Background Document
Technical Discussions
May 1989

THE HEALTH OF YOUTH

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INTRODUCTION

What distinguishes human beings from other species is the long period of time it takes them to reach maturity. This makes them more vulnerable in early life but also offers unparalleled opportunities for development provided that they are adequately protected and nurtured to enable them to survive and grow. Human beings can thrive in the most diverse conditions — in hot or cold or wet or dry climates, in sparsely populated or crowded environments, in highlands or in lowlands. No other species has ever flourished so remarkably over such a wide range of habitats or gained so much control over its destiny. But how that control is exercised depends on how the species is prepared for life. Adolescence and youth are such a time of preparation, a time of exploration and widening horizons, a time for the young to move ahead and meet the challenges of the future.

Healthy development, though among the most critical factors, is but one component of the health of youth. The health of youth rests on a foundation of a well nourished and nurtured childhood, relatively free of serious and debilitating infections and illnesses. Among the antecedents of healthy development in youth is the healthy growth and development in infancy and childhood, a process facilitated by a safe, secure and supportive physical, emotional and social environment. The behaviour of young people is a key to their own present health, their subsequent health in adult life and the health of their future children. Although their health problems take many forms in different cultures, the underlying bases of these problems are often common.

Youth is a period of transition from childhood to adulthood, marked by interlocking changes in the body, in the mind and in social relationships. From being simple, function and behaviour become more complex. The body develops in size and reproductive capacity and becomes more sexually defined; the mind becomes more capable of abstract thinking, foresight, and internal control and acquires a greater awareness of the environment; and the close relationship with and dependence upon parents and older family members begin to give way to more intense relationships with peers and adults outside the family as new challenges are met and new responsibilities assumed.
These new capabilities are the raw materials of development. While the sequence of the changes tends to be the same for all, their onset, duration, and manifestations vary between the sexes, from culture to culture, and from individual to individual. But the increased capabilities of adolescence and youth do not guarantee that healthy development will take place. That depends on other factors, among them the environments of the home, the community, school, work, and leisure. These can provide opportunities for healthy social, emotional, intellectual, physical, sexual and moral development and for the building up of trust and resilience; or they can be characterized by lack of opportunity for education, training, jobs, secure and loving family relationships; and by the insidious attractions of dangerous substances such as tobacco, alcohol, and other drugs, or by the presence of dangerous conditions on the road, in the workplace, or in war.

In many societies the conditions in which the young person lives have changed radically from those of his parents because of the mass media, migration, urbanization, a diminution of the extended family and changes in the standard of living. This makes the tasks of both young persons and the traditional guardians of their development more difficult, since they are now faced not only with the problems of their personal transition to adulthood but also with the changes in the world about them.

The environment itself, however, can do no more than provide opportunities for healthy development. It is also necessary that the young should experiment with new forms of behaviour. The need and the wish to behave differently are often accompanied by risk-taking, anxiety about succeeding, and uncertainty about the future, as well as by intense excitement and creativity. Whether these new forms of behaviour and feelings lead to an enhancement of self-esteem and greater maturity depends not only on the success of the adolescent in achieving development but also on the way in which adults and peers react to him or to her. A loving and stable environment that encourages gradually increasing independence and sets appropriate limits will build up self-esteem in the adolescent and lead to health-enhancing achievements in school, at work, in leisure, at sport, and in new relationships. The combination of instability in the family with excessive negative pressures in the environment is more likely to lead to health-damaging behaviour such as the use and abuse of tobacco, alcohol, and other drugs, poor eating and oral hygiene habits, irresponsible sexual relationships leading to unwanted pregnancies and sexually-transmitted diseases including HIV infection, excessive risk-taking (often linked with alcohol use) on the road, at work, at home, and in leisure activities, intentional violence to oneself or others, and mental breakdown.
The health problems of adolescence and youth tend to be different from those of younger children, who are more vulnerable to disease. Health care systems are rarely designed to deal specifically with young people, who are no longer at ease in child care units but are not quite ready for adult treatment units either. On socially sensitive matters, particularly in relation to sexual behaviour and the use of alcohol or other dangerous substances, they are less likely to come forward for care and more likely to come late when they do come. One of the major reasons for this is their belief that health workers will not be sympathetic to their needs, and this may often be true. The participation of young people in their own health care increases its likelihood of success. An increased understanding of young people's needs by health workers and a change in the attitude of young people to health services may both be needed.

Adolescence and youth are a crossroads in life in which, paradoxically, healthy development is dependent both on the support of adults and on their willingness to relinquish control to permit maturation. The new directions that young people take depend on multiple factors, but there seems to be a clustering of health-enhancing or health-damaging forms of behaviour that become progressively more ingrained through the years of adolescence. The concern and understanding that young people show for their own health and their contribution to health for all are significantly affected by the human and material environment in which their development takes place and the responsiveness of all sectors to their health needs. This response needs to be coordinated at all levels and may call for changes in intersectoral planning, training and programme delivery so that the optimum use is made of current resources. To achieve and sustain the health of young people is the task of all, including the young people themselves. The benefits to be gained are great, not only for the young people at this transitional period of life but also for the future of every society for whom young people are a great resource for the health of all.
Adolescence has been defined by the World Health Organization as being between the ages of 10 and 19 years, and youth as between 15 and 24. This document takes youth as beginning with adolescence and deals with the whole group of young people from the age of 10 to the age of 24. While chronological definitions are statistically convenient, there is in fact great variation in the timing and duration, though not the sequence, of the biological, social, and psychological changes that characterize this period of transition, which in most cultures is considered to begin with puberty.

Physically the changes include the adolescent growth spurt, in which the size and shape of the body change markedly and accentuate the differences between boys and girls. Puberty is also a time when reproductive capacity is established; the sex hormones secreted during this period not only affect the tissues of the body but are also related to changes in sexual and emotional behaviour. The timing of these events however, shows wide variations from one individual to another; in normal boys, for example, there is roughly a five-year range (from about 11 to 16) for the age at which puberty is reached. In girls puberty begins on the average some two years earlier and extends over a slightly shorter period. This is often a source of anxiety in adolescents, who are highly sensitive to differences between themselves and their peers, especially in appearance.

Psychosocially there are also marked changes during adolescence. The chief task of adolescence is to acquire a sense of identity, which means to some degree drawing apart from older members of the family, developing more intense relationships with peers, and taking major life decisions. During adolescence there is a gradual move from involvement with groups of the same sex to mixed groups, and sexual pairing may ultimately take place. Because they mature earlier girls may experience romantic interest before boys; this sometimes leads to sexual activity, depending heavily on the cultural context. In traditional societies the earlier maturation of girls has been acknowledged by early marriage. However the mean age of marriage has generally been rising, while the age of puberty in both sexes appears to be falling. There is now a longer
period during which premarital sexual intercourse may occur and an increasing likelihood of this happening.

The conflict with parents so often described in western societies as the "generation gap" is perhaps more imaginary than real. It is much more common to find young people and their parents sharing the same fundamental values. The differences are likely to occur in relation to more ephemeral subjects (however deeply felt at the time) such as style of dress and taste in music. Disagreements can be used to promote healthy development if in the process there is a give and take that gives weight to the young person's viewpoint in the family's value system.

During this period the young person's thinking moves from the concrete to the abstract and language is increasingly used to manipulate ideas and conceptualize the ideal. An orientation toward the future now begins in earnest. As moral independence grows, alternative courses of action and their consequences come to be considered. How the young person uses this new cognitive and moral capacity is inextricably linked to the strong emotions that emerge during this time of life and to whether the conditions of life are such that these manifestations of development are rewarded.

This is a period of great creativity and energy, new experiences, new ideas and skills. To achieve healthy development the young person needs to stretch himself or herself in ways that are not destructive. Most young people the world over succeed in meeting the challenge.

There have been dramatic changes in the relative and absolute numbers of young people (Fig. 1). Between 1960 and 1980 the world's population increased by 46%, that of young people between the ages of 15 and 24 by 66%. Four out of every five of these young people live in developing countries. In 1985 children under the age of 15 constituted 45% of the population of Africa, about 38% of that of Latin America and South Asia, and 21-29% of that of East Asia and Europe. The competition for education, training, jobs, and housing places great stress on the young in developing countries, just at a time when their countries are requiring more sophisticated skills in the job market. The proportion of people of working age who can support dependents is much greater in the richer countries than in the poorer ones.

Stability is important for young people. The migration from city to city and country to country has increased, and young migrants often encounter new cultural patterns and frequently a hostile environment. This they may have to face without parental support, and it may lead to an increase in their mental
and behavioural problems. Amongst those most vulnerable are homeless youths, refugees and victims of war. Perhaps the greatest change has been the phenomenal increase in the movement from rural to urban areas, particularly in the developing world. While in 1975, one person in four lived in cities, it is expected to be two out of five in the year 2000, an increase of 60%. In developed countries, already highly urbanized, the two out of three people who lived in towns in 1975 will become three out of four by the year 2000. A disproportionate number of urban migrants are young — about a quarter between the ages of 15 and 24, with a somewhat larger number of males than females. This is not surprising, as the primary motive for migration is to seek education or employment. Children and young people together account for over 70% of the total rural-urban migration in the less developed countries. This switch from what is often a traditional and relatively stable rural society to urban conglomerations that often lack an infrastructure for family support or health care is one of the major barriers to the healthy development of young people today.
EXCEPT in extremely deprived circumstances, the bodies, mind, and relationships of the young change during this period, but not necessarily in a healthy way. WHO has defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The sociocultural context in which adolescent development takes place has a profound influence on individual health. Some of the conditions that affect development are described below.

The Family
The fundamental unit of all societies is the family. The family is usually the major source of the basic necessities of life and health: love and tenderness, adequate food, clean water, a place and time for rest, clothing, and sanitation, to the extent made possible by socioeconomic, cultural, and environmental conditions. But the family takes many forms. In traditional, rural societies it is usually the extended family and includes several generations plus cousins, uncles, and aunts. This structure provides great material and moral support to the young as well as a variety of role models preparing the way for adulthood. Along with it there is a relatively high degree of control. In industrialized societies the family has gradually shrunk to become the nuclear family, consisting solely of parents and their children. It is characterized by less parental control but at its best provides moral, educational, and vocational guidance; in it the young typically have greater latitude in choosing friends, education, work, and a spouse in societies in which such choices are possible. Both models can be the basis for healthy development. In modern times, however, the stability of the family has been seriously threatened. The divorce rate has risen sharply almost everywhere, the number of single parent families has increased dramatically, and large numbers of young people have left their families prematurely and migrated to towns. Even where young people remain within their families of origin, because of the radical changes in social conditions many parents feel ill equipped to help their children prepare for experiences they themselves have never had.

