somewhat from this punitive approach.

The aim of legislation on drugs is generally to keep illicit drugs out of the hands of the populace, either to prevent crime or for economic, medical or public health purposes. In some settings, laws have been passed at different times, with little or no consistent policy. One committee in India pointed out, for example, in the course of urging that a new single-text law be introduced, that “the present legislation on the prevention and control of drug abuse has grown piecemeal over the last 120 years and consists of several laws passed at different times and with different objectives” (cited by Jayasuriya (17)). In fact, in most laws, there is no explanation of the reasons behind their adoption. One exception is the Peruvian Health Code, which acknowledges in a straightforward way that:

Drug dependence is a public health problem... The health authority shall be required to maintain strict control over the illicit use of any drug or narcotic which acts on the human body with all the characteristics of a poison causing degeneration of the race and the human species.

Globally, legislation on prevention of drug use can be divided into two different, though not unrelated, types: (1) legislation that seeks to control the production, sale or use of certain specific dependence-producing drugs through criminal law, and (2) legislation that controls the production or distribution of all pharmaceutical products, medical and non-medical. There is hardly any uniformity in the type of law used between one country and another, though some countries have borrowed patterns from others; this is particularly true of countries that were formerly colonies. In general, a mix of criminal law and public health law is used (20).
As Jayasuriya (17) notes:

From the perspective of the mechanics of control, drug abuse laws can be classified into two broad categories. The first consists of laws that proscribe certain activities and provide for a system of licences or monopoly to ensure that supplies are available for legitimate purposes. The second category of laws are more advanced in that, apart from proscribing various activities and providing for legitimate supplies, these laws also deal with other possible methods of regulating the drug abuse problem, such as: treatment and rehabilitation (whether voluntary or compulsory); education on drug abuse prevention . . . etc.

Definitions

The types of drugs that are “restricted”, “regulated”, “prohibited”, “controlled”, or “dangerous” vary greatly and are determined, with few exceptions, by national legislation. In the early years of this century only a small number of drugs were regulated, opium being one of them. Jayasuriya (17) notes, however, that “with the rapid proliferation of substances and drugs that lend themselves to addiction or dependence, the trend has been to widen the net and to bring under control almost all such substances and drugs the indiscriminate use of which is medically inadvisable”. This has prompted the drafting of two international conventions (see pp. 193-194). Differences in terminology make intercountry comparisons difficult, and also add measurably to the difficulty in defining what we refer to here as dependence-producing drugs, particularly as the term is not used in the normal course of legislation.

Dependence-producing drugs are known variously as “narcotics”, “psychotropics”, “drugs”, “poisons”, or “substances”, and in most legislation are assigned to different categories, with use being either absolutely prohibited or regulated in certain ways, usually as part of a medically supervised regime. The Bolivian Decree-Law of 1973 speaks, for example, of three categories of substances: those that are “dangerous”, those that are “controlled”, and those that are to be used “under supervision”. “Narcotic drugs or preparations” are defined as “substances which, whether or not they produce psychic dependence, profoundly affect the conduct and behaviour of the individual and under the influence of which antisocial acts are committed”. The law also defines “psychotropic drugs” and “pharmaceutical products”, “depressants”, “stimulants”, and “hallucinogenic substances”. Several other countries (e.g., Argentina and Burma) make similar distinctions, though often not in such detail. In Tunisia, the term “poisons” is used to embrace toxic substances, narcotics and dangerous substances; the law in the Philippines has only two categories, “prohibited” and “regulated” drugs.

There is also another complementary set of definitions that is important to this discussion, i.e., those that define exactly what is meant
by “drug-dependence” and “drug-dependent person”. These definitions, as we shall see in a later section (p. 182), establish the conditions under which persons are either legally eligible for or subject to commitment for treatment or rehabilitation. Table 21 reproduces a number of these definitions, some of which are more elaborate than others.

**Lawful prescribing and use of drugs**

Under many drug-abuse laws, special categories of health care personnel are authorized to “prescribe” dependence-producing drugs. This is another method of regulating drug use:

The philosophy underlying the concession extended to medical practitioners to prescribe narcotics and other dependence-producing substances is that they serve a useful function in therapeutics for certain specific indications (17).

However, numerous countries have established special control mechanisms to prevent such drugs from being diverted to non-medical uses.

**Table 21. Definitions of terms used in legislation on drug dependence**

<table>
<thead>
<tr>
<th>Country</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada (Nova Scotia)</td>
<td>Drug dependence: “a state of psychological or physical reliance or both on one or more chemical substances that alter mood, perception, consciousness or behavior to the apparent detriment of the person or society or both”</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Drug-dependent person: “uses narcotics and is in a state of physical or mental dependence”</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Drug-dependent person: “through the use of any dangerous drug undergoes a psychic and sometimes physical state which is characterized by behaviors and other responses including the compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effect and to avoid the discomfort of its absence”</td>
</tr>
<tr>
<td>Mexico</td>
<td>Drug-dependent person: “other than for therapeutic purposes, voluntarily uses or experiences the need to use any narcotic or psychotropic substance”</td>
</tr>
<tr>
<td>Philippines</td>
<td>Drug dependence: “a state of psychic or physical dependence, or both, on a dangerous drug, arising in a person following administration or use of that drug on a periodic or continuous basis”</td>
</tr>
<tr>
<td>Singapore</td>
<td>Drug addict: “through the use of any controlled drug: (a) has developed a desire or need to continue to take such controlled drug; or (b) has developed a psychological or physical dependence upon the effect of such controlled drug”</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>A person is to be regarded as being addicted to a drug: “if and only if, he has as a result of repeated administration become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued”</td>
</tr>
</tbody>
</table>

While in many settings the "prescription" itself acts as a control mechanism, several countries, e.g., Ecuador, Mexico and Tunisia, require that special prescription books, some requiring enormously detailed information, be kept for dependence-producing drugs (17). Another method of control is to tailor the prescription to the patient's needs, and to make it valid only for a limited period; thus, in Brazil, the period is 30 days, in Haiti seven (17). If long-term use is indicated, special permission must be sought in Iraq, Lebanon and Mexico from the Ministry of Health or the Narcotics Control Board.

Abuse of "prescription" drugs is also a problem of enormous proportions in some countries. On the whole, laws and policies do not overlook the possibility that this special authority afforded to medical practitioners and pharmacies to dispense drugs will itself be abused, so that most countries impose stiff penalties for violation of the rules governing prescribing.

The legislative approach to prevention of drug use is twofold, being based not only on prohibition but also on education and awareness. The first approach focuses on ensuring, to the greatest extent possible, that minors do not come into contact with dangerous drugs, and imposes particularly stiff penalties on persons selling or supplying drugs to minors or inciting them to use drugs. Punishment is even at times imposed on parents or guardians for failure to ensure that minors do not obtain or use a dangerous drug. The second approach is to educate young people about the hazards of drug use, in the hope that, if they are aware of the consequences, they will be less likely to use drugs.

Prohibition

One of the patterns in evidence in drug-abuse legislation around the world is the prohibition of certain activities that fall outside what is acceptable. These are often wide-ranging. In Sri Lanka, for example, the Poisons, Opium and Dangerous Drugs Ordinance prohibits such activities as sowing, planting, cultivating, obtaining, possessing, importing, exporting, manufacturing, consuming, using, selling, supplying, and transporting drugs (17). The Health Code of Mexico prohibits any illicit "dealings" with drugs, encompassing a variety of activities ranging from production and manufacture to handling and packaging, from mixing, wrapping and storage to preparation, sale and supply. The Singapore Misuse of Drugs Act of 1973 uses a word often found in legislation on drug abuse, namely "traffic", which includes such acts as selling, giving, administering, transporting, sending, delivering and distributing. In short, most legislation aims to prevent any activities relating to illegal drug use and abuse.

The provisions of the law applicable to possession, selling, supplying and distribution are those most relevant to adolescents. While the penalties attached to such illegal acts often fall equally on adults and
minors who commit them, laws in some countries apply most harshly to those who “deal” with the young or expose them to drug use.

Israel’s legislation, in addition to general provisions on drug transactions, makes the following three acts punishable offenses: (1) giving a dangerous drug to a minor, (2) being a person responsible for a minor, allowing him to obtain or use a dangerous drug; and (3) inciting a minor to obtain or use a dangerous drug. Other acts aside, a person is presumed to have committed any of these offenses if he either gives to a minor, or to another person for a minor, a utensil designed for use with a dangerous drug; or invites, or directs a minor to, or detains him in, a place where persons usually “indulge” in the use of dangerous drugs or a place where he can obtain or use a dangerous drug. The law in the Philippines is harshest of all, since it authorizes the death penalty for anyone who, unless authorized by law, sells, administers, delivers, distributes, or transports a prohibited drug or acts as broker in any such transactions. If the recipient of the drugs is a minor, the death penalty is mandatory. In Bulgaria, anyone “inciting” someone else to use narcotic substances can be punished with up to five years of imprisonment. When the “incitement” involves a child or minor, the penalty can be up to eight years in prison.

The South American Agreement on Narcotic Drugs and Psychotropic Substances (1973) makes supply, application, procurement or delivery of narcotics to minors (or mentally handicapped persons) an aggravating circumstance which can result in a harsher sentence (21).

Some toxic substances that can legally be sold to adults cannot be sold to minors, on the principle that the health of the young must be protected. Some of these substances are known to have a stupefying effect and are therefore specifically banned on grounds akin to those for drug control. In Mexico, as in many other countries, the sale to minors of thinners, adhesives, varnishes, and other substances that can be abused by inhalation, is prohibited. Such products must also display the warning: “Contains toxic substances, prolonged or repeated inhalation of which causes serious damage to health. Keep out of reach of minors.” (22).

Educational measures

Promotion of awareness of the consequences of drug use and abuse, as opposed to the traditional, criminal sanction of such use, is now one of the mainstays of the preventive approach. The hope, simply put, is that education on drug abuse will deter drug use. Worldwide, there is a trend, though it is a relatively recent innovation in the developing world (17), towards the use of educational measures as part of the battle against drug abuse. Several countries in Africa, Latin America, and Asia, as well as Europe, have introduced drug education (23), though as Jayasuriya points out, its “novelty makes it somewhat difficult to define its exact scope, content, or objectives” (17).
Many informational and educational campaigns, while being either a necessary antecedent or complement to the prohibitive approach, are carried out without involving legislation. Others are mandated by law for all citizens, and some are aimed particularly at young people. While all of these are part of general drug-abuse prevention programmes, some come under the aegis of ministries of health, some of ministries of education, and some, quite naturally, are collaborative.

Legislation in Bolivia, for example, makes the National Drugs Council, in collaboration with the educational authorities, responsible for planning educational and preventive programmes. They have the responsibility for outlining the basic approach to be adopted throughout the country in explaining what factors influence the development of drug addiction, as well as the harmful individual consequences of drug abuse. In Mexico, the Health Code (1973) requires that education on the danger of drug use be given to the general public, as well as being made part of health programmes in schools.

Legislation in Italy is comprehensive, requiring the Director of Education, in cooperation with the Provincial Schools Council, to establish a Committee on Education, Programming and Research. The principal objective is to assist schools in educating students about the potentially harmful effects of the use of narcotics or psychotropic substances. To achieve this goal, support is provided: (1) for the creation of training courses for schoolteachers at all levels to give them the skills and knowledge necessary to instruct young people on drug-abuse issues; and (2) for the establishment of similar courses for the parents of pupils. Italian law also makes provision for drug-abuse information to be conveyed to young persons doing military service.

In Colombia, primary and secondary school education programmes are required to include, as a matter of course, information on the risks of drug dependence (24). In Peru, the Ministry of Education is required to include various aspects of drug abuse in all teacher-training programmes, and to carry out information campaigns among schoolchildren and organized community groups. The National Information System, acting in conjunction with the Ministry of Health and the Ministry of Education, is required to disseminate information to the public on the prevention of drug abuse. In Brazil, the National System for the Prevention, Surveillance and Suppression of Narcotics, established by Decree No. 85110 of 2 September 1980, has the task, inter alia, of promoting, in cooperation with the competent agencies, the inclusion in teacher-training courses of instruction about narcotics and substances causing physical or mental dependence, and of promoting, in collaboration with the competent agencies, the inclusion of specific items in primary education curricula, in order to inform pupils of the nature and effects of narcotics or dependence-producing substances. The provisions of the 1980 Decree complement those of a law of 1971, notable for its directness, which provides for:
... the implementation of national and regional plans and programmes for mass education, especially of youth, aimed at explaining the harmful effects resulting from the misuse of narcotics and other dependence-producing substances, and eliminating the causes of such misuse.

The following steps must be taken by the appropriate authorities:

At the beginning of each school year, the States, the Federal District, and the Territories are to organize courses for the benefit of members of the teaching staff of educational establishments, with the object of training them to conduct a campaign on the school premises against traffic in and the illicit use of narcotics and other dependence-producing substances. In the course of the school year, primary, secondary, and higher educational establishments are to organize lectures on the harmful effects caused by these substances, attendance at these lectures being compulsory for pupils and students and optional for parents. The directors of educational establishments are to take all necessary measures to prevent traffic in and the use of the above-mentioned substances on school premises.

Burma makes drug education programmes mandatory for parents, the thought being that this will ensure that, through them, children will learn of the dangers of drug use without having to be given medical advice.

Legislation in Portugal seeks both to educate youth about the risks of drug abuse, and to address some of the underlying conditions that may lead to such abuse. The Study Centre for the Prevention of Drug Abuse was established in 1976 and is responsible for:

(a) studying the psychosocial conditions that may contribute to instability, maladjustment, and antisocial conduct in connection with drug abuse and related problems;

(b) drawing up, proposing, and implementing primary, secondary, and tertiary prevention programmes in order to solve drug abuse problems;

(c) drawing up, proposing, and implementing programmes to solve the psychosocial problems of population sectors that are at high risk from drug abuse and other forms of psychic and emotional disturbance;

(d) centralizing national and foreign documentation and preparing and disseminating appropriate information on the above matters in order to assist specialists working in agencies for the prevention of drug use and rehabilitation of drug users;

(e) promoting and supporting the active participation of community associations and groups in achieving local solutions to problems arising from drug abuse.

In the Philippines, the Dangerous Drugs Act of 1972 requires that information on the adverse effects of dangerous drugs (including their legal, social, and economic implications) be incorporated into the curricula of all public and private schools, whether general, technical,
vocational, or agricultural. Under Regulations issued in 1974 by the Dangerous Drugs Board, all educational and informational materials and programmes on drug abuse, regardless of their intended purpose, must be submitted to the Board for evaluation and coordination before such materials are distributed or programmes implemented.

Prevention and intervention measures, if they are to have the desired effect, must be aimed at the age group at greatest risk of becoming drug users. One way to determine age of greatest vulnerability is to look at statistics showing the age of first use. As this varies a good deal from country to country, from region to region, and from drug to drug (see Table 18, p. 169), each country or region must do its own research into age of first use, and use the data in deciding how to go about alerting the young to the undesirable effects of drug use.

**Treatment and Rehabilitation**

Efforts to prevent drug use, commendable though they may be, are notoriously ineffective; for many young people, drugs represent the challenge of a new experience. Other strategies must therefore be adopted. Treatment and rehabilitation are important ancillary measures in the fight to control drug abuse and are certainly necessary for the protection of the health of individual drug abusers. More than 20 years ago, a WHO survey criticized the lack of treatment facilities, despite the fact that drug addiction was recognized even then as a serious public health problem (25). There have been some significant changes since then.

Progress in treatment has been made over the past two decades, built largely upon the premise that the drug addict is above all a sick person for whom there is a need for suitable and effective treatment (18). Some of the pioneering changes in the approach to drug users were triggered by changes in laws and policies in Thailand from 1957 to 1959. Having outlawed the smoking and sale of opium, Thailand established special hospitals for treating those addicts who wished to receive treatment (17). This began a trend towards diverting drug users away from the criminal process and into drug-treatment programmes.

The basic philosophy in many countries has thus shifted away from punishment to treatment and rehabilitation, as noted in the objectives and definitions in some items of legislation. The principal objective of the treatment and rehabilitation of drug-dependent persons in Colombia, for example, according to Section 77 of Decree No. 1188 (1974), is "to enable the individuals to once more become useful members of the community". The definitions given in Indonesian law are more detailed and express high hopes. Thus, the term "rehabilitation", according to Section 1 of the 1976 Act, encompasses all "endeavours to restore a drug-dependent person to physical and/or mental health in order that he may readapt to his living environment and recover dexterity, knowledge, and skills". In Bolivia, rehabilitation is the "readaptation to the bio-
psycho-social environment of persons who consume or are addicted to narcotics or drugs containing controlled substances”, according to Section 112 of Decree-Law No. 11245 (1973). In many countries, the provision of appropriate treatment to citizens is required by law.

The classic course of treatment and rehabilitation, as described by Porter et al. (18), consists of three distinct stages: (1) detoxification; (2) social rehabilitation; and (3) aftercare and stabilization.

Detoxification, usually preceded by some form of crisis intervention, is the natural starting-point. Its objective is to wean the individual from drug dependence. Several different approaches to detoxification are currently being used throughout the world, many of which rely on drugs themselves. These include: methadone for opiate withdrawal (Australia and Thailand); tincture of opium and chlorpromazine (Burma); the major neuroleptic drugs, including antidepressants (Egypt); symptomatic treatment, including methadone on a voluntary outpatient basis (Hong Kong); gradual withdrawal using opium (India); prescription morphine and pethidine (Indonesia); “cold turkey” only (Philippines) (18).

Social rehabilitation is aimed at restoring social functioning to its previous level, though it is recognized that this often replaces the individual in the very atmosphere that initially contributed to drug use. Two approaches have been used, one institutionally based, the other based on the community or family. Some examples are: social support centres (Burma); inpatient treatment centres and aftercare (Hong Kong); residential programmes (India); hospital and residential rehabilitation centres (Malaysia); on-the-job training (Pakistan) (18); and family foster care under the direction of a hospital establishment (France).

Aftercare is basically a form of reinforcing follow-up care, and may follow either detoxification or rehabilitation. Aftercare aims at assisting the person to make the personal adjustments necessary to remain drug-free. The varying approaches to aftercare include: scheduled visits at residential social support centres (compulsory by law in Burma); voluntary aftercare (Hong Kong); individual counseling or psychotherapy and social work guidance (Indonesia); mandatory aftercare visits (Malaysia); social activities (Philippines); voluntary aftercare combined with compulsory residential care (Singapore) (18).

The treatment process, as Porter et al. note (18), had its “beginning in one of the three following inpatient settings: (a) specialized hospitals for drug dependence; (b) special drug-dependence units within psychiatric institutions, or (c) dependence units in general hospital settings”. There is a trend now towards outpatient programmes, focusing on total continuity in care. Examples of such programmes include: self-care, vocational, occupational and recreational training (Mexico); mobile health teams for detoxification and general health care (Pakistan); rural detoxification (Thailand); adolescent outpatient care (Switzerland and the USA).

In the best of all worlds, all three stages should be included in treatment programmes. The reality is, of course, quite different: because
of a shortage of resources, human as well as financial, many programmes never go beyond the detoxification stage.

We shall take up later the legal and policy requirements controlling access to drug-treatment programmes, but a few words are first necessary about the special needs of adolescent drug users, and particularly of addicts. First, the young drug user or addict is thought, by reason of his immaturity, to be particularly vulnerable. Boyd (2) has described a profile of adolescent drug users who have undergone treatment in the United Kingdom. They are:

... guilt-ridden, sensitive, and extremely self-critical. They suffer from a great deal of immaturity at various levels in a largely unintegrated ego. They are profoundly affected by their emptiness and failure, and out of despair they either endorse society's contempt for them by self-denigration and self-destruction, or they display a false bravado and band themselves together as a deviant group of apathetic social isolates who are fundamentally loved neither by themselves nor by anyone else.

The young drug user is also:

... basically unhappy about his predicament and he longs to be rid of it, even if at first he admits to neither of these facts ... In the young, such postures [as addiction] are still tentative, frequently unstable, not yet deep-rooted and thus to some extent amenable to change, as maturation proceeds, either spontaneously or with appropriate psychiatric assistance.

It is essential to treat addiction at its earliest stages “before it has taken on the dimension of a lifetime habit entrenched in the fully formed character of the adult” (2).

Second, the characteristics of adolescence make it particularly important that the adolescent willingly accepts the treatment offered to him, otherwise it is unlikely that any benefit will be derived from it. As Boyd points out (2):

To be effective the whole program, including that of drug withdrawal, must be a joint enterprise between doctor and patient. It is especially unprofitable to impose a wholly arbitrary scheme on the adolescents. Of all age groups his is the most stubborn, and that stubbornness will usually be provoked to obduracy by the insistent over-ruling of an adult, however reasoned the argument may be.

This raises the associated and equally important issue of confidentiality. For drug treatment to be an attractive, voluntary exercise for the young it is often necessary to guarantee, if only initially, a measure of confidentiality. This means that requirements that parents must be notified of, or give consent to, the treatment need to be dispensed with in the interest of making the prospect of treatment less daunting for the young.

Third, in view of the foregoing, the punitive approach to drug use—for so long the only one adopted in drug-control legislation— is
particularly inappropriate for dealing with younger drug users. Punishment "is not the answer to [the] adolescent's difficulties" (2).

Fourth, while it may be true that inpatient centres, providing appropriate medical and psychiatric care, tend to afford the best opportunity for adolescents—providing an environment away from their usual family and social setting, which has almost certainly contributed to their pattern of behaviour—such treatment is not effective for all (2). It is therefore often urged that a variety of treatment modes, in addition to custodial care, should be available to cater to individual needs. Still, whatever the method, the treatment must address the basic causes of drug abuse, and not merely attempt to achieve a rapid withdrawal from drugs.

All of this leads on to a discussion of the basic legal and policy issues pertaining to drug treatment and rehabilitation programs for adolescents. As we shall see, the approaches vary, some being in conflict with the principles established in the foregoing paragraphs. The basic questions are: How are those in need of treatment identified or reported? What are the rules governing access to treatment? And what special protection is afforded to adolescent drug users in need of treatment?

Identification of drug users

Historically, criminal law has been used as a deterrent to drug use, and is still one of the principal tools used in identifying and reporting drug users in need of treatment. In many settings, it is not clear whether the underlying aim of the legislation is punishment or rehabilitation. Some of the legislation applies to all drug users, some is specifically applicable to adolescents. (See Table 22 for some examples of legislation on compulsory reporting of drug abuse.)

One approach requires reporting by a wide array of personnel and institutions, including hospital and clinic staff, medical practitioners, law-enforcement officers, prison and public authorities, and parents. Most commonly, medical practitioners who encounter drug-dependent individuals in the course of their practice are required to report them; failure to do so is itself sometimes considered an offence (26). Indeed, Bolivia requires that "all persons" report the presence in their midst of individuals who appear to be under the harmful influence of drugs. The rules laid down in 1970 in Sweden, however, leave the physician some measure of discretion, merely recommending that any physician who knows or has reason to suspect that narcotics are being abused by persons under 20 years of age should report his observations to the Child Care Board in cases where he considers that he cannot, without the Board's assistance, help the minor concerned to desist from such abuse. The Board may intervene only in cases where other measures are inapplicable.

The requirement that physicians initiate the reporting process is of special concern since it places competing interests at odds. As Porter et al. (18) point out:
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<table>
<thead>
<tr>
<th>Country</th>
<th>Reporter and basis of report</th>
<th>Agency notified</th>
<th>Content of report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colombia</td>
<td>Doctors treating patients who need drugs in quantities greater than therapeutic doses</td>
<td>Competent health authorities</td>
<td>Name, age, marital status, nationality, domicile, daily dose, how long drug used</td>
</tr>
<tr>
<td>Italy</td>
<td>(a) Any physician attending or assisting a person using narcotic drugs or psychotropic substances</td>
<td>Centre established for care and rehabilitation of persons using narcotic drugs</td>
<td>Fact of use</td>
</tr>
<tr>
<td></td>
<td>(b) Police</td>
<td>Nearest centre and local magistrates</td>
<td>All cases of such use coming to their attention</td>
</tr>
<tr>
<td>Mexico</td>
<td>Qualified medical personnel within eight days of observation of drug addiction in user treated</td>
<td>Nearest office of Ministry of Health and Welfare</td>
<td>Identity of person, diagnosis, and opinion on need for treatment</td>
</tr>
<tr>
<td>Senegal</td>
<td>Any physician while carrying out diagnosis or treatment who becomes convinced person is illicitly using drugs</td>
<td>Chief Medical Officer of Region</td>
<td>Identity of person</td>
</tr>
<tr>
<td>United Kingdom (England and Wales)</td>
<td>Doctor attending person suspected or considered to be addicted to controlled drugs</td>
<td>Prescribed authority</td>
<td>Such particulars as may be prescribed by regulations</td>
</tr>
<tr>
<td>Zambia</td>
<td>Any medical practitioner who prescribes dependence-producing drug for more than four months</td>
<td>Permanent Secretary administering the Dangerous Drug Act</td>
<td>Report of case</td>
</tr>
</tbody>
</table>


A reporting requirement puts the physician in the position of having to choose between protecting confidentiality and fulfilling the legislative requirements.

This may also deter the drug-dependent person from seeking help.

Law enforcement authorities in many jurisdictions (Ecuador, Hong Kong, Japan, Norway and Singapore, for example) are empowered to order individuals to be tested for drug use, if such use is suspected (17, 18). Court-ordered medical examinations are also common (Chile and Senegal) (17). These were initially introduced largely as part of efforts to suppress illicit drug use through criminal law but in some cases, have developed into treatment programmes.

A number of countries make it clear in their laws that parents have a duty to watch their children for signs of drug dependence, to report them if they show such signs and, often, to ensure that they receive treatment. Indonesia’s Act No. 9 of 1976 on narcotics differentiates between underaged addicts and adult addicts. In the case of the former, parents or guardians are obliged to report them to the appropriate Ministry of Health officials and to take them to a hospital or to the
nearest physician for the necessary treatment. Adult addicts, on the other hand, are obliged by the law to report themselves to Ministry of Health officials.

In Malaysia, a parent or guardian, acting on behalf of an addicted minor, must report to a Social Welfare Officer so that the minor may be admitted to a rehabilitation centre. It is the parent's duty not only to report a child who may be a drug abuser but also to ensure that he undergoes treatment, whether or not he is willing to do so.

Some countries involve teachers in the process of identifying young people in need of treatment; such efforts seem to be predominantly part of the strategy for drug control itself. In Bolivia and the Philippines, teaching staff are required to notify the authorities of cases in which school pupils have used drugs. The Philippines legislation actually imposes penalties on schoolteachers who fail to assist in the apprehension or arrest of anyone, including pupils, who violates the provisions of the Dangerous Drugs Act of 1972.

Other surveillance systems have also been established to detect youthful drug abusers. Thus, the Secretariat for Health and Welfare, acting in conjunction with the police, is required by Mexican law to maintain constant surveillance in the vicinity of schools, in parks, in certain urban areas, and in other public places in which the use or abuse of inhaled substances, such as thinners, adhesives, and dyes, has been observed (22).

**Entry into treatment**

Three main approaches have been adopted regarding entry into treatment: (1) voluntary entry into treatment; (2) compulsory commitment to treatment; and (3) diversion from the criminal system for treatment of drug dependence.

*Voluntary admission*

An individual's desire to be treated for drug dependence, as repeatedly stressed in the literature, is an important indicator of the chances of success of the treatment. Indeed, the conventional wisdom is that any drug treatment system should be designed to maximize access as well as choice, but there is little discussion in the legislation of "voluntary" admission to programmes, possibly because it is regarded in the same way as other voluntary efforts to seek medical care. Most legislation concentrates on establishing systems for compulsory commitment. Peruvian legislation, for example, requires drug-dependent persons to undergo treatment either at home, in a private establishment, or in a State centre for the rehabilitation of such persons. The drug-dependent person may himself apply for treatment or the application may be made by his relatives or by the court. Expert medical opinion must be presented on the question of addiction, but treatment is voluntary, at
least in the first instance. In Egypt, the Philippines and Thailand, if a person voluntarily applies for treatment in prescribed facilities, criminal proceedings against him for certain drug-related offences are then withdrawn (18), so that there is an incentive to seek such "voluntary" treatment.

The issue of whether an underaged adolescent can "consent" to health care treatment in the absence of parental approval was discussed in Chapter 2. The trend, mentioned there, towards statutes that authorize such procedures is the consequence, in part, of the realization that adolescents with drug problems are deterred from seeking care by the requirement for parental consent. A number of countries have statutes that permit adolescents voluntarily to enter drug treatment programs without parental involvement, at least initially.

