Bali Youth Forum

Staying Healthy

1. **Introduction: What we are aiming for**

**The Goal: All adolescents and youth are empowered with the information, skills, health services, human rights protections, family and social support that they require to avoid ill health and premature death, during their youth and as adults.**

This goal is premised on the human rights of adolescents and youth, including their right to the highest attainable standard of health, among others. It also reflects intergovernmental commitments (see Appendix 1). Achieving this goal is a moral imperative and will also benefit everyone, youth and adults alike, because it is an essential condition for national and global justice, sustainability and prosperity.

Today’s adolescents and young adults, ages 10 to 24, are one of the largest generations ever. Nearly 2 billion strong, they are over one quarter of the global population. About 90% of them live in low- and middle-income countries. Most are healthy compared to other age groups, but they also face risks as they mature, explore the world around them and develop new capacities. With knowledge, skills and social support, most adolescents and youth can stay healthy by adopting healthful behaviors and by avoiding risks that would jeopardize their current and future health and longevity.

Unfortunately, many young people, especially those already disadvantaged or marginalized by income and other factors, do not have the support and resources that they require from their families, communities, governments and the international community. The relatively low priority given to the health of adolescents and young adults by the health sector, and by other sectors that are crucial to their health such as education, reflects the fact that most young people are currently healthy. Although important learning has occurred in recent years, especially in the context of HIV and AIDS, data to justify investments in adolescents and youth overall, and in specific interventions to help them stay healthy, are limited. Further, until very recently, global and national health policies, funding and actions have tended to give primacy to communicable diseases, and to technology-based prevention (e.g. immunization) and medical treatment.

Further, countries and the international community have invested relatively little in the underlying determinants of health, including numerous social and economic factors that jeopardize adolescents’ and youth health. Many of the most significant underlying determinants of[[1]](#footnote-1) poor health among adolescents and youth, such as discrimination based on gender, sexuality and age, are embedded in societal norms, attitudes and political institutions that commonly give little respect to, or protect, the human rights of adolescents in particular. Communities and families are often reluctant, or find it difficult, to respect adolescents’ human rights and their evolving capacities to take decisions, or to assist young people to resist social and economic pressures to act in ways that harm their health.

Finally, some of the main challenges to health in adolescence and young adulthood are behaviors that are particularly complex to address because of contradictory forces, such as pressure from peers and social taboos that obstruct adolescents’ and youth access to the information and services that they need, among other factors:

1. Unsafe sexual activity especially of adolescents, the unmarried and sexual minorities;
2. Use of tobacco and misuse of substances such as alcohol and psychoactive drugs;

harmful eating patterns and inadequate physical activity;

1. Unintentional injuries and violence and other risk-taking such as unsafe driving.

Further, many of these can be both a cause and a consequence of neuropsychiatric disorders especially depression which are highly prevalent among young people.

Fortunately, these health challenges can be largely prevented and the underlying determinants addressed. With political will and leadership, backed by community and youth participation, the necessary laws, policies and programs can be developed to ensure that adolescents’ and youth have access to full and accurate information relevant to health and sexuality; to provide opportunities for skills building; and to make health and other supportive services available and accessible.

Such laws, policies and programs must meet the diverse capacities and requirements of younger adolescents (ages 10-14), older adolescents (15-19), and young adults (20-24), both males and females. They must be responsive to gender differences and other characteristics, such as residence (including not only rural-urban but also conflict and humanitarian situations), income, and marginalization, among others. The health sector itself can remove barriers such as regulations and practices that exclude adolescents, the unmarried and sexual minorities from sexual and reproductive health information and services; payment requirements; unsuitable hours and location of health services; or inadequate provisions for privacy and confidentiality, among others.

As important, the social and economic determinants of poor health in adolescence and young adulthood, including violations of their human rights, can be addressed by many sectors including education, justice, labor, youth and women, among others. Priority actions include, among many:

1. Eradication and mitigation of harmful practices, including both traditional ones such as early and forced marriage, and newer ones such as bullying and harassment using the internet;
2. Elimination of discrimination, especially by sex, in key sectors such as education and employment;
3. Prevention and mitigation of sexual coercion and violence, particularly, but not only against girls and young women;
4. Poverty reduction;
5. Curtailment of commercial promotion of harmful products to adolescents including foods high in sugar and fats, tobacco, and alcohol.

