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Adolescent Health and Development (AHD)

A Resource Guide for World Bank Operations Staff
and Government Counterparts

James E. Rosen

April 2004



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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

ADOLESCENT HEALTH AND DEVELOPMENT (AHD) *A Resource Guide for World Bank Operations Staff and Government Counterparts*

James E. Rosen^a

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The AHD Resource Guide was prepared by the Health, Nutrition and Population unit in the World Bank's Human Development Network with input from a wide range of colleagues and institutions. It responds to the request for greater information on AHD from Bank staff and country clients. We acknowledge the generous support of the Dutch government for the development of the guide.

Abstract: This resource guide begins with an overview of AHD issues, laying out the case for governments to direct attention and resources to AHD. It discusses good practices to improve a range of youth health outcomes. The next section focuses on the relationship between poverty and young people's health and outlines strategies to provide health services to poor youth. The final section of the guide examines the current efforts of the World Bank to promote AHD. Technical appendixes provide further examples and concrete information for use in project design and analysis. More information will be found on the Bank's AHD website, which is currently under development.

The guide supports the effort to better integrate adolescent health and development (AHD) concerns into the analytic and lending work of the World Bank. It also has been created to give Bank staff members essential information with which to engage their counterparts in policy dialogue on AHD and to advocate for greater government attention to the needs of youth. Increasing the effectiveness of Bank efforts directed at AHD will help the Bank to improve the health and well-being of youth in developing countries. The main audience for the guide is Bank operations staff members and government counterparts associated with poverty reduction strategies and human development sector projects. External Bank partners and other organizations interested in youth may also find the guide useful.

Keywords: adolescents; development; poverty; health; early marriage; Millennium Development Goals.

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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ACRONYMS AND ABBREVIATIONS

AHD	Adolescent health and development
AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
CAS	Country Assistance Strategy
DALY	Disability-adjusted life year
DHSP	District Health Services Pilot Project
DOTS	Directly Observed Treatment, Short Course
FRESH	Focusing Resources of Effective School Health
GRSP	Global Road Safety Partnership
HIV	Human immunodeficiency virus
HNP	Health, Nutrition, and Population
IEC	Information, education, and communication
IPT	Intermittent preventive treatment
MAP	Multi-country AIDS Program
MDG	Millennium Development Goal
NGO	Nongovernmental Organization
PRSP	Poverty Reduction Strategy Paper
SMASH	Social Marketing for Adolescent Sexual Health
RH	Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary counseling and testing for HIV
WHO	World Health Organization

FOREWORD

With the World Bank in the process of crafting its first-ever comprehensive strategy on children and youth, this publication comes at a critical time for the Bank and its clients. In its current form, the strategy places healthy behaviors of young people squarely in the forefront of concerns for the Bank. Youth in particular is a new area of focus for the Bank, and the guide and children and youth strategy address adolescent health in an integrated way.

The international community is increasingly recognizing the importance of young people—the “largest generation ever,” now numbering 1.7 billion—to health outcomes and to achievement of important development goals. Many of the Bank’s client governments are showing heightened interest in meeting the needs of the adolescent age group, not only in the health sector but in related areas such as education and employment that are all key to reducing poverty and accelerating progress in achieving the millennium development goals (MDGs).

By refocusing attention on the health needs of this age group, the Bank is following the lead of many of its most important partners on global health issues. For example, the World Health Organization, in its recent policy note, *Strategic Directions for Improving the Health and Development of Children and Adolescents*, highlights actions to meet adolescent health and development needs.

This focus on adolescents and youth is necessary, because of the mistaken perception that adolescence is a relatively healthy period of life. If we look only at the disease burden during the adolescent years, adolescents do appear relatively healthy compared to vulnerable groups such as small children and the elderly. However, taking a broader look at risk behaviors and their impact on the health of adults, a different picture emerges. As shown in the WHO State of the World’s Health 2002, over one-third of the disease burden and almost 60% of premature deaths among adults can be linked to behaviors or conditions that were initiated or occurred during adolescence, for example, tobacco and alcohol use, lack of exercise, poor eating habits, and risky sex and sexual abuse. Thus, it makes sense for countries to focus attention on both the diseases of adolescence and on risk factors that have their roots in adolescence. It is encouraging that the vast majority of this disease burden is preventable using cost-effective strategies. Waiting to act will prove far more costly to societies.

Nowhere is this more apparent than in the battle against HIV/AIDS. As the statistics demonstrate, the centrality of young people in beating back this terrible epidemic is now unquestioned. With more than one billion dollars now committed to fighting AIDS through the multi-country AIDS program (MAP) and other instruments, the World Bank has an unprecedented opportunity to help countries address the youth dimension of the epidemic.