In point of fact, however, "voluntary" entry of young drug offenders into treatment and rehabilitation programs is largely made contingent on an application by an adult, whether a parent, a guardian or another relative. Many countries combine the duty to seek out drug treatment with other parental duties, as in Austria's Federal Law of 3 July 1980 (Serial No. 319). This Law prescribes that the parents or legal guardians of a minor, as part of their lawful duty to care for and educate the child, must ensure that, if he requires medical attention, he undergoes the necessary treatment or surveillance, which would include treatment for drug dependence.

The Austrian statute follows the classic rule that those who have legal custody of an adolescent have the legal authority to act on his or her behalf, and this rule is followed, for example, in the Philippines. The voluntariness then really rests not with the adolescent but with others, and the consent is not the adolescent's but theirs. The law in Italy provides an apt example of this; Section 95 of the Law of 22 December 1975 on drug control lays down that:

... any person using narcotics or psychotropic substances for personal non-therapeutic purposes may submit, to the local health office, an application to undergo diagnostic tests and to receive therapeutic and rehabilitative care. Such persons are free to choose their own place of treatment and to select the physician to attend their case. In the case of minors or persons incapable of understanding or volition, requests for action may be made either by the person concerned or by the persons responsible for his care and protection. At their request, the persons referred to above may maintain anonymity in dealings with centres and nursing homes, physicians, social welfare workers, and subordinate personnel.

The legislation in Austria distinguishes between compulsory and voluntary treatment. Any person, whether adult or minor, assumed to be misusing narcotics must undergo a compulsory medical examination to determine whether medical treatment is "essential." If treatment is found to be essential, it is compulsory. If, however, treatment is judged merely "worthwhile" for the person, then a treatment program that is feasible and reasonable under the circumstances may be arranged. This is
subject to the consent of the person concerned—except that, in the case of a minor, the consent of the parents or legal guardians is required.

**Compulsory civil commitment**

The attractiveness of a society free of drug dependence, coupled with the tremendous problems such dependence creates, has legitimized the attempts of governments to intervene in the interests of public health. There is nothing new in this. “Compulsory confinement for treatment has been one legal response to deviant behaviour, including mental illness, and drug and alcohol dependence” (18). Legislation imposing compulsory drug treatment is thus a common pattern and, in 27 of the 43 countries surveyed by Porter et al. (18), compulsory civil commitment was authorized by legislation in one of three basic forms:

(a) as part of general mental health legislation;
(b) as part of mental health legislation specifically mentioning drug dependence;
(c) as part of special civil commitment legislation on drug dependence.

Commitment is not automatic. Certain criteria usually have to be satisfied, on the basis of medical evidence; in a few instances, however, a request by a third party is sufficient (27). While the criteria for civil commitment for drug dependence vary from country to country, the abuse of drugs is nearly always one factor used as an indication for treatment, whether it be linked to a psychosis or mental deterioration, to an impairment to health or temporary incapacitation, or to “dangerous behaviour”. In some countries, compulsory admission depends on whether a person is actually addicted to drugs. This is the case in Canada, (British Columbia, Nova Scotia, and Prince Edward Island), Indonesia, Japan (narcotics), Malaysia, Mexico, Peru, Singapore, Thailand, and Tunisia (18). (See Table 23 for some examples of the grounds on which individuals may be committed.) In Thailand, for example, the Psychotropic Substances Act of 1975 empowers the Secretary-General of the Narcotics Control Division to commit a dependent person (defined as a person who “consumes, ingests, or applies by any means the psychotropic substance and shows the symptom of addiction to the psychotropic substance, which may be detected by a medical science method”) for treatment or rehabilitation (28). Colombian legislation prescribes that persons who are “suffering from the effects of consumption of drugs or substances which produce physical or psychic dependence” can be obliged to undergo treatment.

The legislation in Somalia provides that any person who “by reason of serious mental deterioration caused by the habitual improper use of narcotic drugs in any way endangers himself or another” may, at the request of the police authorities or other interested party, be required to undergo detoxification. In Malaysia, if, as a result of a medical
Table 23. Grounds for compulsory civil commitment

<table>
<thead>
<tr>
<th>Country</th>
<th>Grounds for commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Drug addicts who might impair their own health or that of others, or disturb the public peace</td>
</tr>
</tbody>
</table>
| Burma            | (a) Addiction to narcotic and dangerous drugs; or
|                  | (b) Occasional use of narcotic and dangerous drugs          |
| Canada: British Columbia | Person in need of treatment for narcotic dependence |
| Nova Scotia      | Person who is an addict                                     |
| Italy            | Use of narcotic drugs or psychotropic substances for personal, non-therapeutic purposes, plus need for medical treatment and assistance |
| Malaysia         | Person reasonably suspected of being drug-dependent         |
| Peru             | Drug addiction                                              |
| Singapore        | Suspicion of drug addiction; if after medical examination or urine tests, it appears that treatment, rehabilitation, or both, are necessary |
| Tunisia          | Drug dependence                                             |

In most countries having compulsory civil commitment legislation, a medical examination must be conducted to determine whether a person should be committed. The legislation generally specifies that the medical examination be conducted by a medical practitioner or psychiatrist, though in some countries the police, or medical and social welfare centres can be involved in the appraisal of a person's condition.

In some legislation, the sole object of the examination is to determine whether the person concerned is a drug addict, since this may be the only ground for compulsory civil commitment. In a few jurisdictions, the legislative provisions require that the examination should address additional matters: some examinations must take into account the probability of repeated abuse if a person is not hospitalized (Japan); some must consider whether a person would benefit from treatment (USA: Massachusetts); some legislation requires a statement from the examiner as to why hospitalization cannot be avoided by other means (Federal Republic of Germany: Bavaria). "On the whole", conclude Porter et al. (18), "the legislation requires little more than a finding of drug or alcohol dependence, the examiner being given very much of a free hand in this connection."

Periods of treatment provided for in compulsory civil commitment legislation vary widely, ranging from not more than eight hours to a term of up to ten years. The length of stay is generally related to the purpose of treatment, which may include: short-term emergency assistance for alcohol or drug dependence (Canada: Prince Edward Island, Japan (stimulants), Sweden, USA: Massachusetts and Wisconsin); medium-term periods of several days to six months for treatment for drug and alcohol dependence (Malaysia, Thailand); long-term treatment for drug and alcohol dependence associated with mental illness, ranging from six months (Federal Republic of Germany: Bavaria) to an indefinite term as long as dangerousness persists (Switzerland: St. Gallen). In some jurisdictions, relatively long terms of compulsory civil commitment are imposed (drug dependence plus the need for treatment: Prince Edward Island, three years; drug dependence plus other criteria: USSR, up to ten years) (18).

Much compulsory civil commitment legislation also includes provision for periodic review of the status of committed persons. Where review is authorized, it may be conducted by a variety of bodies. In some jurisdictions, the laws establish commissions or boards specifically to review the status of committed persons, while in others a government officer or an administrator of the hospital where the person is being treated is responsible for periodic review. In 18 of the 33 cases reviewed by Porter et al. (18), no periodic review provisions were found in legislation on compulsory civil admission.

**Diversion from the criminal justice system**

The fact that criminal law has often been used as the major means of establishing drug-control systems, means that drug dependants often
find themselves caught up in the criminal justice system. In many countries special arrangements exist for channelling offenders into treatment. At some stage, the fact of drug or alcohol dependence may become a factor in the way that the criminal justice system deals with the offender. The tendency is to divert such individuals, in one way or another, from the criminal justice process. According to Porter et al. (18), the following patterns exist:

1. **Treatment pending or in lieu of trial**

   This can come into effect in several ways: when a person debilitated by drug use is arrested, but needs emergency medical help; when a person is found to be under the influence of drugs (France); when a person is found to be drug-dependent after arrest (France, Philippines, Sweden, USA: Massachusetts). In these circumstances, a course of treatment is prescribed, either pending or in lieu of trial.

2. **Treatment in lieu of imprisonment**

   This usually permits the suspension or waiving of the sentence after conviction if a successful course of treatment is followed by an addict. Treatment is thus substituted for punishment, and is used as an incentive. This practice is found in only a few countries.

3. **Treatment concurrent with sentence**

   Three patterns are found here: "(i) treatment of convicted persons while serving prison terms; (ii) treatment prior to imprisonment, the period of which may be deducted from the prison term; or (iii) treatment as a condition of discharge from prison" (18, 29).

   In some cases there are limits beyond which the law will not go in waiving criminal penalties in favour of rehabilitation. In the Philippines, for example, if a drug-dependent person escapes from the treatment centre, he may reenroll himself for confinement within one week of the date of his escape; in the case of a minor, his parent, guardian or relative may surrender him for recommitment. If, subsequent to recommitment, the drug dependant escapes again, he is no longer exempt from criminal liability for the use or possession of dangerous drugs.

   Adolescents in many countries, at least those who are minors by legal definition, are covered by a juvenile justice system that historically has taken pains to avoid subjecting them to the rigours of the criminal process. In many of these countries, minors never enter the criminal justice system per se but are routed, instead, through the juvenile courts. The use of drugs, and certainly drug dependence, is sufficient reason in some countries for a court to declare a young person "delinquent", a "youthful offender" or "in need of supervision"—all of which justify either taking the minor into custody for treatment or ordering him to undergo a course of therapy while remaining in the family or community setting.
Legislation in Massachusetts (USA) is indicative of the way in which young drug abusers are handled. The Drug Rehabilitation Law of 24 December 1981 (Section 13) sets out the procedures to be followed. The Department of Youth Services can refer to the rehabilitation programme young people who have violated drug laws. The Director of that programme, if necessary, can arrange for a medical examination to determine whether the minor is "a drug-dependent person who would benefit by treatment". If the Director finds that this is so and adequate treatment is available at an appropriate facility, he may recommend to the Department of Youth Services that the person be admitted to the facility as either an inpatient or an outpatient. In making such a decision the Director must consider the past record of treatment, if any, afforded to the person at a facility, and whether or not the person complied with the terms of any prior admission. The "nature of the treatment to be afforded and the facility to which the person will be admitted" must be spelled out specifically. The period of treatment may not exceed one year.

**International Agreements**

In the realm of substance abuse—tobacco, alcohol and drugs—drug abuse is unique in that a number of international agreements address the issue, the most important being two conventions: the Single Convention on Narcotic Substances, 1961, as amended in 1972 (30), and the Convention on Psychotropic Substances, 1971 (31). These are basically drug-control treaties and together represent an attempt to outlaw, at the international level, the production, manufacture, trade and use of these substances for non-medical purposes. While the Conventions are concerned mainly with the control of production and trade in drugs, both also contain provisions aimed at preventing use, and more importantly, on the treatment of individuals. Thus, Article 38 of the 1961 Single Convention and Article 20 of the 1971 Convention require certain activities to be carried out relating to the "prevention of abuse of drugs." They call for steps to be taken for the "early identification, treatment, education, aftercare, rehabilitation and social integration" of individuals involved in drug production and trafficking, and, as far as possible, to promote the training of personnel necessary to effect treatment programmes. In addition, they call for action to promote understanding, both among personnel who work with the problems of drug abuse and the general public, of the "problems of drug abuse and of its prevention".

The need for multinational cooperation in curbing illicit drug traffic has also led to several regional arrangements, between them covering...
practically the entire globe (32). As Porter et al. (18) observe: “The various regional groupings are of widely different types, some being geographical and economic in character”. Of these, the most important is the South American Agreement on Narcotic Drugs and Psychotropic Substances (1977), which is based on the desire for intercountry collaboration on drug control. Among other things, it requires that the participating countries (33) harmonize their legislation on the criminal prosecution of drug traffickers. It also repeats in large measure the language of the Conventions on the “treatment, rehabilitation and social integration of drug addicts”, but is specific on the question of what “treatment and re-education” shall be given to “convicted addicted” persons. Treatment must always be ordered (34). The Agreement also, for the first time, takes the view that drug addiction, and for that matter, habitual intoxication, must be regarded as diseases and appropriate treatment provided. The individuals concerned are thus regarded as patients rather than criminals.

The effects of these international agreements on national legislation—particularly on treatment and prevention—have been mixed. Jayasuriya (17) says that “undoubtedly” the Single Convention has provided “mechanisms for minimizing the abuse of narcotics on a global scale”. According to Porter et al. (18):

In countries where there was previously little legislation on treatment, [the Conventions] have stimulated the development of such legislation. In countries with well established laws and treatment programmes, however, they have had little overall impact.

Yet the view persists that these agreements do provide a useful “framework” and perhaps even guidance for national efforts, legal as well as political, to address the questions of drug and substance abuse. Indeed, it is felt that regional efforts, backed as they are by international conventions, can provide the framework for significant influence on national legislation (18).

Conclusions

Not all drug use is universally condemned; not all drug users are viewed as in need of help. Indeed, some societies have a marked tolerance for the use of some drugs and substances—alcohol and tobacco are prime examples (35). Many users, especially young ones, are merely experimenting, many are seeking short-term pleasure and escape; not all become addicts. There is no doubt, however, that in many cases drug abuse produces suffering and dependence.

In many countries of the world, particularly the less developed, there is a lack of sufficient reliable facts about the nature and extent of drug problems. This hinders, to a considerable extent, any attempts to deal with the subject at the public policy level, principally because the information on which an assessment of needs could be based is vague and unreliable.
Criminal sanctions aside, there are two basic components of any drug abuse effort: prevention and treatment. Legislation has a role to play in laying the foundations upon which both these components are based and regulated.

The preventive approach, now largely focusing on drug abuse education, as opposed to criminal sanctions, is aimed at: sensitizing the public, and in particular those most vulnerable, to the adverse consequences of drug abuse, by means of public information and education; enhancing and reinforcing individual restraint in matters of drug use; creating a body of public opinion that not only supports the notion of a drug-free society but is also ready to seek and support humane rehabilitative programmes for those who do abuse drugs; deterring use before it starts, through a variety of mechanisms ranging from personal awareness to criminal law; sanctioning, nearly always through criminal law, activities connected with illicit trafficking in drugs.

As we have seen, many countries, through their legislation, have established anti-drug education and information programmes; so far their effect is not entirely known. It is assumed that, if individuals understand the effects of drug use, they will be less apt to use such substances. Yet the experimental use of drugs is endemic to adolescent experience in many settings and the fascination of such activities persists. The fact that preventive education programmes exist, and that more emphasis is being placed on them is, however, laudable, particularly where parents are also involved. There are limits, though, to what education and information can do. As Edwards & Arif (35) point out:

Ideally, programmes should begin with primary prevention, but, as in many countries when drug dependence is already a recognized problem, intervention must begin with treatment and rehabilitation.

The recent shift in emphasis away from the punitive approach necessitates a specialized set of short-range goals for treatment programmes, which differ from those associated with the preventive approach. Common short-term objectives have been listed by Edwards & Arif (35):

- to bring drug-dependent persons and experimental users into contact with treatment facilities;
- to persuade drug-dependent persons to accept treatment;
- to reduce the medical and psychological complications of drug abuse;
- to improve the social functioning of drug-dependent persons;
- to reduce criminal or unlawful behaviour associated with drug abuse;
- to establish aftercare services to prevent relapse; and
- to reduce illegitimate traffic in illicit drugs, by reducing demand.

In the treatment of drug-using adolescents, a few basic principles apply which, if kept in mind, will increase the chances of reaching these objectives.

One lesson of drug-treatment experience is that motivation for treatment is a key factor in success. Where possible, the emphasis should
be on "voluntary" treatment programmes. The guiding legal principles should be "explicitly designed to maximize the free exercise of choice and discretion" (18).

The degree of confidentiality offered by the programme is also thought to be another element for making it "attractive" to young drug users. Some commentators have urged that treatment services offered to minors should be absolutely confidential. Porter et al. (18) warn that "failure to ensure voluntary access under strict conditions of confidentiality through legislative enactment could effectively bar entry of youth" into treatment and rehabilitation programmes. There is now a growing body of legislation that guarantees for the young the right to consent to treatment without the need for parental notification and consent. That is not to say that parents cannot help, but the time to involve them, if at all, may be later in the process rather than earlier.

Compulsory commitment to treatment and rehabilitation programmes is, of course, an effective way of channelling those in need into care, but should be an approach of last resort for adolescents. The compulsory commitment process can be a valuable triggering event in an individual's rehabilitation process, but as entry is forced the regime is accepted only grudgingly, since the "motivation" is externally imposed. Compulsory commitment has the added disadvantage of causing a conflict of values: those of personal liberty versus society's interest in moulding a socially productive person. Where compulsion is resorted to, adequate procedural protections should be afforded, and the criteria on which commitment is based should be clearly stated. In the main, it must be remembered that, where young drug users are involved, the compulsory option is the less preferable one.

In the final analysis, sensible laws and policies to combat the problem of drug abuse must be relevant in the wider social context. Approaches to the problems arising from drug abuse among adolescents must be based not on fantasy but on the hard realities, bearing in mind that the causes, consequences, and contexts are inextricably intertwined.

References and Notes

1. Drug abuse has commonly been defined as the use of drug for other than legitimate medical purpose. Drug misuse occurs whenever one is indiscriminately, but legally, administered by a physician or pharmacist. Habituation is the need to continue use of a drug unaccompanied by physical withdrawal phenomena. Addiction is continuous use in which there are physical withdrawal phenomena. ANUMONYE, A. Nigerian drug scene. Lagos, A. Anumonye, 1977, p. 13.
4. According to Boyd (2), in 1968, of the narcotic addicts being treated at one special drug clinic in London, 27% were teenagers and 17% were aged 18 or under.

6. CANNABIS SATIVA (its formal name) is also known by the following names: 
   - bhang in India; ganja in Jamaica; kif in Algeria and Morocco; takouri in Tunisia; kifah, asarath, and manho in Turkey; hawwah et kef in Lebanon and the Syrian Arab Republic; zamba; liamba; and riamba in Brazil and in Central Africa; marijuana in the United States, suma in Mozambique; and nangory in Madagascar.

7. It has recently been estimated that in the United States in excess of 20 million smoke cannabis and that the age of first use is now as low as 12 or 13. For this reason an information programme for 9- and 10-year-olds is being proposed to reduce the incidence of teenage "dope" smoking.

8. SMART, R. G. ET AL. Drug use among non-student youth. Geneva, World Health Organization, 1981 (WHO Offset Publication, No. 60). Almost all previous studies had been either school- or clinic-based, yet vast numbers of young people the world over do not attend school; they are, as the authors suggest, "an important segment of the youth population of developing countries".


20. It will be seen from the section on compulsory treatment (pp. 189-191) that a third source of legislation is also important, namely that concerned with the treatment of mental illness.


23. In December 1972, UNESCO organized a meeting on Education in More-Developed Countries to Prevent Drug Abuse, and the following definition of drug education was adopted: "Drug education is a broad range of concerted activities relating to teaching/learning situations and experience which attempts to maximize opportunities for the intellectual, emotional, psychological and physiological development of young people. It involves the total educational process embracing both cognitive and affective domains." Meeting on Education in More-Developed Countries to Prevent Drug Abuse, unpublished UNESCO document. ED/MD/26, 1973.
The legislation also promotes the establishment of citizens' committees to disseminate information on the hazards of drug abuse in the hope of mobilizing public opinion in favour of its control. They are required to broadcast advertisements and public information to combat traffic in and consumption of drugs.


This is the case in, for example, Bolivia, Colombia, Cyprus, Finland, France, Hong Kong, Indonesia, Italy, Japan, Malaysia, Mexico, Senegal, Singapore, Somalia, Sweden, Tunisia, United Kingdom, and Zambia (3). Because compulsory civil commitment involves loss of liberty, a number of questions arise over what legal protection is afforded to ensure that the process is not abused. For a detailed discussion of this topic, see Porter, L. et al. (18).

The court may order treatment for drug addiction in addition to the penalty provided for drug offenses, e.g., in Argentina (treatment for an unspecified time, implemented first and counted as time served under the sentence, which term may not exceed); Brazil (treatment in clinic attached to prison while serving sentence); Burna (addicts may be admitted for medical treatment in prison hospitals); Hong Kong (person is subject to transfer from prison to detention in an addiction-treatment centre); Philippines (after rehabilitation, person is returned to court for initiation or continuation of prosecution of case and, in case of conviction, full or partial duration of prior period of treatment may be deducted from penalty); Poland (court may commit person for treatment before sentence is carried out: term not less than six months or more than two years; applies to habitual use of alcohol or other intoxicant and court decides upon discharge from treatment institution in light of results of treatment).

United Nations. Single Convention on Narcotic Drugs, 1961. New York, 1962. As of September 1985, there were 11 signatories. The roots of the Convention reach back to the early years of this century. International Opium Conventions were signed in 1912 and 1921. A Convention for Limiting the Manufacture and Regulating Distribution of Narcotic Drugs was signed in 1931, along with an Agreement on the Suppression of Opium Smoking. These were followed, in 1936, by the Convention for the Suppression of the Illicit Traffic in Dangerous Drugs, with three Protocols being signed in subsequent years, before the Single Convention was introduced.

United Nations. Convention of Psychotropic Substances, 1971. New York, 1977. As of September 1985, there were 81 signatories. The major objectives of the 1971 Convention are to control production, marketing and exportation of hallucinogens — stimulants that have dependence-producing qualities.

These include, among others, the South American Agreement on Narcotic Drugs and Psychotropic Substances, the Pompidou Group of the Council of Europe, efforts by the Colombia Plan countries, the Association of South East Asian Nations (ASEAN), and the Conference of Ministers Responsible for Health of the Caribbean Community.

The South American Agreement on Narcotic Drugs and Psychotropic Substances (ASEP) was concluded in Buenos Aires on 27 April 1973 by the South American Plenipotentiary Conference on Narcotic Drugs and Psychotropic Substances, having regard to the recommendations of the South American Governmental Expert Meeting on Narcotic Drugs and Psychotropic Substances which was held from 29 November to 4 December 1972, likewise in Buenos Aires. The Agreement entered into force on 26 March 1976 and at present the following 10 States are Parties: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela. For an English translation of the Agreement, see International digest of health legislation, 36 (4): 961-966 (1980). For a description of the steps being taken by the State Parties under this agreement, see: Cattani, H. R., The South American Agreement on Narcotic Drugs and Psychotropic Substances and the drug control policies of the States Parties. International digest of health legislation, 36 (1): 228-234 (1985).
34. Treatment, according to Article 46 of the Agreement "shall consist primarily of appropriate detoxification measures, without prejudice to other types of therapy and whatever else is required for rehabilitation".


**Legislation**

**Austria**

**Bolivia**
Decree-Law No. 11245 of 20 December 1973, promulgating the law for control of dangerous substances (Section 6) [IDHL, **28**: 911 (1977)].

**Brazil**
Law No. 5726 of 29 October 1975, Measure 10, prescribing preventive and countermeasures against traffic in and use of narcotics and other dependence producing substances.
Decree No. 85110 of 2 September 1980, establishing the National System for the Prevention, Surveillance and Suppression of Narcotics, and laying down other provisions [IDHL, **33**: 740 (1982)].

**Bulgaria**
Decree No. 3211 of 12 December 1975, promulgating the Law to amend the Penal Code (Section 354b) [IDHL, **28**: 6-7 (1977)].

**Burma**
The Narcotics and Dangerous Drug Rules, 1974 of 20 February 1974 (Rule 68) [IDHL, **28**: 207-211 (1977)].

**Colombia**

**France**
Decree No. 77-826 of 29 July 1977 amending certain provisions of Decree No. 71-690 of 19 August 1971 [IDHL, **29**: 348 (1978)].

**Haiti**
Decree of 18 December 1975 on the prevention of dangers to public health, national economy and public safety caused by trade and use of narcotics (Sections 62 and 63) [IDHL, **29**: 145 (1978)].

**Indonesia**
Act No. 9 of 26 July 1976 of the Republic of Indonesia (Narcotics) [IDHL, **29**: 746 (1978)].

*For the sake of concision, International digest of health legislation has been abbreviated throughout to IDHL.*
Israel
Dangerous Drugs Ordinance Amendment (No. 2) Law, 1968 [IDHL, 22: 319 (1971)].

Italy
Law No. 695 of 22 December 1975 on the control of narcotics and psychotropic substances, and the prevention, cure, and rehabilitation of associated cases of drug dependence (Sections 85–89) [IDHL, 28: 1906–1012 (1977)].

Malaysia
Dangerous Drugs (Amendment) (No. 2) Act, 1975 [IDHL, 31: 83 (1980)].

Mexico
Regulations of 7 January 1983 for the control of substances which are psychotropic when inhaled [IDHL, 33: 35 (1982)].

Peru
Decree-Law No. 22095 of 21 February 1974 (Sections 4, 9, 20, and 21) [IDHL, 32: 261 (1981)].

Philippines
Dangerous Drugs Act of 1972 (Republic Act No. 6425) [IDHL, 24: 892 (1973)].
Board Regulation (Dangerous Drugs Board) No. 3 of 1974 [IDHL, 27: 612 (1976)].

Portugal
Decree-Law No. 792/76 of 5 November 1976 on the structure of the Study Centre for the Prevention of Drug Abuse, replacing the Centre for Research on Young People [IDHL, 30: 635 (1979)].

Singapore

Sri Lanka
Poisons, Opium and Dangerous Drugs Ordinance [IDHL, 31: 721 (1980)].

Sweden
Circular of 5 February 1970 of the National Board of Health and Welfare concerning the obligation of physicians to notify the Child Care Board of abuse of narcotics among minors [IDHL, 23: 338 (1972)].

Thailand

Tunisia

Union of Soviet Socialist Republics
Decree of 25 August 1972.

United States of America
Massachusetts
Drug Rehabilitation Law of 24 December 1951, General Laws of Massachusetts (Chapter 111E) (Section 13).
11. Health Care for the Handicapped and Disabled

Some years ago the United Nations' Report on children estimated that at least 5% of the children in any given population are severely handicapped, while between 10% and 15% need special attention because of physical abnormalities, chronic illness, accidents, or mental disabilities (1). Each year some 60,000 children with physical or mental handicaps are born in the Federal Republic of Germany (2). Nearly a million young people in France suffer from the effects of mental retardation, cerebral palsy, or other developmental problems (3). An estimated 15% (about 761,000) of all children in Turkey are "different", as defined by the local euphemism (4). There are an estimated 4 million handicapped Filipinos, half of whom are under 25 (5).

A decade ago, a Commonwealth survey put the number of blind children in Bangladesh in need of surgery at 50,000; the numbers with leprosy and with paralysis as a result of poliomyelitis in the United Republic of Tanzania at 20,000-25,000 and 20,000-30,000 respectively; the number of "orthopaedically" handicapped in India at 400,000; and those with symptoms of mental retardation in India at between 1.4 and 1.8 million (6). The "disabled" in the United States number more than 35 million, of whom roughly half are adolescent or younger (7).

Worldwide, at least one person in ten suffers from either a physical, mental, or sensory impairment, and in any community an estimated 25% "are prevented by the existence of disability from the full expression of their capacities" (8). The Declaration of the Charter for the 1980s, drawn up by the Rehabilitation International Assembly, put the total number of disabled at 500 million, a daunting figure. The difficulties in providing care are equally awe-inspiring: it is estimated that 70% of all disabled—350 million individuals—have to live without the help they need.

Handicaps imply a special set of health care needs, some of which are concerned with diagnosis, others with treatment, and others ultimately with rehabilitation or maintenance. This chapter will explore the various legal arrangements that have been created in the last decade to address the issue of health care for the handicapped or disabled adolescent.

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* An earlier version of this chapter was published as: Health care for handicapped adolescents: international legislative and policy trends. *Journal of adolescent health care*, 3: 103-109 (1982).
Legislative Framework

The year 1981 was designated as the International Year of Disabled Persons. As far as the legislative aspects of the subject are concerned, there were two important precursors: the two International Conferences on Legislation Concerning the Disabled, the first in Rome in 1971, and the second in Manila in 1978. According to the Manila Statement (9):

Every developing country should legislate before 1981 . . . to ensure the right of access to and the provision of educational, medical, social and vocational services needed to enable all disabled persons to enjoy their rights and develop their full potentials.

The Statement established ambitious goals and contained some guidance on the issues that legislation should address, including the types of care and services to be authorized, the preventive programmes to be created, the resources to be made available and the administrative arrangements necessary to cater for the needs of the handicapped. Even many so-called ‘developed’ countries have yet to address these issues satisfactorily. Nevertheless, it serves as a point of departure and an expression of international will.