 II. Who we are talking about

Comprehensive analysis of mortality and disease burden in the age group 10 to 24 estimates the Global Burden of Disease (GBD) by WHO region, using cause-specific Disability Adjusted Life Years DALYS) for the year 2004. This methodology encompasses both Years of Life Lost (YLL) to premature mortality and Years of Life Lost to Disability (YLD). Worldwide, the 10-to-24 age group is described as follows:

* Portion of Global Burden of Disease: An estimated 15.5 percent of the global burden of disease is carried by young people ages 10 to 24. 93 percent of this burden is in low and middle-income countries, with over half of it in Africa and South Asia alone
* The leading risk factors worldwide for incident DALYS in this age group: alcohol and other drug use, unsafe sex, and iron deficiency.
* Main causes of global DALYs in this age group: neuropsychiatric disorders in particular uni-polar depression, and unintentional injuries (12%).
* Main causes of disability globally: neuropsychiatric disorders including substance misuse; unintentional injuries (mainly from road traffic accidents); infectious (such as HIV) and parasitic diseases; maternal conditions; diseases of the sense organs (especially vision impairment, corrected by the provision of glasses); and respiratory disease (particularly asthma, in high-income countries).
* Similarity and difference between high and low-income countries: Both low and high-income countries have high burdens of disability in this age group, but the mortality burden is much higher in low-income countries.
* Differentials by age group and sex: Across regions, the disease burden more than doubled from the level in those aged 10–14 years to the level in those aged 20–24 years. There is a clear increase in disease burden from injuries in men aged 20–24 years, whereas the disease burden in women, in this age group is increased by maternal conditions, particularly in Africa, south East Asia, and the eastern Mediterranean, and by communicable disease in Africa.

III Main risks and challenges to be addressed

Based on knowledge of the main risks and challenges that adolescents and youth face to staying healthy, this section emphasizes three of the main actions that adolescents and youth can and need to take to protect their health now and for the future, especially in countries and communities worldwide: practicing safe sex, adopting healthy life styles, and avoiding other risks to health. Each of the sub-sections provides data on the health challenge and suggests the supportive actions that families, communities and nations need to take. This paper names, but does not elaborate the actions needed to reduce and eliminate the underlying determinants of adolescents’ and youth health (education, employment/livelihoods, political/civic participation, etc.) because other papers for the Global Youth Forum do this.

1. **Practicing Safe Sex**: This section briefly describes the pattern of unsafe sex among adolescents and youth and its implications for their health and for the global burden of disease. The section briefly describes the little that is known about utilization of health services, particularly sexual and reproductive health services, by adolescents. It comments on their access to health information, sexuality education and skills building for health.

**The extent and consequences of unsafe sexual activity**:

Adolescence marks a stage in the life cycle when adolescents and youth begin to form their identities, attitudes, and beliefs, as well as relationships. With the onset of puberty typically occurring between the ages 10-14 years, adolescents become curious about sexuality and sexual and reproductive health issues, making early adolescence a pivotal time to learn about these issues through comprehensive sexuality education and other appropriate means. Yet too often, adolescents lack the relevant information, education, and services that protect their sexual and reproductive health. They may engage in unsafe sex with dire consequences, or be compelled into situations that put them at risk, including early pregnancy and childbearing, violence and sexual coercion, and HIV infection.

Adolescent pregnancy and childbirth is associated with great health risks for girls: complications of pregnancy and childbirth are the leading cause of death among adolescent girls aged 15-19 in developing countries. About 16 million girls aged 15-19 give birth each year; in nine out of ten of these cases, the girl is already married. Child marriage marks a violent and abrupt initiation into sexual relations for these girls, who are often married to bridegrooms who are much older. In 2010, one in three young women aged 20-24 (34 per cent, or 67 million) were married by age 18; half were in Asia, one-fifth in Africa. If present trends continue, 142 million girls will be married by their 18th birthday in the next decade; this translates into 14.2 million girls married each year, or 37,000 girls married each day.[[2]](#footnote-2) Most adolescent girls, whether married or unmarried, give birth with insufficient information, health care, and support; some key risks they face include prolonged labor, obstetric fistula, post-partum infection, HIV and mother to child transmission.[[3]](#footnote-3) Adolescent girls and young women also face high levels of morbidity and mortality as a result of unsafe abortion. In 2008, there were an estimated 3 million unsafe abortions in developing countries among girls aged 15-19.[[4]](#footnote-4)