This Guide helps to illuminate connections among the various important areas of adolescent health that are also tied to major health problems worldwide, including early pregnancy, smoking, road safety, and malaria. The Guide complements other World Bank lending and analytical work to support investments in youth. The chapter on adolescent health and poverty shows how the poverty-health quintile analysis pioneered by the Bank can be applied to the adolescent age group. The work also complements World Bank-sponsored analyses of investments in the youngest citizens—infants and children.

Our hope is that World Bank staff, counterparts in client countries, and the development community at large are able to use and benefit from this guide.

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Special thanks goes to Nandini Oomman for her analysis of poverty and health, which section 4 and Appendix G draw on extensively; to Manju Rani for adolescent-specific tabulations of the Demographic and Health Survey data on poverty and health status, which underpin the analysis in section 4 and in Appendix G; to Mary Gawlik for her fine editing; and to Doris Toolanen for her initial work on the mapping of Bank efforts in adolescent health and development and on some of the case examples presented in Appendix A.

The author of this Report is grateful to the World Bank for having published the Report as an HNP Discussion Paper.

I. INTRODUCTION

1.1 WHY A RESOURCE GUIDE ON ADOLESCENT HEALTH AND DEVELOPMENT?

In recent years, much has been written about young people, their needs, and strategies to meet those needs. In part, this literature reflects a growing recognition that governments must address the concerns of young people before their lives spiral downward in a cycle involving poor health, risky behaviors, violence, and poverty.

This resource guide supports the effort to better integrate adolescent health and development (AHD) concerns into the analytic and lending work of the World Bank. It also has been created to give Bank staff members the essential information with which to engage their counterparts in policy dialogue on AHD and to advocate for greater government attention to the needs of youth. By increasing the effectiveness of Bank efforts directed at AHD, the Bank will meet its ultimate goal in this area to improve the health and well-being of youth in developing countries.

The main audience for the guide is Bank operations staff members and government counterparts associated with poverty reduction strategies and human development sector projects. External Bank partners and other organizations interested in youth will also find the guide useful.

1.2 WHAT DOES THE RESOURCE GUIDE CONTAIN?

The resource guide begins with an overview of AHD issues, including laying out the case for governments to direct attention and resources to AHD. It then discusses good practices to improve a range of youth health outcomes. The next section focuses on the relationship between poverty and young people's health as well as outlines strategies to provide health services to poor youth. The final section of the guide examines the current efforts of the World Bank to promote AHD. Technical appendixes (see Appendixes A–H) provide further examples and concrete information for use in project design and analysis. The print version of the guide is meant to accompany the Bank's Web site on AHD, which is currently under development. The Web site expands on much of the information available in this print version and includes more in-depth examples and practical guides for including AHD in policy documents such as the Country Assistance Strategy (CAS) and the Poverty Reduction Strategy Papers (PRSPs).

1.3 INTERSECTORAL CONNECTIONS

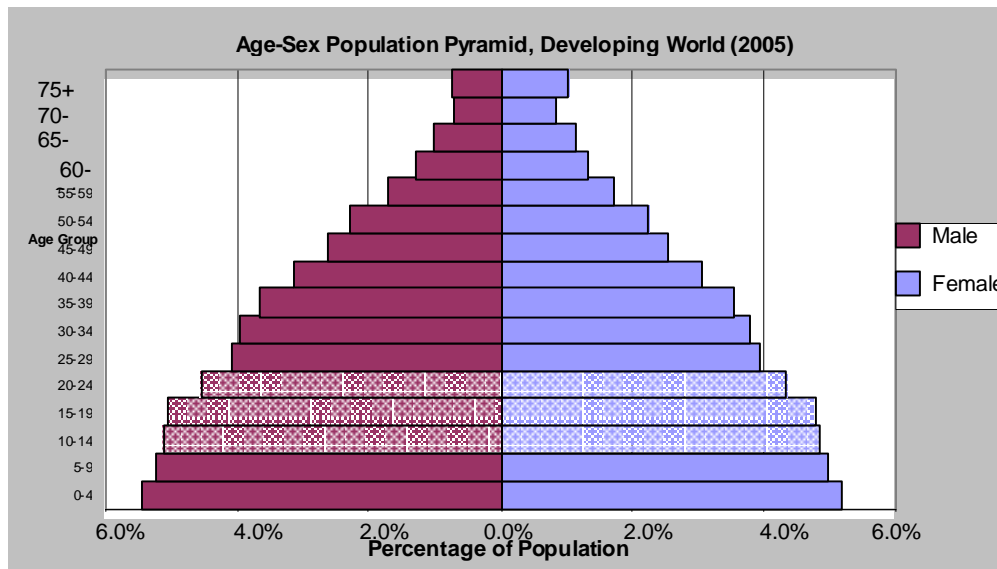
Health is just one of many interrelated areas of youth development on which the World Bank focuses. The extensive efforts of the Bank on behalf of youth encompass a long list of work in the education and social protection sectors. All of these efforts are designed to help young people not only become problem free but also develop fully into caring, committed, and connected people with the skills they need to succeed in life. Information on this work can be found in other Bank publications (see Appendix B, Key Readings and Web Resources) and on the Bank's Children and Youth Web site (www.worldbank.org/childrenandyouth).