Education
Formal education is of great importance to the development of all young people. It is in school that literacy, numeracy, and thinking skills are fostered.
and exercised and where knowledge is acquired. School also often introduces young people to sport and provides the conditions for healthy, supervised exercise. Schools and teachers also restore the stability of youngsters who have been uprooted from their culture or whose families are unstable. They are a major source of education and guidance about specific health issues and sometimes provide health screening and services. In developing countries there has been a dramatic rise in school attendance among young people; it starts, however, from a low base and favours boys rather than girls. From 1960 to 1985 the percentage of boys between 12 and 17 years of age enrolled in schools jumped from 28% to 52%, that of girls from 15% to 40%, while in developed countries by 1985 about 85% of both boys and girls were enrolled (Fig. 2). In 1960, in the 18-23 year old population less than 6% of males and 2% of females in developing countries were enrolled in school. This increased

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**Figure 2**  
*Trends in enrolment ratios* for 12–17 year olds, 1960–1985, *developed and developing countries*

* 12–17 year olds enrolled in educational establishments as a percentage of the total population in the same age group.  
Source: UNESCO
by 1985 to 17% and 10% respectively. In the developed countries by 1985, 22% of young men and 17% of young women in this age range were enrolled at educational institutions. Depending on the policies and resources of the country, schooling for young people may be obligatory, available, or accessible. But even where education is available many young people cannot attend school for economic reasons or because of too early marriage, and others do not attend because of psychosocial or moral difficulties.

A focus on young women

Although both young women and young men in many parts of the world continue to suffer from the consequences of underdevelopment and poverty, given sociocultural barriers and poor access to education, it is young women who bear the largest burden of extreme disadvantage. By now it is well accepted that for equitable and sustainable development and for closing the social gap, a focus on providing education, resources, skills and other social support measures to young women will take us a long way. The special risk involved in social and human terms related to pregnancy at a very young age is well known. Consideration needs to be given to women's perspectives so that they can achieve their educational, economic and social aspirations, and enhance their participation in their societies in partnership with young men.

Employment

Perhaps the single most important condition for the healthy development of young people leaving school is employment. As more young people attend school expectations are raised which the other sectors may be unable to satisfy. While it is clear that the young make a significant contribution to the economies of their countries, they are all too frequently subject to a disproportionate burden of unemployment (Fig. 3), which sometimes leads to psychological stress. Employment is often a significant indicator of the acquisition of adult roles and responsibilities, and the first experiences are crucial to the development of the habit of work. In many industrialized countries unemployment is often cited as an important contributing factor in drug use and alcohol abuse. Among young people, those with least education, refugees and members of ethnic minorities are often much worse off than their peers. Many young men seek employment in or are conscripted into military service and will die or be disabled to a disproportionate extent in time of war.
Many adolescents start their working life too early and are either unable to go to school or both work and go to school, and they suffer from fatigue and have a greater number of work-related accidents than older workers. While economic activity is rare among adolescents below the age of 15 in industrialized countries, estimates suggest that there are around 80 million young workers between the ages of 10-14 in the world, primarily in developing countries. The true extent of this situation is not known since such employment is often clandestine and underpaid and many countries do not possess the data.
Spiritual development
All young people need the opportunity to expand their spiritual horizons and develop their value systems. In most societies religions with institutionalized faiths and ethical and moral codes provide a suitable basis, but young people may venture beyond the conventions of their societies in their quest for understanding. Youth is a time when moral independence and a questioning attitude often emerge, and growing up with a stable system of values provides the essential security that permits moral maturation. At its best religion encourages the spiritual awakening that accompanies adolescence and youth.

Community organizations
The healthy development of young people requires that they should have the opportunity to give expression to their newfound physical, mental, social, and moral energies. Youth and community associations offer this opportunity and help the young to explore new territory and give thought to others, provide guidance to minimize the risks involved in new experiences, and put their energies to constructive use. They often form an important link between the health sector, the family, and the school.

Policies and legislation
Policies and legislation can have a powerful impact on the conditions for healthy development. However, there is rarely any attempt to create coherent policies for health that take into account the many different sectors that affect it. While a plethora of legislation in virtually all countries affects the lives of young people — e.g., minimum age for marriage, alcohol consumption, the purchase of cigarettes, licence to drive, age for military service, conditions for obtaining contraceptives, a termination of pregnancy, or minimum age for leaving school — it is rarely coordinated with the health of young people in mind and is often a source of conflict between the young and the authorities. The strength of the health services and the amount of appropriate attention they can give to the young depend to a large measure on national priorities as expressed through policies and legislation.

Health services
Healthy development presupposes the availability and accessibility of health care at primary, secondary, and tertiary level. This is found not only in the health sector but also in other relevant ones such as education, labour, culture, sport and religion. Services for health need to be coordinated across all these sectors and referral should be appropriate and timely. The services must strive to promote health by providing sound information directly to young people with whom they are in contact and indirectly to others who interact with the
young. They should identify those with health risks at an early stage, providing effective care and treatment for injury and disease, monitoring for those who are chronically ill, and rehabilitation for those who are recovering. In most countries of the world, health services do not have the resources to meet these objectives, and they are also often not attuned to the special needs of adolescents and youth, who are perceived as being relatively healthy. As is shown below, while young people are relatively disease-free, they have other health problems that often arise from behaviour in environments beset with risks. Young people also have particular sensitivities that require special training for health workers if the services already available are to be better used by them.
HEALTH PROBLEMS AND THE BEHAVIOUR OF YOUNG PEOPLE

A healthy environment providing both support and opportunities for young people is a necessary but not sufficient condition for healthy development. Much of the burden for health-enhancing behaviour falls on the adolescent or youth themselves, who must increasingly take, and act upon, decisions of an educational, vocational, and personal nature with major health consequences for the present and future.

Conditions originating during childhood manifest during adolescence

The health problems of young people may have their origins at an earlier stage of life or arise primarily during adolescence and youth. Some of these conditions become manifest during youth, others in more apparent or aggravated form later in life. While many of the health problems originating in childhood are attributable to conditions largely beyond the control of the child, such as disease or inadequate nutrition, in adolescence and youth many are more closely linked to behaviour in interaction with the environment. Sometimes the consequences of health problems in childhood continue in adolescence or give rise to new stresses during this period of life.

The sequelae of infections and malnutrition during childhood are a considerable burden on young people. Although no single condition exacts a major toll on adolescents, in aggregate they impair normal function. In the most impoverished communities those who survive repeated cycles of diarrhoeal and respiratory disease or undernutrition fail to attain full adult growth and, perhaps, full psychosocial and mental development, and they are less productive at work. Girls who do not achieve their full growth potential are at greater risk of having low birth weight infants when they start childbearing. Infections such as poliomyelitis in childhood may leave the individual permanently disabled.
A number of serious infections acquired during childhood, such as tuberculosis or rheumatic heart disease are often exacerbated during adolescence. Thus, in Egypt, for example, chronic rheumatic heart disease accounts for over 10% of deaths in young people. Pregnancy complicates the disease and accounts for a higher mortality rate among women during their reproductive years. Deterioration in these and other chronic diseases of childhood and adolescence such as insulin-dependent diabetes mellitus (juvenile diabetes) may be further aggravated by the adolescent's tendency to deny the disease. Under such circumstances therapeutic compliance and control of the condition may be difficult.

**Mortality**

When mortality is used as an indicator of health priorities the health of young people has attracted neither concern nor attention. In most developed and many developing countries the age group 15-24 years has relatively low mortality rates, lower than that of any other adult age group.

In most developing countries the very high infant and young child mortality rates and other pressing concerns of development have led the health needs of young people to be ranked low for health development. Yet there are grounds for concern in all countries. In most the majority of deaths among the young are preventable and occur in otherwise healthy and potentially productive people. Accidents account for 20% to over 60% of deaths among young people, with generally higher rates among males (Table 1). To these figures may be added deaths from suicide and external violence, all of which appear to be increasing. In many developing countries infections such as gastrointestinal and respiratory diseases, and tuberculosis, still continue to rank among the four or five leading causes of death in this age group.

Pregnancy related deaths are far more important than is apparent from the mortality statistics. The aggregation of maternal mortality in the five year age group 15-19 obscures the extremely high risk found among young women aged 15-17. Even so, the aggregated data show that young women aged 15-19 have anywhere from a 20% to a 200% higher risk of dying during pregnancy or delivery than those who are older (Fig. 4). In the absence of health care a pregnant woman below 17 years of age has as high as a 5-7% chance of pregnancy-related death.
Table 1

Accidents as a percentage of all causes of death among young persons aged 10-24 years in certain countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Males</th>
<th>Females</th>
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</thead>
<tbody>
<tr>
<td>America</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>1985</td>
<td>37.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Canada</td>
<td>1986</td>
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</tr>
<tr>
<td>Chile</td>
<td>1986</td>
<td>17.5</td>
<td>10.1</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>1986</td>
<td>42.2</td>
<td>19.2</td>
</tr>
<tr>
<td>Cuba</td>
<td>1986</td>
<td>66.9</td>
<td>61.5</td>
</tr>
<tr>
<td>USA</td>
<td>1986</td>
<td>51.9</td>
<td>43.7</td>
</tr>
<tr>
<td>Uruguay</td>
<td>1986</td>
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<td>27.7</td>
</tr>
<tr>
<td>Asia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1987</td>
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</tr>
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<td>Israel</td>
<td>1986</td>
<td>40.3</td>
<td>26.7</td>
</tr>
<tr>
<td>Japan</td>
<td>1987</td>
<td>49.2</td>
<td>20.2</td>
</tr>
<tr>
<td>Singapore</td>
<td>1987</td>
<td>36.4</td>
<td>12.5</td>
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<td>Australia</td>
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<tr>
<td>New Zealand</td>
<td>1986</td>
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Source: WHO Databank
The impact of perinatal anoxia, toxic exposure, or a variety of central nervous system infections in infancy or childhood may not be obvious until the child enters school, when minimal brain damage and visual or hearing defects are either specifically tested for or become evident from disordered learning or behavioural patterns. Undetected and uncorrected, many minimal disorders of sight, hearing, or speech may have profound effects on the child’s learning ability and school performance, self-esteem, general behaviour, and subsequent personality. Similarly, specific disorders such as dyslexia not only affect the child or adolescent’s immediate educational prospects but may reduce his or her subsequent aspirations, attainments and self-esteem.

With modern advances in treatment and care many children with genetic and metabolic diseases such as cystic fibrosis, haemophilia, and the haemoglobinopathies survive to adolescence and adulthood. The health care system is faced by the new challenge created by these circumstances to facilitate the integra-
tion of such individuals into personally satisfying and productive lives, with due recognition of their right to a normal social and marital life.

**Problems that arise particularly during adolescence**

The normal physical growth and maturation of adolescence may be adversely affected by inadequate diet, untimely or inappropriate physical stresses on the growing body or pregnancy before physiological maturity is attained. Inadequate information on which to base decisions about behaviour, inappropriate choice of behaviour for whatever reason or lack of supporting services or means to make the appropriate choice are also likely to result in immediate or future risk to the health of young people.