Some adolescents do not know how to avoid becoming pregnant, or are unable to obtain contraceptives. However, even where contraceptives are widely available, sexually active adolescents are less likely to use contraceptives than adults. In Latin America, Europe and Asia only 42-68 per cent of adolescents who are married or in partnerships use contraceptives; in Africa the rate ranges from 3-49 per cent.[[5]](#footnote-5)

In 2010, young people aged 14-24 accounted for 42 per cent of new HIV infections in people aged 15 and older. Among young people living with HIV, nearly 80 per cent live in sub-Saharan Africa. Globally, young women aged 15-24 have HIV infection rates twice as high as in young men, and account for 22 per cent of all new HIV infections and 31 per cent of new infections in sub-Saharan Africa.[[6]](#footnote-6) Coverage of the MDG indicator on the use of condoms among young people aged 15-24 at last high-risk sex varied across regions; in many countries the rates of condom use at last high-risk sex were generally less than 50 per cent, with notably lower rates or use reported by females compared to males.[[7]](#footnote-7)

Across all economic strata around the world, adolescent girls and young women live under the threat of sexual violence and abuse. It is estimated that up to 50 per cent of sexual assault cases are committed against girls under age 16. Globally, the prevalence of forced first sex among adolescent girls younger than 15 years ranges between 11-48 per cent.[[8]](#footnote-8)

**Utilizing SRH services** by age and sex, region: Note the lack of published service statistics by the three age groups we are interested in; limited research on utilization of services by adolescents and on the several barriers.

There is a lack of internationally-comparable data on health service utilization by adolescents and youth. Nonetheless, experiences from countries show that the main barriers are:

1. Laws and regulations excluding young and/or unmarried people from services, or limiting particular services to which they can have access, or requiring adult consent for their use of services;
2. Lack of health services overall, including sexual and reproductive health services as well as mental health services;
3. Health providers’ attitudes and practices which can be highly judgmental, and fail to protect young people’s privacy and confidentiality;
4. Inadequate supply of drugs and commodities, including emergency contraception, female and male condoms or post HIV exposure prophylaxis, as well as lack of support for positive health behaviors including, for example consistent condom use or ARV adherence, among others;
5. Other aspects of services including location and hours of services; and
6. Stigma, discrimination or human rights violations by families, and communities.

These constraints on young people’s ability to stay healthy have been recognized in intergovernmental agreements, by many countries and by the international community as problems to be urgently addressed by the health sector and others. Efforts are underway in many countries to provide adolescents with the services they need delivered in a friendly manner. There are also complementary efforts to increase community support for the provision of health services and adolescent demand for them.

From these efforts and from research projects there is a growing understanding of the barriers that adolescents face in obtaining health services and what they perceive to be friendly health services. There is also growing evidence of effective ways of increasing the use of health services by different groups of adolescents - by making health workers and health facilities adolescents friendly, by generating community support and by informing and involving adolescents in the provision of health services. However, we still do not know how to do this at scale and in a sustained manner, in low-resource settings. And more importantly do this in a way that protects and safeguards the human rights and agency of adolescents.

**Accessing and acting on health information and education**: It is widely agreed that adolescents have a right to and require information about the physical, psychological (emotional and cognitive), and social changes they will experience as they mature so that they can manage them in healthful ways. They need and have a right to know about, develop skills for, have access to healthy food and recreation that will help ensure that they enter adulthood at a healthy weight, without dependence on tobacco or other substances, and with habits of eating and exercising that will help keep them healthy throughout life. They must also have comprehensive sexuality education (information and skills building) from a young age so that they can understand, manage and make decisions about the feelings, relationships, and physical and emotional developments that all adolescents and youth experience in the realm of sexuality and interpersonal relationships. Adolescence is also a critical time for the development of commitment to and skills for gender equality and respect for human rights.

The scientific evidence indicates that curriculum-based, comprehensive sexuality education programmes, that include both abstinence and risk reduction strategies, and that replicate the characteristics of evaluated sexuality programmes are effective in increasing knowledge, clarifying values and attitudes, increasing skills and impact on sexual behaviour.. [[9]](#footnote-9),[[10]](#footnote-10)

Based on such evidence, education on sexuality is becoming increasingly accepted[[11]](#footnote-11) as the way to meet adolescents’ and youth’s right to and need for accurate, complete, non-judgmental and timely information and education on health and on sexuality. Where it is available,it rarely has the breadth of content, the quality of delivery, or the scale that has been agreed in intergovernmental negotiations, by health and education ministers and by youth themselves.