The development of legislation over the last decade should be considered in its proper context. At an international level, the most significant document is the United Nations Declaration on the Rights of the Disabled (1975) (10), Article 6 of which states that:

Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthotic appliances, to medical and social rehabilitation . . . and other services which will enable them to develop their capabilities and skills to the maximum . . .

This is based on the United Nations Declaration on the Rights of Mentally Retarded Persons (1971) which states that the ‘mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings’ (11).

Earlier, the Declaration of the Rights of the Child (1959) had stated that ‘the child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition’ (12). This right to treatment and rehabilitation, however, will become more than theory only if nations begin to put in place the legal machinery through which the necessary services can operate.

Over the last decade, an increasing number of countries have introduced legislation on the care and rehabilitation of the handicapped. A comparative study undertaken in 1976 by the Department of Economic and Social Affairs of the United Nations revealed that, as of 1970, many countries had legislation on rehabilitation services for the handicapped (13). An update of that study indicated that, between 1970
and 1976, nearly 45 countries enacted laws on the subject (14). Two general trends were noted: (1) an expansion in the coverage of programmes for the handicapped; and (2) a more determined attempt to link together the numerous programmes for the handicapped, so that their needs are addressed in a coordinated manner. The examples cited below reflect these trends and indicate that the health philosophy underlying the legislation has four main aims: prevention, detection, care and treatment, and rehabilitation. Some of this legislation is directed towards the handicapped as a group, some specifically towards adolescents. In the former, programmes for adolescents are subsumed under the general legislative provisions rather than being dealt with separately.

Definitions

Many items of legislation concerning disabled persons include a definition of who may be considered to be "handicapped". The definitions are often detailed, and are important because they determine who is eligible for specialized care. Three brief examples are given below.

The Handicapped Persons Act of 1968 of Zambia states that the "handicapped" are:

... those persons who by reason of defect of mind, senses, or body, congenital or acquired, are unable to take part in normal education, occupation and recreation or require special assistance and training to enable them to take part in (these) normal activities.

In Portugal a "handicapped" individual is defined as one:

... who by injury, deformity or disease, whether congenital or accidental, suffers permanently from diminished capacity to engage in occupational or ordinary activities of daily life.

In the United States the federal government defines as "disabled" (synonymous with "handicapped"):

... any person who has a physical or mental impairment which substantially limits one or more major life activities or has a record of such impairment or is regarded as having such impairment.

There are distinct parallels between these statements and the definition found in the United Nations Declaration on the Rights of the Disabled (16), which describes a disabled person as anyone who is:

... unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities.
There are, of course, varying degrees of disability, and some legal texts acknowledge this. The United States Department of Health and Human Services states, for example, that a "severely handicapped" person is one who requires "multiple services" over an extended period of time.

Though few of the legal definitions are identical, they do tend to focus on four crucial factors. First, they use similar language to describe the handicapped or disabled. Among the synonymous, recurring words are "injured", "deformed", "diseased", "impaired", "defective", and "deficient". Second, they distinguish between types of handicap: physical, sensory, and/or mental. Third, they identify the origin of the disability: "congenital or acquired". And fourth, they describe how the handicap "limits" a person's ability to participate in the "normal" or "ordinary" activities of life.

Outside legislation, an attempt is beginning to be made to distinguish carefully between the meanings of words that the law has largely treated as interchangeable synonyms. The International classification of impairments, disabilities, and handicaps (ICIDH) takes the view that all three are stages or conditions going beyond mere disease or disorder. The relationship is actually progressive and linear, one stage potentially leading to another:

\[
\text{disease} \quad \text{or} \quad \text{impairment} \rightarrow \text{disability} \rightarrow \text{handicap} \quad \text{disorder}
\]

An impairment is defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function". The term impairment is more inclusive than disorder. Impairments may be temporary or permanent, and involve "an anomaly, defect, or loss in a limb, organ, tissue, or other structure of the body, or a defect in a functional system or mechanism of the body, including the systems of mental function".

A disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". Disabilities are linked to abilities. They may be "temporary or permanent, reversible or irreversible, and progressive or regressive", and are characterized by either excesses or deficiencies, in terms of performance or behaviour in carrying out normally expected activities.

A handicap is defined as "a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual". Handicaps arise mainly out of the gap between a person's ability to perform and his expectations or those of others. A handicap is thus a social phenomenon, representing the social and environmental consequences for the individual who has an impairment or a disability.
Appropoaces to Health Care for the Handicapped

Health care as a part of comprehensive care

One trend in recent legislation is for health care to be a component of a larger, comprehensive framework that includes a wide range of services for the handicapped. France is a prime example of this trend. In 1975, legislation established a comprehensive system that provides not only medical but also social protection to the handicapped. According to Law No. 535 of 30 June 1975, “the prevention and detection of handicaps” as well as “care, education, training, vocational guidance, employment, a guarantee of minimum resources, social integration, and access to sports and leisure activities” for persons who suffer handicaps are a national obligation. To further this obligation, a National Advisory Council for the Handicapped was established for a three-year period. The Council was created pursuant to a joint order of the Ministers of Justice, Education, Agriculture, Labour, Social Security and Health, emphasizing the cross-disciplinary nature of the problem, and is composed of representatives from some 25 associations or governmental bodies that deal with the handicapped.

Similar arrangements have been made in Costa Rica, Spain, and Trinidad and Tobago. In Spain, the Royal Association for the Education and Care of the Handicapped replaced a number of other agencies as the principal coordinating body for matters relating to the handicapped. Section 4 of Crown Decree No. 2828 of 1 December 1978 makes the Board of Administration of the Association responsible for: (1) encouraging measures for the effective prevention of handicaps; (2) coordinating the various services necessary for the proper and comprehensive care of the handicapped; (3) promoting the quality and increasing the coverage of special education and strengthening all related activities; (4) encouraging the general rehabilitation of the handicapped; (5) encouraging the social rehabilitation of the handicapped through the removal of any barriers that hinder that process; and (6) promoting research, gathering information, and collecting data concerning topics relating to the various types of handicap and their prevention, special education, rehabilitation, care, etc. The Trinidad and Tobago Council for Handicapped Children has similar responsibilities.

In Costa Rica, the National Council on Rehabilitation and Special Education is charged with the task of determining policy and coordinating activities with the Ministry of Public Health in matters concerning the promotion, organization, establishment and supervision of rehabilitation services and special education.

Health care for specific categories of handicap

Programmes in other countries tend to be less centralized and coordinated, though attempts are being made to meet the needs of all the handicapped. In Italy, for example, the Law of 10 March 1971 extended assistance to all categories of the physically and mentally handicapped
not otherwise covered by other legislation (14). Legislation in many other countries, however, supports programmes specifically focused on one type of handicap, e.g., for deaf-mutes, the blind, crippled, mentally ill or subnormal, etc. Each represents a part of a larger programme. This pattern has the advantage of eschewing the idea that the handicapped are a homogeneous group with similar needs. The variations are vast, as are the specialized legislative responses. This is not to say that generalizations are impossible. Certain problems are common to all handicaps, and are discussed below.

Elements of Health Care Programmes

Prevention

The task of prevention is as enormous as it is necessary. It is one of two principal strategies recommended by the WHO Expert Committee on Disability Prevention and Rehabilitation in its 1981 report (16), which emphasized the importance of:

... prevention of disability through all types of measures, within and without the health sector, that contribute to a reduction in the incidence of impairment. If impairment is already present, measures should be taken to reduce the severity or to postpone the occurrence of disability and handicap.

Most health programmes for the handicapped make provision for some form of prevention. In the United States, although the states are responsible for carrying out programmes for the handicapped, the federal government provides funds for preventive programmes. Under federal guidelines, states may qualify for such funds if they can show, among other things, that the proposed programmes will: (1) reduce the incidence of handicapping conditions caused by complications of childbearing; or (2) reduce infant and maternal morbidity and mortality by providing health care to mothers who are likely to have complications.

Maternal and child health services are often the logical focal point of preventive programmes. In Spain, in an effort to prevent “subnormality” associated with problems in pregnancy, a system of uniform periodic examinations and record keeping—the National Plan for the Prevention of Subnormality—has been instituted. The goal is to monitor carefully the health of the expectant mother and fetus. The key document is a free booklet—available to each woman with a confirmed pregnancy—in which the results of pregnancy-related visits, examinations, and treatments are entered. The system offers specific safeguards to protect confidentiality and personal privacy. Indeed, if a woman objects, the records will not be kept.

In Mexico, the Regulations on Prevention of Disabilities and Rehabilitation of Disabled Persons, 1976, promote a preventive programme that includes education in hygiene, genetic counselling, prevention of accidents, and timely detection, in addition to appropriate
HEALTH CARE FOR THE HANDICAPPED AND DISABLED

Medical treatment. Of these components, genetic counselling is emerging, worldwide, as a key to the prevention of congenital handicaps (14).

On a wider scale, a number of preventive programmes exist that aim to reduce birth defects and, in general, prevent diseases that may lead to handicaps; these include inoculation and vaccination programmes for rubella and poliomyelitis. Programmes linked to accident prevention are important here also.

The situation regarding disability prevention differs substantially between the developed and developing countries, partly because of differences in the principal causes of disabilities. According to the WHO Expert Committee on Disability Prevention and Rehabilitation (16) “the major causes of disabling impairments in the developing countries are malnutrition, communicable diseases, low quality of perinatal care, and accidents (including violence”). Under these circumstances, the recent increased emphasis on immunization to reduce the incidence of communicable diseases—poliomyelitis, tuberculosis, measles, tetanus, diphtheria, and whooping cough—is a key feature of preventive programmes undertaken as part of primary health care services. Such programmes also focus on improving nutrition and perinatal care.

The situation is somewhat different in the developed world, where accidents play a substantially greater role as a cause of disability. Disabilities may also be caused by chronic somatic, cardiovascular, pulmonary, and psychiatric diseases, genetically induced impairments, and chronic pain. Chronic alcoholism and drug abuse are also emerging as major causes. This situation requires quite different strategies in which accident prevention has a major role (16). Legislation also has an important part to play (see Chapter 13 on occupational health and safety and Chapter 14 on accident prevention).

Detection and reporting

Detection is the linchpin of health care programmes for handicapped adolescents. As a WHO Expert Committee (16) said “Once impairment has occurred, it is desirable, whenever possible, to prevent any long-term disability. This requires improved early detection followed by early, effective curative care.” Some countries have instituted special reporting or registration requirements to ensure that those with disabilities, particularly those who are classified as “high-risk”, are identified early and receive the types of services they need. In Canada, the federal government maintains a voluntary register, while some of the provinces require compulsory registration (13). Czechoslovakia imposes an obligation on community doctors to report the handicaps they detect, and schools also keep a register of handicapped students (14). In Denmark, both schools and physicians are required to notify social welfare agencies when anyone under the age of 20 years needs special disability care (14). There is also a need to inform the disabled themselves about special treatment and where it is available. In the
Federal Republic of Germany, under Section 126 of the Federal Social Assistance Law (1971), health centres have been assigned this duty (14).

**Treatment and rehabilitation**

Rehabilitation is the mainstay of most programmes for the handicapped adolescent and is the most frequently mentioned long-term aim. Legislation and regulations in Costa Rica, France, the German Democratic Republic, the Philippines, Portugal, Spain, Trinidad and Tobago, the United States, and Zambia mention rehabilitation and establish programmes for that purpose. The reasons for such programmes range from the “broadly humanitarian” to the “strictly pragmatic and economic”, focusing principally on productivity (16). The goal of the programme for the handicapped in Portugal is to make it possible for individuals “to maximize their physical, mental, professional, economic and social potential”.

The Rehabilitation Services Administration in the United States provides grants to states for a fairly comprehensive set of services: (a) vocational rehabilitation (including medical, social and psychological); (b) testing, fitting, training and use of prosthetic and orthotic devices; (c) recreational and vocational therapy; and (d) psychological and occupational therapy; and (e) speech and hearing therapy. Under the Development Disabilities Act (1970), federal funds have been provided to support rehabilitation services for the more than eight million children and adults who suffer “development disabilities” caused by mental retardation, cerebral palsy, epilepsy or neurological conditions related to mental retardation. To be eligible for such services, individuals must satisfy the following conditions: the disability must be substantial, be detected or become evident before 18 years of age, and be expected to continue indefinitely.

The “severely disabled” are those for whom rehabilitation is practically impossible, though current theory holds that most of the handicapped can be rehabilitated to a greater or lesser degree. Among this group are many who need to be institutionalized. Many of these individuals suffer from mental disabilities, but for some the care is often little more than custodial. The “institutionalization” of the handicapped involves a special set of procedural issues, not the least of which is: on whose authority should the handicapped be placed in an institution? (For a full discussion of this topic, see Chapter 12 on mental health.)

The Child and Youth Welfare Code in the Philippines permits the handicapped to be placed in a public or private institution that can provide proper care, training, or rehabilitation. The Department of Social Welfare screens the applications of parents or guardians, which must be supported by the opinion of a “reputable” diagnostic centre. There are also special procedures, for instance, for use if the parents disagree with the recommended course of action.

Many other countries have more elaborate legal provisions to safeguard the rights of both the parents and the adolescents. Some
include the use of ombudsmen or child advocates, others special judicial hearings.

The former policy of institutionalizing physically or mentally “abnormal” adolescents has largely been abandoned in favour of community- or family-based care. Except for the severely disabled, the current tendency is to leave adolescents in familiar social settings. As a WHO Expert Committee (17) pointed out, “it is remarkable how well most handicapped young people can cope if given substantial understanding and assistance”. Programmes focus principally on assisting the families of disabled adolescents, both financially and by the provision of services. This may be as much a result of existing conditions as of a change in philosophy. In Japan, for example, only 18% of young people who are severely handicapped (mentally or physically) can be accommodated by the 27 treatment facilities; the other 82% must be cared for in the community (18).

The success of the community-based approach has been borne out in recent studies of the interaction between families and young people with birth defects in the United States (19). Not only is family-based, community care as good as, if not better than, institutionalized care, it is achieved at a lower cost to society as a whole.

This approach is in evidence in the German Democratic Republic where, under Section 3 of the Ordinance of 29 July 1976, local and district councils are responsible for maintaining a variety of modes of care and education, depending on the extent of the disability. These include health care and social welfare establishments for: (1) the care, training, and education at preschool and school age of severely disabled children and young people who are able to attend school but require care; (2) the care and development of children and young people who are unable to attend school but are capable of development, in nurseries and homes; and (3) the care of children and young people who are both unable to attend school and incapable of development, and who therefore are in need of institution-based care.

In France, the emphasis is on early detection and treatment. When a handicap is detected, the young person may receive medical-social assistance that is designed to prevent or reduce the “aggravation” of the handicap.

Responsibility for Providing Assistance to the Handicapped

The legislation surveyed is quite explicit as to who is responsible for providing care to the handicapped. Of necessity, the initial legal responsibility generally falls to the parents, though some countries make access to health care a right that the state must provide for. The care of the handicapped can be a costly matter and in many cases the state, as a matter of public policy, takes on the task and offers assistance to those who are eligible. In the Philippines, Article 62 of the Child and Youth Welfare Code makes this plain: when a child has special health problems, the parents are entitled to assistance from the government to the extent
necessary to obtain the appropriate care and treatment. It is the responsibility of the provincial and local authorities to provide for children with physical disabilities.

In Costa Rica, young people have the right to expect both the parents and the state to take measures to safeguard their health. The regulations in Ireland are somewhat more precise and the underlying philosophy is that of socialized medicine, so that the costs of outpatient services for young people with long-term disabilities—mental handicaps, mental illness, phenylketonuria, cystic fibrosis, spina bifida, hydrocephalus, haemophilia and cerebral palsy—are borne by the state.

The system of state support for the care of the handicapped is even more extensive in the German Democratic Republic, where the Ordinance of 29 July 1976 made several improvements in the social assistance available to the severely disabled and handicapped. Thus it provided special maintenance allowances for the severely disabled or mentally handicapped between the ages of 3 and 18 years of age. Section 6 of the Ordinance goes as far as making "suitable dwellings" available to the families of those who are severely disabled.

Conclusions

Health care for the handicapped adolescent is as complex as it is specialized. The brutal fact is that, given the weight of numbers, the scarcity of health resources in most countries, and the variety of special needs, many handicapped adolescents do not receive the health care they require. Where health care is accessible, the simple model of the physician or health worker providing treatment in isolation is often inappropriate. As a WHO Expert Committee (17) has said: "The problem of adolescents with multiple handicaps is so complex that neither the parents nor the physician alone can cope with the situation."

Better care for disabled children is one of the most important aims of legislation concerning disabled persons. Prevention is being given increasing emphasis (14), and rehabilitation has been increasingly recognized as a right. From a formal legal point of view this is encouraging, but the matter does not end with legislation: the services established by law are often inadequate in practice. A WHO Expert Committee (17) has stated that:

Governments should pay attention to the special needs of handicapped adolescents and ensure that the services providing care are not merely custodial; they should also take into account the fact that the handicapped have to cope with many additional difficulties in adolescence and that inadequate care during this crucial period may have lifelong negative effects on their health and work.

The goal of providing health care to the handicapped adolescent will not be attained until appropriate legal and policy decisions have been made. In the past decade, some advances have been made in this area, but law and policy are only a beginning. Their aims can only be achieved
HEALTH CARE FOR THE HANDICAPPED AND DISABLED

if resources are found and programmes initiated focusing on the health needs of handicapped adolescents.

References and Notes

4. UNITED NATIONS. Obstacles limiting the access of disabled children to rehabilitation services and education. New York, Department of Economic and Social Affairs, 1976 (Document ST/ESA/47).
8. Declaration of the Charter for the 1980s, approved by the Assembly of Rehabilitation International, 14th World Congress, Winnipeg, Manitoba, Canada, 26 June 1980. The world figures from other sources confirm this: 450 million people suffer from some form of physical or mental impairment. Injuries from accidents total 20 million a year (road accidents constitute half of these), resulting in about 110,000 permanent disabilities. Some 10-15 million suffer from blindness—it is estimated that 250,000 children go blind each year due to chronic vitamin deficiencies. 15 million suffer from cerebral palsy; 70 million have hearing impairments; 15 million are epileptic; 20 million have leprosy; and millions more are crippled. COMMONWEALTH SECRETARIAT. A survey of legal measures in the Commonwealth designed to assist the disabled. London, Legal Division, 1981, pp. 1-3.
13. UNITED NATIONS. Comparative study on legislation, organization and administration of rehabilitation services for the disabled. New York, Department of Economic and Social Affairs, 1976 (ST/ESA/28).
14. UNITED NATIONS. Recent trends in legislation concerning rehabilitation services for disabled persons in selected countries. New York, 1977 (Sales No. E.78.IV.1).
LAWS AND POLICIES AFFECTING ADOLESCENT HEALTH

Legislation

Costa Rica
Decree No. 5347 of 3 September 1973 to promulgate the Law establishing a National Council on Rehabilitation and Special Education [IDHL, 26: 507 (1975)].

Egypt
Law No. 39 of 1975.

France
Law No. 75-535 of 30 June 1975 concerning social and medico-social institutions [IDHL, 26: 785 (1975)].
Law No. 75-692 of 30 July 1975 establishing a National Advisory Council for the Handicapped [IDHL, 26: 785 (1975)].

German Democratic Republic
Decree of 20 June 1971. Ordinance of 29 July 1976 on the further improvement of social assistance to severely disabled and handicapped persons (Section 3) [IDHL, 29: 73 (1978)].

Germany, Federal Republic of

Ireland

Italy

Japan

Mexico

Netherlands

New Zealand

Philippines
Presidential Decree No. 603 (Child and Youth Welfare Code) dated 19 December 1974 (Sections 134(3) and 173) [IDHL, 27: 628-631 (1976)].

Portugal
Law No. 6/71 of 8 November 1971 laying down the principles governing the rehabilitation and social reintegration of handicapped persons [IDHL, 24: 215 (1973)].

*For the sake of concision, International Digest of Health Legislation has been abbreviated throughout to IDHL.*
Spain
Order of 24 October 1978 establishing the health booklet for pregnant women [IDHL, 31: 373 (1980)].
Crown Decree No. 2828 of 1 December 1978 regulating the Royal Association for the Education and Care of the Handicapped (Section 4) [IDHL, 31: 373 (1980)].

Trinidad and Tobago

Turkey

United States of America
Development Disabilities Act (Public Law 91-517 of 1970), United States Code Annotated, Title 42 (Section 6001).

Zambia
Handicapped Persons Act, 1968 (Section 2) [IDHL, 21: 434 (1970)].
Adolescence, by its very nature, is filled with stress. The effect of stress on mental health has been the subject of much discussion by health care providers. There is widespread confusion over which aspects of adolescent behaviour may be considered part of the natural course of individual development and which should more properly be viewed as a manifestation of a deterioration in mental health.

It is true that "a few serious psychiatric illnesses do begin during adolescence, but most adolescents grow psychosocially without major turmoil" (I). Nevertheless, Mauss reminds us that "the disposition to emotional and social difficulties during this period is substantially greater than during other developmental periods" (2). Many of those in need of care and counselling, particularly the emotionally disturbed, often go undetected.

Countries throughout the world are just beginning to discover the "true extent of mental illness and emotional disturbances in children" (3). It is often difficult to obtain an accurate picture of incidence, which may be expected to vary widely from setting to setting. Westman (3) has observed:

As is true with mentally ill adults who are called criminals, alcoholics, and vagrants, emotionally disturbed children are often not recognized as such because they are disguised by labels, such as mental retardation, learning disability, delinquency, and drug abuse. Furthermore, emotional disturbances in children are concealed by many over-riding social conditions, including family disturbances, racism, poverty, cultural differences, and educational inadequacies. Because of these broad social, cultural, economic, and familial influences, the individual emotionally disturbed child is frequently overlooked.

Some years ago the Joint Commission on Mental Health of Children, considering the population under 25 years of age in the USA, described their mental health status as follows: 0.6% were psychotic; 2-3% suffered from severe mental disorders and needed immediate psychiatric care; and an additional 8-10% were emotionally disturbed and required some form of help (4). As Wilson (5) points out:

It is difficult to interpret those figures, but 10 percent is probably a fair estimate of the number of adolescents whose behavior raises threshold questions of mental disorder; the number whose behavior raises questions of true "craziness" is certainly smaller.

Suicide is perhaps the most dramatic indicator of adolescent mental health problems. The rate of suicide among adolescents is rising in many
parts of the world (6). In the USA the rate of adolescent suicide has more than doubled over the last 20 years, from 5.9 to 12.8 per 100,000 (7). Suicides are the third leading cause of death, after traffic accidents and homicides, among persons aged 15–24 in the USA (8). Table 24 compares the rates of suicide for the 15–24-year age group in sixteen industrialized countries (9). Except in the United Kingdom, suicide rates for males are uniformly 2–5 times higher than these for females, perhaps because males tend to be more “successful” in their suicide attempts. Females in the USA are nine times more likely to attempt suicide than males, but males are seven times more likely to succeed (10). It may be that attempted suicide is a more accurate reflection of emotional disturbance, but information on attempted suicide is somewhat limited. As many as one in ten adolescents in the USA attempt suicide at some time. It was estimated in 1984 that, in a 12-month period, half a million adolescents in the USA would attempt suicide, and that 5000 would succeed (10).

Other forms of self-destructive behaviour are also associated with poor mental health. Drug and alcohol abuse are now seen by some as forms of “slow suicide” (6). A report issued in 1973 (6) pointed out that “many successful suicides and suicidal attempts occur among people who at the time are under the influence of alcohol or drugs”. A correlation between mental disturbance, drug use, and suicide has been established.

Table 24. Suicide rates per 100,000 population for selected countries, 1980

<table>
<thead>
<tr>
<th>Country</th>
<th>Male Total population</th>
<th>15-24 year age group</th>
<th>Female Total population</th>
<th>15-24 year age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>16.4</td>
<td>17.6</td>
<td>5.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Austria</td>
<td>37.8</td>
<td>38.8</td>
<td>14.9</td>
<td>6.7</td>
</tr>
<tr>
<td>Canada</td>
<td>22.3</td>
<td>27.8</td>
<td>7.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Denmark</td>
<td>41.1</td>
<td>16.3</td>
<td>22.3</td>
<td>7.7</td>
</tr>
<tr>
<td>France</td>
<td>24.7</td>
<td>14.0</td>
<td>10.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Germany, Federal Republic of</td>
<td>28.3</td>
<td>19.2</td>
<td>14.1</td>
<td>5.6</td>
</tr>
<tr>
<td>Ireland</td>
<td>6.4</td>
<td>6.2</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Israel</td>
<td>6.1</td>
<td>10.8</td>
<td>3.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Japan</td>
<td>22.2</td>
<td>16.6</td>
<td>13.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>11.8</td>
<td>6.2</td>
<td>9.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Norway</td>
<td>13.3</td>
<td>20.4</td>
<td>8.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Poland</td>
<td>21.8</td>
<td>13.5</td>
<td>4.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>27.6</td>
<td>16.8</td>
<td>11.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Switzerland</td>
<td>34.5</td>
<td>31.0</td>
<td>15.4</td>
<td>13.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>11.0</td>
<td>6.4</td>
<td>6.7</td>
<td>3.0</td>
</tr>
<tr>
<td>United States of America</td>
<td>19.0</td>
<td>20.0</td>
<td>6.7</td>
<td>4.7</td>
</tr>
</tbody>
</table>

*Data for 1980 not available. Data for 1979 shown for Canada, the Netherlands, Poland, and Switzerland; 1978 data shown for France, Ireland, and the USA.
*Jewish population only.
*England and Wales only.
nearly half of the suicidal adolescents in the USA have been involved in some form of drug or alcohol abuse (10). (For a more detailed discussion of alcohol and drug use and abuse see Chapters 9 and 10.)

Curran & Harding, in their treatise on The law and mental health: harmonizing objectives (11), make the following introductory comments:

It has long been known that there is a dynamic relationship between concepts of mental illness, the treatment of the mentally ill, and the law. . . . Mental health legislation is now widely recognized as a critical factor which can either impede or facilitate the development of mental health services.

Curran & Harding’s analysis focused on the larger issues of mental health legislation but did not consider in detail how laws, policies, and programmes specifically affect adolescents. It is fair to say that, on the whole, legislation in this field contains very few specific provisions relating to mentally ill adolescents.

The purpose of this chapter is to examine why and how this is so. It is derived mainly from the important and substantial report by Curran & Harding but also includes information from other surveys of international health and mental health legislation (12–14).

**History of Mental Health Legislation**

The mentally ill or retarded have often been treated badly in the past, the main tendency having been to hide or isolate them. It is only in the last century that legislation has begun to play a positive role. Much early legislation, of which the oldest appears to be the French Law of 30 June 1883 on “lunatics”, can be seen as a reaction to abuses that grew out of what has been called the “asylum era” (11, 15).

Curran & Harding (11) summarize the history of this period in the following manner:

Most of the commitment laws stressing judicial or police involvement were enacted in the middle of the nineteenth century. Emphasis on formal structures and court review continued during the asylum era. The mentally ill and the retarded were segregated and generally lost their legal capacity and civil rights. Significant changes in treatment methods and in public attitudes towards the mentally ill did not tend to have an effect upon the law until the middle of the current century. The mental health legislation of many countries was significantly revised after 1950. The last two decades have seen more varied and often more piecemeal changes in response to the greater complexity of the mental health systems themselves and the lesser concentration upon long-term hospitalization of the chronically ill.

The “content and philosophy” of the foundations of mental health law have substantially changed over the years; however, several themes have persisted. One of these is treatment. The little treatment available in earlier programmes was usually accessible only to the criminally insane, and legislation reflected this narrow approach (14). The categories of patients for whom mental health treatment was accessible were slowly
enlarged to include "mental defectives, epileptics, alcoholics and drug addicts, mentally ill offenders and prisoners, and sexual psychopaths" (16). Legislation and programmes progressed towards providing "a full range of preventive services, community services, psychiatric hospitals, special hospitals, aftercare and home-care organizations, and social and occupational rehabilitation centres" (11, 17). As Bannister (18) has said, "Informed opinion now disassociates mental illness from criminality, and the emphasis is on treatment rather than detention."

Another theme, procedural rights, has also persisted. Its roots reach back to the last century, when reforms helped to establish the rules and procedures on involuntary commitment as well as making provision for voluntary commitment (11). A WHO Expert Committee on Mental Health described the commitment procedures as "archaic" and in its 1955 report (19), levied the criticism that:

Most existing mental health legislation is unsatisfactory, although in some countries laws based on outmoded concepts of mental abnormality, when interpreted liberally, can be made to work fairly well in practice (20) ... The greatest single weakness is that purely legal considerations are given too much weight, and medical considerations too little.