Nor are the hazards of infectious diseases totally absent during adolescence. If immunizations have not been effected or natural immunity to such infections as poliomyelitis and mumps acquired during childhood, the consequences, such as paralysis with poliomyelitis and infertility following mumps, are often more frequent and more severe in the young person. The combination of the energy demands of the adolescent growth spurt and an inadequate diet may contribute to tuberculosis. Adolescent girls require 10% more iron than boys to make up for the losses in menstrual blood. By adulthood women require 35% more iron than men, which they rarely receive; as a consequence anaemia is twice as frequent in adolescent and adult women as in men.

In sport, recreation, or work excessive stress may be placed on the bones before the epiphysis has fused and result in skeletal damage or impaired growth in the adolescent. Excessive competitiveness with the emphasis on winning may place enormous mental pressure on the young adolescent for whom the approval of peers and parents is so important.

Before full growth is achieved, and because of social and economic circumstances, children and adolescents may be obliged to take on the physical work responsibilities of adults. The workplace and tools of work are almost always designed for adults. The incompletely grown adolescent in such circumstances works inefficiently, is less experienced in the handling of tools and machines, and as a consequence runs a higher risk of occupationally linked death or injury.

The estimated 5%-10% of adolescents who are or become disabled are another special category. Because of the greater self-consciousness of the adolescent and the strong need for peer approval, the disabled teenager suffers greater psychological and social stresses. Young people need above all to be helped to develop to the fullest extent possible and lead lives integrated with those of their peers. The nature of the help needed will differ according to the nature
of the disability, whether cognitive, of impaired vision, hearing, or mobility. Attention needs to be focused on the individual rather than on the impairment.

A natural part of the growing-up process is exploratory and experimental behaviour, and this sometimes carries risks with it. Thus many of the health problems that are particular to adolescence and youth are essentially behavioural in origin, including substance abuse, some forms of sexual behaviour, and accidents and injuries, including suicidal behaviour.

**The interrelationship of problem behaviours**

There is growing evidence to suggest that problem behaviours cluster together. They include alcohol and drug abuse, cigarette smoking, and sexual precocity. Those who smoke cigarettes are more likely to progress to cannabis; problem drinkers are more likely than others to use illicit drugs; heavy drinking and the use of some other drugs are accompanied by antisocial behaviour and implicated in traffic accidents, a major cause of death and disability in young people. The use of tobacco, alcohol, and other drugs is associated with poorer performance at school, at work, and in sport. The use of one drug is more likely to lead to multiple drug use (Fig. 5). Substance use is primarily a social rather than a solitary activity in adolescence; a major American survey shows that

![Figure 5: Prevalence (%) of substance abuse among 15-24 year old smokers and non-smokers in Norway, 1986](source: Nils Johan Lavik, 1987)
71%, 68% and 81% respectively of those using alcohol, marijuana, and LSD never used them when they were alone. Peer pressure plays a significant role in problem behaviour and may be particularly significant for the young person who comes from a divided family, lives in an unrewarding environment, and is less successful at school, in sport, or in making friends.

**Sexual behaviour and reproductive health**

In some ways the burgeoning sexuality that comes with puberty is the starting point in all societies for the transition from childhood to adulthood. This passage is often marked by religious rites after which young people, especially girls, are treated differently and are more closely supervised in relation to the opposite sex. This is due to the possibility of conception in the girls and the awakening of the sexual response system, which, although not new to adolescence, may now lead to unwanted pregnancy. Another major concern arising from the increase in premarital sexual activity among young people is the possibility of contracting a sexually transmitted disease (STD) or HIV infection leading to AIDS.

While sexual feelings can be expressed in many ways not in themselves harmful to health, any expression of the sexual urge is often greeted with anxiety and/or anger by adults, and frequently with fear, guilt, and shame by the young. These responses combine to drive both sexual feeling and sexual behaviour underground, making communication about them and healthy development of sexuality within affectionate and responsible relationships more difficult.

In many developing countries the response to puberty, especially for girls, is marriage, with the expectation that the young girl will bear her first child soon thereafter. It also usually ends her formal education, sharply reduces her economic prospects, and restricts her social development, although it opens up for her new and important relationships with husband, child, and family. However, because these young women have not reached full physical and physiological maturity they have as much as three times the risk of dying from eclampsia, obstructed labour, haemorrhage, or infection as older women. If they survive they run a high risk of vesico-vaginal fistula or recto-vaginal fistula which, if not repaired, leaves them physically and emotionally disabled for the rest of their lives. In developed countries pregnancy in the unmarried teenager may lead to forced marriage before she or her partner is ready and a greater likelihood of divorce or, as often nowadays, an economically and socially depressed future as a single parent. In nearly all, the early onset of childbearing is associated with high fertility.

An unwanted pregnancy also often leads to an induced abortion, which is likely to come later in the pregnancy for an inexperienced or ashamed
adolescent and carry greater risks to health, future fertility, and life if performed in unsafe conditions, which is probable if the procedure is illegal. Recent evidence from developed countries shows that particularly young girls are increasingly likely to choose abortion rather than pregnancy. Those who do not abort tend to remain unmarried. While some live in consensual union, many have to cope alone and are therefore deprived of social, educational, and economic opportunities. In these circumstances they are unlikely to be ready for the demands of parenthood, and the child and subsequent children are likely to suffer.

A second major potential consequence of unprotected sexuality in adolescence is the acquisition of a sexually transmitted disease (STD), often with devastating effects on future fertility. The incidence of STD among adolescents has increased markedly in the last 20 years. As a consequence the rates of admission to hospital for pelvic inflammatory disease are also rising in many developed and developing countries, the two age groups most affected being those of 15-19 and 20-24 years of age. As a further consequence the rate of ectopic pregnancy is rising sharply in both developed and developing countries. Included amongst the major STDs are gonorrhoea, chlamydial infection, syphilis, herpes, and HIV/AIDS (also transmitted by other means). Three of the major obstacles to the control of these diseases among adolescents are the ignorance of young people of the symptoms of STDs, the asymptomatic nature of some STDs, particularly in women, and the reluctance of young people to present for help because they expect to be met with anger and hostility. Two of the diseases: — genital herpes and AIDS — are at present incurable. The former may have severe psychosocial effects on the individual because of its unpredictability and the risk of infecting others, the latter because of its devastating and deadly nature and the reaction of others to the infected.

Young people, like adults, sometimes have sexual problems that are especially frightening because they encounter them without a wider experience of the world. These problems include sexual dysfunction, sexual variation, and sexual harassment or abuse (especially of girls by older men). Sexual variation, particularly homosexual feeling (although it may not be labelled as such), is common but transient in young adolescents, and perhaps 5-10% remain homosexually orientated throughout their lives, many more being bisexual. Because homosexuality meets with disapproval in most societies it is a special cause of anguish.

Sexual abuse of young people is an important problem in most societies. Intercourse with a minor (other than a spouse), whether forced as in rape, or enticed, as sometimes in incest or paedophilia, is universally condemned.
Prostitution, whether by the young male or the young female, is also denounced, but it is only sometimes seen as arising from economic need or family disruption. Many feel that premature marriage before the girl has had a chance to develop fully is also a form of mistreatment.

**The use of alcohol**

Over the past 30 to 40 years increasing percentages of young people have started to drink alcoholic beverages, their alcohol consumption has increased in quantity and frequency, and the age at which drinking starts has declined. Problem drinking increases with age in adolescence and is more common in males than in females. Exemplary of this are the results of surveys from selected countries shown in Figure 6. Distinctions that once separated cultures, sexes, and social classes are vanishing as young people in developed and developing countries alike are increasingly using and abusing alcohol. Excessive alcohol consumption creates numerous health problems and shortens the life span. Heavy drinkers are at greater risk of cancer, ulcers, heart disease, muscle wastage, malnutrition, and cirrhosis of the liver, a leading cause of death in a number of countries. The pregnant woman who drinks exposes her unborn child to a greater risk of brain damage, growth deficiency, and mental retardation as a result of the high levels of alcohol in the bloodstream. But drink not only affects the body, it also affects behaviour. In the longer term the heavy alcohol user is more likely to suffer the social consequences of loss of friends, marital instability, and child abuse, of failure at school, in sport, and at work. Just as important as chronic use, acute intoxication often removes inhibitions that would otherwise prevent risky sexual behaviour and it is especially heavily implicated in aggression, crime, suicidal behaviour, and accidents on the road and in the home, which are a major cause of disability, disfigurement, and death in youth.

Drinking is seen as a way of appearing to be adult, a view which may be encouraged by the example of older family members and media idols. If the family is excessively tolerant or full of discord the risk is greater. Peer pressure plays a major role in sustaining drinking behaviour, which is seen as a way of gaining social approval, although it may lead to the opposite if associated with drunkenness. Drink also often has a positive image among the young, being associated with toughness, rebelliousness, attractiveness, and sociability. Like their elders, they use alcohol as a quick way of reducing anxiety and, because the future seems limitless, even if the long-term consequences of drink are known (and they often are not) they are likely to be discounted or ignored. Some young people, unable to cope with the pressure to achieve some of the developmental tasks of growing up, whether in the family, in their social relationships, at school, or in seeking or doing work, turn to drink for emotional relief.
Figure 6
Young persons drinking heavily as a percentage of all young people in the same age group

Various sources, years and definitions used for heavy drinking
The use of drugs
Drug use is a health hazard with particular relevance to young people. While drugs of one kind or another have been used throughout history by adults, in recent decades drug-taking has become particularly associated with the counter culture of the young in rebellion against convention and in quest of new experience. But what was, even in recent times, restricted to relatively small numbers or specific geographical areas has become epidemic in many parts of the world, especially among the young. The average age of drug users has declined in recent years, and multiple drug use has become more common. The use of one drug is likely to lead to the use of many often in the quest of stronger and stronger effects and with more dangerous consequences.

Drugs other than alcohol come in many forms. Opium has been in regular use in parts of Asia for millennia, but heroin, its derivative, has recently become a serious threat to the health and lives of young people throughout the world. Mescaline and LSD are used for their hallucinogenic effects, coca and khat as stimulants valued for their capacity to produce a feeling of euphoria. Some young people, including the very poor living in urban slums, use solvents that can be found in everyday materials. Cannabis is used in all parts of the world (Fig. 7). The use of prescription drugs such as amphetamines and barbiturates, common in the adult world, also appears to be increasing among the young.