As a result, very few young people have even the most basic information that they require. For example, according to the most recent population-based surveys in low- and middle-income countries, only 24% of young women and 36% of young men have an adequate knowledge of HIV prevention and transmission.[[12]](#footnote-12) In all countries that have conducted surveys of young women, knowledge of three or more modern contraceptive methods is lower than knowledge of any one modern method. Significant regional variations exist. About 80 percent or more of young people know of three or more modern methods in most countries outside sub-Saharan Africa but, within sub-Saharan Africa, at least 80 percent of young women know of three or more methods in only 5 of 20 countries and of young men in only 4 of 19 countries. [[13]](#footnote-13).

The Global Youth Forum paper on education includes information about comprehensive sexuality education, which can be provided in or out of schools for children, adolescents and youth who are enrolled in school and out of school for those who have finished school or dropped out. Generally, the most effective training and curricula are the products of collaboration between health and education professionals, NGOs and government ministries.

**B.** **Adopting Healthy Life Styles:** The four main risk factors for the increasing occurrence of non-communicable diseases in adulthood are behaviours adopted during adolescence: tobacco use, harmful use of alcohol, unhealthy diet, and inadequate physical activity. While it was thought for years that these diseases occur primarily in affluent countries and populations, today poor people and poor countries bear the main burden of these risk factors and their consequences.

1. *Tobacco*: The vast majority of tobacco users worldwide begin during adolescence. Today more than 150 million adolescents use tobacco, and this number is increasing globally. Data on tobacco use in the past 30 days were available in 62 countries, representing 45% of the worldwide population of young people. Rates of early tobacco use were high in Austria, Chile, Malta, and Namibia in both boys and girls and in boys in Indonesia, Jamaica, and Jordan. In the European regions, Latin America, North America, and many sub-Saharan African countries, rates of tobacco use were similar for boys and girls. In most Asian regions, the Caribbean, and the eastern Mediterranean rates were higher in boys.[[14]](#footnote-14)

Bans on tobacco advertising, raising the prices of tobacco products, and laws that prohibit smoking in public places reduce the number of people who start using tobacco products. They also lower the amount of tobacco consumed by smokers and increase the numbers of young people who quit smoking.

1. *Alcohol*: Harmful levels of drinking among young people is an increasing concern in many countries because it reduces self-control, increases risky behaviours, and is a primary cause of injuries (including those due to road traffic accidents), violence (especially domestic violence), and premature deaths. Data on binge drinking in the past month were available for 51 countries and 17% of the worldwide population. Rates are substantially higher for children aged 15 years than for those aged 13 years. In general, estimates for binge drinking from high-income countries were substantially higher than those for low-income and middle-income countries, with the exception of some Latin American countries. Austria, Ireland, and the USA had the highest rates with close to a third of children aged 15 years reporting binge drinking in the past month[[15]](#footnote-15). Regulating access to alcohol is an effective strategy to reduce harmful use by young people. Bans on alcohol advertising can lessen peer pressure on adolescents to drink.
2. *Obesity*: During adolescence, people gain up to 50% of their adult weight, more than 20% of their adult height, and 50% of their adult skeletal mass. Girls tend to gain relatively more fat, while boys gain relatively more muscle. Caloric and protein requirements are high in adolescents because of increased growth and physical activity and other considerations such as menstruation and pregnancy. At the same time, poor eating habits are common among young people.

The consequences of childhood and adolescent overweight and obesity are serious. Being overweight or obese increases the risk for heart problems, high blood pressure, and other medical problems and the psychological impact of being overweight can be devastating. Nearly 3 out of 4 obese adolescents will remain so as adults.

Data on children aged 13–15 years who were overweight were available for 71 countries. In higher income countries, rates of overweight were substantially higher in boys than girls. Canada, Greece, Italy, Malta, and the USA were notable for their high rates, particularly in boys—more than a third were overweight. Within low and middle-income countries there was substantial variation in rates of overweight, with the lowest rates in Burma, Malawi, Mongolia, Pakistan, and Sri Lanka. Many low-income and middle-income countries had substantial rates of overweight, with China, eastern Mediterranean countries, Latin American countries, Mauritania, Oceania, and Thailand having between a fifth and a third of boys overweight. Tonga had the highest rates of overweight with about 60% of children aged 13–15 years fulfilling the criteria[[16]](#footnote-16).