Recent legislation in some countries has tried to overcome some of the problems—the social stigma, the labelling, the alienation from society. A move towards voluntary hospitalization has sought to remove the previously inflexible admission and discharge requirements, allowing freer access, more active participation of the patient's family in the treatment, and the conversion of the mental health institutions into something more closely akin to other hospitals. Changes in the types of care offered in some mental hospitals have altered their nature from being merely custodial to one offering wider, less centralized types of services. These now include crisis intervention and counselling, day care, foster care, and community-based care.

Of late, much has been done to protect patient rights, including the right to seek review of involuntary commitment orders. This has extended the rights of patients to insist that they be given treatment appropriate to their needs and, in some countries, to refuse some types of treatment (11).

The link between evolution of "psychiatric knowledge" and mental health legislation is clear. As techniques of diagnosis and treatment have improved, legislation and policy have had to be adapted, to a greater or lesser degree. Curran & Harding (11) have summarized the advances as follows:

(a) a much wider range of effective drug treatments is available for the treatment and control of mental disorders. As a result, the prognosis in many disorders has been greatly improved, many more patients can be treated outside hospital, and the average length of stay in hospital can be reduced;
(b) simpler and briefer forms of psychotherapy have been introduced. Behaviour therapies have also become one of the definitive treatments available for the relief of mental illness;
(c) non-specialist physicians are more actively involved in the treatment of mental disorders;
(d) the importance of the social environment of patients has been recognized and "social therapy" has become an important facet of rehabilitation;
(e) a pragmatic approach to the assessment of therapy has been evolved. As a result many psychiatrists now advocate a combination of different forms of treatment and certain treatments are now used much less than formerly.

The basic question of whether all mental disorders should be covered by a single item of legislation is still the focus of much debate. In the older legislation, all categories of illness or retardation tended to be treated as medical-psychiatric responsibilities. Even where a legal distinction was drawn between "the insane" and "idiots", the legal and administrative processes for the two groups were usually the same. Nowadays, there is generally no single, universally applied process, and various approaches have been adopted. Three patterns have been discerned by Curran & Harding: "general scope" legislation covering all categories of mental disorders; "combination" legislation, covering mental illness and retardation in one item of legislation, and other categories of mentally-related disorders in separate legislation; and "separate" legislation that distinguishes between mental illness, retardation, and "all or nearly all other categories" of mental disorder.

Despite recent developments in legislation, the law in most countries continues to lag behind the more innovative mental health programmes, the requirements of mental health care, and the needs of society. In most countries, legislation does not reflect the change to community-based mental health care (though there have been moves in that direction), and both the laws and the mental health care structure have thus far failed to recognize and cope with the new health care delivery systems. However, according to Curran & Harding (11), there is substantial agreement that the general aims of legislation should be:

1. The handling of mental patients as much like other medical patients as possible, thus removing the stigma associated with special treatment.
2. The provision of treatment on a voluntary basis under all possible circumstances and limitation of the use of involuntary measures to situations of last resort and to emergencies. (In an affirmative way, it could be stated that the patient should be handled under the least restrictive method available under the circumstances.)
3. The abolition of special legal "labelling" of the mentally retarded, and the requirement that the retarded receive proper education and habilitation in the same manner as other citizens.
4. The integration of mental health programmes into general health and social services, particularly at the point of delivery in hospitals and in the community.

**Legislative Definitions of Mental Illness and Retardation**

Legal definitions of mental illness and retardation determine the extent to which mental health care is available to various categories of persons, and feature prominently in the regulations governing in-
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voluntary treatment. However, not all legislation defines the terms it uses, which can have advantages and disadvantages: detailed, all-inclusive definitions may establish clearly what categories of persons may be treated or committed for treatment but may also deprive mental health programmes of flexibility and the ability to cater to individual needs. What follows gives some general indications as to how the matter of definition has been handled in various countries.

The terms used in mental health legislation have slowly evolved from the pejorative, such as “lunatic”, “idiot”, and “feeble-minded”, to the less stigmatizing, such as “mentally ill”. The Mental Health Act of 1959 in England and Wales was the first to use the term “mental disorder” (21). Under the Act, a “mental disorder” covered any one of four states of mind: (1) mental illness; (2) arrested or incomplete development of mind (subnormality); (3) psychopathic disorder, and (4) any other disorder or disability of mind. The Act did not define what was meant by “mental illness” or the catch-all “any other disorder or disability”, though it did say that a mental disorder could not be inferred only from conduct that was promiscuous or immoral.

The Mental Health (Amendment) Act 1982, which can be seen as an attempt to modernize and consolidate the law in England and Wales, did not remedy all of the weaknesses of the definitions. The changes in the definitions were largely a result of advances in scientific knowledge, and while employing updated terms, suffered from a certain amount of repetition. The definitions in Section 4 of the 1982 Act (22) were as follows:

“Severe mental impairment” means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

“Mental impairment” means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

“Psychopathic disorder” means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

What was referred to as “subnormality” in the 1959 Act became “mental impairment” in the 1982 Act. Although the latter Act was then repealed by the Mental Health Act 1983, the definitions adopted in the 1982 Act were retained.

In Canada the broad term “mentally disordered person” was used in the Mental Health Act 1964, as amended, of British Columbia and some of the gaps in the definitions in earlier legislation were filled. The term was taken to apply to a person who was either mentally retarded or mentally ill. Distinctions were made between these two classifications,
with a "mentally retarded" person defined as one suffering from subnormality. A "mentally ill" person was defined as a person suffering from a disorder of the mind that (a) seriously impairs his ability to react appropriately to his environment or to associate with others, and (b) requires medical treatment or makes care, supervision, and control of the person necessary for his protection or welfare or for the protection of others. In the Province of Alberta mental health legislation applies to persons suffering from "mental disorders", which are defined basically as a lack of reason or lack of control over behavior. The term "mentally defective" is used in the mental health legislation in South Australia. The term describes two different, traditionally accepted, types. First, it refers to the person who is mentally ill and who, owing to his mental condition, requires supervision, care, or control for his own good or in the public interest or who, owing to mental disorder of the mind or mental infirmity arising from age or the decay of his faculties, is incapable of managing himself or his affairs. Second, it applies to the "intellectually retarded" person.

In the USA, the law of the State of Indiana defines the following terms:

"Mental illness" means a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function. For the purposes of [the relevant chapter of the Indiana Code of 1971] "mental illness" may include, but shall not be limited to, any mental retardation, epilepsy, alcoholism, or addiction to narcotics or dangerous drugs.

"Gravely disabled" means a condition in which a person, as a result of mental illness, is in danger of coming to harm because of his inability to provide for his food, clothing, shelter, or other essential human needs.

"Dangerous" means a condition in which a person, as a result of mental illness, presents a substantial risk that he will harm himself or others.

In the USSR, certain types of disease, including mental disorders, are the object of compulsory treatment under Section 36 of the Fundamental Principles of the Health Legislation of the Union of Soviet Socialist Republics, which were issued on 1 June 1970. Those mental disorders requiring hospitalization are specified in considerable detail. Among them are the following:

1. aberrant behavior in consequence of an acute psychotic condition (psychomotor overactivity with a tendency towards aggressive acts, hallucinations, delirium, a psychological automatism syndrome, disturbed consciousness syndrome, pathological impulsiveness, or severe dysphoria);
2. systematized delusion syndromes if they form the basis for behavior dangerous to the public;
3. hypochondriacal delusional states giving rise to an abnormal aggressive attitude of the patient to specific persons, organizations, or institutions;
4. depressive states when accompanied by active suicidal tendencies;
5. manic and hypomanic conditions leading to a breach of the peace or aggressive manifestation towards other persons;
6. acute psychotic conditions in psychopathic personalities, oligophrenics, and patients with residual manifestations of organic cerebral lesions accompanied by
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excitation, aggression, and other actions dangerous to the patient or to other persons.

The Mental Health Act, 1976, of Zimbabwe defines various terms including "mentally disordered or defective" in language very similar to the law in England and Wales. The definition of "psychopathic disorder" in the Zimbabwian Act is similar to that of the Mental Health Act 1983, but adds the qualification that the disorder should be one "which ... has existed or is believed to have existed in the patient from an age prior to that of eighteen years".

Voluntary Commitment for Treatment

There is a trend, which began in 1959 in England, towards voluntary admissions. Carran & Harding noted that 28 out of 35 countries studied, with legislation on mental health, made provision for voluntary treatment programmes. These were largely precursors of the movement towards "outpatient clinics, day hospitals, hostels, and community care" (J1). At least one-quarter of the jurisdictions surveyed had no legislation on the matter. Of those with such legislation, most (some 24 countries) specified the procedures for access to the voluntary programmes. Three approaches predominated: (1) an application (unspecified whether written or oral) by the person seeking admission, or his parents or guardian if a minor; (2) a written application by the person seeking admission, or his parents or guardian if a minor; and (3) either of the above applications, accompanied by a medical certificate.

Access for adolescents

Not all of the statutes refer specifically to admissions of minors, though many do. For example, neither Brazil nor Egypt makes specific mention of minors; however, in Colombia, Sri Lanka, and the United Republic of Tanzania, any person 16 years of age or over may request admission. In South Australia and Victoria (Australia), Denmark, and Fiji, the minimum age is 18. The legislation authorizing minors to seek treatment in Finland is a general medical treatment statute specifying a minimum age of 15. In all of these jurisdictions, if the person needing treatment is underage the request must be made by either the parents or legal guardian of the person. This is also the case in Malaysia, Pakistan, Peru, Poland, Senegal, Switzerland (city of Basel), Trinidad and Tobago, and Uruguay. In Sri Lanka the request must be in writing and accompanied by medical recommendations. In Norway voluntary admission is permitted on the "wishes" of the person or, in the case of minors, of the parents or guardians. Table 25 summarizes the key elements in the voluntary admission of adolescents in different systems.

Two basic difficulties arise from the way the law deals with minors who need treatment. First, not all of the relevant statutes address the issue of age. The assumption that the procedures set out for admission...
### Table 25. Voluntary admission of adolescents to mental health treatment

<table>
<thead>
<tr>
<th>Country</th>
<th>Age at which adolescents may request admission</th>
<th>Requests on behalf of minors</th>
<th>Medical opinion or certificate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>No specific age</td>
<td>Required</td>
<td>Request by patient alone</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>18</td>
<td>Parents or guardian</td>
<td>Required</td>
<td>Request by patient alone</td>
</tr>
<tr>
<td>Egypt</td>
<td>No specific age</td>
<td></td>
<td></td>
<td>Age is set by medical treatment statute</td>
</tr>
<tr>
<td>Finland</td>
<td>15</td>
<td></td>
<td></td>
<td>No mention of adolescent law authorizes patient to request admission</td>
</tr>
<tr>
<td>India</td>
<td></td>
<td></td>
<td></td>
<td>Only signed request by patient required for treatment</td>
</tr>
<tr>
<td>Malaysia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td>16</td>
<td>Parents in parental authority</td>
<td>Required</td>
<td>Thos at least 12 years may apply for observation and diagnosis. If suitable for treatment, parental consent required</td>
</tr>
<tr>
<td>Senegal</td>
<td></td>
<td></td>
<td>Required to justify treatment</td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>16</td>
<td>Parents or guardian</td>
<td>Request by patient alone</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>16; must be &quot;capable of expressing his own wishes&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>16</td>
<td>Parents or guardian</td>
<td>Request for under-16s only</td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>15</td>
<td>Parents, guardian or person in loco parents</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>15</td>
<td>Parents, guardian or person in loco parents</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>14</td>
<td>Parents, guardian or person in loco parents</td>
<td>Required</td>
<td>If minor objects, hearing required, within 72 hours of admission; minor must be examined and given individualized treatment plan</td>
</tr>
</tbody>
</table>

apply to everyone, including adolescents, may be reasonable, but other statutes may govern required protocol in such matters (laws on child welfare, for example). Second, for younger adolescents, "voluntary admission" is largely a misnomer. Invariably, given the intricacies of the law on health care for minors, it is the parents, or in some cases a legal guardian, who "volunteers" the minor for care. As Curran & Harding observe (11), in most countries "it is considered a voluntary admission when the parents or guardian of a child below the age of majority apply to an institution for a non-judicial admission". Where the age of consent is different from the age of majority, age can be an important factor in the voluntary admission process.

Age of consent to voluntary treatment

The subject of consent to treatment in the area of mental health is particularly complicated, because capacity to consent is closely linked to mental status, understanding, and powers of expression. Usually, the issue arises in the area of "voluntary" programmes or "informal admissions"; as they are termed in the United Kingdom and South Australia. These are programmes in which the person decides to enter for treatment on a voluntary basis. Chapter 2 reviewed how the age of consent to medical treatment affects adolescents and what alternatives are being pursued throughout the world. Health care programmes, based as they often are on consent, have increasingly become the subject of legislation aimed at widening access for adolescents. In many cases these provisions on consent in the general legislation on medical treatment were preceded by mental health laws that made provision for voluntary treatment programmes. For one reason or another, these laws went to great lengths to specify who could voluntarily enter inpatient programmes and such statements of law and policy necessarily affected adolescents. For example, subsection 2 of Section 5 of the Mental Health Act 1959 of England and Wales enabled anyone who had attained the age of 16 years and was "capable of expressing his own wishes" to consent to enter mental health treatment programmes irrespective of the wishes of parents or guardians. This provision preceded by a decade the enactment of legislation enabling adolescents aged 16 years and over to consent to other kinds of medical and health care treatment.

In many countries where legislation authorizes "voluntary" programmes, age limits for consent are set. As a general rule, these limits coincide with the age of majority, and in most jurisdictions the limit is either 16 or 18 years. California (USA) is a notable exception, not only for the age and other criteria set, but also for its stance on parental involvement. The 1979 amendment of the California Civil Code added Section 25.9, which contains the following unique provisions:

A minor who has attained the age of 12 years who, in the opinion of the attending professional person, is mature enough to participate intelligently in mental health
LAWS AND POLICIES AFFECTING ADOLESCENT HEALTH

The course of treatment or counselling itself, according to the law, can proceed without the "involvement" of parents or legal guardian only if those who are supervising the treatment think that such involvement would be inadvisable (23).

Finland permits those aged 15 or older to consent to enter mental health programmes. In Sweden, the law of 1980 on the care of young persons also specifies the age of 15, though the legislation on mental health retains the condition that persons under the age of 18 wishing to enter a programme require the consent of "parents or persons responsible" for them.

Sixteen years is the minimum age for consent in mental health legislation in a wide range of jurisdictions: South Australia and Victoria (Australia), Alberta and British Columbia (Canada), England and Wales, Massachusetts (USA), Norway, Sri Lanka, and the United Republic of Tanzania. In Alberta age alone is not sufficient, the person must be "capable of expressing his own wishes"; these terms reflect the English statute. Moreover, the consent of the minor in these circumstances prevails over objections of the parents or guardian.

In Norway, if the adolescent is under 16 years of age, the "persons with parental authority" can consent. This follows the normal rule, but there are other protections. If the adolescent is over 12 years of age and does not agree to participate in the voluntary programme, a "Control Commission", appointed by the Ministry of Social Affairs, with four members including a judge and a physician, must settle the conflict between the parents and the child.

New South Wales and Queensland (Australia), Denmark, South Africa, Trinidad and Tobago, and Indiana (USA) allow those over 18 years of age to decide for themselves whether they wish to seek treatment and counselling. Legislation in Algeria and Costa Rica speaks of persons who have reached the "age of majority" without setting a specific age. The law in Romania requires that "minors" be represented by either parents or guardian in their request for admission. In some countries 21 years is the age for consent; thus in Indonesia, anyone under 21 years of age and unmarried is considered a "child".

The question of voluntary commitment of minors has been the subject of considerable litigation in the USA, where the courts have traditionally had to interpret the law governing such matters.

Many state statutes in the USA allow parents "voluntarily" to commit or institutionalize their underaged children for mental health treatment. The laws in some 28 states, including Georgia, Illinois, and Pennsylvania, provide examples. The statutes in the last two have been interpreted by the United States Supreme Court in *Parham v. J. L.* (24) and *Institutionalized Juveniles v. Secretary of Public Welfare of Pennsylvania* (1979) (25). Both decisions addressed the question of
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whether the requirements of due process—a right conferred by the US Constitution—were observed in the case of minors “voluntarily” committed by their parents. Two decades earlier, the Court had extended various due process rights to minors in juvenile delinquency proceedings (26). The two mental health care cases raised two questions: first, whether the historical legal presumption that parents act, or make decisions, in the best interests of their children was still a guiding principle; and second, whether the requirement that the receiving institution approve of the admission provided a “sufficient brake on parental discretion” (27). The concerns, as articulated by a lower court in the Parham case (28), were that many people “still treat mental hospitals as dumping grounds”, and that the statute granted “the parents unbridled discretion to institutionalize their children”. The solution, according to the lower court, was to insist, as a minimum, that a court-directed hearing be held to assess whether the commitment was justified. The Supreme Court took a different view, refusing “to discard wholesale pages of human experience that teach that parents generally do act in the child’s best interest” (29). The Supreme Court held that the concurring approval of the receiving institution was a check on potential abuse but considered the process essentially medical rather than legal. The decision has had a mixed reception (27, 30-32).

In these cases, and others, the courts have attempted to untangle the problems created by the procedures, statutes, and sometimes by court decisions regarding the treatment of mentally ill minors on the initiative of their parents. The specific wishes of the minor aside, three groups of interests are in competition: those of the parents, the medical professionals, and the lawyers. It is argued that the parents are best situated to protect the interests of the minor; nevertheless there is always the risk that they will use their authority to dispose of a troublesome family member, or refuse to allow treatment where it is indicated. The medical profession sees the problem simply as one of medical diagnosis followed by prescribed treatment, but there is always the risk of inaccurate diagnosis and unnecessary treatment. As one commentary states, the “evidence of the inaccuracy of psychiatric and psychological diagnosis is little short of devastating” (33). Lawyers have traditionally viewed the procedure of voluntary commitment of minors by their parents as one that impinges on personal liberty and have argued against trapping the young “between the guesses of doctors and the endorsement of family autonomy” (34). Nevertheless, the judicial and administrative barriers that have been created in order to minimize the risk of abuse and inaccuracy have been characterized as “time-consuming procedural minuets” (24) that deter and delay treatment.

Request for discharge

A person who enters a treatment programme voluntarily should also be able to request a discharge or release. This is largely the case, though not all laws set out clearly the procedures to be followed. Where rules
have been established, the procedures for adolescents follow those set out for admission. In British Columbia (Canada), once notice of the desire to leave has been given, the patient must be discharged within 72 hours. The same is true in Sri Lanka, where the parents may issue the notice for those under 16 years of age. In the Canton of Geneva (Switzerland) the persons in charge of a psychiatric institution must take a decision on discharge within 24 hours of submission of a request. If the request is refused, the Council for Supervision of Psychiatric Care must review the case within three days. In Algeria, the procedures set out in Section 186 of the Public Health Code are more detailed. First, the chief psychiatrist may discharge a voluntary patient, even without a formal request, if it is thought advisable. Second, the voluntary patient may be released “automatically” as soon as the written request has been signed by the person who made application for admission and presented to the chief psychiatrist. The same rule covers a request made by a parent or relative. However, a patient will not be released at the request of a third party if he is opposed to the discharge. See Table 26 for a summary of release procedures for adolescents.

Involuntary Commitment

Most statutes make no distinction between the involuntary commitment procedures for adults and those for adolescents. The one widely accepted exception is where juvenile courts or child welfare systems have jurisdiction not only over juvenile offenders, but also over certain minors who have mental health problems. In some jurisdictions, juvenile courts and child welfare boards are empowered to commit a young person for mental health observation and treatment, and the criteria in these instances may differ from those applicable to adults.

In New Jersey (USA), for example, juvenile courts may institutionalize a minor for treatment on finding that (1) “the patient if not committed would be a probable danger to himself or the community” or (2) “the patient is in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any outpatient basis”. (The latter criterion does not apply to the commitment of adults (35)).

In New York (USA), under Section 251 of the Family Court Act, a minor who comes before the juvenile court may be hospitalized for not more than 30 days for an emergency evaluation. If an adolescent before the court on a delinquency charge is grossly mentally ill, very complex and stringent provisions govern his case and somewhat different time-limits apply. There are basically two options, both of which can lead to commitment for mental health treatment: the adolescent may be ruled incompetent to stand trial; or, even if competent, he may be found very seriously ill (Sections 322.1, 322.2, and 322.3). In Sweden, Section 6 of Law No. 621 of 19 June 1980 authorizes the social welfare boards of the counties to take into care any person aged under 20, under certain
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Table 26. Discharge of adolescents voluntarily admitted to treatment

<table>
<thead>
<tr>
<th>Country</th>
<th>Origin of request</th>
<th>Form of request</th>
<th>Maximum delay</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>Patient or parent or relative</td>
<td>Written</td>
<td>Chief psychiatrist may discharge. If request made by parent or relative and patient is opposed, he is not discharged.</td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>Patient</td>
<td>Any form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>Patient</td>
<td>Any form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>Patient</td>
<td>Application</td>
<td>Discharge within 72 hours</td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>Patient</td>
<td>Written</td>
<td>Discharge within 24 hours</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Patient</td>
<td>Written</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>If over 16, patient</td>
<td>Discharge within 72 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>Canton of Geneva</td>
<td>Any form</td>
<td>Discharge within 24 hours</td>
<td>Physician in charge may authorize discharge. If patient's request refused, review by Council for the Supervision of Psychiatric Care within 3 days.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>If over 16, patient</td>
<td>Any form</td>
<td>Discharge at time of request</td>
<td>Patient may be detained for 72 hours for physician to apply for reclassification of patient as involuntary.</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>If over 16, patient</td>
<td>Written</td>
<td>Discharge at time requested</td>
<td>Application must be filed at least 7 days in advance of desired release date.</td>
</tr>
<tr>
<td>USA</td>
<td>Indiana</td>
<td>If under 18, parent or guardian</td>
<td>Discharge within 5 days of request</td>
<td>Patient may also be discharged on medical opinion when treatment no longer deemed necessary.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>If under 14, patient</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Circumstances which include behavior indicative of mental illness, medical neglect of the adolescent, and the inability of the parent to provide the kind of care the board deems necessary.

The key issues in involuntary commitment concern the persons who may apply for commitment, the criteria for commitment, the decision-making authorities, the duration of commitment, and the procedures for
review or appeal. In many jurisdictions the rules governing involuntary commitment are quite complicated, with different procedures governing different types of commitment. The law in Barbados, for example, provides procedures for “medically recommended” patients and “hospital order” patients. The procedures are usually linked to the grounds on which the commitment is sought but may relate to the decision-making authority. For a detailed analysis of all these issues, see Curran & Harding’s treatise on the law and mental health (11).

Table 27 gives examples of various approaches to involuntary commitment.

**Origin of requests**

Institutionalization is usually neither informal nor automatic; it is generally the result of a process begun by a request. Spouses and relatives are authorized to make the request in Brazil, Democratic Yemen, Denmark, Egypt, Fiji, India, Iraq, Ireland, Lesotho, Malaysia, Pakistan, and Peru, and guardians may also have this right (as in Egypt and Fiji). In Ireland, a parent or guardian must make the request if the person is under 18 years of age; an “oath by an informant” is sufficient to begin the process in Nigeria. In many countries, the police are able to submit a request, particularly in instances where public safety is in question or where the person is “neglected”; this is the case in Benin, Democratic Yemen, Denmark, Egypt, Iraq, Kuwait, and Senegal. In the Canton of Geneva (Switzerland), only physicians may make applications for involuntary admission of a patient. The nearest relatives may submit the request in Norway but where none exist or they are “unsuitable” or there is disagreement between them, public authorities—health councils, the social welfare office, the police, or the Prison Board—may make a request for a medical examination, which largely determines whether the person is to be hospitalized. The application must state whether the period of admission is for observation (up to 3 weeks) or treatment (indefinite).

**Decision-making authority**

The power of decision over who will be institutionalized is generally vested in either the courts or the hospitals. South Australia and Victoria (Australia), Benin, Cyprus, Democratic Yemen, Fiji, India, Malaysia, Nigeria, Pakistan, Peru, Poland, and Romania place the decision-making responsibility for the issuing of commitment orders in the hands of a court. In Brazil either the court or the police may issue an order for commitment.

Many countries place the decision in the hands of hospital authorities. There is a trend, noted by Curran & Harding (11), “toward compulsory hospitalization on medical certification alone without prior judicial or administrative tribunal review.” Applications for hospitalization are made to the director of the mental health institution, who then
Table 27. Requirements for involuntary hospitalization of adolescents for treatment

<table>
<thead>
<tr>
<th>Country</th>
<th>Condition of subject</th>
<th>Persons who may apply</th>
<th>Decision-making authority</th>
<th>Medical certificate</th>
<th>Length of stay</th>
<th>Appeal or periodic review</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Mentally ill or retarded person</td>
<td>Next relative, police officer or any other person who has reason to believe adolescent is mentally disabled</td>
<td>Director of mental health facility</td>
<td>2 physicians, one may be on staff of facility</td>
<td>One year, renewal for one year, then two-year period</td>
<td>By patient, relative or anyone else to court prior to hospitalization or within three months after</td>
<td>By director of facility at any time</td>
</tr>
<tr>
<td>British Columbia</td>
<td>Mentally ill or retarded person</td>
<td>Next relative, police officer or any other person who has reason to believe adolescent is mentally disabled</td>
<td>Director of mental health facility</td>
<td>2 physicians, one may be on staff of facility</td>
<td>One year, renewal for one year, then two-year period</td>
<td>By patient, relative or anyone else to court prior to hospitalization or within three months after</td>
<td>By director of facility at any time</td>
</tr>
<tr>
<td>Brazil</td>
<td>Suicidal tendencies, serious aggression towards others, troubling social behaviour, immoral actions</td>
<td>Spouse or relative, superintendent of psychiatric department, welfare board, representative of patient, or other interested party</td>
<td>Police with court confirmation</td>
<td>One physician</td>
<td>Indefinite</td>
<td>No specific provision, no periodic review</td>
<td>By order of hospital director or superintendent</td>
</tr>
<tr>
<td>Egypt</td>
<td>Mentally disordered, dangerous to self, others, or public</td>
<td>Relative or guardian, police, or medical officer</td>
<td>On advice of admission, Board of Control has 30 days to ascertain, or discharge patient</td>
<td>Two physicians, one if adolescent arrested</td>
<td>One year, renewals for 1, then 2, then 3 and 5 years on medical report</td>
<td>Review for renewals</td>
<td>Automatic at end of commitment if not renewed, otherwise by hospital director or Board of Control</td>
</tr>
</tbody>
</table>
Table 27 (continued)

<table>
<thead>
<tr>
<th>Condition of subject who may apply医疗条件</th>
<th>Cargo of authority who may make decision运输</th>
<th>Medical authority of making</th>
<th>Medical authority of making</th>
<th>Length of stay</th>
<th>Appeal</th>
<th>Discharge</th>
<th>Discharge</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Alleged lunacy or mental illness</td>
<td>(a) Court of appeal</td>
<td>(a) General inquiry</td>
<td>(a) General inquiry</td>
<td>Unwilling or dangerous</td>
<td>Unwilling or dangerous</td>
<td>Unwilling or dangerous</td>
<td>Unwilling or dangerous</td>
<td>Unwilling or dangerous</td>
</tr>
<tr>
<td>(b) Alleged lunacy or mental illness</td>
<td>(b) Court of appeal</td>
<td>(b) General inquiry</td>
<td>(b) General inquiry</td>
<td>Unwilling or dangerous</td>
<td>Unwilling or dangerous</td>
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<td>Local court</td>
<td>One physician</td>
<td>Written application to police authorities</td>
<td>Senegal</td>
<td>Mental patient</td>
<td>Unspecified</td>
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United Kingdom
England and Wales
Person with nearest mental disorder relative, or including social worker
One from specialist, one from physician acquainted with person
2 initial periods of 6 months, thereafter yearly periods, renewable
To court through writ of habeas corpus
Patient or person on his behalf, might apply to Mental Health Review Tribunal for discharge (within 6 months of detention, then annually), or if hospital refuses release
Review annual or when renewal sought.