Many health hazards accompany the use of drugs by young people. Adolescent psychoses occur in association with drug-taking. Drugs known to precipitate psychotic reactions include amphetamines and hallucinogenic substances. Some users remain in a psychotic state, with behaviour indistinguishable from that of chronic schizophrenics. Persistent drug use may also block development. It may promote extremely dangerous behaviour; it is associated with suicide attempts and fatal or debilitating accidents through the power of drugs to alter perception and psychomotor reactions. The injection of drugs has brought with it the new lethal health hazard of HIV infection and subsequently AIDS through the sharing of needles with infected persons. As with alcohol abuse, the drug user is likely to fail in many ways, at school, in relationships, and at work. Many young people have turned to crime and prostitution to maintain their supply of drugs.

Among the factors commonly associated with drug use are: family and peer tolerance or active approval of drug use; weak parental control and discipline; ready access to drugs; and alienation. The heroes of youth are generally found in the world of entertainment and sport, seen and heard throughout the world across language and cultural barriers. While many popular idols set a good example for young people, those who use drugs are given wide publicity. Drug
use among young people has become heavily exploited by international criminal organizations thriving on the massive profits made from illegal drug trafficking.

**Figure 7**

**Percentage of young people who have ever used cannabis**

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**Suicidal behaviour**

Of all the destructive behaviour of young people suicide is perhaps the most tragic, since it is irreversible and leaves in its wake not only the unfulfilled promise of a young life but also feelings of grief, guilt, and anger in those who were close to the dead person. Sadly, suicide rates among young people appear to be rising throughout the world in both developed and developing countries, more than in all other age groups (Fig. 8). Suicide is under-reported because of the stigma attached to it, which sometimes includes religious and legal penalties, and because, when there is doubt, death is attributed to accident rather than intention. In most countries suicide ranks after accidents as a leading cause of death among the young. Young men commit suicide much more commonly than young women who, however, attempt suicide with much greater frequency, sometimes causing permanent damage to themselves.
Figure 8a: **Suicide rates in males 15–29 years old (per 100 000)**

### America

- **Bulgaria**
- **Czechoslovakia**
- **Hungary**
- **England & Wales**
- **Netherlands**
- **Belgium**
- **France**

### Asia

- **Singapore**
- **Japan**

### Europe

- **Ireland**
- **Scotland**
- **W-Germany**
- **Denmark**

### Oceania

- **New Zealand**
- **Australia**
Figure 8b: Suicide rates in females 15-29 years old (per 100,000)
The transition to adulthood is often painful, entailing as it does the loss of childhood dependence and new expectations by the young and those around them of more adult behaviour in sexual, social, and vocational roles. The social context of the young person's life is also important. Disruption of normal family relations is one of the most frequent causes of suicidal behaviour. The pressures arising from urban migration, isolation, intense competition at school, and unemployment create stress. For some young people the demands become overwhelming and the possibility of emotional support appears hopeless. When these expectations cannot be met self-esteem is low and depression and sometimes suicide may ensue. However, suicide is not an isolated phenomenon; the causes may be multiple. Recent evidence shows that increased suicide rates are strongly related to the concurrent presence of all of these social factors. It may be associated with drug and alcohol dependence and mental instability. Sometimes it is symptomatic of serious mental disorder with paranoid tendencies or schizophrenia. Depressive maladaptive personality traits and somatic complaints may precipitate suicide attempts in the young. In the majority of young people who commit suicide, however, there is no diagnosable mental disorder and personal and social factors play the major role.

**Intentional injury**

Young people are increasingly victims of violence and themselves physically aggressive towards others. One major source of violence is war, in which of all groups in the population young males are those most likely to die or be maimed. However, social violence appears to be dramatically on the rise. It is often under-reported because of fear of vengeance and lack of confidence in the police and courts. One indication of the spread of violent acts is homicide statistics. Data from the United States are particularly disturbing, showing that 4-5 young people under the age of 18 are murdered every day and 3-4 are arrested for murder. Adolescents are twice as likely as adults to be the victims of crimes, and ten times more likely than the elderly. While these statistics are notably high, they appear to reflect a worldwide upward trend.

This violence is likely to have multiple antecedents — poverty, unemployment, crowding and reduction in the control exercised over the upbringing of young people. But individual factors are also likely to contribute, including drug and alcohol abuse, a sense of failure, frustration and hopelessness, and heavy exposure to violence in the streets and on the screen.

**Behaviour leading to accidents and injuries**

Accidents constitute one of the major causes of death and disability among young people throughout the world, accounting for as much as half of all deaths in many countries for those between the ages of 10 and 24 years. For example
in the United States, motor vehicle accidents caused almost 56% of the spinal cord injuries resulting in para or quadriplegia and a disproportionate number of young people were involved. Furthermore, the rate is increasing in developing countries. Accidents occur on the road, at the workplace, in sport, and at home. Road accidents are often accompanied by intoxication with alcohol or other drugs. Other behavioural factors that contribute to accidental injury in young people are exuberance, lack of experience, a feeling of invulnerability, and risk-taking that comes with the need to demonstrate independence and courage. But environmental conditions can contribute greatly to risks, and it is often a combination of risk-taking with an unsafe environment that leads to injury. Many young people, especially in developing countries start work too young and are especially at risk since they often work in conditions more appropriate for adults, may not have fully developed psychomotor skills, and are too tired to be careful.

**Mental disorder**

Young people are often very vulnerable to the kinds of stress that promote mental instability. Not only must they meet the challenges of development, which are a natural part of growing up, they must also deal with the conditions of modern society, more and more characterized by a weakened family structure, rapid urbanization of living conditions, severe competition for education and employment, and exposure to alcohol and other drugs. Youth is also a time of emotional liability, in which depression and anxiety can occur frequently.

Adolescence and youth are the time of first appearance of some mental health problems. If badly treated, they can easily become chronic and place a great burden on the individual and on society. Early detection of the symptoms and signs of mental disorder and adequate prevention, however, can contribute greatly to the health status of adults in society. Some of the more serious mental disorders, including some psychoses, schizophrenia, and manic depression, appear for the first time in adolescence and youth, though they may have their roots earlier in life. Some young people with relatively minor mental handicap, learning disabilities or minimal brain dysfunction, become emotionally disturbed during adolescence. In some cases somatic illnesses in adolescence may be expressions of serious undiagnosed psychological disorders. Some patterns of behaviour — suicidal attempts, drug and alcohol abuse, delinquency are symptomatic of mental maladjustment. However, while most young people experience some degree of stress, only a relatively small number develop pathological patterns of thinking, feeling, and behaviour.

Young people in certain groups may be more vulnerable. They include those, such as refugees, who have migrated to culturally different environments and
lack adequate support, and those who are physically or mentally handicapped and so under greater stress during adolescence and youth. Disabilities owing to minimal brain lesions such as short attention span or dyslexia may create difficulties at home and at school and interfere with normal maturation. Although many young people with physical and mental handicaps cope extremely well, for some the handicaps can become an extreme source of frustration just as their aspirations are growing, and they sometimes show maladaptive behaviour.

**Conditions originating in adolescence which manifest in later life**

Communications and trade, so effective in transferring education and knowledge have also become the vehicle for enlargement of the market for tobacco, alcohol and drugs and spread the health risks they carry with them. Even in developing countries, many of the chronic noncommunicable diseases are now leading causes of death at a time when many socially rewarding and productive years of life should be expected.

As understanding has grown of the epidemiology of many adult diseases it has become evident that many diseases, disorders, and disabilities of adult life arise as a consequence of events, conditions and lifestyle patterns associated with infancy, childhood, and adolescence. The consequences of anoxia or birth trauma associated with poor obstetric care may not be evident until manifested by impaired school performance. Food preferences and eating habits contribute to obesity and hypertension. Respiratory tract infections may affect pulmonary function in adults, as well as impair hearing and cause rheumatic heart disease. Child abuse may derive from early pathological psychosocial conditions, recent evidence suggesting that, unless they are adequately dealt with, child abuse tends to become intergenerational and should be considered among the adult problems arising during childhood.

**Eating behaviour**

One potential source of health problems is the eating behaviour of young people. In many of the poorest countries of the world malnutrition is a result of lack of access to nutritional foods, not an inadequately balanced diet. However, programmes to end undernutrition have been highly successful in some countries.

Diet has a profound effect on the development of cardiovascular disease, hypertension, obesity, and non-insulin dependent diabetes. Excessive consumption of sugar, fat, and salt during childhood appears to lead to the
establishment of a preference for foods containing those substance and possibly early biophysiological changes that ultimately lead to pathological changes and disease.

According to adult diet intervention studies as much as half of cardiovascular disease mortality may be attributable to dietary factors. Obesity is a major factor in the development of non-insulin dependent diabetes mellitus. Those with a body mass index exceeding 26 and particularly 30 may have as much as a relative risk of 14 of developing diabetes and of acquiring such complications as renal disease and retinopathy. As much as a third to a half of non-insulin dependent diabetes may be attributed to diet.

Decrease in the fat, sugar and salt content of many “modern” diets will thus have a major impact on cardiovascular disease, hypertension, and diabetes. There is also good evidence that such a change in diet will also have an impact on other diseases of adult life such as cancer of the colon and elsewhere.

Concern about obesity is particularly acute in adolescents because of their increased interest in appearance and the loss of self-esteem associated with a poor self-image. Poor eating habits can also lead to acne (although they are not an exclusive cause), which is particularly worrying to young people. The importance of the social and psychological aspects of eating behaviour, is demonstrated by the increasing prevalence among girls in some countries of anorexia nervosa and bulimia nervosa.

Unhealthy eating combined with poor oral hygiene can lead to damaged teeth and gums, which are not only a health problem in their own right but worry young people if they affect their appearance. Poor oral hygiene in adolescence leads to gum disease and the loss of teeth in later life.

**The use of tobacco**

One of the forms of behaviour most damaging to the health of the young is the use of tobacco. In the long term tobacco consumption is implicated in about 90% of lung cancer cases, 30% of all cancer deaths, 75% of cases of chronic bronchitis and emphysema, and 25% of cardiovascular disease, and it increases the risk to health of oral contraceptive use. But it also has short-term effects, increasing the severity of influenza, reducing the immune response, adversely affecting the fetus of pregnant women, and diminishing respiratory and athletic performance. New hazards are arising from the increased promotion of and the use by young people of smokeless tobacco, which contributes to disfiguring diseases of the teeth and gums and cancer of the mouth. Tobacco use by young people is widespread in all parts of the world (Fig. 9) and is increasing
in developing countries, especially among girls. At the same time, there is evidence to suggest that it is decreasing in those developed countries which have long-term smoking control programmes. Tobacco is deadly, but its major negative effects on the body are long-term, while its social and psychological effects are often perceived by young people as positive. The sooner the young start smoking, the larger their loss of life expectancy — eight years if smoking starts at 15 years, four if at 25. As many as 90% of eventual smokers started before the age of 19 years. If tobacco is not taken up in adolescence it rarely is later in life. Three factors are strongly associated with tobacco use by young people: peer pressure; the example of siblings and parents; and employment outside the home. Each of these has major implications for preventive action.