1. *Inadequate physical activity*: Data on physical activity (60 minutes or more on each of the past 7 days) were available for 85 countries representing more than half the world population. With the exception of boys aged 13 years in Slovakia, no country had more than 50% of either boys or girls achieve the recommended exercise level. Boys were more likely to fulfil criteria for activity than girls. This sex difference was particularly striking in several countries of North Africa and the Middle East, where very few girls met the recommendations for physical activity. In most countries in which Health Behaviour of School Aged Children surveys have been undertaken, activity levels seem higher in boys aged 13 years than aged 15 years, with boys having higher rates than girls. Rates of physical activity in many high-income countries were low, with Ireland, Slovakia, and the USA having higher rates of low physical activity and Germany, Norway, Russia, and Switzerland lower. Of low-income and middle-income countries India, Lebanon, and Tanzania were notable for their somewhat higher rates of activity.[[17]](#footnote-17)
2. **Avoiding and Reducing Other Behaviors and Risk factors that jeopardize Health:** Today’s adolescents and youth face a variety of social, economic, environmental, media and other forces, including human rights violations (e.g. in access to education, livelihoods, etc.), that lead many toward situations and actions that can harm their physical and mental health and are likely to shorten their lives.

**1. Harmful behaviors**: Among the most pervasive behaviors, by others toward adolescents and youth, and by adolescents and youth themselves, are:

1. *Violence* in and outside the home, including in schools and in youth and other community based programs. Such violence takes many forms, including gender-based, emotional and physical violence, bullying and harassment; sexual coercion including incest, rape and other assault; violence in interpersonal relationships, gang or other group conflict and bullying; and injury and death during the commission of crimes.

Violence is the third highest cause of death in in young people aged 10-24 years world wide, and the second highest cause in males[[18]](#footnote-18) For every young person who dies due to violence, 20-40 are admitted to the hospital.[[19]](#footnote-19) Bullying is widespread. Some examples from recent survey data of the proportion of 13 to 15 year olds (boys and girls) who report having been bullied at least once in past 30 days include 47% in Peru, 48% in the Philippines; 50% in Indonesia; 58% in Ghana, and 61 % in Egypt.

Sexual violence in particular increases during puberty. According to *the Report of the United Nations Secretary-General’s Study on Violence against Children*, “sexual violence predominantly affects those who have reached puberty or adolescence. Adolescent boys are at greater risk of physical violence than adolescent girls, while adolescent girls face greater risk of sexual violence, neglect and forced prostitution”.[[20]](#footnote-20)

Violence has serious consequences on the individual, including post-traumatic stress disorder, depression, suicide; high-risk health behaviour such as smoking, alcohol, drug misuse and also physical inactivity, obesity. Being a survivor or perpetrator of violence has long term consequences such as reduced productivity of the individual, costs incurred by the justice, health and social welfare systems. No single intervention or single sector can address all forms of violence. Multi-sectoral action is needed, starting early and taking a life course approach. It is also important to collect data, identify risk and protective factors, and monitor and evaluate interventions .

1. *Traffic injuries and deaths*: Globally, road traffic injuries are the leading cause of death among young people aged 10-24 years. Each year nearly 400,000 people under age 25 die on the world’s roads – an average of 1,049 a day. Most of these deaths occur in low- and middle-income countries and among vulnerable road users – pedestrians, cyclists, motorcyclists and those using public transport. In high-income countries, most young victims are novice drivers. Youth Delegates from more than 100 countries to the 2007 World Youth Assembly for Road Safety asked other youth as well as adults to promote and take action for safety on the roads.[[21]](#footnote-21)
2. Unsafe working conditions in the formal sector, and in informal workplaces (such as domestic labor or street hawking), include harm from the nature of the work itself, and also increased risk of physical, sexual and emotional violence or harassment. Younger workers are more at risk from serious non-fatal accidents than are their colleagues, due to general lack of work experience and understanding of workplace hazards, as well as a lack of safety and health training and their general lack of physical and emotional maturity. In addition, they may be reluctant to speak out about problems and keen to please their employer. In the European Union, for example, the incidence rate for non-fatal accidents is 50% higher among young workers than among any other age category.