II. OVERVIEW OF ADOLESCENT HEALTH AND DEVELOPMENT ISSUES

2.1 WHO ARE YOUTH?

More than a quarter of the world's population is between the ages of 10 and 24 years. Most (86%) of the world's 1.7 billion young people live in developing countries where they often make up 30% or more of the population (see Figure 1). Box 1 provides insight about how this group is described.

Figure 1: . Projected age-sex population pyramid, developing world, 2005.



Source: Population Division, 2002.

Box 1 Defining Adolescence and Youth

Few societies agree on the boundaries of adolescence because most societies define adolescence in terms of both age and life circumstance, and thus, the meaning of the terms *adolescent*, *youth*, and *young person* vary across countries. Political considerations or the availability of data for certain ages also can determine how societies define *youth*. In Bolivia, for example, the President's Decree on Youth issued in 1999 defines *youth* as those people between 18 and 30 years old. Other countries have narrower or broader age ranges. Internationally, one can find some agreement on definitions, spearheaded by the World Health Organization, which defines *young people* as persons in the 10–24-year age group and combines *adolescents*, ages 10–19, and *youth*, ages 15–24. Rather than adhere to a strict definition of the age range, this resource guide uses the terms *young people*, *youth*, and *adolescents* interchangeably to refer to the 10–24 age group. This broader use of the terms underscores the need for policies and programs to focus less on age and more on recognizing the specific developmental needs of people as they transition from childhood to adulthood.

2.2 WHY ADOLESCENT HEALTH AND DEVELOPMENT IS IMPORTANT

As children mature into adults, they must acquire a range of interrelated knowledge and skills that will allow them to lead fulfilled and productive lives. These skills are critical to helping young people stay healthy, learn, obtain a job or livelihood, and participate fully in society. The following sections describe key issues that highlight the need for a focus on AHD.

Young people face serious health challenges. At first glance, the stage of youth appears to be a relatively healthy—although not hazard-free—period of life. Young people account for 15% of the disease and injury burden worldwide, and more than 1 million die each year, mainly from preventable causes (WHO, 1999). Nonetheless, roughly 70% of premature deaths among adults can be linked to behavior that was initiated during adolescence, for example, tobacco use, poor eating habits, and risky sex (WHO, 2001a). In particular, young people are affected by the following serious health challenges:

- About half of all HIV infections occur in young people under age 25, with girls disproportionately affected.
- On average, one-third of women in developing countries give birth before age 20; a large proportion of these pregnancies are unplanned.
- Each year, between 2 million and 4 million adolescents undergo unsafe abortion (WHO, 2001a).
- Teen mothers are twice as likely as older women to die of pregnancy-related causes (World Bank, 1998), and conditions such as malnutrition place teen mothers' children at higher risk of illness and death (AGI, 1998).
- Nutritional deficiencies such as anemia are widespread in both young men and women. They increase the risks that girls and young women face during pregnancy and childbirth (Delisle, Chandra-Mouli, & de Benoist, 2001).
- Millions of youth die tragically or suffer because of other preventable health hazards such as road accidents, substance abuse, suicide, and infectious diseases such as malaria and tuberculosis (Laloo; 2002; WHO, 2001a).

Adolescent health and development affect economic prosperity. Investing in the health and development of young people not only is the right thing to do but also is the smart thing to do for countries that want their economies to grow faster. The following approaches can lead to effective benefits:

- By reducing HIV infection in young people, countries can lessen the devastating economic effect of HIV/AIDS.
- By encouraging young people to postpone marriage and childbearing, countries can foster a reduction in family size and a slowing of population growth, which, when combined with investments in health and education, can contribute to higher economic growth and incomes (Birdsall, Kelly, & Sinding, 2001).
- By investing in education, health, and other youth-focused interventions, individuals—and societies—can gain benefits that outweigh the costs (Knowles & Behrman, 2003; World Bank, 2002c).