Figure 9 Smoking prevalence among young people

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The healthy development of young people depends on many interlocking factors. Two of them were mentioned above: living conditions, which provide the basic ingredients and opportunities for physical, mental and social development, and the ways in which young people realize their own potential in meeting the challenges of growing up. While most make a successful transition from childhood to adulthood, many succumb to hazards along the way. A third major factor in achieving health is the effectiveness of the community’s infrastructure for health. First examined are policies and legislation that can enhance or deter action for health, then the kinds of programmes that exist, their special characteristics, and the ways in which they are perceived and utilized by young people. Programmes of many kinds exist to promote health, prevent problems, and provide care and rehabilitation. To be effective for young people, policies must be coherent and action well coordinated across the many different sectors that affect their physical, mental, and social development.

Policies and legislation

Policies for health

Policies, whether explicit or implicit, provide the basis for the promotion of young people’s health. Those of relevance to the health of young people cut across virtually all sectors of government and are the concern of many nongovernmental organizations. In addition to the health sector itself, laws relating to education, employment, social welfare, population, defence, religion, sport, culture, women, and youth, among others, have major implications for young people. As specific public health measures such as improved sanitation, a clean water supply and immunization programmes have succeeded to some degree in controlling disease, attention has been turning toward those health problems more characteristic of adolescence and youth in which there is a major behavioural component. Policies and legislation have too often been ad hoc responses to health problems as they capture public attention rather than anticipatory action before a problem has become
widespread to promote health enhancing conditions or behaviour. They are, moreover, rarely examined as a whole for ways in which they might reinforce rather than diminish their joint impact.

**Law and the concept of a minor**

While law is used in all societies to define the concept of a minor, i.e., as someone not yet considered fully adult, it is defined inconsistently not only between countries but within them as well. Such legislation covers the minimum legal age for marriage, sexual intercourse, work, voting, driving, and military service. It is also relevant to whether a young person alone can obtain health care of certain kinds, in confidentiality as between health providers and young people, and in the balance of rights and duties between parents and the state. It may perhaps be noted, that, while the legal age for driving, voting, or military service is likely to be known by the young person, laws about health service use are not.

**The law and reproductive health**

There is a trend toward more health education in school systems, not only on general issues but also on sexual and reproductive matters. How this is implemented is subject to great variation. In some parts of the United States, for example, and in many developing countries, sexual subjects, if taught at all, are taught in a highly constrained manner, and it is common to see what may be called family life education exclude sensitive topics of sexuality altogether. For young people, who have left school the situation is even bleaker, although many nongovernmental organizations have succeeded in reaching some of this population group. Education and information on reproductive health and health care itself are complementary, but this unitary approach is rare. Access to reproductive health services, especially for contraception and induced abortion, is sometimes prohibited by law for young people, especially if they are unmarried or beset by difficulties of access and consent; and this may delay or deter them altogether from using the service. There are also serious obstacles to the diagnosis, treatment, and control of sexually transmitted diseases among young people because of the requirement of parental consent and of disclosure of sexual contacts. The possibility of HIV infection and of questions about sexual practices and/or drug use is likely to serve as a deterrent to young people’s use of screening and treatment services.

**The law and substance use**

The use of tobacco, alcohol, and other drugs has particularly harmful effects on young people in both the short and the long term. Young users are also special targets for the sale of these harmful products due to their susceptibility of
forming lifelong habits. Many laws aim at reducing the use and abuse of harmful substances by placing restrictions on the source of the product, its distribution, promotional advertising, the population groups that may buy it, the places in and means whereby it may be sold, the manner and quantity in which it may be used, the ways in which treatment for problems arising from its use may be available, and the relationships of all these activities to the system of criminal justice. Thus, for example, it has been shown that although significantly raising the tax on cigarettes has no effect on adult smoking it may greatly reduce the number of new smokers among young people. The rapidity and extent of travel, the pervasiveness of the mass media throughout the world, and the existence of transnational networks of both legitimate and illegitimate businesses require legislation and policies developed in an international context, though appropriately designed for any given culture.

The law and disability
Young people who suffer from physical, sensory, or mental handicap, whether congenital or acquired, have an especially difficult time during adolescence and youth when they must face new challenges, but they are often neglected by health systems. As a result, their condition goes frequently undetected and untreated at an early stage, with consequent loss to the community of a large

The young blind
During International Youth Year, the Braille Foundation of Uruguay organized a programme of activities intended especially for blind young people in view of the fact that there are no programmes specifically for sightless youth in Latin America. The activities took place through 187 organizations of or for the blind in Latin America, covering 19 Spanish-speaking countries.

Special attention was paid to bringing the riches of literature to those unable to read. A collective book about Louis Braille was drafted by young blind people of various countries, including testimonials, anecdotes, comments and reflections on the use of the braille system in everyday life, work, and education. Recordings on cassette were made of a selection of novels, stories, and articles about the particular information needs and concerns of young people. A monthly magazine — Entretodos — was published in Spanish and Braille containing articles for and by the young and sightless.
and potentially valuable human resource (at least one in ten persons in the world). While some progress may be occurring in preventing handicap through better perinatal care and immunization programmes, it is also true that many handicapped children who would once not have survived now live on into adolescence and beyond, thereby increasing the need for appropriate help. Better care for disabled young people is one of the most important aims of legislation in this area. Policies where established are increasingly promoting an approach that focuses support for young disabled people within their families and communities. Schools and youth organizations can play an important role in treating the young person as a healthy individual who has a particular difficulty and not be segregated from other young people.

**The law and mental health**

Where treatment is available for mental health problems there are often difficult legal issues regarding informed consent or the voluntary withdrawal from treatment of an emotionally disturbed young person. While there has been a trend for some time towards a more humane view of psychological disturbances that recognizes the need for treatment and rehabilitation rather than segregation and institutionalization, policies and laws promoting such services tend to lag behind and the services are largely restricted to the developed countries. In developing countries where a system of support was once available in the rural community, urbanization and the decline of the extended family have exposed many young people to greater emotional stress without providing either traditional or modern means of care. If legislation for mental health does exist, it tends to be in relation to treatment rather than prevention.

**The law and occupational health**

There is a long tradition of legislation to protect the health of children and adolescents, including the establishment of a minimum age for work, screening before employment, and prohibition of work in hazardous conditions and for long and unsociable hours. But there are many complications. Not all countries have such laws, and where they exist they often apply only to the public sector and even then are often not implemented. Paradoxically restrictive legislation designed to protect the young person's health may keep him or her unemployed and contribute to mental stress and poverty.

**The law and accidents**

The relevant legislation takes many forms, including restrictions on the use of alcohol and other drugs and protection of occupational health. In the industrialized countries there are minimum age requirements for driving licences,
mandatory use of seat-belts in cars and protective headgear for motorcycles, and penalties for drinking and driving. Educational programmes for the young to prevent accidents exist in many countries, but reach only a fraction of those at risk of accidental injury.

The law and public health
Many laws affect public health generally and are not directed specifically at young people, although legislation, particularly in developed countries, for health education and for fluoridation of water supplies to prevent dental caries is of special relevance to the young. Laws that protect the environment and the safety of food, water, and medication, that provide for health services generally, and that foster the necessary conditions for education, family welfare, employment, housing, sport, culture, religion, and recreation all have an impact on the health of young people.

Action for Health:
A need for the primary health care approach
The principles of primary health care such as self-care, participation, intersectoral action and appropriate technology, are particularly suited to the promotion of young people's health. While policies and legislation can help promote conditions fostering healthy development and contributing to an environment low in risk and high in opportunity, direct preventive action is also needed. Programmes for health can be designed to promote and support healthy behaviour, to prevent problems from arising, to identify and care for those at risk, and to treat and rehabilitate those who have suffered from illness or injury. Many programmes originate in sectors other than health, and there needs to be close liaison across sectors to facilitate appropriate referral and sometimes joint action. The programmes are directed at primary, secondary, and tertiary prevention and take many forms in providing information, education, guidance, counselling, care, treatment, and rehabilitation. Although the main target group is young people, it is often important that other people who influence their health either directly, such as family members, peers, educators, and youth leaders, or indirectly, such as media people and sports and entertainment figures, should also be considered as appropriate target groups.

Primary prevention of health problems among young people involves facilitating normal healthy development and the establishment of healthy lifestyles among the young. The main features of primary prevention include specific policies, the provision of information through a variety of channels, and education. The role of policies, law and regulations has already been described.
Policy approaches at primary prevention which are not just directed at young people, but which greatly affect them include the control of advertising of tobacco and alcohol or codes of conduct, as in France, among automobile manufacturers to refrain from emphasizing or promoting sales on the basis of speed.

**Primary prevention**

Information to young people can be provided through channels of primarily one-way communication such as radio, television, newspapers, magazines, books, videos, films, cassettes, records, live entertainment, diskettes, comics, cartoons, posters, pamphlets, and graffiti; or through two-way communication by people in person, by telephone, or through an exchange of written messages, sometimes aided by computers. Interactive communication is especially powerful since it permits the young person to pose questions and explore issues of special individual significance ensuring that the information has a greater degree of personal relevance. While some information is deliberately designed to promote health, and in the public sector is usually factual in nature as in a textbook or documentary, a great deal of information reaches young people more indirectly in the private sector through fictional presentation in the entertainment media or in advertisements, and it may be false or distorted. Throughout the world young people are bombarded with information and messages, sometimes of a contradictory or competing nature, which they must somehow interpret and evaluate.

Education not only provides information to young people but is also charged with the task of nurturing intellectual as well as social and moral development. Education for health includes not only guidance on hygiene, exercise, rest, eating, drinking, maturation, sexuality, and relationships but also enables young people to manage their health destinies. There are two major vehicles for such education: the school system, which often provides formal training in health education through the teaching in other subjects; and the family, the primary source of knowledge and habit formation for everyone. At the primary level many other people can play a significant role. Most young people come in contact with health workers at some time and, regardless of the immediate purpose of the care they are providing, they are in a powerful position to educate young people and their guardians about health matters. Leaders of youth organizations are also in an excellent position to provide education on health to their members and to others, including school-leavers, whom they may be best able to reach. Religious and community leaders can also serve to educate young people about matters affecting their health. Perhaps most influential of all for young people are the modern heroes of entertainment and sport who can be recruited for this purpose. But for education to work successfully, not only must educators be knowledgeable, they must also be
skilled at communicating with the young. This means being able to listen sensitively and without condemning the individual, whatever they may think of his or her behaviour.

Youth in Sweden organize for a non-smoking generation
An association of young people was formed in 1978 with the primary goal to have their schools free of smoke. There are about 60 local groups who work in their communities and schools arranging non-smoking discos, outings, sport activities and exhibitions. The emphasis is on portraying non-smoking as something attractive in addition to providing information on the health dangers of smoking. Efforts are also made to sensitize young people to the economic aspects of tobacco cultivation and use in third world countries.