United Republic of Tanzania
Person of unsound mind and not under proper care or control, or who is dangerous, found wandering, or cruelly treated or neglected
Police
One physician
Indefinite
Permanent Commission of Inquiry may appeal to court on behalf of patient

By Visitors Committee of hospital, or at request of relative or friend if they will care for patient, or by court order on application by interested person

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3. In these countries the law permits the patient himself to apply for involuntary admission—a practice that borders on voluntary admission.
decides whether to admit, in British Columbia (Canada), Costa Rica, Egypt, Peru, Sudan, Canton of Geneva (Switzerland) and the Syrian Arab Republic. In Norway it is the medical superintendent of the psychiatric facility who decides. The Council of Europe recommendations No. R(83)2 of 1983 on "involuntary placement" emphasize that the persons who take the decision "should be different from [those] that originally requested or recommended placement" (36). Some of the more recent laws in European countries have adopted this approach (for example, those of Norway and Sweden).

Conditions meriting involuntary commitment

As discussed earlier (p. 218), the definitions of mental illness and retardation are important because they establish the grounds upon which persons, including adolescents, may be involuntarily hospitalized. Many of the legislative enactments do not define terms but do establish criteria. The most common term is "dangerousness", which essentially "requires a finding that the patient, owing to mental illness, constitutes a danger to himself or to others around him, or to the community at large" (17). In many jurisdictions, e.g., Cyprus, Denmark, Egypt, Malaysia, Peru, Poland, and Sweden, it is the existence of a "mental illness" or "disorder" in conjunction with "dangerousness" that serves as the criterion. In other jurisdictions, the need for treatment or care must be demonstrated. In the city of Basel (Switzerland), the mentally disordered who are a danger to "public security, order or morals, or to self" and who are in need of care, supervision and treatment may be subjected to involuntary commitment. In other jurisdictions, dangerousness is only one of several grounds that may be considered. In England the Mental Health Act 1983, in addition to requiring the existence of a "mental disorder", specifies that an assessment must show that the hospital setting is the sole means of ensuring the necessary treatment. Under subsection 2 of Section 3 of the Act, an application for admission for treatment must show that (a) the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree that makes it appropriate for him to receive medical treatment in a hospital; (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he is detained under this section.

In Democratic Yemen, India, and Pakistan, all of which follow the Lunacy Act 1890 of England and Wales, three grounds exist: lunacy, person at large or neglected, and incompetency. The second category covers anyone believed to be a "lunatic" who is either found wandering, is dangerous, not under proper care, or "cruelly neglected". Fiji follows the same pattern, though it does not refer to " lunacy " as such. In the
United Republic of Tanzania, the law permits involuntary hospitalization for anyone of "unsound mind", which is defined along the same lines as "persons at large or neglected" in the countries mentioned above. In Nigeria, the mere "suspicion of lunacy" is sufficient to start an inquiry; the conclusion that the person is "insane" leads to commitment. A few countries, Benin and Sudan among them, still require criminal behaviour before a mentally ill person may be hospitalized.

As was previously noted, there is a trend away from institutionalization in some countries. The Council of Europe in its recent recommendations urges that an "involuntary patient" should be placed in an "establishment . . . only when, by reason of his mental disorder, he represents a serious danger to himself or to other persons" or when the disorder is so serious that failure to commit him "would lead to a deterioration of his disorder or prevent the appropriate treatment from being given". The Council recommended that commitment be considered only as a last resort. Recent legislation in England and Wales, Bavaria (Federal Republic of Germany), and Ireland reflects this philosophy.

The Mental Retardation Code in the District of Columbia (USA) is also indicative of the trend in the USA and elsewhere to emphasize rehabilitation under the least restrictive alternative for care. If either a parent or guardian petitions the court for commitment, a judicial hearing is required. In the case of those under 14 years of age or who are not competent to express a view, the court may order "residential" commitment only if it finds that

- the person is at least moderately mentally retarded, on the basis of a comprehensive evaluation performed in the six months before the hearing;
- commitment to the facility is necessary for adequate habilitation;
- the facility in question is capable of providing such habilitation; and
- commitment to the facility is the least restrictive habilitation alternative.

If the person is over 14 and legally competent, and objects to commitment, the petition must be dismissed. Concerning the hearing, the law also specifies various procedural matters, regarding counsel, presence of the person, cross-examination, review of decisions, etc.

Medical assessment or certification

In most jurisdictions the hospitalization of an adolescent will also require a medical assessment certifying that the person is in need of treatment or falls into one of the specified categories of persons in need of hospitalization. A medical certificate is required for all categories of commitment in Democratic Yemen, India, and Pakistan (71). Certificates also play an important role in South Australia, Brazil, British Columbia (Canada), Denmark, Nigeria, Romania, Senegal, Syrian Arab Republic, and the United Republic of Tanzania. In Ireland, the recommendation of two medical practitioners is required. In Paraguay, two physicians, one a
psychiatrist, must certify a patient for hospitalization. In Cyprus, the medical certificate or opinion is part of the inquiry that precedes the decision on hospitalization. In the Sudan, the certificate may only be issued by a psychiatrist. No certificate is required in Malaysia.

In the Canton of Geneva (Switzerland), a medical certificate is required in all cases. The certificate must give details of the patient’s symptoms, the conditions that require his admission, and a statement of the degree of urgency of the admission. In Norway, a physician who examines a patient and finds grounds for hospitalization must submit a written report summarizing his findings.

A few countries have certificate requirements that differ according to the type of commitment sought. In Japan, if the commitment is “compulsory”, that is, ordered by the Governor of the Prefecture, two medical opinions are necessary; if the commitment is “involuntary”, that is, resulting from an application by the person responsible for the disordered person and accepted by the head of the mental health institution, only one opinion is needed. In Peru, if a “general application” is made, one medical certificate is required; none is needed if the commitment is ordered by the court. In Egypt, two certificates are normally required, but if the commitment arises out of an arrest, only one is needed.

Certification, while often the key to hospitalization, cannot be separated from other factors, as the law in Sweden indicates. In Sweden, the certificate, termed a “care certificate”, must confirm that the person is suffering from a mental illness, that “inpatient psychiatric care” is “unavoidably indicated”, and that one or more of the following conditions exist: (a) as a result of the illness the patient is manifestly unaware that he is ill, or as a result of dependence on narcotics is manifestly unable to evaluate his need for care correctly, and his condition can be expected to improve as a result of care or can be expected to deteriorate if care is not provided; (b) as a result of the illness the patient constitutes a danger to the personal safety or physical or mental health of others or to his own life; (c) as a result of the illness the patient is unable to take care of himself; and (d) as a result of the illness he has a way of life that is seriously disturbing to his neighbours or others.

**Length of commitment**

By its very nature, the treatment of mental illness varies in length from case to case. In general, legislation on commitment reflects this lack of consistency. The predominant pattern is to permit hospitalization for an “indefinite” period of time as in Victoria and South Australia (Australia), Brazil, Cyprus, Denmark, Malaysia, Norway, Peru, Romania, Senegal, Syrian Arab Republic, the United Republic of Tanzania, and Indiana (USA). Though Bahrain and Iraq have “informal” systems for handling the mentally ill, they also allow
indefinite periods for treatment. Some legislation does not specify the permissible duration of hospitalization. This is the case in Costa Rica, Democratic Yemen, Fiji, India, Japan, and Pakistan. A few countries fix time limits for the hospitalization, thereby requiring some form of review of the patient’s situation before longer periods of treatment are permitted. British Columbia (Canada), Egypt, and Lesotho set a one-year limit. A few jurisdictions allow for “temporary” institutionalization, during which a decision on long-term commitment is to be reached. In South Australia the limit for this period is 30 days, in Nigeria 28 days, and in India 90 days.

Commitment procedures for observational purposes are also classed as involuntary, and have traditionally been used to allow physicians to make a diagnosis. The “observational” commitments, usually based on a physician’s certificate of necessity, are short-term, and are not often used nowadays, except in dealing with the criminally insane. Curran & Harding (11) attribute this decline to two factors: the improved ability to make diagnoses outside the hospital setting and increased use of community-based mental health programmes.

Emergency hospitalization may be used for patients who need “immediate treatment, supervision, and care, on account of a violent outburst, a suicide attempt, or other bizarre behaviour of sudden onset” (11). These cases are usually handled by the police, at least initially, and court screening and medical review are sometimes dispensed with. In some countries health officials can initiate the procedure. The time limits vary greatly, but most are very short: Basel-Stadt (Switzerland), Trinidad and Tobago, and Uruguay allow 24 hours; Cyprus, England and Wales, Iraq, and Indiana (USA) allow 72 hours; Romania specifies five days, Malaysia and Nigeria, seven days, Peru and Massachusetts (USA), 10 days; New York (USA) allows 30 days for emergency evaluation of minors.

Appeal and periodic review

Two patterns are predominant in the legislation with regard to appeals against the decision to hospitalize. In some cases the statutes and regulations contain nothing on the subject, which usually means that appeals are not permitted; in other cases they establish procedures for appeal, either as part of mental health law or as part of the rules governing civil or criminal judicial proceedings. Legislation in Brazil, Egypt, and Senegal falls into the first category. Of the countries with legislation in the second category, India permits appeal to the local court, or in some states to the Director of Health Services; in Japan the appeal must be taken to the Governor of the Prefecture. In Sudan, the appeal may be filed with a provincial judge. In British Columbia (Canada), there are various avenues for appeal: (1) prior to actual hospitalization or within three months of commitment, the decision may be challenged in court; (2) 30 days after admission an appeal may be
taken to a special panel within the facility for a "hearing" on the commitment; and (3) a writ of habeas corpus is also available. In Norway, Switzerland, and the United Kingdom, appeals are dealt with by special bodies that oversee the mental health system. In Norway, where the superintendent of the facility has authority to admit the patient, an appeal may be submitted to the Control Commission, which oversees the process. In the Canton of Geneva (Switzerland), the patient has the right of appeal to the Council for the Supervision of Psychiatric Care within 10 days of admission. The Mental Health Review Tribunals in the United Kingdom generally oversee the appeal process, though the legality of the "detention" may be tested in court through a writ of habeas corpus.

Periodic review of the patient's condition is essential as treatment prepares him for release. Some systems have no provisions on review while some establish detailed procedures. It is difficult to know whether the absence of specific legislation means that periodic review is not available. In Brazil, India, Peru and Senegal nothing is said of periodic review. In British Columbia (Canada), Egypt, and the United Kingdom review is necessary prior to a request to renew the period of commitment. In Sudan, the psychiatrist in charge of treatment is required to file monthly reports on the patient's condition.

**Discharge**

Two aspects of the discharge process are especially important: the conditions under which a patient can be discharged, and the person or body who has the authority to take the decision. As a general rule, those with the authority to admit a person to a facility also have authority to release patients. In addition, in almost every instance, those in charge of a mental health facility can release a patient. This is the case in Brazil, British Columbia (Canada), India, Malaysia, Norway, Peru, and the Canton of Geneva (Switzerland). In the United Kingdom, either the hospital manager or the Mental Health Review Tribunal can discharge a patient when his condition warrants it. In some countries the courts play a role; thus in Senegal and the United Republic of Tanzania, either the hospital authorities or a court may order the discharge, while in Romania the local people's court controls the discharge process.

**Education, Counselling, Rehabilitation and Training Programmes for Adolescents**

Many of the laws and policies governing mental health care create general systems with regulations applicable to adults and adolescents alike. Nevertheless, there is evidence that increasing attention is being given to adolescents. Four aspects of this development stand out: first, mental health legislation has begun to include provisions on adolescents; second, comprehensive health legislation has given particular attention to
the problems of the mentally ill adolescent; third, laws governing social services have also concentrated on these problems; and fourth, laws and policies concerned exclusively with adolescents are being adopted.

Mental health legislation

In Greece, Decree-Law No. 104 of 11 August 1973 on mental health regulates the procedures and institutions providing care. Section 6 authorizes the establishment, in general hospitals with more than 300 beds and children's hospitals with more than 50 beds, of special neurological and psychiatric departments for the young, including adolescents. It also authorizes special day-time and night-time treatment and education centres, intended to accommodate minors, between the ages of 3 and 17 years, who suffer from any kind of mental disorder.

Norway, under Law No. 28 of 15 April 1977, has established "psychiatric policy clinics" for children and young persons regulated by special guidelines dating from 1975.

In the United States, the Federal Government has enacted a number of statutes authorizing the funding of a wide range of mental health programmes. The statutes include the Social Security Act (Titles IV, V, XVI, XIX, and XX), the Education for All Handicapped Children Act, the Developmental Disabilities Act, and the Rehabilitation Act. One recent statute is the Mental Health Systems Act (1980) which, in Section 203, authorizes the Secretary of Health, Education and Welfare (now Secretary of Health and Human Services) to make grants for services for "severely mentally disturbed children and adolescents". These services can be undertaken only by public or private non-profit-making agencies and must be directed towards particular activities for adolescents and children. First, the grants must be for "support services" for "auxiliary mental health services that are unavailable under the Education for All Handicapped Children Act of 1975" or for cooperative programmes that work with the juvenile justice authorities. Second, they can be for projects, undertaken by public authorities, to establish coordinating mechanisms for the programmes already being carried out under the federal statutes mentioned above, or for other state programmes.

Earlier, the Community Mental Health Center Act was amended in 1978 to permit community centres, over a three-year period, to develop services, including a "program of specialized services for the mental health of children". These include diagnosis, treatment, and follow-up services and any necessary liaison activities.

Comprehensive public health legislation

The Algerian Public Health Code extends the right of rehabilitation and of reintegration into society to any child "suffering from a behavioural disorder... or mental deficiency". Rehabilitation, education, and preparation for "social reintegration" are to be provided in
special centres established by decrees of the Minister of Public Health. These centres, which also deal with other categories of health problems, are to cater for "children suffering from predominantly intellectual deficiencies connected with neurological and psychic disorders", who require medical supervision, including "severely retarded, moderately and severely feeble-minded, and slightly feeble-minded children" (Section 267(1)) and "children suffering from behavioural disorders susceptible to psychotherapeutic rehabilitation" (Section 267(3)).

The Health Code of Guatemala, in Chapter IV, details the steps that should be taken for minors who are suffering or are at risk of suffering from developmental disorders related to their mental condition.

In Romania, under the law regulating health care, health units are to provide "children suffering from physical or mental developmental handicaps with medical care and . . . differentiated treatment with a view to their rehabilitation and integration into social activities".

Social assistance legislation

In Denmark, the legislation on social assistance authorizes the Minister of Social Security to regulate the institutions that extend care to individuals suffering from extensive physical or mental disabilities. A series of ministerial circulars details the responsibilities of authorities who manage these institutions, including special day-care or full-time institutions for children and young persons.

Law No. 333 of 19 June 1974 deals with social assistance. While the Ministry of Social Security has overall responsibility for the national programme, the Danish Board of Social Security handles matters at the central level, with the services themselves provided by the local authorities under the auspices of the social security committees. Special provisions apply to children and young people, including, where necessary, arrangements for psychological examination. Provision is also made for those under 18 years of age who require mental health care during the day or round the clock.

In addition, the county authorities operate counselling centres for young persons with behavioural problems. The state operates a network of special care institutions for persons with mental handicaps, including young persons’ homes, observation homes, and treatment homes. Hostels are also maintained specifically for young persons requiring special assistance.

Circular No. 111 of 18 March 1976 contains the implementing regulations. The aims of the counseling centres, according to the circular, include "reducing the number of children and young persons with behavioural problems and [minimizing] the effects of such problems". The centres are staffed by psychologists, educators, and social counsellors, as well as psychiatric and medical advisers.

In Finland, amendments to the law on child protection enacted in 1981 authorized local social welfare boards to provide the special care
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required by young persons with a disease or handicap, who could not be
cared for by their parents. Law No. 63 of 23 January 1981 stipulates, in
Section 23, that the measures taken should cease when the grounds for
taking action no longer exist or when the child reaches 18 years of age.

Hungary has established special centres to provide "social occup­
tational therapy" for the mentally disabled over the age of 16 who, while
able to engage in some activities, are unable to live independently or be
cared for by their families. The programme ensures that the mentally
impaired receive education, treatment, and medical care. The education
is intended to enrich the patients' knowledge, encourage independent
reasoning, and develop behaviour patterns that will allow them to lead
as normal a life as possible, either inside or outside an establishment.

Legislation focusing on adolescents

Many countries have special legislation that applies to the
education, care, and rehabilitation of adolescents. Such legislation often
forms part of special codes for minors that deal with a wide range of
matters, from juvenile delinquency to health care and protection. The
line between behavioural problems, delinquency, and mental health can
often be blurred but the system established in legislation is usually meant
to be flexible enough to allow distinctions to be made.

In Chile, as in many other countries, the problems of minors are
given specific attention. The National Service for Minors, part of the
Ministry of Justice, in addition to providing care for minors who lack
parental protection or guardianship or whose normal development would
be threatened by their parents or guardians, oversees the care given to
minors who display "behavioural disorders" or who are in conflict with
the law.

The Code for Minors in El Salvador establishes a social welfare
service that provides medical, psychiatric, psychological and social care
for those under the age of 18 years.

The Law on Child Welfare in Indonesia defines a "child" as anyone
who is under 21 years of age and has never been married. Young persons
who have behavioural problems are entitled to the care or assistance
necessary to overcome them (Article 6). Those who are disabled are
entitled to special care to enable them to attain the highest level of
development possible (Article 7).

In the Congo, the state has a duty to assist young persons (anyone
up to the age of 35 years) who are physically and mentally disabled. The
assistance includes ensuring that they receive the necessary medical and
welfare services, as well as vocational training.

In many countries, there is a lack of information on the prevalence
of mental disorder. Some have taken steps to remedy this deficiency. For
example, in Uruguay, a special commission has been established to
ascertain the number of children up to the age of 14 who suffer from
mental disease or a significant degree of mental retardation or disability.
and to analyse the age and sex distribution as well as the type and origin of the disease or disorder. This information is to be used to formulate a national plan for prevention and treatment.

The Child Health Institute in Greece operates under the supervision of the Minister of Social Services. The Institute was established primarily to carry out research on questions relating to the physical and mental health and social welfare of children. The Institute is to use the results of this research in formulating proposals on how the state can improve child health, and is to exchange and disseminate the results and scientific knowledge and opinions relating to these issues. An allied institution, the Centre for Research in the Field of Forensic Child and Adolescent Psychology and Psychiatry, has a more specific focus. The Centre concerns itself with research on the following: behavioural disorders of children and adolescents; the experimental application of measures aimed at preventing mental abnormalities, antisocial behaviour and criminality among children and adolescents; and ways of improving the use of facilities in order to provide more effective solutions to the problems associated with the mental health status of children and adolescents. The Centre also trains specialists in the fields of adolescent psychiatry and psychology.

The problems of prevention of mental disorder have been addressed in a number of countries. For example, Spain has a national programme for the "prevention of subnormality", with the Ministry of Health and Social Security in charge of executing the national plan. The activities include genetic counselling, pregnancy surveillance, early detection of developmentally-related mental disorders during infancy, vaccination programmes (rubella and measles), and programmes for children suffering from cerebral palsy. In both Greece and Spain the prevention programme contains a research component on mental disorders, their causes, and consequences.

**Patients' Rights**

While institutionalization may be necessary for some patients suffering from mental illness, it is important that the treatment provided should be appropriate, and tailored to the individual, and that treatment should be provided in a way that respects individual dignity.

**International declarations**

Certain instruments of the United Nations provide an indication of the views of the international community on the care and treatment of the mentally disabled. These instruments are generally based on principles enunciated in the Universal Declaration of Human Rights of 10 December 1948. The most direct reference to the rights of mentally disabled persons is in the Declaration on the Rights of Mentally Retarded Persons of 20 December 1971, which states that "the mentally
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The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings" (37). The Declaration goes on to list the various aspects of care, security and protection to which the mentally retarded person is entitled, and gives strict guidelines for the legal safeguards that should be afforded:

Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. The procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

More than a decade earlier, the Declaration of the Rights of the Child of 20 November 1959 (37), founded on the right of children "to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity", referred specifically, in Principle 5, to the rights of variously handicapped children:

The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

The Declaration on the Rights of Disabled Persons, of 1976 (37), a precursor of the International Year of Disabled Persons (1981), included the mentally ill in the definition of the term "disabled person", while reaffirming the principles set out in the two previous declarations.

When viewed against the background of these statements by the international community, much of the older legislation is "obsolete and irrelevant" (18). By contrast, more recent laws have dealt with diverse matters such as the right to privacy and confidentiality, the right to treatment and care, the right to refuse treatment, and the procedural right of "due process". As might be expected, these issues have been addressed in different ways, and in some cases the trends have not yet been formally established as legal rules.

Right to confidentiality

In all areas of health care, the confidentiality of relations between patient and physician is based on the grounds that it protects the patient from potential stigma, and that it facilitates the therapeutic relationship (5). It is assumed that certain patient information will be made available to other people only for narrow, specified purposes. Many ethical rules applicable to health care professionals recognize the obligation to preserve confidentiality, and the breach of such rules may give rise to legal and other sanctions. Although the right to confidentiality is not absolute (5), its scope is expanding. Some of the exceptions are rooted in common sense. For example, information about the patient's condition
may be imparted to other health care providers who are assisting with treatment. Information may also be disclosed when a court so orders, and under certain circumstances, information may be given to close relations. Persons may waive the right to confidentiality (5), though the question of who may do so in the case of the mentally ill adolescent is crucial. In a few countries, the storage of health data in computer systems and the use of such data by health insurance programmes have raised new, and often complicated, technical issues that are slowly being resolved in the law. Appropriate legislation appears to be one of the surest ways of protecting the confidentiality of information concerning mentally ill adolescents (38).

Right to privacy

The right to privacy, grounded in the precepts of human dignity, is different from the right to confidentiality. It is the right to keep information about one's activities from others and, for adolescents, from parents and guardians in particular (5,39). As Wilson says of the situation in the USA (5):

"For the minor receiving mental health treatment, the right of privacy means (1) the right to be left alone, and, more importantly, (2) the right to choose the time and circumstances under which, and the extent to which, his beliefs and behaviors may be shared with others or withheld from others."

The right of the mentally ill to privacy and to have private communication, either by telephone or post, or during personal visits, is recognized in a growing number of countries including Ireland, Sweden, and some states in the USA. The acquisition by adolescents in some countries of the right to consent to health care treatment is an expansion of their right to privacy. However, in many settings, parents can still influence these "rights". Moreover, the minor's right to give effective consent to treatment does not necessarily imply a right to confidentiality and privacy with regard to the parents.

Right to treatment

Many public health statutes speak of "right to health care"; this right is often ill-defined, but recent developments have helped to clarify it. Indeed, statutes have been the primary vehicle for establishing the right to treatment, in so far as they specify whether persons who are confined because of mental illness have a right to something more than custodial or punitive care. A series of court cases in the USA have reinforced the basic point that adolescents who are confined in institutions, largely as a result of judgements within the juvenile justice system, have the right to rehabilitative treatment and care (40).

The definition of the right to treatment elaborated in the Mental Health Systems Act (USA), which aims at improving federally funded
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The right of the patient to be informed of his rights and of the basis for any decisions affecting him is now guaranteed in several European countries, following the recommendation made by the Council of Europe. In Norway the patient or his representative must receive a detailed written explanation of the assessment on which commitment is based, the decision, and the grounds for it. The same is true in the Canton of Geneva (Switzerland). The right to request a review of the decision to commit is also guaranteed in a growing number of countries.

In some countries, certain types of archaic, inhumane, and dangerous modes of treatment are being abolished or restricted. Norway has issued new regulations on what are called “coercive treatment measures”, limiting the use of “means of restraint” and prohibiting corporal punishment in mental health care.

Right to refuse treatment

The right to refuse certain kinds of treatment, under certain circumstances, can also be found in the legislation of some countries. This right has grown out of the view that, in normal circumstances, persons may refuse treatment on the basis of religious scruples or personal philosophy, as long as the public is not threatened by the
untreated condition. As far as adolescents are concerned, one of the most controversial issues relates to sterilization of the mentally disabled. (For a full discussion of this topic, see Chapter 6, pp. 95–97.)

The application of the right to refuse treatment to mental health care raises some difficult issues, especially when compulsory treatment has been ordered. The element of age and the characteristics of adolescence further complicate matters because much depends on the mental status of the individual. Westman, in a commentary based on experience in the USA (2), explains one of the concepts that make this field controversial:

To permit a child to decline essential treatment might prevent that youngster from reaching adulthood. In other words, a child ought to be able to enter adulthood in optimal physical and mental health. Accordingly, the presumption is that children should receive necessary health and mental health care and no one—the child’s parents, society, or the child—should interfere with that aim.

At the same time, it is clear that, in some countries, “minors” have the right to challenge decisions imposing certain kinds of medical treatment upon them, unless they are found to be incapable of exercising their right. By reason of their disability, those who are severely mentally ill are often unable to exercise their right to refuse or consent to treatment.

To protect the interests of these adolescents, elaborate systems have been developed. The Michigan Health Code, for example, permits any adolescent patient over the age of 13 years to object to being placed in a treatment centre by parents or guardians. Such patients are entitled to assistance from the hospital in preparing the objection, the services of a lawyer, and an independent medical examination.

Conclusions

Adolescents with mental disabilities are a “vulnerable group since their disabilities are compounded by the biological and psychological changes of puberty” (1). This can complicate not only the diagnosis but the treatment, whether it be rehabilitative or custodial. In so far as it stimulates a more considered appraisal of the position and treatment of adolescents, this situation may, in fact, have its positive aspects.

The move towards modernizing general mental health legislation has gathered momentum in the last decade (11, 14) and most of the general trends have benefited adolescents. The increasing adoption of modes of treatment other than involuntary hospitalization, the move away from indeterminate periods of commitment, the extension of the scope of access to voluntary and community-based programmes, and the development of measures to protect patients’ rights are all significant developments.

Many countries are now beginning to complement their general mental health programmes with others that focus particularly on the
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young. Some of these have been greatly facilitated by moves towards permitting adolescents of a certain age to consent to treatment (43). Voluntary programmes aside, the question of who has power to decide whether an adolescent is placed in treatment, either for reasons of mental illness or retardation, remains a contentious issue in some jurisdictions, most notably the USA. The battle for control involves three main contenders: the parents, the courts and lawyers, and the mental health professionals. The adolescent who requires treatment is often caught in the middle. There are, of course, no easy answers and predictably, legislative responses have varied. None the less, it is clear that all have a role to play, the major question being one of balance.

The social status of the mentally ill or retarded adolescent is still low in many countries (44). While legislation could assist in raising that status, many laws fail to reflect current thinking on mental health issues or to provide a framework for the development of progressive programmes. The overriding consideration of lack of resources, which affects all mental health programmes, is always present. The situation in the USA has been described as follows (45):

Substandard quality of care in public mental health hospitals and clinics, the scarcity of needed alternative settings and inadequacies throughout the system are largely due to insufficient funding, which, at this period of shrinking budgets, is worsening to an alarming extent. In order to economize, hard-won gains in services are being lost, staff-patient ratios are being reduced, physical plants are deteriorating and programs of demonstrated value are being dropped to the serious mental health detriment of the young patients. We therefore see increased funding as essential to correcting such harmful conditions.

There is still much to be done to overcome the years of legal neglect of this whole subject. But the role of law has its limits; it cannot, by itself, make good the inadequacies of the mental health care systems in many countries. Without the resources necessary for implementation, enactment of legislation is often a mere paper exercise.