In many countries in Sub‐Saharan Africa and South Asia, youth employed in the informal sector suffer as much or more than adults from the common conditions in these occupations (ILO, 2002) including irregular income, lack of safety and health standards, and distance from family, among others.

2. **Mental illness**: The main cause of DALYs in young people are neuropsychiatric disorders (45%), in particular uni-polar depression. Many of the health issues and their determinants reviewed above can undermine mental health; and poor mental health can undermine physical health, encourage risk taking and culminate in suicide. At least 20% of young people will experience some form of mental illness - such as depression, mood disturbances, substance abuse, suicidal behaviours or eating disorders. Pre-existing mental health problems may get worse during the demanding emotional and physical development of adolescence. For instance, anxieties or phobias may intensify, or symptoms of depression may become more severe. In addition, most mental disorders in adulthood, possibly more than 75%, have their symptomatic onset during youth (15-24 years of age).

 3. **Harmful media and communications** : Globalization, new communication technologies and the associated social networking are changing the lives of many young people. Access to information and communication channels can provide young people with new opportunities to gain knowledge, mobilize and contribute to society as never before. For instance, young people can use mobile telephones or the Internet to find information on health and sexuality[[22]](#footnote-22).Access to such resources, however, remain unequal. Further, these technological developments can introduce new health challenges by encouraging, for instance, dissemination of inaccurate or otherwise harmful content or even social isolation.

1. Addressing these Challenges to Staying Healthy

**Policies, programs and health services, human rights protections, and a positive socio-economic environment are all required to enable adolescents and youth to stay healthy, in particular to delay sexual debut and practice safe sex when they become sexually active; avoid the four main risk factors for NCDs; and resist pressures to behave in other ways harmful to their health.**

Much is already known about what adolescents and youth require to stay healthy, and about the investments that can and should be made even while conducting research to determine what specific strategies work best. This section briefly reviews what can and must be done by the health sector to promote and ensure: health and sexuality education and information for all; readily available, acceptable and accessible health services; and reduction or elimination of “negative factors” (such as harmful practices and violence) as well as the enhancement of “protective factors” such as schooling and economic security. (The other background papers for the Global Youth Forum papers provide focused analysis of the negative (“risk”) and protective factors.)

It is essential that all policies and programs be based on knowledge of the different needs of each age group (10-14, 15-19, 20-24) and of girls and young women compared to boys and young men. Further, research and program experience strongly suggest that including young people in designing, implementing and monitoring health information and services for them increases the likelihood that programs and services will be both attractive to young people and more effective.

1. **Providing good quality health services to adolescents and youth**, **particularly Sexual and Reproductive Health services**

At least four requirements need to be met. In doing so the health sector will be strengthened for everyone, and, as services are utilized for preventive care, future costs to the health sector will likely be reduced. These requirements are:

1. **Improving the quality of care** in sexual and reproductive health services, with a focus on adolescents: The required elements have been laid out in WHO guidelines[[23]](#footnote-23).
2. **Training and supervising staff** to inform and serve young people, especially adolescents;

1. **Managing and financing facilities and services** to meet the particular requirements and constraints of each age group, by sex and other characteristics.
2. **Disaggregating health management information (HMIS)** by the three age groups and by sex at a minimum.

The preferred approach is to strengthen existing health services to meet the requirements of adolescents and youth, while bolster health systems capacities in ways that provide a foundation for providing services to all. Generally, freestanding, specialized services just for adolescents and youth are neither scalable nor sustainable, especially in resource-constrained situations, although some such services can be useful sources of learning and also may be necessary to reach highly disadvantaged or marginalized groups of young people.