Secondary prevention
The identification and reduction of risk is the basis of secondary prevention. It is well recognized that some individuals on the basis of genetic, biomedical, psychological or social circumstances are more vulnerable than others to develop disease, disability or other consequences of unhealthy development. When interventions are available and effective, the identification of such individuals or groups has been shown to be cost effective in preventing progression to a diseased or disordered state and ensuring a reasonably healthy, satisfying and productive life for the individual.

Outside of the family, the most common system that identifies young people in special need of health care is those school services which provide screening for speech, hearing, vision, oral health, and learning disabilities. Health workers within or attached to the educational system then provide the necessary care or treatment or refer the young people to more specialized services. It is much more common for the screening to be for physical or sensory disorders, rather than for learning and emotional disorders, which remain largely untreated. Many schools do not have adequate screening services, and a great many of the world's adolescents and young people are not at school. Young people are consequently much more heavily dependent on self-screening or on their families for appropriate care. The more widespread and sound public information on health subjects is, the more likely it is that young people outside the formal services will seek care when they need it.

In some work situations screening for health takes place when employment is requested, and less commonly as a regular part of employment conditions.
Much more use could probably be made of the work situation in combination with the health sector for the identification of young people at work where health is at risk. This is true not only of the private sector but also of the public sector, where young people are recruited for the armed forces, security forces, nursing, etc. Social services and criminal justice are two other sectors that are often able to identify young people who need health care to prevent aggravation of difficulties they may currently be experiencing. Youth organizations also can and often do play a major role in risk identification and reduction by requiring or providing some form of health examination on entry and by monitoring young people in their organizations. This is a function that can readily be strengthened by close cooperation between the health and youth sectors.

Within the health sector itself the primary health care worker or the family doctor is in an especially good position to note or anticipate health problems in adolescents, in families, for example, with poor hygiene or eating habits. Some countries, like Cuba, have established an intensive risk identification system through liaison between community organizations and multidisciplinary health services. Family planning clinics and clinics providing legal termination of pregnancy are also in a position to identify young persons who are sexually active but not using contraceptive methods effectively and to provide appropriate care and counselling. Widespread screening for risk identification currently takes place in France, where families are requested to come at five-yearly intervals for full examination. While the interval is rather long for the young and not all families appear, the principle is one that has much to recommend it for the health of young people. There are also a growing number of specialized centres for adolescent health in, for example, Chile, France, Peru, Switzerland and the United States, which provide an opportunity for multidisciplinary screening and treatment.

The effectiveness of secondary prevention depends on the effectiveness with which young people in need are reached early enough to strengthen their resilience. As many forms of behaviours that give rise to problems are interrelated and tend to increase in severity throughout adolescence and youth, due attention in early adolescence has much to recommend it. But to achieve that requires a two-way process in which not only do the formal sectors seek the young person but the young person is willing to trust, confide in, and seek out those who can help him or her. In many spheres in which prevention would be possible — e.g. in more effective use of contraception to prevent too early pregnancies, in early diagnosis of a sexually transmitted disease, or in help with an incipient drink or drug problem, the young person is often afraid to
approach the providers of services because of the possibility of disapproval and punishment; and he or she often does not know whom to go to for what kind of help. A major challenge is to make services and service providers more accessible to the young.

The sex counselling hotline

A telephone counselling service run by around 120 trained volunteers was started by the Planned Parenthood Federation of Korea in June 1985. Over a period of six weeks, the service was widely advertised as a "youth sex telephone counselling service" in a daily newspaper, and in various other magazine and broadcasting outlets.

During the first three months, over 2,300 calls were received, of which nearly three-quarters were appropriate counselling calls. Nearly 70 per cent of the calls were from males, of whom, 70 per cent were less than 20 years old. The largest group of problems concerned sexual feelings, followed by anxieties about physical change and unwanted pregnancy.

In some developed countries counselling and guidance are available to give young people help when they are in difficult situations or must make important decisions. People with the ability to listen well who feel and show respect for the individual adolescent or youth are more likely to attract young people seeking help, whether they are in a professional setting or not. The counsellor must recognize that only the young person can change his or her behaviour, no matter what others may wish. The evidence in all systems suggests that, to achieve a sustained change the young must themselves be involved in the planning and implementing of any programme designed to help them. In many developed countries some professional counselling is provided in school systems and health services by a network of trained peer counsellors or by independent practitioners. This is rare in developing countries, where the guidance tends traditionally to be more authoritarian and be provided by family members or by religious figures and community leaders. When counsellors do exist in the school system, for example, they are sometimes there to punish or correct young people, not to attract those with emotional or psychosocial problems.
**USA: Tackling drug dependency “Youth to Youth”**

“Youth to Youth”, an organization to prevent and treat addiction to drugs, was founded in 1982 in Columbus, Ohio, and belongs to the National Federation of Parents for Drug Free Youth. It is one of the oldest and most successful teenage drug prevention programmes in the US.

The philosophy of “Youth to Youth” is founded on two beliefs: that positive peer influence and support is a powerful and effective weapon against taking up drugs; and that teenagers and adults working together can develop comprehensive programmes that really work.

Each summer, a national “Youth to Youth” conference is held for adults and teenagers interested in promoting drug-free youth groups in their own communities. Small groups led by professional counsellors and experts in the fight against drugs, develop plans for application in their own communities. The conference also offers groups the option of inviting a team of professional helpers to visit their own community and help them develop a programme on-site. “Youth to Youth” staff and teenagers lead two to three day workshops for adults and youth from the community, who are then in a position to spearhead the development of a similar “Positive Peer Programme”.

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**Tertiary prevention: treatment and rehabilitation**

A key element in tertiary prevention of disease and disorders in young people is the availability and social and psychological accessibility of facilities for treatment and rehabilitation for illness and injury. The prevention of the further progression or the development of complications from illness or injury can be greatly facilitated by providing the young person with an understanding of the nature of the problem and by sensitizing those who provide care to the special needs and perceptions of the young. Services that provide treatment for young people are largely in the health sector and show much variation. They are predominantly aimed at physical illness (whether chronic or acute) and injury, and to a lesser extent at problems of mental health. Most hospitals and outpatient clinics, however, are divided into paediatric and adult services, and the adolescent or youth is often placed either with children or with adults at a time when the company of peers is of special value. While the curative approach is essential for a pathological condition or injury, there is every reason...
for it to be accompanied by a broader educational approach dealing with the causative factors, especially when they can be changed by the action of the young persons or their family. When prolonged hospitalization is necessary, efforts must be made to maintain to the greatest degree possible a normal environment including, for example, continued schooling, association with peers, and exercise compatible with recovery, so as to help psychosocial and physical development and pave the way for a return to normality. In some developed countries individual, family, and group therapies are available to deal with psychological difficulties. Given appropriate training, directive approaches targeted on specific behaviour and psychodynamic approaches aimed at modifying underlying factors can be employed successfully. Providing such help early to prevent more serious or chronic psychological disorder is highly cost-effective, but little attention has as yet been given to the need for it in most developing countries. As traditional support structures decline, how can greater personal help be brought to young people to prevent minor problems from becoming a threat to health or life?

Young people are particularly vulnerable to disabilities arising from accidents and injuries occurring on the road, in sport, at work, and in the home. Spinal cord injuries resulting in paralysis or other impairment are particularly devastating for young persons just beginning life, and rehabilitation needs to be directed at the whole individual so that they are able to develop physically, psychologically, and socially to the fullest extent possible and be integrated into society. This requires a high degree of cooperation between sectors, particularly between health, education, labour, youth, and social services, and major involvement of community and nongovernmental organizations. The efforts must be directed not only at the young person but also at those who interact with him or her as well, and this may call for retraining and sensitization of health workers, teachers, and employers so that they are better equipped to integrate the young person into his or her natural setting. While disability and impairment are greatly disheartening to the young, they frequently demonstrate great resilience and courage and overcome them to a remarkable degree, if given appropriate support and understanding by those around them.

**Approaches to health care**

The health service needs of young people are met in several ways: through general health services to which young people have access; through health services specially designed for adolescents and youth, either independent or embedded within general services, or through general community, education and social services and associations for youth that include a health component.
The activities outlined in the previous section are performed in a wide variety of ways that vary in origin, focus, and objectives but rarely provide integrated and comprehensive services for young people, let alone national policies and programmes.

**The school**

Traditional health education to promote personal hygiene and healthy behaviour is provided widely, usually in a didactic manner. Other aspects of health are touched upon and sometimes sexual education is offered. Unfortunately this is frequently omitted or presented inadequately, either because the teachers are poorly prepared or because the authorities frown upon it or or expressly forbid it. Evidence also suggests that the simple provision of didactic information has little effect on attitudes or behaviour. Some schools provide screening services for visual, hearing, and some learning disabilities. There is a growing interest in developed countries in screening for behaviour associated with cardiovascular disease risk taking into account such indicators as ponderal index, fitness, and blood pressure; the latter, however, requires special equipment, training, and skill which are not always available. Schools usually provide a structured opportunity to learn sports important not only for physical fitness, but often for the experience in team-work and for the constructive use of leisure-time.

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**Health education reduces the risks of cardiovascular disease**

A controlled study of the introduction of comprehensive health education was carried out in six randomly selected schools in Oslo, Norway between 1979 and 1981. The programme, focussed on nutrition, cigarette smoking, alcohol use and physical activity, involved adolescents aged 10-15 years. Important indicators of success were noted. There was a significant reduction in the onset of smoking, particularly among the younger adolescents. The students from the intervention schools reported improved eating habits (less butter, more bread, more low-fat milk) than those from the reference schools. Boys participating in the programme increased their physical activity and girls experienced lower increases in weight and body mass index than those not participating. Total serum cholesterol increased more in the reference group than in the intervention group for both males and females although no differences were found in levels of HDL cholesterol.
Health services
A second major source of health care provision for young people is through a general health system in which special provision is made for adolescents or young people, although it is much more common for them to be treated either in the child or the adult treatment units. When a segment of the service is focused on young, it ranges from a minimum setting aside of certain hours for them to a multidisciplinary team approach dealing with the full range of their health problems, with both inpatient and outpatient services. More rarely, there are independent health clinics for young people attached to larger institutions. The primary characteristic of the more successful units appears to be multidisciplinary, professionals from such disciplines as medicine, psychology, social work, and health education joining forces to provide a full service from preventive education through treatment to rehabilitation. Many such programmes are experimental, they exist in only a few developed countries, and they are far from adequately evaluated as yet but there is sufficient evidence to suggest that the very flexibility of multi-disciplinary approaches lies closest to the perceptions and expectations of young people, who think of their health in holistic rather than fragmented terms.

Treating attempted suicide
A treatment centre attached to Bicetre Hospital in France offers a specialized service for adolescents. Forty percent of those hospitalized at the centre do not come for purely physical or physiological reasons, but because of attempted suicide. The policy of the centre is that no young person should feel that he or she has an anxiety which cannot be voiced; and no young person who is suffering from obvious emotional distress is ever left on his own.