References and Notes

9. To provide a context for the figures, it should be noted that except for males in Israel and Norway the suicide rates are lower for this age group than for any other.
15. "For more than a hundred years, the problem of treating unwilling patients without prejudice to the liberty of the individual was the mainspring of all attempts to provide effective mental health legislation in the United Kingdom. Fear of wrongful detention resulted in the development of a complicated legal machinery to protect people against needless confinement." Bannister, Y. Problems in the harmonization of health legislation at the regional level with reference to the Commonwealth Caribbean. International digest of health legislation, 33: 423-445 (1982).
17. The approach on which legislation on mental health has been based, and the manner in which it has evolved over the years, can readily be seen in the words chosen to describe the subjects of the legislation. The Lunacy Act 1890 forms an example of early legislation in England and Wales; similar legislation exists even now in Burma, Democratic Yemen, India, and Pakistan. Other early laws spoke of the "insane," "lunatics," and "idiots." Sometimes the term "seelie-minded" was used. The title of later legislation in England and Wales, the Mental Health Act, 1959, denotes a departure from the pejorative words previously employed. It addressed, in a broad way, the problems of the "mentally disordered"; prior to the passage of this law a Royal Commission had used the terms "mentally ill" and "mental defective.
Elsewhere, terms equivalent to "mental illness" and "mental disease" came into use in non-English-speaking countries as well. The French Law of 1838 had used the term "aliénés" (lunatics); a Ministry of Health Circular, more than a century later (1948), spoke of "malades mentaux" (mentally ill persons); in Spanish-speaking Latin America the shift was from "alienados" (lunatics) and "dementes" (demented) to "enfermos mentales" (mentally ill persons) (see ref. 11). Bannister, Y. Problems in the harmonization of health legislation at the regional level with reference to the Commonwealth Caribbean. International digest of health legislation, 33: 423-445 (1982).
20. For example, the French Law of 30 June 1838 on lunatics has appeared to maintain its relevance more for what it does not say that what it does. The void has been filled through the years by ministerial guidelines that have kept procedure current with generally accepted international practice.
21. The Mental Health Act 1959 was perhaps the single most influential piece of mental health legislation yet introduced. The approaches adopted in it represented "the state of the art" in the philosophy and practice of the treatment of mental illness. The ripples of change it prompted can be seen in numerous countries.
22. For a comparison of the language of the definitions in the 1942 amendment and the 1959 Act, see ref. 11, p. 141.
23. It should be noted that this provision applies only to outpatient treatment, not to hospitalization.
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24. 442 U.S. 584 (1979). For a straightforward and succinct presentation of these two cases, see: Historic Supreme Court decisions on the voluntary admission of minors issued, Mental disability law reporter, 3 (4): 231–234 (1979).


29. The cases that with what Westman (3) referred to as “three inaccurate assumptions prevalent in legal circles today: 1. The parents of disturbed adolescents are inclined to be too ready to have them institutionalized. The clinical evidence is to the contrary: actually it is inordinately difficult for parents to resolve to maintain their children in needed residential care. 2. Psychiatrists keep children in hospitals for unnecessarily long periods of time. There is no evidence for this belief, which is based upon outdated conceptions of mental hospitals. The disappearance of a problem in the hospital setting does not mean that the adolescent is ready to live in the community. 3. Adolescents mean what they say. There is a developmentally determined discrepancy between the words and actions of troubled teenagers.”

30. Schemmerhorn, A. E. “Voluntary” commitment of mentally ill or retarded children: child abuse by the Supreme Court. University of Dayton law review, 7: 1–31 (Fall 1981). Schemmerhorn says the decisions are “both contradictory and surprising”.


38. The American Psychiatric Association has approved the Model Law on Confidentiality of Health and Social Service Records, which was prepared by its Task Force on Confidentiality of Children’s and Adolescents’ Clinical Records and its Committee on Confidentiality. A highly technical instrument, the Model Law is “designed to serve as a prototype for potential enactment in the individual states. The model is broadly drawn: it applies to all medical, psychiatric, and social service records. Although some provisions may be considered controversial, each jurisdiction can decide for itself which are desirable and/or ‘enactable’ given the local legislative and professional ambiance.” American journal of psychiatry, 136: 137–147 (1979). For a brief synopsis of the Model Law see Mental disabilities law reporter, 3 (2): 145–146 (1979).

39. Roscoe Pound, a pre-eminent American legal scholar, said that the right of privacy was basically “the demand which the individual may make that his personal affairs shall not be laid bare to the world.” Pound, R. Interests of personality. Harvard law review, 28: 343–362 (1915).


41. This portion of the Act has, in fact, been called “divisive.” Proponents wanted the provisions to be mandatory and enforceable against states. State officials wanted
43. Wilson (5) has expressed strong views on the decision-making of adolescents. He says, "It is the strongest sort of fireside induction that adolescents are less competent than adults, largely because they seem impulsive and lacking in the judgment and wisdom that supposedly are gained through experience".
44. WOLFENSBERGER, W. The origin and nature of our institutional models in changing patterns of residential services for the mentally retarded. Washington, DC, President's Committee on Mental Retardation, 1976.

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Mental Health Act, 1980 [JDHL, 33: 281 (1982)].

Benin
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British Columbia

For the sake of concision, International digest of health legislation has been abbreviated throughout to IDHL.
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13. Occupational Health and Safety

Most individuals, if they are to work for wages at all, begin their work experience during adolescence. The transition to this occupational life is an important one but, as a WHO Expert Committee has observed (1), "modern social environments, including the working environment, pose a variety of difficult problems", some of which are health-related. Legislation has traditionally adopted a paternalistic position, seeking to "protect" young workers from exposure to work settings and practices that are deleterious to their health. Health has been one of the central themes in the history of the development of what have come to be known as "child labour laws" (see p. 257). Of late, the focus has shifted, generally, to occupational health and safety legislation.

The health aspects of youth employment, or as some call it, "exploitation", are of great importance, since the age structure in many countries is such that almost half of the population is under the age of 15. For many of these, as Loke says (2), "childhood is simply adulthood in miniature". Their working lives begin early. The ILO study *Children at work* (3) estimated in 1979, certainly conservatively, that 56 million children under the age of 15 were at work, the vast majority of them in the developing world, and half of them in factories. Other estimates have put the figure as high as 100 million (4). Many young people labour in "gruelling and hazardous" conditions (2). The ILO report describes how young people, and specifically children, when employed, tend to work in labour-intensive sectors of industry. Thus, in Thailand, child labour is prevalent in the glass industry, cold storage plants and food canning, where long hours are often spent in high or low temperatures. In Greece and Peru, more than half of the child labour force is engaged in some aspect of agricultural work, deemed by some to be the "most harmful labour sector" (5).

In Mexico, working life in the agricultural sector begins at age 6. Children begin at age 5 to work as sari makers in Pakistan; from age 6 until marriage (at age 14 or 15), young girls from poor families in Morocco work at carpet looms (nimbleness of hands is prized) (2). More than 20000 children, some only 5 years old, work in the match factories of India, where the working day is 16 hours long (5), and many children work in the coal mines of Assam (the small tunnels will not accommodate adults), despite a constitutional ban on the employment of anyone under age 14 in a mine.

Practices of this sort are not limited to any one part of the world. In the USA, the practice of employing very young workers to harvest farm crops has been criticized as creating "sweatshops in the sun" (6) as well
as exposing them to dangerous pesticides (7). Despite a virtual legal ban on dangerous work, the United States Labor Department has repeatedly found minors (under 18) illegally engaged in various hazardous occupations, such as operating tractors and large farm machinery, working in coal mines or in manufacturing or storage areas involving explosives, taking part in logging, roofing and wrecking, slaughtering and meat packing, and operating power-driven bakery machines, circular saws and guillotine shears (7). Every year, fatal and crippling accidents occur to young workers because they are ill-trained to handle dangerous equipment.

The International Labour Office has collected some statistics on occupational accidents among young people (8).

Many young workers are employed in an environment and in conditions that are a genuine hazard to their life, health and normal growth. Their accident rate is higher than average (according to official statistics, 44 per cent of employment injuries involved workers under 30 in France in 1979 and 48 per cent in the Federal Republic of Germany in 1978, though in both cases young workers represented less than 30 per cent of the labour force). This may well be explained by the large number of young people engaged in manual work which, by its very nature, is a more likely source of accidents, but there is also their unawareness of the risks involved because they have not been properly informed, because they lack experience and thus the right reflexes, and because of the natural inclination of the young to take risks and ignore safety rules.

An ILO study (5) has catalogued a few of the dangers: youthful peddlers of petrol often suffer burns; young rubbish collectors incur permanent spine damage from carrying heavy loads; the combination of machinery, pesticides and prolonged exposure to the elements and insects makes farm work particularly unsafe and unhealthy; in industry, machinery-related accidents coupled with the harmful effects of exposure to toxic substances and industrial dust maim, injure and paralyse many young workers; long hours of work without a balanced diet may lead to a permanent state of malnutrition with all its consequences, including nerve damage.

There is yet another, less obvious, occupational health problem—the inability to get a job. Unemployment, in the current economic recession, is rife among young people. In the United States of America, about half the unemployed are between the ages of 16 and 24 (9), though numerically young people constitute only one-quarter of the labour force. The 1978 figures for the proportion of young people among the unemployed were comparable for other industrialized nations and were often higher for developing countries (see Table 28).

Unemployment poses threats to health of a different kind from those discussed above. The frustration and anxieties endured by unemployed adolescents can impair their sense of self-esteem and may reach such severe proportions as to create situations that have been described as “social dynamite”. Some have even gone so far as to suggest that, at least in certain settings, the hard-fought-for legal
restrictions on hours of work, hazardous work or other working conditions "are the source of the most severe difficulties in providing job opportunities for the young work force" (10). To understand how this whole debate has come about, it is necessary to see the problem in its historical context.

Historical Background

The so-called "child labour" laws, the basis of much of what will be described later in this chapter, were largely a product of nineteenth century social reforms that focused on the plight of young workers (11). Economic efficiency and necessity, rather than workers' welfare, were the engines that drove the machine of industrialization. A kind of complicity between parents and employers helped maintain the practice of employing children for long hours in unhealthy atmospheres. The response ultimately was a movement for child labour reform built on an enormous concern over the way that modern industry used and abused young workers. A preoccupation with unhealthy work conditions, as an important part of child welfare, gave the movement vitality. One early twentieth century reformer vividly described the plight of children in industry (12):

It is a sorry but indisputable fact that where children are employed, the most unhealthful work is generally given them. In the spinning and carding rooms of cotton and woollen mills, where large numbers of children are employed clouds of lint-dust fill the lungs and menace the health. The children have often a distressing cough, caused by the irritation of the throat, and many are hoarse from the same cause. In bottle factories and other branches of glass manufacture, the atmosphere is...
constantly charged with microscopic particles of glass. In the wood-working industries, such as the manufacture of cheap furniture and wooden boxes, and packing cases, the air is laden with fine sawdust. Children employed in soap and soap-powder factories work, many of them, in clouds of alkaline dust which inflames the eyeballs and nostrils. Boys employed in filling boxes of soap-powder work all day long with handkerchiefs tied over their mouths. In the coal mines the breaker boys breathe air that is heavy and thick with particles of coal, and their lungs become black in consequence. In the manufacture of felt hats, little girls are often employed at the machines which see far from the skins of rabbits and other animals.

The conditions were seen as wretched by many, and obviously one of the strongest arguments that reformers could use was the need to safeguard young workers from the ill effects of work at too young an age, for too many hours and in jobs where the risk of accident and injury was too high. These dangers were real enough, as a local physician in a New England textile mill pointed out at the turn of the century (13):

[A] considerable number of the boys and girls die within the first two or three years after beginning work. . . . 36 out of 100 of all the men and women who work in the mill die before or by the time they are 25 years of age. Because of malnutrition, work strain, and occupational diseases, the average mill worker's life in Lawrence, Massachusetts was over 22 years shorter than that of the manufacturer.

The history of the child labour legislation is particularly interesting because it was inspired by health concerns. The roots of the movement in the United Kingdom (11) go back to the 18th century; occupational cancer was first reported in chimney sweeps in 1775 and the employment of children in sweeping chimneys was banned by the Chimney Sweep Act of 1788. In 1802, when public opinion was aroused over an epidemic among pauper apprentices in the mills of England, Parliament passed the Act for the Preservation of the Health and Morals of Apprentices and Others Employed in Cotton and Other Mills. This fixed the length of the working day at 12 hours, banned night work, and required rooms in factories to be lime-washed and adequate clothing to be made available to the youthful employees. Though limited to cotton mills, the Act set in motion a chain of events that lasted over 100 years and produced legislation—on minimum age for employment, prohibition of certain types of work (dangerous machines, mines), hours of work, medical examinations—that ultimately covered most industrial work that could be performed by adolescents.

The French approach was similar but more direct. With a single law in 1841 “concerning the work of children employed in factories”, most of the issues were resolved. As Forssman & Coppee (11) point out:

It set the minimum age for admission to employment at 8 years (under the Napoleonic rule the minimum age had been 10), and fixed a working day of 8 hours for children between 8 and 12 years old. It prohibited the employment of young persons between 12 and 16 years of age for more than 12 hours daily, or at night (i.e. between 9 p.m. and 5 a.m.), except in emergencies, and placed a total ban on night work of children under 13 years of age. Children under 16 years of age could not be employed on Sundays or holidays, and all children admitted to employment had to go to school until the age of 12.
The law, oddly enough, aroused hostile reactions even among the workers and was flouted everywhere, principally because it was seen as a device for reducing children's earnings. These problems, and others, were addressed in subsequent legislation, principally in 1874 and 1892, and eventually uniform, acceptable provisions for protecting child labour were laid down.

In the USA, child welfare and education were also the leading issues (14, 15). In Connecticut, laws were enacted in 1813 to require education for working youth. This spilled over into the regulation of conditions at the workplace, particularly where these had harmful effects on young workers. By 1860, eight states in the USA had enacted laws restricting the number of hours a child could work on a given day. Pennsylvania was the first, in 1848, to ban the employment of very young children (those under 12) in factories. By 1930, most states had also specified minimum ages for the employment of children. The number of hours worked per day had by then been reduced to eight. Now all states have “child labour” laws.

The pattern of development of legislation has been similar in both western European industrialized countries, and more recently in the developing world. However, lately it has been supplemented by legislation focusing on occupational health and safety for all workers.

In brief, then, laws concerning employment of children have been enacted for three fundamental health-related reasons (14-16):

1. to prevent children from engaging in perilous or hazardous occupations;
2. to prevent children from injuring themselves because of their inexperience or carelessness;
3. to prevent the overworking of children during an important phase of their physical and mental development.

In what follows, the legal and policy requirements that affect the health and safety of young workers will be described and analysed. They include, not necessarily in order of importance, the minimum age for employment, the prohibition of the employment of young workers in certain types of work, requirements for medical examination, and the control of working conditions, including hours of work, night work, and work undertaken by students.

Minimum Age for Employment

One of the central features of the child labour laws is the minimum age at which a “child” may be legally employed. Such laws are designed, according to the Cuban law of 1977, “to protect the normal physical and mental development of young persons”. The child labour law in the state of Utah (USA) balances the need to encourage “the growth and development of the young by providing work opportunities” with that
for "adopting reasonable safeguards to protect them from certain working hazards". Their purpose, then, is straightforward: to keep the young out of the labour market until such time as society feels that they are prepared for work. Employment is defined in Jamaican legislation as being engaged in "any undertaking, trade or occupation, carried on for profit or gain, irrespective of whether the employment is gratuitous or for reward".

No universal minimum age rule exists. The ILO Convention on minimum age (1973) set the age for employment at 15 (17), but, so far, only 20 countries have ratified it. Not surprisingly, therefore, the age varies from country to country, but the range is relatively narrow. The Algerian Labour Ordinance of 1976 fixes the age of employment at 16 years (18). The age is 15 in Cuba (those aged 15–16 being employable only in "exceptional cases"), 14 in Madagascar (19), 13 in Hong Kong and 12 in Jamaica. Under the constitution, child labour is prohibited in the USSR (20).

Not all work for the young is objectionable per se; some exceptions to the minimum age provisions are usually made for the casual employment of young people in work that is traditionally performed by them, is carried out in the domestic, familial setting, or is not hazardous. In the United States, for example, some state laws permit the employment of young people in such tasks as newspaper delivery. Many states also have "street trade" regulations on minimum age, usually fixed at 10–12 years, that permit children to sell newspapers or to work as scavengers, but also require them to have special work permits (14).

In Jamaica, the minimum age does not apply where the child is used as a source of labour by parents or guardians. Bahrain permits the employment of those between the ages of 14 and 16, but only if special permission is given by the Ministry of Labour and Social Affairs (20). Exceptions are made for domestic servants, temporary workers and some of the labourers engaged in the agricultural sector. In Madagascar, according to Section 83 of the Labour Code, exceptions from the minimum age for employment, i.e., 14 years, can be made by the Minister if "due regard" is given to "local circumstances and for the work that the child may be called upon to do".

The history of child labour laws being what it is, the minimum age of employment is often closely linked with the upper age set for compulsory attendance at school. In the USA, about half the states forbid children under the age of 16 to work outside school hours, when school is in session; the other half fix the age at 14 (14).

Prohibition of Certain Types of Work

While it may be acceptable for adolescents to be engaged in certain "safe" types of work, legislation has generally sought to protect them from work that is dangerous or risky. Some of these items of legislation are more specific than others, but age is generally one of the factors
taken into account. Legislation in Bahrain bans the employment of "juveniles" (under the age of 18) in "jobs hazardous to health". The 1976 Regulations in Singapore prescribe that "no child or young person may be employed in any occupation or in any place or under working conditions injurious or likely to be injurious to [that individual]". In Algeria, it is unlawful to employ those under 18 in "unhealthy, dangerous or arduous jobs" or where the effects of the work would be "prejudicial to their health".

The commonest restriction is one that prohibits employment of the young in "industrial undertakings" purely on health grounds. In Colombia, the minimum age for such employment is 14, the same applies to "agricultural establishments". Section 6 of the Arab Convention No. 7, on occupational safety and health, bans from industrial work those under 15, "unless they are trained" (27). In Denmark, those under 14 may not be employed in work that is "dangerous".

Words such as "dangerous", "arduous", and "hazardous" may be acceptable in common usage, but from a legal point of view, they are not specific enough to define what is acceptable and what is not. Many countries have therefore taken pains to draw up long lists of the types of work from which the young are excluded, thereby making the legislation much more specific. Some of these efforts have been more successful than others. In Colombia, for example, anyone under 18, and women of all ages, are prohibited from working where contact is possible with lead or its compounds, vapours, dusts or gases from harmful inorganic substances (e.g., mercury, cadmium, chromic acid, cyanide vapours from electrochemical processes, silicon dust, toxic organic compounds, such as benzene and other hydrocarbons, insecticides and pesticides, radioactive substances and radiation, and substances that are skin irritants. The USSR has one of the most comprehensive lists. Decisions taken in late 1980 by the State Committee for Labour and Social Questions and the Central Council on Soviet Trade update regulations dating from 1959, which list several thousand "types of arduous or dangerous industrial work" from which young workers are excluded (22).

Experience in the USA is somewhat different since, by federal law, "oppressive child labour" practices have been forbidden since 1938. The Fair Labor Standards Act gave the Secretary of Labor the authority to prevent the employment of those aged 16-18 in jobs that are "particularly hazardous" or "detrimental to their health or well-being". So far, the employment of those under 18 has been banned in 17 types of work (see Table 29). The regulations appear to be based, as Greene & Morales say (23), as much on the premise "that age itself is a reliable indicator of other personal characteristics, presumably required by certain standards of safe occupational performance, such as manual dexterity, depth perception, physical agility and balance and judgement, as on anything else". The list has not been appreciably changed over the last decade, despite a general trend to upgrade job safety standards (14).
Table 29. Types of work in which those under 18 may not be employed under the Fair Labor Standards Act in the USA

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of work</th>
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<tbody>
<tr>
<td>1</td>
<td>Occupations in or about plants manufacturing explosives or articles containing explosive components</td>
<td>9</td>
<td>Occupations in connection with mining, other than coal</td>
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<tr>
<td>2</td>
<td>Occupations of motor-vehicle driver and helper</td>
<td>10</td>
<td>Occupations in or about slaughtering and meat packing establishments and rendering plants</td>
</tr>
<tr>
<td>3</td>
<td>Coal-mining occupations</td>
<td>11</td>
<td>Occupations involving the operation of bakery machines</td>
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<tr>
<td>4</td>
<td>Logging occupations and occupations in the operation of any sawmill, lathe mill, shingles mill, or cooperage-stock mill</td>
<td>12</td>
<td>Occupations involved in the operation of paper products machines</td>
</tr>
<tr>
<td>5</td>
<td>Occupations involving the operation of power-driven woodworking machines</td>
<td>13</td>
<td>Occupations involved in the manufacture of brick, tile, and kindred products</td>
</tr>
<tr>
<td>6</td>
<td>Occupations involving exposure to radioactive substances</td>
<td>14</td>
<td>Occupations involving the operation of power-driven hoisting apparatus</td>
</tr>
<tr>
<td>7</td>
<td>Occupations involved in wrecking, demolition, and shipbreaking operations</td>
<td>15</td>
<td>Occupations in roofing operations</td>
</tr>
<tr>
<td>8</td>
<td>Occupations involving the operation of power-driven metal forming, punching and shaping machines</td>
<td>16</td>
<td>Occupations in excavation operations</td>
</tr>
<tr>
<td>9</td>
<td>Occupations in or about plants manufacturing explosives or articles containing explosive components</td>
<td>10</td>
<td>Occupations in or about slaughtering and meat packing establishments and rendering plants</td>
</tr>
<tr>
<td>11</td>
<td>Occupations involving the operation of bakery machines</td>
<td>12</td>
<td>Occupations involved in the operation of paper products machines</td>
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<td>13</td>
<td>Occupations involved in the manufacture of brick, tile, and kindred products</td>
<td>14</td>
<td>Occupations involving the operation of power-driven hoisting apparatus</td>
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<tr>
<td>14</td>
<td>Occupations involving the operation of power-driven hoisting apparatus</td>
<td>15</td>
<td>Occupations in wrecking, demolition, and shipbreaking operations</td>
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<td>15</td>
<td>Occupations in roofing operations</td>
<td>16</td>
<td>Occupations in excavation operations</td>
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<tr>
<td>16</td>
<td>Occupations in roofing operations</td>
<td>17</td>
<td>Occupations in excavation operations</td>
</tr>
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</table>


It has been argued that the list is “anachronistic”, “internally inconsistent” and “incomplete” (23) and that it has been superseded by the enactment of the Occupational Safety and Health Standards Act. Even so, the federal law has had a wide influence, and those states that have amended their laws have copied the federal list; others have chosen to keep the formulas established at the turn of the century (24). As a result of amendments made in 1974, the child labour restrictions do not generally apply to the work of the young on family agricultural enterprises or on farms where the parents are employed, or when the child is employed as an actor.

The Finnish approach, like that adopted in the Soviet Union, has been to draw up a detailed list of types of work from which the young are excluded. This list is composed of four general parts: (1) work involving mechanical hazard; (2) work involving other physical hazards (not included in (1)) such as noise, pressure, radiation; (3) work involving chemical hazards (31 groups are listed); and (4) work involving biological hazards (bacteria and viruses).

Another type of legislative or policy approach has been to prohibit the employment of young workers in specific types of work or work dealing with hazardous substances. Often these prohibitions are found in specific laws relating to occupational safety and health in specific industries. For example, the ban on “underground” work for young
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workers, usually as part of the child labour laws, has slowly become more or less universal, a result in large measure of the reforms of the last century concerned with mining practices. Cuba and Singapore are two examples of countries in which such a ban exists. Norway, with the development of the North Sea oil industry, has banned the employment of those under 18 in the offshore oil fields.

There has also been a flurry of legislative activity aimed at protecting the young from work that would expose them to ionizing radiation. A large number of countries now have legislative guidelines controlling the employment of young workers in such occupations, and Denmark, Greece, Italy, Kuwait, Malaysia, Syrian Arab Republic and Tunisia prohibit it. Except in the Syrian Arab Republic where the age is 16, the universal minimum age for such work appears to be 18 years.

In France, special rules exclude those under 18 years of age from work involving asbestos. In Ireland, the Regulations of 1974 impose the same rule in respect of abrasive surface blasting operations. Order No. 71/77 in Zaire regulates work in the lead-related industries. In the Philippines, rules implementing Republic Act No. 679 of 1970 ban under-18s from engaging in work where “noxious substances and poison” are used.

There is nothing magical about the age limits set by law. The assumption seems to be that, at some age, individuals can assume the risks of hazardous work or work safely under such conditions. It must be said, however, that work that is by its nature hazardous remains so even for older, supposedly more mature workers (25). This has been finally recognized, as witnessed by the flurry of legislation to protect all workers at the workplace.

**Medical Examinations**

Pre-employment medical examinations are a common requirement. Such examinations are carried out for many reasons but two predominate: (1) to protect the young person; and (2) to protect the employer. Basically, they are used as a screening device in seeking to ensure that the individual is fit for work. If the work is difficult, an examination will ensure that the individual is able to perform it. This serves both to protect the employee’s health and to assure the employer that he is engaging a physically fit employee; in this sense, economic factors are also involved.

These reasons are reflected in legislation, some of which makes medical examinations mandatory, some optional. In Madagascar, Section 84 of the Labour Code gives labour inspectors the option of requiring “children” (generally intended to mean young persons over 14 years of age) to be examined “to ensure that the work on which they are employed is not beyond their strength”. If it is, they will, if possible, be reassigned to lighter work. The Employment of Children and Young Persons Regulations in Singapore require that young people be examined
and found medically fit for employment in any "industrial undertaking". A pre-employment physical examination for young workers up to the age of 18 is mandatory in some parts of the USSR. In both Norway and the Philippines, those under 18 must undergo medical examinations before they can be employed in industry. These examinations are designed according to the Norwegian Regulations of 1977, to "ensure that there are no medical contraindications to their undertaking such work". The law in Bahrain is especially vigilant on behalf of those aged 14–16, who, if they are to be employed, must first pass a medical examination. In Ireland, a young worker may be employed without first being medically examined, but may not remain employed for more than ten days unless examined and found fit.

Medical surveillance during the course of employment is also a requirement sometimes imposed by legislation. Thus annual examinations of all workers under 18 are required in the Russian Soviet Federal Socialist Republic. All workers in the agricultural industry in France must undergo a medical examination on engagement and another after one year to make sure that they are still fit. In addition, the occupational physician in charge has the responsibility of maintaining "special medical surveillance" of high-risk groups, including those under 18 years of age.

In Ireland, every "young person" employed in a "lead process" must undergo a medical examination "at least once every month". Those under 21 who work in underground mines in the Syrian Arab Republic must have a full medical examination and this must be repeated each year. In Argentina, all workers must undergo pre-employment physical examinations and periodic re-examinations.

Conditions of Work

Where the employment of adolescents is permitted, rules are usually laid down that prescribe the conditions of work. These rules determine, in the main, the hours of work; others specify the types of work that are suitable for young workers.

A number of countries and territories have laws or policies that are concerned with the conditions under which young workers may be employed, Cameroon, Ecuador, Egypt, Hong Kong (26), Kenya, and Sweden being among them. The Swedish regulations, as established in Order No. 1 of 11 May 1978 by the National Board of Occupational Safety and Health, lay down rules for the employment of those under 18, and an annex lists the types of work that, from a health and safety point of view, are acceptable for anyone over 13 years of age.

In Bahrain workers aged 14–16 may work no more than six hours and night work is forbidden, as is the case almost everywhere. Shift work for those under 18 is barred in Algeria. Recent legislation in Peru on night work has specifically sought to bring the rules into line with the position taken in the two ILO Conventions (Nos 79 and 90) on the subject (27).
The Protection of Young Persons (Employment) Act (28) in Ireland uses a two-tier system for defining the acceptable maximum number of hours of work per day, per week and per month. For those aged 15–16, eight hours per day or 40 hours per week are permitted; those aged 16–18 may work nine hours per day, 45 hours per week, and 172 hours in any four consecutive weeks. In Cuba, the number of hours worked by young persons between 15 and 16 years of age may not exceed seven hours per day or 40 hours per week, irrespective of the branch of production, and they must not be permitted to work on rest days, except where their work is carried out for reasons of exceptional public interest. Young industrial workers over 13 years of age in Hong Kong, in addition to being limited to eight hours of work a day, must have a one-hour break after each five consecutive hours of work and must not “lift or carry any load exceeding 18 kg”.

Part-time work is permitted for young students in many countries, but this work must be done outside school hours. In the USA, all states have compulsory school attendance laws, the minimum school-leaving age nearly coinciding with that for full-time employment. However, at least nine states have reinforced that rule by banning the employment of young people during school hours (14, 29). Schoolchildren of certain ages in Hungary, under Ordinance No. 11 of 1978, may work “in activities of public utility” during the school year. Those aged 13–18 may work, after a medical examination, a total of 12 days in the school year. Hours and types of work differ for various age groups: those aged 13–14 may perform light, daytime physical work for not more than four hours per day; 15–18-year-olds may do light, daytime physical work for not more than six hours. Of course, they must not do any work “liable to harm their health”. (The minimum age for employment in Hungary is 15.)

It is normal to require rest breaks during the working hours, half an hour being the usual requirement. Madagascar has gone one step further in ordering that “women and children” (the latter term referring to those under the age of 14) be given a daily rest period of at least 11 consecutive hours between working periods or shifts. For those under 14, Peruvian law prescribes a 14-hour rest period, part of which must include the interval between 8 o’clock in the evening and 8 o’clock in the morning.