B. **Making health services, especially sexual and reproductive health services, more accessible and acceptable to adolescents and youth**

The health sector, using a human rights perspective in all of its activities, needs to address:

1. **Legal and regulatory barriers**: In many countries, access to health services by particular groups is still restricted by law, and/or by health ministry regulations. This is particularly the case in regard to sexual and reproductive health services, such as contraceptives and safe abortion. The health sector can do a great deal to modify its own regulations and procedures in ways that support access to and utilization of health services, particularly sexual and reproductive health services, by adolescents, the unmarried, disadvantaged or marginalized young people, those at high risk of health problems and risk-taking now or in later life, and others with particular needs. For example, policies and criteria for training and supervising health workers can require supportive and respectful service delivery to adolescents, the unmarried and other key groups; drug and commodity approvals and purchasing guidelines can undergird provision of services that are particularly important to young people, including for example, emergency contraception, female as well as male condoms, and post HIV exposure prophylaxis; and relaxation of payment requirements for youth can promote service utilization.. While the role of the health sector in generating supportive laws may be limited, the health sector can and should advocate for legislation that supports universal access to health services, especially sexual and reproductive health services, for disadvantaged adolescents and youth, both married and not married.
2. **Social barriers**: While the health sector cannot itself address all of the barriers and risk factors, it can promote positive community norms and attitudes about the human rights of adolescents and youth in regard to sexuality, marriage, and gender roles; gender equality, nondiscrimination, and the elimination of sexual coercion and violence that put adolescents and youth at risk of poor health. Specific actions include avoidance of gender stereotypes and promotion of gender equality by health personnel and in health information and education materials; advocacy for policies that will encourage later marriage and girls’ education at least through secondary school; among many others.

 The sector can also analyze, and then act on, social factors that constrain use of health services, especially sexual and reproductive health services, by adolescents. It can assess, and develop information and programs to prevent, young people’s exposure to NCD risk factors, such as social and commercial pressures to use tobacco. Similar work can focus on reducing and eliminating other factors reviewed above that jeopardize the physical and mental health of adolescents and youth in local circumstances.

**C. Informing, educating and building the skills of adolescents and young people to stay healthy and to enjoy their human rights**

This section briefly outlines two primary means to enhance adolescents’ and youth’s knowledge and skills about health and sexuality, while also helping create a social climate more conducive to their health and wellbeing. These are comprehensive sexuality education, and other means to communicate with, and encourage communication among, adolescents and youth about their health and human rights.

1. **Comprehensive Sexuality Education**: The development, testing and delivery of comprehensive sexuality education are not detailed here because the paper for the Global Forum on education does that. As noted above, the health sector has vital roles to play in helping to achieve good quality curricula, staff training and supervision, and other practical standards identified in technical guidelines produced by UNESCO. A vital additional element in these programs, not addressed in the UNESCO guidance, is prevention of NCDS. Country-based projects and programmes for adolescents and youth can be promoted and designed by the health sector in collaboration with other sectors such as education and communications. Promotion of healthy life styles, and opportunities to develop decision making among adolescents and youth will help them stay healthy and reduce their risk of NCDs in adulthood. Another critical role of the health sector is to work with these and other youth programmes to ensure effective referral mechanisms and direct access for the participants to good quality health services as described above.
2. **Other ways for adolescents and youth to obtain information and skills:** Many channels already exist, and new ones frequently emerge for communication among and with adolescents and youth. These could be far better utilized to disseminate health and sexuality information and encourage healthful behaviors, as well as facilitate utilization of health services, among young people. Examples include social media of many kinds, peer-to-peer outreach, inter-active internet information sites, among others.

In addition to media innovations, considerable investment has been made, for example, in “peer educators”[[24]](#footnote-24) for sexual and reproductive health. Overall, these programs have not been effective and can be counterproductive if the peer educators provide incorrect or incomplete information, or go beyond the topics in which they have been trained. When supporting young people to reach out to other youth it is essential to provide clear guidance and strong supervision on what information to provide, and how to respond to questions and debate, as well as strong back-up from and referral to professionals and health services.

**D. Development and enforcement of policies and legislation to enable adolescents and youth to reduce their risk of NCDs**

Policies and legislation to protect adolescents from harmful high levels of saturated fats, trans-fats, sugar and salt, are the cornerstones of national programs to respect and fulfil adolescents’ rights and prevent behaviors that increase the risk of NCDs. Policies must target product design, advertising, marketing, sponsorship and promotion of harmful substances to youth. Increasing taxes on unsafe products such as tobacco is another way to decrease demand, especially for adolescents who are particularly sensitive to price increases. Policies and legislation can limit young people’s access to, and use of such products by creating and enforcing a minimum age of purchase, for example, on tobacco and alcohol and by mandating public places, schools and other places where adolescents congregate be 100% smoke and alcohol-free[[25]](#footnote-25).