Open discussion on every topic is encouraged, including those problems such as parental violence and sexual abuse which are hard to address. Talks range across subjects such as rape, drugs, suicide, diet, wearing a helmet when motor-bicycle riding, and fears of pregnancy. Young people can also obtain full medical examinations to identify problems and allay fears.

Single problem interventions
A third approach is the provision of prevention and care in relation to a single problem such as pregnancy, abortion, sexually transmitted disease, smoking, alcohol use, drug use, obesity, anorexia, learning disorders, psychotic states, or
suicidal behaviour. Despite the fact that there is evidence of the interrelationship of a number of forms of problem behaviour, the single-issue approach is more common. Some health care needs such as the treatment of anorexia or of psychotic states are dealt with in an inpatient setting. While hospital wards for anorexic patients are likely to be primarily for adolescent girls, since they are the group most commonly afflicted, young people are more likely to be treated along with older people in psychiatric wards or hospitals. Some problems such as the use of tobacco are dealt with primarily through the provision of information. Some campaigns showing success in a few developed countries where a multifaceted approach has been adopted involving restriction on advertising and on access to cigarettes. Drug and alcohol use and abuse are often treated separately, and where treatment facilities exist young people are more often than not treated along with older people. However, there have been successful prevention programmes as below.

**Youth to youth: reducing alcohol use**

The use of peer leaders as facilitators for alcohol abuse prevention with adolescents has been shown to be an essential component of successful programmes recently. The WHO collaborative study on alcohol education and young people compared a peer led programme to a teacher-led programme to no programme at all in 25 schools in Australia, Chile, Norway and Swaziland. The educational programme emphasized refusal skills for alcohol use among eighth and ninth graders in the four countries. The peer led educational programme appeared to be efficacious in reducing adolescent involvement with alcohol across a variety of settings, economies and cultures. Peer leaders are unique in their ability to influence peer group behaviour because they are members of the peer group, are credible role models and disseminators of social information and utilize the same language as their peers. Peer leaders can be trained to modify environmental, personality and behavioural factors that are predictive of alcohol use among adolescents, and become a viable alternative to teachers and adult leaders.

Maternal and child health care clinics can provide help to all pregnant women, but in many countries, if the young mother is unmarried, she may anticipate an unfriendly reception. The same is true of family planning services, many of which have an implicit (and in some countries explicit) policy of discouraging their use by unmarried girls and rarely deal with young men. By contrast, some
family planning services have outreach programmes providing minimally better information about family planning to young people within culturally accepted constraints. It is doubtful, however, whether providing information without services goes very far toward preventing unwanted pregnancies. Services for the detection and treatment of sexually transmitted diseases are rarely designed in such a way as to make it easy for young persons to use them. Because of the stigma attached to such diseases most young people prefer to use a service where either they are not known or they are not seen to enter clinics designated specifically for that purpose. A simple change of name or the provision of more privacy within the clinics could improve the situation at very little cost.

**Hospital based services for high-risk adolescent women**

Two programmes have been functioning in Brazil, in maternity hospitals, to address the problem of unplanned, repeat pregnancies among adolescents. At both of these hospitals, staff had noted that one-quarter to one-fifth of their cases were adolescents under 20, present for childbirth or complications of induced abortion. Visits are made by specially trained staff to post-partum/post-abortion young women to invite them to discuss concerns, including those about contraception.

Previous attempts at community outreach to adolescents were not successful as young women, who had never been pregnant were unwilling to use family planning services at the hospitals. However, those who had been patients and received services or talks from staff returned for follow-up services and after some time, youth from the community began to appear. This has been attributed to word-of-mouth referral from those young women apparently satisfied with the services, encouraging their friends to attend.

**Youth associations**

A fourth major health care setting for young people consists of organizations or associations designed primarily to encourage young people's interest in sports, recreation, or community service but including a health component. Youth organizations sometimes require some form of health vetting before accepting a young person for membership and they often provide information, education, or training in regard to such health subjects of relevance to young people as fitness, eating habits, personal hygiene, and sport. Because of the variety of activities commonly available, and because the atmosphere is much
more participatory than that of either school or health services, it is somewhat easier for an adolescent or youth to choose the right person and the right moment to raise sensitive subjects. Youth organizations also train for leadership and conduct campaigns for public health that both promote the social development of their members and education and training in public health issues.

### Addressing school drop-out due to pregnancy

The Dar-Es-Salaam Youth Centre in Tanzania, provides services to young women forced to discontinue their formal primary school education because of pregnancy. The backbone of the Centre is a well-rounded curriculum to allow the completion of school requirements but courses are also provided on topics related to general health and hygiene, parenting, family life education and income-generating skills. Day care is available for the infants and is the only one of its kind in Tanzania for infants under the age of three.

The counselling services provided are pivotal. Individual and group sessions emphasize the development of self-esteem and self-reliance, assess the individual needs of the young women, as well as provide information. Home visits have also been made and have uncovered the degree to which mother and infant illness prevent participation. Maternal and child health services were introduced in the Centre and a good referral system developed with local government health and family planning services. Absenteeism has been reduced and the overall health status of the young women improved.

It is yet to be seen whether such a resource-intensive, multidisciplinary approach could be replicated on a wider scale and is too early to assess whether repeat pregnancies are avoided and the young women have improved economic futures. What has been demonstrated is increased self-confidence among the participants in their abilities as students, income-earners, and mothers.

### Intersectoral action

One of the most important aspects of the health system at all levels and in all sectors is its capacity to refer successfully and cooperatively across boundaries. The first requirement for this is good communication, including awareness of the other services' or sectors' structure and responsibilities. Whether at
national or district level or in primary, secondary, or tertiary prevention and care, some form of regular intersectoral interaction is essential so that young persons are not confined to compartments or dealt with in contradictory ways.

"The Door" – A Centre of Alternatives

"The Door" was established in New York, USA, in 1972, on the recommendation of a group of young professionals who felt that the vital needs of urban youth could be met only by a new approach to youth services. "The Door" was created as a model to demonstrate the effectiveness of comprehensive, integrated services and of networks or linkages between existing service systems. More than 400 young people from all over the New York metropolitan area come to "The Door" daily. There a wide range of activities and services are available to them. These are easily accessible and assembled under one roof in a setting architecturally designed to permit appropriate privacy in a friendly atmosphere. To thousands of disadvantaged adolescents, "The Door" has become a viable alternative to life-styles that are self-destructive, providing an acceptable source of help for young people who are unable or unlikely to approach the traditional agencies and institutions.

Young people too, need help for self-referral, since the majority may well escape risk identification or screening systems. For a variety of reasons they often do not approach the health services directly when they have health problems. They may not realize that they need the help of health workers; they may not know that a service is available; where it is, how much it costs, and whether they would be accepted as clients; they may be afraid of seeking help if they think that their confidentiality will be violated, that they will have to reveal confidential information about other people, that they are likely to be reproached or punished, or that other people will become aware that they have problems. For young people to seek and obtain appropriate help trust is essential. They are likely to make the first approach to anyone they feel they can rely upon, whether in a formal service or not. For this reason it is of vital importance that key groups in the community have a basic understanding of young people's health needs and that health workers are trained to have not only that understanding but also the interpersonal skills needed to work effectively with the young. Equally important is the involvement and participation of young people in the planning and provision of services.
While many approaches have been tried to promote the health of youth, they are most frequently on a small experimental basis, more often than not in developed countries, and rarely effectively evaluated. There are a number of reasons for this. Many health sequelae appear in later life. Programmes aimed at prevention are not as dramatic in terms of results as those aimed at cure, and the results are long-term, while governments, sensitive to public reaction, frequently focus on short-term results. Evaluation of outcome is also technically difficult and requires not only a skilled approach but also willingness to wait over lengthy periods to assess the results. In many countries adolescent and youth health is given low priority because the group is considered to be healthy, although not only are there health problems specific to young people but it is also in this age group that the pattern is set for later health behaviour and consequences. A modest reduction in smoking in this age group may have a great impact on public health and public health costs years later, as well as setting a better health example for the next generation.

To adopt appropriate strategies a number of criteria need to be met. Sound information about young people's health status and behaviour is still lacking. The utilization in programmes of what is known about change in behaviour lags behind. The training of people who interact with the young to be knowledgeable and skilled in communicating is at present extremely limited. These are areas where the strengthening of workers at all levels is necessary. Evaluation of activities rarely goes beyond operational indicators. The utilization of young people in planning and implementing programmes, which is known to be of value, is still relatively rare. Social factors, so powerful an influence on young people's behaviour, are not generally considered along with biomedical services. An intersectoral and interdisciplinary approach remains the most likely path to successful health promotion. While interventions need to be culturally appropriate, it is essential that national and community leaders should be willing to examine their assumptions in the light of sound information. A positive approach generally works better than a negative one, and campaigns to promote health behaviour in young people should take advantage of this principle in attempting to change behaviour. Most important of all, young people learn by example. Those who promote health in any capacity and in all sectors can begin by reflecting on the ways in which what they are asking young people to do can be manifested in their own lifestyles.
PRINCIPLES OF INTERVENTION FOR YOUNG PEOPLE’S HEALTH

Experience to date suggests a number of principles that appear to be effective in promoting the healthy development of young people:

• a prolonged supportive environment with graded steps toward autonomy enhancing self-esteem and promoting healthy lifestyles
• a positive interaction between young people and the key adults and peers in their lives
• continual monitoring of the healthy development of young people within the sociocultural context
• the development of programmes based on a sound understanding of young people’s beliefs and behaviour within any given culture
• the use of people to implement programmes who respect the young, have a sound knowledge of their needs, and are trained in communication skills
• the use in programmes of established principles of learning, behaviour, and development
• the focusing of programmes on groups of interrelated behaviour rather than single forms
• the use of an intersectoral approach in programmes in which key groups interacting with the young are optimally involved, including the school, the family, the health system, religious and community leaders, and community organizations
• a close linkage of community-based programmes with complementary school-based programmes, with programmes directed at those who have left or do not attend school, and the health care system
• the involvement of young people themselves in the planning and implementation of programmes, to the greatest extent possible.
A strategy for enhancement of the health of young people and their communities that is gaining increasing recognition is that of primary health care (PHC) carried out with the participation of the young. In many countries more than half of the population are under the age of 25 years, and they constitute a formidable workforce that can be harnessed for health action and become converts to the philosophy of Health for All. The widespread adoption of primary health care by countries all over the world has encouraged the delivery of health-related services in non-institutional settings by non-medical personnel. This has opened the door for organizations other than those for health, including some with a large youth membership, to explore new ground. The philosophy of primary health care, which emphasizes the sharing of responsibility for health protection among individuals, the community, and health workers complements that of interdependence and self-reliance promoted by many youth organizations.