Despite these regulations, it has been noted (28) that:

Many young people continue to work long hours despite the trend towards a reduction in the number of years spent working and in the normal and average working day, and despite increasingly strict laws and regulations, particularly for certain groups such as young workers and women. To some extent this is because they tend to be concentrated in certain sectors where progress in this field is very slow: agriculture in the developing countries and certain badly paid manual sectors in the industrialised countries. Often, the youngest workers have longer hours than others because they work overtime to supplement meagre wages.
Conclusions

Contemporary legislation to protect the health of young workers is being affected by a number of influences acting in different directions. In the industrialized world, an enormous body of legislation is being generated on occupational health and safety for all workers, and laws and policies are becoming more rigorous in pursuit of this overall objective. As one report says "nowadays the occupational health services are mainly concerned with problems of prevention related to work and the working environment" (11). Some developing countries are copying this pattern.

At the same time, an "industrial revolution", of sorts, is still taking place. The issues faced in some countries over the past 100 years will have to be faced by other countries as they become industrialized. As a WHO Expert Committee pointed out (1), "shifting patterns of employment and unemployment related to technological development and especially to the relentless pressure towards industrialization in the developing countries" are of enormous importance in the field of occupational health and safety. Recent legislation in Angola requires enterprises employing more than 30 "illiterate minors from 14 to 16 years of age" to provide facilities where they can receive a "basic education" (30). As this process of protecting the welfare of young workers continues, care must be taken not to fall into an all too common trap. As Forssman & Coppee warn (11):

In the world of work, many cases can also be observed in which prohibitions which were imposed too systematically or without giving reasons for them, or over-protection, produce results contrary to those expected.

This brings us to the "persistent phenomenon" (1) of unemployment. In the industrialized world youth unemployment is high, while in countries undergoing industrialization, youth is a major source of labour and income. Though the various ILO Conventions on conditions of work have sought to eliminate the harmful practices of the past, it is not clear how much influence they have had. It is estimated that 75% of the world's youth currently live and work in rural areas. The pressure on them to work under grossly unsatisfactory conditions will be high for several decades and may recreate the situation that was seen in the developed world in the nineteenth century. Efforts will be needed to avoid this, since whatever the economic exigencies, there is little justification for continuing with labour practices that threaten the life and health of the young.

Principle 9 of the Declaration on the Rights of the Child (31), still serves as useful guidance:

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which could prejudice his health or education or interfere with his physical, mental or moral development.
References and Notes

4. ILO reports, No. 9, September 1979.
24. FOR example, see Massachusetts Annotated Laws, Chapter 149, Sections 61, 62 (1965); California Labor Code, Sections 1293-1294 (West’s Annotated California Code 1971).
29. The nine states are: Alabama, Colorado, Iowa, Kansas, Nebraska, Nevada, New Hampshire, Tennessee, and Utah.

Legislation

Algeria
Ordinance No. 75-31 of 1976 (Sections 180, 194 and 260).

Angola
Decree No. 58/82 of 9 July 1982.

Argentina
Decree No. 251 of 5 February 1979 on occupational medical services prescribing regulations for the implementation of Law No. 19587 and repealing the Annex approved by Decree No. 4166 of 1973 (Section 27) [DHIL, 32: 543 (1981)].

Bahrain

Cameroon
Law No. 74-14 of 27 November 1974 (Section 93).

Colombia
Resolution No. 02460 of 22 May 1979 prescribing various provisions concerning accommodation, health and safety in work places (Sections 691 and 696) [DHIL, 32: 293 (1981)].

Cuba
Law No. 3 of 28 December 1977 on labour protection and occupational health [Sections 41(a), (b), and (c)] [DHIL, 33: 909 (1982)].

Denmark
Order of 4 July 1968 to promulgate the Law on the protection of workers in agriculture, forestry, and horticulture [Section 19A(4)] [DHIL, 21: 562 (1970)].

Ecuador

Egypt
Law No. 137 of 6 August 1981 promulgating the Labour Code (Sections 143-150) [DHIL, 33: 909 (1982)].

For the sake of concision, International digest of health legislation has been abbreviated throughout to DHIL.
OCCUPATIONAL HEALTH AND SAFETY

Finland
Ordinance No. 212 of 10 March 1972 concerning the assignment of young employees to dangerous work (Annex) [IDHL, 23: 715 (1972)].

France
Decree No. 77-946 of 17 August 1977 on special health measures applicable in establishments where employees are exposed to the effects of asbestos dust (Section 12) [IDHL, 29: 349, 350 (1978)].
Decree No. 82-397 of 11 May 1982 on the organization and operation of occupational medical services in agriculture (Sections 30 and 32) [IDHL, 33: 570 (1982)].

Greece
Decree-Law No. 181 of 19 November 1974 on protection against ionizing radiations (Section 3) [IDHL, 29: 373 (1978)].

Hong Kong
Employment Ordinance of 1979 (Chapter 57) (Section 73).
Employment of Children Regulations of 1 September 1979 (Section 5).

Hungary
Ordinance No. 11 of 16 December 1978 of the Minister of Health on health requirements for the employment of schoolchildren in activities of public utility (Sections 1-4) [IDHL, 30: 240 (1979)].
Ordinance No. 29 of 1979 of the Council of Ministers amending the Labour Code (Section 4) [IDHL, 31: 855 (1980)].

Ireland
Protection of Young Persons Act.
Safety in Industry Act, 1980 (Section 51) [IDHL, 32: 553, 555 (1981)].

Italy
Decree No. 185 of 13 February 1964 (Section 65) [IDHL, 15: 543 (1969)].

Jamaica
Juvenile Law, Chapter 189 (Sections 69 and 70).

Kenya
Employment Act (No.2) 1976 (Part IV) [IDHL, 28: 385 (1977)].

Kuwait
Decree of 12 November 1977 promulgating Law No. 131/977 concerning the organization of the use of ionizing radiations and the precautions against the hazards associated therewith (Section 12) [IDHL, 29: 601 (1978)].

Madagascar
Ordinance 75-013/DM promulgating the Labour Code (Sections 83 and 94).
Radiation Protection Rules, 1974 (Section 5(2)) [IDHL, 29: 597 (1978)].

Norway
Regulations of 14 October 1977 on medical examinations of young employees [IDHL, 30: 112 (1979)].
Regulations of 1 June 1979 (Section 8) [IDHL, 31: 121 (1980)].

Peru
Presidential Decree No. 03-81-TR of 13 February 1981.
Philippines
Revised Rules and Regulations implementing Republic Act No. 671, as amended [IDHL, 24: 885 (1973)].

Singapore

Sweden
Order No. 1 of 11 May 1978 of the National Board of Occupational Safety and Health on the employment of minors [IDHL, 31: 553 (1980)].

Syrian Arab Republic
Order No. 290 of 12 March 1975 prescribing conditions of work in mines applicable to workers under 21 years of age (Section 1) [IDHL, 31: 839 (1979)].

Tunisia
Law No. 81–85 of 18 June 1981 on protection against hazards from sources of ionizing radiation (Section 3) [IDHL, 33: 606 (1982)].

Union of Soviet Socialist Republics
Law of 29 March 1971 (Section 76) [IDHL, 26: 427, 429 (1975)]

United States of America
Occupational Safety and Health Standards Act, as amended [Section 213 (1) A, B].

California

Massachusetts
Annotated Laws, Chapter 199 (Sections 61, 62) 1965.

Utah
Utah Code Annotated (Section 34–23–1) of 1974.

Zaire
Order No. 71/77 of 5 May 1977 prescribing measures for the prevention of occupational lead poisoning [IDHL, 30: 658 (1979)].
14. Accident Prevention

The word "accident" is generally taken to mean something that has happened in a more or less random way and largely because of bad luck or fate. However, as often pointed out, most accidents are preventable and many are the result of human error combined with an "environmental" hazard.

Accidents wreak enormous havoc. In the USA during 1983, 91,000 accident victims of all ages died (1). Between 1979 and 1981, some 81 million people suffered injuries in any 12-month period; approximately one-third of them occurring in the home, and causing 3 million disabling injuries and 20,000 deaths (1). If these figures are correct, about one in three of the population, on average, is the victim of an accident in any year!

According to a WHO Expert Committee (2) "accidents constitute one of the main causes of death in adolescents throughout the world, accounting for about half of all deaths in the age group 10-19 years". Recent statistics bear this statement out, as can be seen from Fig. 5, which shows the leading causes of death for the age group 10-19 years. Deaths due to accidents account for approximately 50% of deaths in seven of the 15 jurisdictions considered—England and Wales (48.5%), France (54.6%), the Federal Republic of Germany (57.2%), Italy (56.6%), Norway (54.0%), United States of America (58.2%), and Venezuela (45.3%). The trends over time, as might be expected, vary from country to country. When compared with the figures for 1973, the percentage of deaths due to accidents had risen in 7 countries, declined in 7, and remained the same in one, Japan (39.8%). The greatest decreases occurred in Israel (43.4% to 33.3%) and Yugoslavia (52.1% to 40.4%); the greatest increases were in Mauritius (28.2% to 39.9%), Thailand (14.6% to 19.3%) and Venezuela (38.1% to 45.3%).

These are rather alarming statistics. A WHO Expert Committee (2) pointed out that, when comparisons are made with other "life stages", especially infancy and old age, mortality rates in adolescence are relatively low. Even so, the tendency for accident-related mortality rates to rise rather dramatically during adolescence is borne out, in part, by the statistics available from four European countries: France, Italy, Norway and the United Kingdom. As shown in Fig. 6 accident mortality rates increase sharply, especially among males, after the age of 10 years. Fig. 6 also highlights another aspect of this subject: to the extent that generalizations can be made, accident-related mortality rates are significantly higher for young males than for females.
Fig. 5. Leading causes of death by percentage for the age group 10-19 years in 15 selected countries and territories

- A: Heart diseases
- B: Malignant neoplasms
- C: Accidents
- D: Pneumonia and influenza
- E: Suicide and self-inflicted injuries
- F: Congenital anomalies
- G: All other external causes
- H: Diseases of the circulatory system
- I: Appendicitis and appendicular sepsis
- J: Enteritis
- K: All other causes

All causes = 100%
It would appear from the available data, at least for Europe, that motor-vehicle-related accidents account for the majority of deaths in the adolescent age groups (3). Mortality rates from this cause tend to be higher in the industrialized countries but rates are rising to the same levels in some developing countries also. Such things as accidental drownings, fires, falls and poisonings are the other major causes of death but, as one European report points out (3), “these in combination tend to play a less dramatic role in the pattern of mortality among the young”.

Mortality reflects only a “small fraction of the total health problem” (2). Accident morbidity is, however, much less fully documented and hence the data are much less reliable. One estimate of the magnitude of the problem in Europe, made by a WHO Technical Group (3), has suggested that, for every child or adolescent who dies as a result of an accident, another will be permanently handicapped, ten others will have to be hospitalized for approximately 30 days due to the injuries, and about 1000 will suffer an accident that does not require hospitalization.

The patterns of behaviour that give rise to accidents among the younger age groups, in particular adolescents, are still not fully defined (some accidents must surely be purely “accidental” occurrences for which no rational explanation can be found). It is thought that accidents
in adolescence are due largely to incomplete mental or physical development and/or limited life experience (4). The literature has focused particularly on the experimental, impulsive, risk-taking behaviour (2) of adolescents, especially males, as a consequence of the state of adolescence, that makes them particularly accident-prone. (See Fig. 7 for the principal factors in traffic accidents involving adolescents.) One survey in the USA (5) has noted that:

Experience has shown that adolescent males (and, to an increasing extent, adolescent females) tend to seek sometimes dangerous challenges without taking possible risks into account to the extent most adults would. Impulsive, risk-taking behavior has relevance for the health and safety of adolescents—whether the activity involved is working, driving a car, skiing, skin-diving, hang-gliding, or climbing—and is even more important in group activities, where peers may provide social support for high risk activities.

Fig. 7. Principal factors in traffic accidents involving adolescents

![Diagram showing factors linked with the adolescent (endogenous) and factors linked with the environment (exogenous)](source: WHO Technical Report Series, No. 609, 1977)
There is every indication that accidents figure prominently in determining the health status of adolescents. In this chapter, we shall look briefly at the types of laws, policies and programmes that have begun to address the problem of accident prevention among adolescents. Motor-vehicle-related accidents, which appear to be the main focal point of legislative initiatives, are often associated with alcohol and drug abuse (see Chapters 9 and 10). Nevertheless accidents and their prevention are also linked to other subjects such as, *inter alia*, occupational health and safety (see Chapter 13), firearms safety, and home safety. In view of the wealth of legislation on the subject, however, the main emphasis here will be on motor vehicle accidents.

**Prevention of Motor Vehicle Accidents**

**Requirements for driving licences**

Driving begins for many during adolescence. In most countries, those who drive must obtain a licence. The primary reason for driving licences is quite simply to guarantee that those who drive meet certain minimum requirements relating to the safe handling of motor vehicles. There are, perhaps, three basic components of these requirements: age, health, and aptitude. Decree No. 66–72 of October 1972 in Guatemala states that drivers must be “free of impediments to driving”; the Norwegian regulations of 1979 stipulate that drivers must have vision, hearing, and “mobility sufficient to ensure safe and satisfactory handling of the vehicle”. The public policy pursued is one of accident prevention; the health connection is obvious.

A minimum age provision is a common feature of the legislation. Worldwide, the range is from 14 to 21 years.

In many countries medical examinations, going beyond those for vision and hearing, are required. The list of medical conditions that can support the withholding of a driving licence is vast. The Moroccan Order of 1975 contains a detailed list with the following category headings: cardiovascular, visual, nasopharyngeal, laryngotracheal, hearing, mental and psychological, neurological, motor function, thorax, and abdomen. Norway and Sweden have similar regulations, though in the case of Norway, at least, a licence may be issued subject to special conditions as specified in a medical certificate.

Under a 1982 resolution, Brazil requires both medical and “technical” examinations before a licence is granted. The same is true in Hungary, where driving lessons are a prerequisite, and repeat medical examinations are performed at intervals of 1–5 years depending on age. In Norway the first licence is “provisional” for two years.

**Seat-belts**

In the wake of a record number of deaths from road accidents, the State of Victoria (Australia), in 1970, led the world by making it compulsory for those travelling in cars to wear seat-belts.
France, in 1973, was the first major European country to introduce a policy of compulsory seat-belt wearing (6). This legislation was preceded by a requirement that belts be "fitted" in the front seats of new cars from April 1970. By July 1973, their use was required in rural areas, and later in urban areas at night. By 1975, seat-belts were required to be fitted in all older cars. This methodical phasing is thought to be the reason for the success of the French programme (7) (see below).

The seat-belt, as Mackay says (7), "is the cornerstone of the automobile occupant protection policy in Europe". Between 1973 and 1976, 13 European countries adopted laws that required seat-belts to be worn in the front seats of motor vehicles (see Table 30) leaving six countries without such laws (Greece, Ireland, Italy, Portugal, United Kingdom and Yugoslavia).

The discussion on compulsory seat-belt use in the United Kingdom is particularly interesting not only because it lasted for so long (nearly ten years, the wearing of seat-belts finally being made compulsory in 1982), but also because of the vigorous public and parliamentary debate that surrounded it. Proponents, early on, stressed the benefits to health and safety that would accompany such a policy. It was calculated that the mandatory use of seat-belts in cars would reduce annual traffic fatalities among car occupants from 3037 to 1777 (based on 1972 figures) (7), and also substantially reduce both human suffering and hospital costs (8). The opponents consistently resisted the proposal on the grounds that making seat-belts compulsory was an infringement of personal liberty on the part of the government. (In point of fact, by 1976, 98% of all cars in the United Kingdom were fitted with seat-belts (7)).

These arguments about compulsory seat-belt use have been largely duplicated in the debate in the USA (5), where New York (in July 1984) was the first state to make such use compulsory (other states are slowly introducing similar laws). Elsewhere, massive public campaigns have been undertaken to encourage voluntary use in the interest of safety. Some of these have given rise to catchy phrases such as "Buckle up",

<table>
<thead>
<tr>
<th>Country</th>
<th>Date</th>
<th>Country</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>August 1975</td>
<td>Luxembourg</td>
<td>June 1975</td>
</tr>
<tr>
<td>Belgium</td>
<td>June 1975</td>
<td>Netherlands</td>
<td>July 1975</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>January 1974</td>
<td>Norway</td>
<td>January 1975</td>
</tr>
<tr>
<td>Denmark</td>
<td>January 1976</td>
<td>Spain</td>
<td>July 1975a</td>
</tr>
<tr>
<td>Finland</td>
<td>July 1975</td>
<td>Sweden</td>
<td>January 1976</td>
</tr>
<tr>
<td>France</td>
<td>July 1973b</td>
<td>Switzerland</td>
<td>January 1976</td>
</tr>
<tr>
<td>Germany, Federal</td>
<td>Republic of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>January 1976</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


b Only in rural areas: elsewhere, only at night.
“Belt up”, “Get it together”, and “Klink klink” (ostensibly the sound of the belt being fastened). Moreover, many of the newer cars are fitted with buzzers to remind the occupants that seat-belts are not yet fastened. Belt use in the USA, however, is still at a low level.

Once the question of seat-belt use was settled in the United Kingdom, the Road Traffic Act of 1972 had to be amended by the Transport Act, 1981, so as to include Section 33A, which gives the Secretary of State the authority to issue regulations concerning the circumstances under which it is an offence not to wear a seat-belt. A special offence was created for those under 14 who were found to be riding in the front seat of a vehicle without the belt fastened. Some exceptions are made to the mandatory seat-belt rule, however, the most important being for individuals who hold a certificate stating that it is “inadvisable on medical grounds” to wear a seat-belt.

The success or otherwise of programmes to increase seat-belt use yields interesting lessons. Bombarding the public with messages about seat-belt use, without the backing of legislation making their use compulsory, appears to be ineffective. In the late 1970s, only about 20% of car occupants in the USA used seat-belts consistently, despite a massive public education campaign (5). This was well below the 70% rate aimed at when the programme was undertaken (9). On the other hand, in France, two years after legislation was introduced, usage was estimated to be of the order of 80%, “with virtually no enforcement, but with a lot of propaganda” (7). In Ontario (Canada), the mandatory seat-belt law increased seat-belt use from 23% to 51% during the first six months of its existence (5). Thus legislation appears to be an important ingredient in achieving high rates of seat-belt use.

The trend that began in Australia in the early 1970s has now spread beyond the industrialized nations. Between 1978 and 1981, Botswana, Côte d’Ivoire (Ivory Coast), Malaysia, Senegal, and Swaziland enacted seat-belt legislation. In Swaziland, the seat-belts in the front must be “securely fastened” during driving. Adults are responsible for seeing that front-seat passengers under 14 years are “buckled in” properly. Penalties of up to ten days’ imprisonment may be imposed if car occupants are found in violation of the law. In Côte d’Ivoire, the Decree of 1981 permits exemptions from use for individuals who for reasons of height or health (a doctor’s certificate is necessary) are “manifestly unsuited” to seat-belts. In Senegal, under the 1981 Decree, seat-belt use is compulsory outside “built-up” areas and on motorways and between 21 h 00 and 7 h 00 in “built-up” areas.

Protective headgear

Certain types of motor-vehicle-related accidents occur mainly among adolescents—motor cycle accidents are an obvious example. Motorcycle use is a particularly popular mode of transport among adolescents, and their use is increasing, as is the number of accidents resulting from
that use. This trend was already apparent a decade ago in the USA, where the number of motorcycle accidents increased from 235,000 in 1965 to 378,000 in 1973. Deaths resulting from these accidents more than doubled in the ten-year period from 1964 to 1974 (from 1600 to 3400). Most of these accidents affected people in the age group 15–34 years (70); many of the fatalities were due to head injuries.

During the 1970s, therefore, certain states and local authorities took preventive measures, and a number of statutes and ordinances were passed requiring that motor cyclists wear protective headgear ("crash helmets"). Despite the health-related reasons for these rules, most have been successfully challenged in the courts so that several of the states have repealed the crash helmet requirements (5). As a result, the wearing of protective headgear is largely left to the individual’s discretion, except in the state of Maine, where motorcyclists must wear such headgear during their first year on the road. In addition all persons under 15 years who operate or ride on a motorcycle must wear protective headgear.

In the United Kingdom, on the other hand, the Road Traffic Act 1972, Section 33(1), gave the Secretary of State the authority to make regulations on the use of helmets “affording protection to persons on motorcycles” and their use was made mandatory. The results have been remarkable. For example, the Head Injuries Unit at Addenbrooke’s Hospital, Cambridge, a special unit established in response to the plethora of severe head injuries arising from motorcycle accidents in the early 1970s, was closed in late 1984 because of under-utilization.

Legislation on this matter has been introduced in other parts of the world. Under a 1981 Decree, for example, Guinea made crash helmet use compulsory for users of two-wheeled motor vehicles.

Traffic Accidents and Alcohol Consumption

It has been estimated that between one-third and one-half of all fatal road accidents in industrialized countries are caused by drivers who are under the influence of alcohol or drugs (71).

Rates can often be misleading but in Finland, between 1950 and 1975, the number of alcohol-related road accidents increased from 20 per 100,000 inhabitants to 75.1 per 100,000, while cases of drunk driving increased from 37.5 per 100,000 to 379.0 per 100,000. At the same time, alcohol-related traffic accidents, as a percentage of all road accidents, rose only modestly from 9.4% to 12.9% (12) (see Table 31).

In Switzerland, between 1963 and 1977, while motor vehicle accidents were increasing, the number of alcohol-related accidents and the number of individuals injured in these accidents nearly doubled. Curiously, the overall number of fatalities did not rise substantially, but

*Under regulations made in 1980, adherents of the Sikh religion, if wearing turbans, are exempted from this requirement.*
the percentage of those killed in alcohol-related accidents did (13) (see Fig. 8).

The statistics for California demonstrate an interesting interplay between alcohol and accidents. Between 1950 and 1979, the proportion of drivers involved in fatal accidents who were under the influence of alcohol increased from 14% to 33% (1975) then fell to 30%. The proportions involved in non-fatal accidents did not change markedly over nearly 30 years: 12.5% in 1950, 10.5% in 1967, and 13.1% in 1979 (14).

Most of the statistics available come from industrialized countries. Some evidence exists, however, that drunk driving is not confined to the developed world. Fully 27% of drivers involved in traffic accidents in

<table>
<thead>
<tr>
<th>Year</th>
<th>1950</th>
<th>1960</th>
<th>1968</th>
<th>1975</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrests for drunkenness per 100,000 inhabitants</td>
<td>3668.0</td>
<td>2964.0</td>
<td>3188.0</td>
<td>5842.0</td>
</tr>
<tr>
<td>Alcohol-related road traffic accidents per 100,000 inhabitants</td>
<td>20.0</td>
<td>28.5</td>
<td>44.9</td>
<td>76.1</td>
</tr>
<tr>
<td>Cases of drunk driving per 1000 registered vehicles</td>
<td>37.5</td>
<td>96.0</td>
<td>147.2</td>
<td>379.0</td>
</tr>
<tr>
<td>Alcohol-related road traffic accidents as % of all road traffic accidents</td>
<td>9.4</td>
<td>5.8</td>
<td>7.3</td>
<td>12.8</td>
</tr>
<tr>
<td>Cases of drunk driving per 1000 registered motor vehicles</td>
<td>17.0</td>
<td>11.8</td>
<td>5.3</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Lusaka, Zambia, had blood alcohol levels in excess of the legal limit (15).

In recent years, alcohol-related driving problems have emerged as a primary focus of programmes addressing the social problems caused by drinking. According to a recent study there are numerous reasons for this, not the least of which is that, "trends in alcohol-related accidents . . . generally run counter to the declining rates for all accidents. While road traffic safety is increasing, alcohol-related road traffic safety is not . . . alcohol-related road accidents continue to increase" (12, 16).

Over the last decade, in the USA, some 25,000 people have died each year as a result of accidents caused by drunk drivers, according to a recently released report by the President's Commission on Drunk Driving (17). Almost half of all road accidents are alcohol-induced; for persons aged 16–24 such accidents are the leading cause of death, and the annual economic loss - through lost work time, cost of health and welfare services, and medical expenses - resulting from accidents caused by drunkenness is conservatively calculated at US $20,000 million (17).

When the ingredients of youth and driving inexperience are added to the combination of cars and alcohol use, the risk of accident becomes particularly high. The recent documented rise in the traffic accident rates in the USA among young people is thought to be largely a product of three factors: (1) the lowering of the age at which a driving licence can be acquired; (2) the lowering of the age at which alcohol may be obtained and consumed; and (3) the tendency for young persons to start drinking at an earlier age (18). Whitehead (19) found a link between the lowering of the legal drinking age and the rise in traffic accidents. For example, in Ontario (Canada), between 1970 and 1974, drivers in the age groups 16–19 and 20–24 experienced the greatest increases in alcohol-related collisions (20). Indeed, 46% of all fatally injured drivers in Canada from 1974 to 1976 were under the age of 24 (21). During the last two decades a disproportionate number of teenagers have been convicted of drunkenness and motoring offences, and the peak incidence of drunkenness offences in England and Wales occurs at age 18 (22). In France, for an 18-month period from 1977 to 1978, 11% of the fatal traffic accidents in small towns involved males aged 15–20 years. An analysis of the factors that affected these accidents revealed that alcohol played no role for those under the age of 15, was unimportant for those aged 15–16, but was a major factor for males aged 18–19 (23).

Legislation on alcohol consumption and driving

As far as legislative measures to regulate alcohol use by drivers are concerned, the tendency has been to admit, in most cases, that the combination of the two is socially acceptable, but that there are limits. The majority of countries are therefore willing to "tolerate" some intake of alcohol by drivers. However, seven countries, namely Bulgaria,
Czechoslovakia, the German Democratic Republic, Hungary, Poland, Romania, and the USSR (24), prohibit the drinking of alcoholic beverages before and during driving.

**Permissible blood alcohol levels**

Blood alcohol content (BAC) (usually measured in grams of ethanol per 1000 grams of blood) is generally used to specify permissible legal limits for alcohol consumption. The established legal minima vary from 0.5 g to 1.5 g. In Finland, Greece, Iceland, Netherlands, Norway and Sweden, the upper legal limit is 0.5 g; in Denmark the figure is 0.6 g. Algeria, Austria, Belgium, France, the Federal Republic of Germany, Spain, Switzerland and the United Kingdom, most of Australia and two states in the USA have set the limit at 0.8 g. Most of the states of the USA and New Zealand have set the limit at 1.0 g and four states of the USA have adopted the highest limit, 1.5 g (24).

Setting limits is one thing, enforcing them another. Most of the above-mentioned countries permit the police to administer either blood or breath tests. Since 1975, various countries, including Algeria, Australia (Western Australia), France, Gabon, Hungary, and New Zealand, have legally approved of breath and blood tests. In Ireland and Sweden, blood and urine samples may be taken to establish alcohol levels.

Estimates made in Australia by Drew (cited by Moser (24)) seem to indicate that, if someone drinks and drives regularly (and adolescents appear not to do so), they are likely to be apprehended within 5–7 years. In the USA (Kansas City), the probability of actually being arrested while driving under the influence of alcohol is about 1 in 200 (25); in the Federal Republic of Germany it is 1 in 300 (26). These odds do seem to deter people from drinking and driving. In the USA, where the number of people killed in accidents involving alcohol declined from 28,000 in 1980 to 25,600 in 1982, this decline has partly been attributed to “the increased perception by the public of the risk of arrest for drunken driving” (27). Information on permitted levels of BAC, methods of testing, and penalties in a number of countries is given in Table 32.

**Minimum age and driving**

The minimum ages for consuming alcoholic beverages and for driving are not unrelated (see Chapter 9, pp. 152–156, for a full discussion of the drinking age). Experience in the USA in this regard is particularly instructive.

Despite the widespread, recognized violation of laws setting the minimum drinking age at 18, support has increased in recent years in many states for legislation fixing 19, 20, or 21 as the minimum drinking age. As Smart (28) has observed, “apparently no aspect of alcohol
control legislation has been so often changed in recent years as the legal age for drinking or the purchase of alcohol. It is widely believed that legislation raising the drinking age will result in a decrease in the number of fatal highway accidents involving teenagers who have been drinking, and this is, in fact, being borne out in certain countries that have already changed the drinking age.