**E. Ensuring young people’s effective participation in policy making, program implementation and communication**

As noted above, many intergovernmental agreements, including the ICPD Programme of Action and, most recently, the Resolution of the 2012 Commission on Population and Development, recognize that young people have a right to participate in decisions that affect them, and that policies and programmes are much more effective with their full and meaningful participation. At the same time, young people are mobilizing in virtually every country, and they are building both skills and organizations to represent them. The increased political commitment, as well as financial and human resources, described below, will ensure that the largest ever generation of adolescents and youth have an effective voice in decision-making and can hold all stakeholders, including themselves, accountable for progress.

Effective youth participation requires that those who control decision-making create opportunities for that participation, and also provide the financial and human resources required. In a wide variety of settings, decision makers and gatekeepers, from families to the highest levels of national power and intergovernmental decision-making, have provided access to decision making with beneficial effect. **Investments are being made and must be greatly expanded in three areas**: young people’s capacity to advocate and to participate in policy and program deliberations; their ability to communicate fully and effectively with each other regarding their health, among other issues; and leadership and organizational development for those whom young people trust to represent them.

1. **Advocacy and information sharing by youth for their health and human rights:** Experience shows that those who make decisions must “open their doors” to youth; provide them with full, accurate and timely information and materials on the issue being decided; and assist them to develop skills and experience in policy and program analysis as well as in advocacy and negotiation. This requires time and resources from everyone involved. Young people should not be expected, nor is it possible for them, to “participate” without financial and human resources as well as access.
2. **Communication with and among adolescents and youth:** The continuing revolution in communications technologies offers previously unimagined opportunities for youth to communicate with each other, to provide information in ways that are appealing, and to build consensus and mobilize. But such opportunities will only be realized if two conditions are met: supportive and knowledgeable adults collaborate with young people on content and methods of communication; and funding is made available. In addition, as revolutionary as virtual communication is, opportunities for young people to meet and work directly with each other are also vital, particularly for building trust and identifying leaders.
3. **Youth leadership and organizational strengthening:** An important challenge is to identify, and then to make sustained financial and other investments, in leaders and organizations that are trusted by adolescents and youth to represent them in all their diversity even while young people are constantly entering and leaving the age group. Effective approaches to date to meet this challenge include: investment of time and effort by the gate keepers to meet and dialogue with young people of all backgrounds;decision-making with them about where to invest and whom to support; inclusion of “retired” youth who have aged out but have expertise and knowledge to share while also helping to build the next generation of leaders and organizations.
4. **Conclusion**

Staying healthy requires joint actions by adolescents and youth, families and community institutions especially schools and the media, and the public health system. The inputs that adolescents and youth require are known, and much has been learned about how to deliver them effectively, particularly at small scale. The priority challenges to address now include:

1. Greatly expanding financing and national capabilities to provide health and sexuality good quality, human rights-based information, education and services to all adolescents and youth, with priority to those who are disadvantaged in various ways;
2. Increasing investments and actions by the health and other sectors to create an enabling social environment in which adolescents and youth can stay healthy; and
3. Ensuring that diverse and representative adolescents and youth have an effective voice on health policies and programs in every country and in global arenas.

**Appendix 1: Summary of Committee on Population & Development 2012 Resolution on Adolescents and Youth**

1. Calls on governments to take into account the implications of their population age structure in medium and long-term planning and make youth development a priority across all sectors;
2. Urges governments to protect the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence, and regardless of age and marital status;
3. Urges states to invest in multiple actions to improve opportunities for young people to gain access to productive employment and decent work, making links with education and training policies, among others, and taking into account gender equality and the empowerment of women;
* Urges all states, and calls upon governments, with the full involvement of young people, to meet the sexual and reproductive health service and information needs of adolescents and young people and, in so doing, to safeguard their rights to privacy, confidentiality, respect and informed consent;
* Calls upon governments to provide young people with evidence-based and comprehensive education on human sexuality, sexual and reproductive health, human rights, and gender equality;
* Calls on governments to pay particular attention to adolescents and youth, especially girls and young women, in scaling up HIV prevention, treatment, care and support, and provide comprehensive information, voluntary counseling and testing to adolescents and youth;
* Urges governments to eliminate harmful practices such as early and forced marriage, female genital mutilation, and other violations of girls’ and women’s human rights, and to enact and enforce laws and take other measures in this regard; and
* Calls upon and encourages governments to support and invest in effective youth participation including in decision-making.
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