Meeting youth development needs through participation

Many national and international bodies working with young people emphasize community service as a major programme activity, regarding it a priceless opportunity for young people to develop a sense of civic responsibility. Activities undertaken in a comradely atmosphere with peers provide a propitious occasion for the acquiring of social skills. Young people and adults working as partners build foundations for joint action based on their respective strengths and competence. Such experiences affirm the value of the young in the eyes of adults and increase mutual respect and understanding.
There is a deep-felt need in human beings to nurture as well as to be nurtured. Indeed, part of the passage to adulthood involves channelling the drive to be counted as a useful and caring human being, particularly before mate selection and family formation begin. Nurturing behaviour can be tested and enhanced within the context of real relationships formed during the carrying out of community health activities.

By encouraging the involvement of young people in community health activity, the validity of experimental learning as an aspect of self-help is reinforced. The opportunity to arouse the enthusiasm and energy of the young so as to change their environment fosters an approach to dealing with the problems and conflicts of life in a constructive manner. The healthy young person is one who is able to realize his or her potential for personal growth while contributing to the community.

Young people are often willing to volunteer time for health action, thinking that the experience can further their aspirations for the future. Indeed, by exercising responsibility and sharing in decision-making important lessons are learned, new skills are attained, and a status is achieved that can contribute to the young person’s acceptance by his or her community on adult terms.

**Encouraging healthy behaviour**

Youth organizations tend to employ a holistic approach to meeting the needs of young people, dealing with problem behaviour relating to, for example, smoking and sexual activity, in a larger context. This is in accordance with the young persons’ own perception of health issues, which are not seen as separate from social and economic circumstances. Adolescence is clearly the time for the acquisition of healthy behaviour and, rather than being targeted as the perpetrators of problems, young people can advocate and exemplify health to their peers and to adults. As the young are often testing experiences new to themselves, it may be easier for them to abandon or modify attitudes and beliefs than their elders can.

Youth organizations can and do play a leading role in promoting education about sensitive topics. They can reveal publicly the health and social problems resulting from lack of information on, for example, sexual behaviour, and they can demonstrate the positive effects of introducing new ideas and approaches, in relation, for example, to changes in traditional values such as those favouring birth spacing, and promoting the status of women.
Health education is often carefully integrated into the programmes of youth organizations, so that young people meeting for reasons having little to do with health incidentally obtain support for dealing with physical, social, and emotional problems in a nonjudgemental and sympathetic environment.

Family life education among teenagers in school
The Young Women's Christian Associations of Trinidad and Tobago and Guyana have developed a project to involve young women in education about "Family Life". As well as informing young people about the negative consequences of sexual activity, the project offers support to teenage mothers and counselling to families where alcoholism, violence, and tension exist.

The YWCA staff carry out the project in conjunction with girls in different schools. They began by encouraging the girls to describe their own problems and discuss them openly, and then undertook a more structured course of sessions in which participants could bring problems before professional speakers and counsellors. Key problems identified include: not receiving sincere and accurate information about sex from parents; the process of personal physical and psychological change; malnutrition among a high proportion of young people.

Young people and Health for All
It goes without saying that the young are the leaders of tomorrow. But by virtue of their numbers and their improved education throughout the world, they are also increasingly becoming the leaders of today.

Almost all countries have youth organizations acceptable to the government that function at community and national level. In addition, there are innumerable welfare organizations with a considerable youth membership involved in development activities. Experience shows that young people who have been active in social and political organizations play an important role in influencing their peers and are perceived as harbingers of social change; and they often go on to become political leaders. Health for All is therefore an especially suitable target for the enthusiasm of youth.
Young people and “Health for All”

The Jatio Tarun Sangua (National Youth Organization) of Bangladesh has been running a primary health care programme in around 1,000 village and urban communities all over the country. The activities are run by young volunteers, some of whom are qualified doctors and teachers, and they focus primarily on health education.

The target population is young people in and out of school (age range 15 – 35 years), and subjects include hygiene and sanitation, good eating habits, late marriage and family planning, anti-smoking and anti-alcohol campaigns. The volunteers organize sporting and cultural activities, as well as providing family planning and health services in some areas.

Some PHC programmes specify a role for young people. Young people's contribution to family life has been adopted as a part of basic MCH strategies in many countries, its starting-point being the traditional role of the older sibling in the upbringing and care of smaller children. Knowledge and techniques acquired in the classroom are taken home and used in the improvement of family nutrition, animal husbandry, and sanitation. Some parents who have not been to school themselves are particularly receptive to new ideas brought home from the classroom. Young people are often indispensable to the functioning of community-based PHC as health aides and handpump caretakers, and they provide valuable labour for the construction of latrines and protected water sources. In addition, they can carry out local surveys to identify children with special problems and those who have not been fully immunized, and they can inquire about the health and social concerns of their peers. By virtue of their contact with the people in their community they can speak on health and development issues through youth and other community organizations. They can be instrumental in changing attitudes in the way health is perceived, protected, promoted, and delivered by creating social motivation and demonstrating acceptance for change.

Prerequisites for the effective participation of young people in health development are sound training, open communication, unambiguous information, a non-judgmental approach and most important of all, flexibility and awareness that much can be learned from young people to themselves.
Boy scout and girl guide health caravans

Over the past several years, members of the Egyptian Federation of Boy Scouts and Girl Guides have been bringing health education and supplementary services to villages in seven governorates. Small groups of well-trained Scouts and Guides, some from medical schools, establish themselves in existing community and youths centres for several weeks and make visits to homes inquiring about the health needs of the children, identifying those who somehow were missed by the national immunization teams, referring them to the centres where basic care can be provided.

This past year, their activities have expanded to include subjects identified by themselves as relevant to their own health concerns. Posters have been made and distributed on the dangers of drug and alcohol use; sports competitions organized between teams of smokers and non-smokers; surveys will be undertaken to enquire about the needs of other young people for information about sexual development and family planning; and, accident prevention strategies are being developed.

While some health and education programmes run by youth organizations have received due recognition by governments, they often do not form part of national health strategies. More attention to their involvement and more resources to deal with it are needed at the international and national levels. Governments motivated to support youth organizations technically and financially through the training and promotion of youth leaders can benefit from the ability of young people to bring about and sustain meaningful changes. Of special importance are increased cooperation and coordination among international health and youth organizations so that resources can be more effectively utilized and management capacity enhanced.

The challenge is that of encouraging young people to become advocates for health in a way appropriate to their needs and perceptions. Whenever their cooperation has been sought, they have responded enthusiastically and with appreciable success. Such success is as important for their own self-esteem and development as it is for the health of their communities.
IMPLICATIONS FOR ACTION

This review of the situation and needs of young people for healthy development shows that, while some progress has been made, much more urgently needs to be done, especially in view of the rapidly changing world conditions. Some of the action needed may be listed:

**Research**
- What are the major areas in which more knowledge is urgently needed, and how are priorities to be assigned?
- What more needs to be known about healthy physical, mental, and social development in the context of each of the world's cultures?
- What are the minimum conditions for such development to take place?
- What is the reality today in each country in regard to the development, state of health, and behaviour of young people?
- Which groups in each society are in most urgent need of help?

**Training and sensitization**
- What skills and knowledge are required for the effective interaction of each of the key groups that work with young people (including young people themselves)?
- What strategies for training are needed to reach them?
- What are the best approaches to be employed?

**Strategies and approaches**
- What is the best mix of policies in relation to helping young people help?
- What are the principles of effective programmes?
- How can an intersectoral approach best be developed?
- How can the participation of young people in the promotion of their own health and that of others be increased?

**Advocacy**
- What changes in outlook and policies are needed in each country to promote the health of young people and in which groups?
- How can changes be brought about within the cultural context and value systems of any given country?

**Evaluation**
- Which policies, laws, and programmes need evaluation?
- How can evaluation best be achieved with the full cooperation of all involved?
SUMMARY

The document has reviewed the health of young people in the world today by examining the ways in which their physical, mental, and social needs are being met. Adolescents and young people are no longer children, but they are not yet adults. They need both support and opportunities to develop their expanding psychosocial and physical capacities and, when given a chance, they make an essential contribution not only to their own healthy development but also to that of society as well. For this purpose good communication between young people and all the key groups of adults who have an influence on their lives is important, especially on sensitive issues. Sound education in one generation free from myths and misinformation, will enhance the knowledge of the next generation. Respect for the individual, shown by good listening, builds self-esteem in the young, and is perhaps the most important single factor for healthy development.

To meet the challenges of development young people must be active in mind, body, and spirit. But they run many health risks along the way. Many of the traditional support systems that helped prepare them for adult roles no longer exist, and cultural boundaries are being rapidly eroded through the vastly expanded mass media and travel characteristic of the world today. War, unemployment, and severe competition for education and training levy their toll on the young. Young people are often keenly aware of the major social issues, but it is less common for them to think about specific health issues or the health consequences of their behaviour. There has been a general increase in their use of harmful substances such as tobacco, alcohol and other drugs, to which they are exposed not only through advertisements and entertainment but also by the example set by their elders and by the relatively easy access to such substances. There have also been changes in sexual behaviour especially before marriage, which have resulted in an increase of unwanted pregnancies and sexually transmitted diseases, including HIV infection.

Much of the behaviour of young people during adolescence and youth not only affects their immediate health, as by the increased risk of accident and injury in association with alcohol or drugs, but can also have devastating effects on their health in the years to come. Such conditions as obesity, disease of the gums and the loss of teeth, hypertension, diabetes, infertility, cardiovascular disease, lung and other cancers, and cirrhosis may have their origins in
behavioural patterns during the adolescent years. And the patterns young people adopt will serve as models for their children, thus perpetuating poor health.

Adolescence and youth form an old topic of conversation, but a rather new one for scientific inquiry and for sound action based on knowledge. In the sphere of health, while much progress has been made in disease control, less attention has been given to the behavioural health needs which, as has been shown, are of particular importance for young people. How can the policies and programmes for health that countries adopt best meet the health needs of young people? The health services of most countries cater for the child and the adult, but rarely for the adolescent and young person who have special needs and sensitivities. Policies and legislation in the many different sectors that have an impact on young people’s health — education, employment, social services, youth, culture and sport, as well as health are rarely coordinated in such a way as to provide a systematic approach to young people’s health. Programme action to promote health, prevent problems, identify and reduce risk, and provide care and rehabilitation often originates in many different sectors through both governmental and nongovernmental organizations. To be effective an intersectoral approach is needed, with appropriate flexible referral across the sectors and between all levels. The need for this, however, remains largely unmet in most of the world.

Most young people are resilient, energetic, idealistic, and ready to help others, and millions of young people throughout the world do help others, both inside and outside formal organizations. Youth is a crossroads in life, a time when future directions are determined for better or for worse. Society faces the challenge of providing a basis for the healthy development of the young. They can do the rest.
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