Table 32 Permissible blood alcohol content (BAC) for drivers, permitted methods of testing, and penalties

<table>
<thead>
<tr>
<th>Country or region</th>
<th>BAC (g of ethanol per 1000 g of blood)</th>
<th>Permitted methods of testing</th>
<th>Penalties</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>0.8</td>
<td>Breath testing permissible in all provinces</td>
<td>Fine of $500-$2000 and/or detention for: 6 months (1st offence); 2 weeks to 1 year (2nd offence); 3 months to 2 years (each subsequent offence)</td>
<td>Criminal Code of Canada, Section 236</td>
</tr>
<tr>
<td>Colombia</td>
<td></td>
<td></td>
<td>Any degree of alcohol intoxication is an aggravating circumstance; cause of accident</td>
<td>Road Traffic Code</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>0.5</td>
<td>Blood test and medical examination may be required; limit for analytical error 0.3</td>
<td>Penalty may include transfer from sector of work</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Not fixed</td>
<td>Legislation provides for breath tests if police officer considers reasonable cause exists</td>
<td>Legal sanctions against drunken driving; cancellation of driving licence for certain time (up to 2 years for subsequent offence within 2 years), or fines</td>
<td>Motor Vehicles Amendment Act, 1977</td>
</tr>
<tr>
<td>Italy</td>
<td>Not fixed: jurisprudence: 1.5-2.3</td>
<td></td>
<td>Temporary or definitive suspension of driving licence, fines, detention up to six months</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>0.5</td>
<td></td>
<td>Loss of driving licence; maximum of 2 years detention or fine of $10000 yen</td>
<td>Law of 1972</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1.0</td>
<td></td>
<td>Police may take the car keys from a person considered unfit to drive</td>
<td>Transport Act, 1952</td>
</tr>
</tbody>
</table>
Table 32 (continued)

<table>
<thead>
<tr>
<th>Country or region</th>
<th>BAC (g of ethanol per 1000g of blood)</th>
<th>Permitted method(s) of testing</th>
<th>Penalties</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>0.5</td>
<td>Breath test; if positive, medical examination, including blood test</td>
<td>Detention of at least 21 days; driving licence may be suspended for at least one year</td>
<td>Law of 1936, as amended in 1959, 1962 and 1966</td>
</tr>
<tr>
<td>Union of Soviet Socialist Republics</td>
<td>0.0</td>
<td>—</td>
<td>Suspension of driving licence for 1 year (second time, 3 years); death sentence possible if accident as consequence of unsober driving</td>
<td>—</td>
</tr>
<tr>
<td>United Kingdom (England and Wales)</td>
<td>0.8</td>
<td>Screening breath test; medical examination, including blood test, may be asked for by police or driver</td>
<td>—</td>
<td>Road Safety Act, 1967</td>
</tr>
</tbody>
</table>


In Michigan, the drinking age was raised from 18 to 21 in late 1978. Wagenaar (29, 33), after analysing the accident mortality rates for the young (aged 18-25) from 1972 to 1979, concluded that raising the age was “an effective counter measure for the major cause of morbidity and mortality among young people”. In Ontario (Canada), a similar survey, after the drinking age was raised from 18 to 19, indicated that raising the age just one additional year had had only a minimal effect (30). On the other hand, in New York in the first six months after the drinking age was raised from 18 to 19, 18-year-old drivers were involved in 21% fewer road accidents (fatal and non-fatal) attributed to alcohol use (31). Smart concludes, after reviewing the results of research in North America, that lowering the drinking age tends “to increase consumption, alcohol-related traffic accidents and admissions to treatment” for young people, while raising the age tends “to decrease alcohol-related accidents” (28). The most recent survey, in nine USA states that raised the minimum drinking age between 1976 and 1980, corroborates Smart’s earlier finding since it was found that an increase in the drinking age resulted in a decrease in the number of fatal accidents involving young drivers affected by the age change (32, 33).

It is clear that concern in the USA over teenage alcoholism and drunk driving has increased, and that it has become increasingly common for state legislatures to reject an age as low as 18 as the minimum drinking age. In fact, by 1984, 19 states had stipulated 21 as the minimum age (34). Current thinking is that, for such measures to be
more than "cosmetic", they should be accompanied by alcohol education programmes for all high-school-age students as well as older drivers, and by more vigorous and effective enforcement machinery, especially with respect to those who sell or supply alcoholic beverages in violation of the minimum age restrictions. This is in line with the recently released recommendations of the Presidential Commission, which urged, among other things, that states enact statutes to: (1) set the minimum age for drinking at 21; and (2) impose a mandatory 90-day suspension of the driving licence for the first conviction of drunk driving, plus either 100 hours of community service or a minimum of 48 hours in jail (17). These recommendations seem representative of current trends in legislation.

As an adjunct to this "official" activity, the subject of teenage drunk drivers and automobile accidents in the USA has become the focal point for a variety of public interest groups, including MADD (Mothers Against Drunk Driving), SADD (Students Against Drunk Driving) and RID (Remove Intoxicated Drivers). The national network of these organizations has mushroomed in recent years and affiliates exist in nearly all 50 states of the USA. Their efforts have centred on raising the minimum drinking age, stiffening the penalties for drunk driving, and requiring mandatory education and treatment for drunk drivers. They have been involved in most of the legislative reforms that have occurred in the last five years, and their success is reflected in the legislation. In 1983 alone, some 40 states toughened their drunk driving laws and eight states raised the drinking age (35). For information on the provisions of drunk driving legislation in some states of the USA, see Table 33.

Criminal penalties

The criminal sanctions that are used to deter drunken driving include fines, withdrawal of the driving licence, mandatory education, treatment or rehabilitation programmes and imprisonment. The criminal offence of driving under the influence of alcohol is nearly universal. In Ireland, it is an offence to drive, or attempt to drive, "a mechanically propelled vehicle in a public place while... under the influence of an intoxicant". By definition, when the blood alcohol content exceeds 1.0 g the driver is "incapable of having proper control." In Algeria, driving with a blood alcohol content of over 0.8 g of ethanol per 1000 g of blood can mean imprisonment for a period of 2 months to 3 years. In Canada, the Criminal Code, section 236, sets the BAC at 0.8 g, makes drunk driving an indictable offence and permits court-ordered curative treatment if the "accused is in need of it". Uganda also makes driving while intoxicated a crime.

In Singapore, if the BAC exceeds 1.1 g, the driver is presumed to be "incapable of having proper control of the vehicle." In New York (USA), even though a BAC of 0.5-0.7 g is "prima facie" evidence of not
being intoxicated, a driver may still be convicted of being unable to drive a vehicle by virtue of "alcoholic impairment."

By and large, the response to drunk driving is an exception to the trend towards rehabilitative treatment for alcohol problems. In all but a few jurisdictions, criminal penalties including prison sentences have been used as a deterrent. This approach is being eroded in some countries where alternative methods of dealing with drunk drivers are being developed, e.g., giving those convicted of driving under the influence a choice of mandatory treatment, educational programmes, or the traditional penal sanctions (16).

### Table 33. Drunk driving legislation in the USA

<table>
<thead>
<tr>
<th>State</th>
<th>Minimum drinking age</th>
<th>Duration of licence suspension for first offence (g of ethanol per 1000g of blood)</th>
<th>Existing measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>21</td>
<td>96 hours to 6 months</td>
<td>Toll-free number to report people suspected of driving while intoxicated; dram shop liability</td>
</tr>
<tr>
<td>Colorado</td>
<td>21; 18 (beer)</td>
<td>1 year</td>
<td>Administrative licence revocation; dram shop liability</td>
</tr>
<tr>
<td>Florida</td>
<td>19</td>
<td>6 months</td>
<td>Statewide rehabilitative programme; dram shop liability</td>
</tr>
<tr>
<td>Illinois</td>
<td>21</td>
<td>1 year maximum</td>
<td>Dram shop liability</td>
</tr>
<tr>
<td>Kansas</td>
<td>21; 18 (beer)</td>
<td>Limited use</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>18</td>
<td>80 days</td>
<td>Mandatory education and community service</td>
</tr>
<tr>
<td>Michigan</td>
<td>21</td>
<td>6 months to 1 year</td>
<td>Dram shop liability</td>
</tr>
<tr>
<td>Nevada</td>
<td>21</td>
<td>90 days</td>
<td>2 days in jail or 48 hours of public service</td>
</tr>
<tr>
<td>New York</td>
<td>19</td>
<td>6 months</td>
<td>Education programme; dram shop liability</td>
</tr>
<tr>
<td>North Carolina</td>
<td>21; 19 (beer and wine)</td>
<td>1 year</td>
<td>Limited dram shop liability</td>
</tr>
<tr>
<td>Utah</td>
<td>21</td>
<td>40 days</td>
<td>Dram shop liability</td>
</tr>
<tr>
<td>Vermont</td>
<td>18</td>
<td>3 months to 1 year</td>
<td>Dram shop liability</td>
</tr>
<tr>
<td>West Virginia</td>
<td>18</td>
<td>6 months</td>
<td>Administrative licence revocation</td>
</tr>
</tbody>
</table>

*b Statute making retail server of alcohol responsible for its consequences.
Conclusions

Amid growing concern for the consequences of motor vehicle accidents, law and policy have begun to focus on schemes aimed at preventing injuries and fatalities. Recent legislation has been aimed in large part at making the handling of vehicles safer. The mandatory use of headgear for users of two-wheeled vehicles and of seat belts in four-wheeled vehicles are two examples of legislative and policy advances in the cause of health and safety. Legislation is also increasingly used as an agent in controlling the combination of drinking and driving. The trends, in so far as young people are concerned, seem to be towards raising the drinking age, lowering the legally tolerated limits of blood alcohol content, and stiffening the penalties for violations. These, coupled with comprehensive public education programmes, are producing positive results. Even so, the fatalities and injuries caused by drunk drivers, not to mention the economic losses, continue to exceed the tolerable limits.

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Australia


Victoria


Botswana


Brazil


Canada

Criminal Code (Section 236) [TDHL, 28: 27 (1977)].

Colombia

Road Traffic Code.

Côte d'Ivoire

Decree No. 81-161 of 4 March 1981 (Section 5) [TDHL, 34: 160 (1983)].

France


Gabon

Ordinance No. 26/79 of 8 July 1979 on prevention and detection of driving under the influence of alcohol [TDHL, 34: 159 (1983)].

Guatemala

Decree No. 66-72 of 10 October 1972 promulgating the law on traffic [IDHL, 25: 784 (1974)].

Guinea


Hungary

Ordinance No. 1 of 16 January 1976 of the Minister of Health on medical examinations to determine fitness to drive [TDHL, 28: 60 (1977)].

Methodological Circular No. 5 of the National Institute of Legal Medicine on control and appraisal of blood alcohol levels [TDHL, 30: 240 (1979)].

India


For the sake of concision, International digest of health legislation has been abbreviated throughout to IDHL.
Ireland
Road Traffic (Amendment) Act, 1978 (Section 49(2) and (3)) [IDHL, 30: 74 (1979)].

Japan

Malaysia

Morocco
Joint Order No. 1143-73 of 15 December 1975 of the Minister of Public Works and Communication and the Minister of Public Health establishing, inter alia, a list of physical disabilities for driving vehicles [IDHL, 29: 404 (1976)].

New Zealand

Norway
Law of 1956.
Regulations of 23 February 1976 on the driving licence and the driving test [IDHL, 31: 122–123 (1989)].

Senegal
Decree No. 81–928 of 28 January 1981 amending the first paragraph of Section 142 of the Highway Code (Second Regulatory Part) and adding an Annex 5 on the wearing of seat-belts (Section 53) [IDHL, 34: 160–161 (1982)].

Singapore
Road Traffic (Amendment) Act No. 5 of 1976 [IDHL, 28: 116 (1977)].

Swaziland
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Sweden
Order No. 106 of 12 December 1979 of National Board of Health and Welfare prescribing Regulations on the taking of blood and urine samples in order to determine alcohol levels etc. [IDHL, 31: 570 (1980)].

United Kingdom
Motorcycles (Protective Headgear) Regulations 1980 (Regulation 4(1)).
Transport Act 1981 (Sections 28 and 33A(2) (b) (iii)).

United States of America
Motor
Maine Revised Statutes Annotated, Title 29, Motor Vehicles (Section 1376) (West's Supplement 1983).

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Laws of New York, 1974, Volume 2, Chapter 248, pp. 1050–1051, amending the vehicle and traffic law [IDHL, 26: 896 (1975)].
Uganda
15. Oral Health

Oral health care is an important facet of any overall programme to maintain and improve the health of adolescents; the Public Health Code of Algeria refers to dental infection as “a social scourge”. In many countries, however, oral health programmes are non-existent, largely as the result of shortages of trained personnel to provide the services. Even so, it is frequently possible to carry out widespread education campaigns and preventive programmes to promote oral health, and schools are often a focal point of such activities.

In the USA, dental care and treatment are largely a private responsibility, though preventive programmes do exist for schoolchildren, primarily in the form of education. In the socialist states, dental care is one of the services provided by the health care system. Most countries in Europe provide oral health care to children and adolescents as part of social welfare schemes and such programmes usually have a legislative basis.

The Land of Baden-Württemberg in the Federal Republic of Germany has a comprehensive Child and Adolescent Dental Care Law, enacted on 8 July 1975, which sets out the measures that are to be part of the health care programme for those between the ages of 3 and 18 years. Under Section 2 of the Law, these include: (1) preventive care of teeth and the mouth; (2) regular dental examinations, to be carried out at least once a year, in order to determine treatment requirements and the need for intensified oral health care; (3) follow-up health care, in particular follow-up examinations of children and adolescents requiring treatment; (4) regular oral health education of children and adolescents, with particular reference to preventive measures, sound eating habits, and appropriate dental and oral health care; (5) instruction and advice to parents and other persons in charge of children or adolescents, as well as persons employed in the care, education, and training of children and adolescents, with regard to matters of dental and oral health; and (6) statistical evaluation of examination findings. Section 3 lays down that adolescents are entitled to the services mentioned in items 2-4 above, and Section 4 places the responsibility for ensuring that the measures are taken on the “health offices” (local health departments) in collaboration with the schools.

In Scandinavia, specific statutes also exist devoted to the subject of oral health care and adolescents. The Public Dental Care Law of 1973 in Sweden makes oral health care for those up to the age of 19 the responsibility of every commune. This includes “access to regular and complete treatment” unless the individuals make other arrangements.
The services are free for those between the ages of 5 and 17. Similar legislation exists in Denmark, where, under Law No. 217 of 19 May 1971, communes are also required to establish and provide free preventive and curative oral health services for all school-age children. The programme must include: (1) general preventive measures, including oral health education for children and parents and instruction in oral care; (2) regular examinations; and (3) treatment of oral diseases and malocclusions.

The 1983 law on dental health services in Norway requires that oral health care, including specialized and preventive services, be made reasonably accessible to all persons who are ordinarily or temporarily resident in the country. Provision is also made for the dissemination of information on oral health care. Regular oral health care and examinations are offered to: (a) children and adolescents up to the end of the year in which they are 18; (b) physically handicapped persons; (c) groups of old persons or chronically ill patients (this includes nursing services in institutions); (d) adolescents from 18 up to the end of the year in which they reach their 20th birthday; and (e) other categories determined in an approved plan.

The Scandinavian countries are noted for their high numbers of dentists per head of population (1:1000 as compared to 1:2000 in the USA), so that fully trained dentists are available to provide care and treatment in school dental services. There are, however, other approaches. Since the 1920s, dental nurses in New Zealand have been trained to provide oral health care in schools and in this way comprehensive services to children up to the age of 13 have been provided. The programme has been enormously successful and has been emulated in varying degrees by about 20 other countries within the British Commonwealth and by a growing number of non-Commonwealth countries.

School Oral Health Programmes

In many countries, schools are the focal point of oral health programmes; these tend to include, not only treatment, but also education and prevention which, in combination with community efforts, provide a comprehensive service. In the Canton of Schwyz in Switzerland an Ordinance was promulgated in 1958 requiring the establishment of school dental services. Preventive products (fluoride tablets, etc.) are issued free of charge and schoolteachers are required to provide instruction in oral hygiene. Each commune is required to have one or more school dental officers, whose task is to conduct examinations and encourage parents to see that their children's disorders are treated. Also in Switzerland, in the Canton of Zurich, an Ordinance promulgated in 1965 includes, as part of the school dental programme, restrictions on the amount of sweets that can be consumed on school premises as well as the active promotion of oral hygiene among pupils. In addition, it
imposes penalties for failure to comply (3). In 1975, a study conducted in Pennsylvania to assess delivery systems within a rural educational setting found that students whose parents were not included in the educational process were less likely to use services even when barriers such as cost and availability had been reduced (4). Efforts to reach the community were necessary in order to encourage participation in oral health programmes, together with information on nutrition, personal hygiene and use of professional dental services.

**Oral Health Care in Developing Countries**

Oral care in the developing world varies from being moderately available to scarce, the most common form of treatment often being extraction. Where legislation exists it is usually part of the public health code and the coverage of oral health is often superficial and general. While developing countries, whose populations are largely rural, have a far greater amount of disease resulting from nutritional deficiency and infection than the industrialized ones, their populations suffer less from dental caries. The most prevalent dental problems are gingivitis and periodontal disease. With increasing urbanization, however, and the resulting change from traditional foods to processed and refined products, there is a marked deterioration in the condition of the teeth (5).

In most developing countries with limited budgets for public health, emphasis is inevitably placed on combating communicable diseases, and less life-threatening disorders and diseases receive less attention (5). In addressing the need for oral health care, educational programmes utilizing available resources to reach the broadest audience possible could be designed to supply information on the importance of regular cleaning as an aid to gingival health. Such programmes could also provide information on nutrition and the use of methods of fluoridation. One method of reaching the adolescent audience is to provide school-based oral health programmes, but such programmes reach only a small segment of those concerned in developing countries. Data published by the World Bank show that among secondary-school-age children, only 36% attend school in Latin America, 22% in North Africa and the eastern Mediterranean area, 20% in south Asia and 6.9% in Africa south of the Sahara. Only 50% of the eligible primary-school age group in southern Africa and Asia attend school (6).

In Costa Rica, the “right to health services” includes access to preventive dental examinations. In the Philippines, parents of children with special oral health problems can call on the government to assist in providing the necessary care.

In Algeria, the legislation is more elaborate. Ordinance No. 76-79 of 23 October 1976 embodying the Public Health Code, establishes the objectives of the “oral health care” programme and states that the “detection and prevention of oral and dental infections shall be compulsory for children of preschool and school age.” These preventive
services are to be provided by maternal and child health centres as well as the school health services. Treatment of oral and dental infection is provided free by the State. Provision is also made for the fluoridation of drinking-water.

Legislation in Côte d'Ivoire (Law No. 77526 of 30 July 1977) requires that students who have received a state grant for dental education serve five years in the public sector before they have the option to practise privately.

Fluoridation

Roemer has reviewed the subject of fluoridation recently in her survey entitled Legislation on fluorides and dental health (3), to which readers are referred for a more detailed discussion. Fluoridation has been recognized as an important component of the campaign to create the proper environment for oral health among children and adolescents. When added to public drinking-water supplies in recommended safe amounts, fluoride has been shown in numerous studies to decrease by as much as 60% the incidence of dental caries in children who have drunk it since birth (3). Where feasible, addition of fluoride to the public water supply is an inexpensive (7) way of ensuring that a large segment of the population benefits from it. In spite of this, fluoridation has been introduced in only about 50 countries around the world and, in most of these countries, its use has not been extended to reach the maximum number of people possible. In New Zealand, a country that has been a pioneer in oral health care for children and adolescents, only 50–60% of the water supplies are fluoridated; Canada has extended fluoridation to reach slightly more than one-third of the population. In Europe, fluoridation is restricted essentially to Finland, Ireland, the United Kingdom, and the countries of eastern Europe—Bulgaria, Czechoslovakia, the German Democratic Republic, Poland, Romania, and Yugoslavia—and only about 2% of the population or 14.5 million out of 750 million receive fluoridated water (8). In the Soviet Union, most of the 40 million persons who receive fluoridated water dwell in the larger cities of the European part of the USSR. The major mainland nations of Asia have apparently not yet adopted fluoridation, but Hong Kong and Singapore provide fluoridated water to essentially all of their 7400000 people, and the total number of people served in the Province of Taiwan (China) is about 500000. Some fluoridation is being done in Japan but the exact figures are not available, and Malaysia reports that about half of its population, or 6 million people, receive fluoridated water.

In Central and South America about 35 million persons are now receiving fluoridated water, most of them (22 million) in Brazil. In Colombia, 5 million people and in Venezuela, 4.5 million are covered by fluoridation. The remainder is accounted for by Guatemala (1500000), Panama (510000), and Guyana (45000).
In an effort to bring the benefits of fluoridation to a larger number of people, public health leaders in the United States proposed state-wide legislation instead of seeking action city by city. As of 1978, nine states, namely Connecticut, Michigan, Minnesota, Nebraska, and Ohio (mandatory legislation), Massachusetts, Nevada and South Carolina (enabling legislation), and Kentucky (authorizing fluoridation under public health legislation), had introduced legislation on fluoridation (3). Another state, Pennsylvania, authorized fluoridation under the general powers granted by public health legislation. The latest estimates are that 112 million people in the USA, nearly half of the population, have access to fluoridated water. The Socialist Republic of Serbia (Yugoslavia) has also enacted mandatory legislation (3).

Fluorides occur naturally in some water supplies and foodstuffs and these amounts must be taken into consideration when safe levels of usage are recommended. When natural fluoride concentrations are low, namely less than 0.5 mg/l in temperate climates, adjustments of the fluoride content should be considered to protect against dental caries. In order to control levels of fluoridation, Bulgaria in 1972 issued an instruction making fluoridation mandatory where natural concentrations of fluoride were less than 0.5 mg/l or the incidence of dental caries exceeded 25%.

The introduction of fluorides into public drinking-water supplies may not always be feasible, especially in developing countries. As a result, alternative methods of supplying fluoride have been sought. Of these, the most important are the systemic ones, namely the fluoridation of salt and the use of fluoride tablets. Other methods involve topical application, via toothpaste, mouthwashes, and similar products.

The disadvantages of using salt as a vehicle for fluoride are that salt consumption is usually lowest during the early years of life when the need for fluoride is greatest, and that excessive salt consumption is held to contribute to hypertension. Evidence from several studies, however, both in developing and developed countries, indicates that salt fluoridation may be as effective as water fluoridation in reducing dental caries (9, 10). Switzerland provides fluoridated salt in every Canton except Basel, where the water is fluoridated (11). Colombia and Hungary have also used fluoridated salt as a vehicle for providing fluoride. Mexico, in attempting to reach most of its population, has made the fluoridation of salt mandatory except in areas where fluoride is added to the water supplies or where cases of fluorosis have been reported (3).

Fluoride tablets require optimal compliance with the instructions for their use if their effectiveness is to approach that of public water fluoridation. In the United States, tablets are provided on medical or dental prescription, while in other countries fluoride tablets are available over the counter and there is no control of the amounts consumed, although warnings are printed on the label. In Norway, in 1975, the Regulations on the supply of pharmaceutical products were amended to exempt from prescription requirements sodium fluoride tablets containing up to 1 mg of fluorine per tablet provided that they are accompanied...
by approved directions for their use. Canada prohibits over-the-counter sale of any drug containing fluorides if the largest dosage would result in a daily intake of more than 1 mg of fluoride ion. In a resolution adopted by the Committee of Ministers of the Council of Europe in October 1981 (12), it is recommended that the Governments of Austria, Belgium, Denmark, France, the Netherlands, Switzerland, and the United Kingdom should ensure that the following warning is carried by all over-the-counter medicaments containing fluoride compounds: "To be taken only in accordance with dental, medical or pharmaceutical directions. Should not be taken if your water supply is fluoridated."

Fluoridated toothpastes, gum and mouthwashes are available in many parts of the world and have been shown to reduce the incidence of dental caries markedly, both in areas with fluoridated and those with non-fluoridated water supplies. Fluoride content is regulated by individual countries, and most products are sold without prescription. About 80% of the toothpastes sold in Canada and the United States contain fluorides, and the same is true of 90-96% of those sold in Australia, New Zealand, and many European countries (13). Norway exempts from prescription toothpastes containing fluoride, but does require them to be licensed by the Ministry and be listed as pharmaceutical products. Tunisia exempts from prescription requirements all oral hygiene products containing fluoride compounds at levels not exceeding those specified in the requirements concerning poisons intended for use in human medicine (Ministry of Public Health Order of 1979). The Netherlands ended general fluoridation of public water supplies in 1975 but increased the application of fluorides through dentifrices, rinses and topically applied solutions. Studies of schoolchildren indicated that this method, when used correctly, helped to decrease dental caries by as much as 50% (14).

Conclusions

While oral health services are generally widely available in developed countries, they are almost non-existent in many parts of the developing world. Adolescent oral health care is often provided through school-based preventive and educational programmes, though in developing countries, these may reach only a small proportion of those concerned.

In developing countries, where both services and qualified personnel are scarce, broad programmes focusing on the education of the general public in the importance of oral cleanliness and the use of fluoride, in various forms, may aid in the overall improvement of oral health. Fluoride treatment of drinking-water supply systems, where practical, and provision of fluoride in alternative forms where needed, are cost-effective ways of providing some preventive oral health care.

In developed countries, where oral health services are more readily available, the combination of school-based programmes with community education and preventive-care schemes that involve parents will
encourage continued use of oral health services and promote better oral health.

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Bulgaria
Instructions No. 0-38 concerning the fluoridation of water intended for drinking and domestic purposes [IDHL, 24: 258 (1973)].

Canada

Costa Rica
General Health Law dated 31 July 1972 (Section 3) [IDHL, 26: 465 (1975)].

*For the sake of concision, International digest of health legislation has been abbreviated to IDHL throughout.
LAWS AND POLICIES AFFECTING ADOLESCENT HEALTH

Côte d'Ivoire
Law No. 77-526 of 30 July 1977 prescribing the minimum duration of service to be undertaken in the public sector [IDHL, 31: 4 (1980)].

Denmark

Germany, Federal Republic of
Baden-Württemberg

Mexico

Norway
Regulations of 14 June 1971 of the Ministry of Social Affairs concerning the sale of toothpaste containing fluoride [IDHL, 23: 714 (1972)].
Amendment of 5 November 1975 to the Regulations on the procurement of pharmaceutical products and their supply by pharmacies [IDHL, 27: 606 (1976)].
Law No. 54 of 3 June 1983 on dental health services [IDHL, 35: 357 (1984)].

Philippines

Sweden

Switzerland
Schweiz
Ordinance of 26 February 1938 relating to school dental health services [IDHL, 10: 574 (1959)].

Zurich
Ordinance of 15 November 1965 on school and public dental health care.

Tunisia
Order of 20 January 1979 of the Minister of Public Health exempting certain toiletries containing poisons [IDHL, 30: 649 (1979)].

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Connecticut
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Massachusetts
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Michigan

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Nebraska
Revised Statutes of Nebraska, Chapters 71-3305 and 71-3306 (1973).

Nevada
Nevada Revised Statutes, Title 40, Chapter 445,030 (1967).

Ohio
Ohio Revised Code Annotated, Title 61, Section 6189.20 (1978).

South Carolina
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Yugoslavia
16. Concluding Observations

This study has attempted to reflect the ways in which law and policy affect adolescent health throughout the world. Clearly, it is impossible for such a study to be exhaustive, but an attempt has been made to present approaches that are representative of current practices and to assess the trends apparent on a global scale.

As might be expected, there are great disparities in the ways in which law and policy are used to address adolescent health issues. This is partly the result of differences in legal traditions but also, to a large extent, of differences in culture and socioeconomic conditions. In some cases, law and policy serve only a symbolic purpose, in others they provide a general supportive framework for health services; in yet other instances, they offer specific solutions to pressing social and health problems. Equally, laws and policies may actually inhibit the provision of health care for adolescents.

An important conclusion that can be drawn from the study is that, while law and policy are important, they have their limitations. Many health problems arise out of a complex social environment, and their solution requires a comprehensive approach in which law and policy are only one aspect. There is some debate as to whether legislation, by itself, can ever be an effective mechanism for resolving problems that arise in the area of adolescent health. It is argued that, while legislation may carry with it important messages, it is likely to have little effect if these messages are not translated into action.

It should also be borne in mind that many health programmes for adolescents are outside the influence or scope of the law; often, they are carried out in the absence of specific legislation and sometimes even in contradiction to it. Certainly, to gauge the magnitude of existing programmes simply from the legislation or policy would be misleading. None the less, law and policy have an important role to play in establishing the foundations and boundaries of programmes and in clarifying difficult issues. Decisions as to the approaches to be adopted in a particular setting will obviously have to be made at the national level, but an awareness of what is being done elsewhere can be both instructive and helpful. The focusing of attention and resources on the development of appropriate health care programmes can only be to the benefit of adolescents everywhere.
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