Investing in youth helps break the cycle of poverty. Poverty and inadequate health systems compound the vulnerability of adolescents to sickness and early death. The following facts provide specific examples:

- Poverty is often the root cause when a young person becomes infected with HIV or resorts to unsafe abortion to terminate an unplanned pregnancy.

- A poor teenager is more than three times as likely to give birth as a wealthy teen (Gwatkin, Rutstein, Johnson, Pande, & Wagstaff, 2000).
- Poor health exacerbates poverty by disrupting and cutting short school opportunities, by weakening or killing young people in the prime of their working lives, or by placing heavy financial and social burdens on families.
- Poor youth are particularly vulnerable to sexual violence and exploitation; girls in many countries report having sex in exchange for money or gifts (Shanler, 1998; Weiss, Whelan, & Rao Gupta, 1996).
- Youth from AIDS-affected homes, including 13 million youth under 15 years old who have been orphaned by the disease (UNAIDS, 2002), often have to forgo schooling and other opportunities, which diminishes their livelihood prospects, pushes them deeper into poverty, and increases their own chances of contracting HIV (Rosen, 2001).

Health is a key element of overall youth development. Young people's vulnerability to risky or unwanted sex and other unhealthy behaviors is tied to a host of individual, family, and community factors that influence young people's behavior and that are closely related to economic and educational opportunities. Unfortunately, many youth face an uphill battle to gain the skills and experience they need to compete in today's job market, and many adolescents have limited opportunities for formal education:

- Unemployment rates for youth are typically two or three times higher than for adults, and about 40% of all unemployed people are in the 15–24 age group.
- Although academic enrollment has increased worldwide, many young people still do not enter or complete school. Even for those young people who do attend some school, many fail to achieve basic literacy before dropping out, in large part because of the poor quality of education. Outdated curricula leave students with skills that are largely irrelevant to the modern market economy (World Bank, 1999b).
- In 51 countries, boys are enrolled in schools at higher rates than girls, thus perpetuating gender inequalities. The less schooling a girl has the more likely she is to engage in unhealthy behaviors and to be in poor health (PAI, 1998).

Young people have a right to good health. Young people are entitled to the universal human rights that other age groups enjoy and under which those groups are protected as a result of various international agreements, including the *Convention on the Rights of the Child* (Convention, 1989), the *Programme of Action* of the 1994 International Conference on Population and Development (Programme of Action, 1994), and the *Platform of Action* of the 1995 World Conference on Women (Beijing Declaration, 1995). These rights include the right to marry later and to marry voluntarily. Box 2 lists recent international commitments directed at HIV/AIDS prevention.

Box 2: International Commitments to HIV/AIDS Prevention in Youth

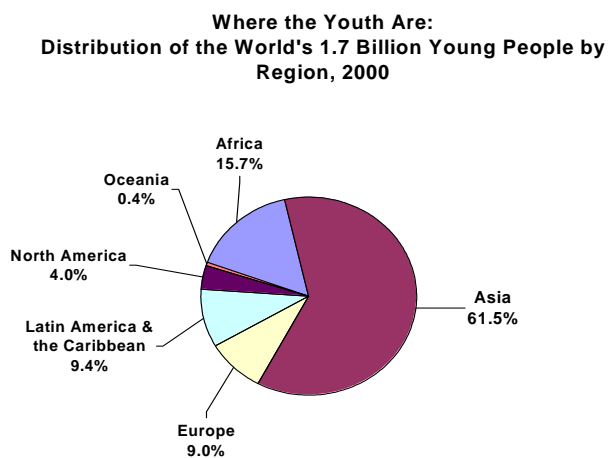
HIV/AIDS prevention efforts increasingly focus on young people. The international community, by means of for as such as the UN Special Session on AIDS in 2001 and the 2002 Special Session on Children, has committed itself to the following (Declaration of Commitment, 2001):

- By 2005, reduce HIV prevalence among young men and women ages 15 to 24 in the most affected countries by 25% and by 25% globally by 2010.
- By 2005, ensure that at least 90%—and by 2010 at least 95%—of young men and women ages 15 to 24 have access to the information, education (including peer education and youth-specific HIV education) and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.

2.3 REGIONAL DIFFERENCES IN YOUTH CHALLENGES

Important regional differences exist in the challenges and opportunities that youth face because of underlying variation in economics, culture, and society (see Figure 2, which shows the regional distribution of the world's young people). For instance, although HIV/AIDS infection is a major problem for young people in sub-Saharan Africa, in South Asia, early marriage combined with health problems such as malnutrition and poor physical development is a more common problem. Substance abuse and related violence and crime are problems that youth face more acutely in Europe and Central Asia and Latin America than in other regions. For an example of analysis of AHD issues in a particular region, see Appendix E, Spotlight on Adolescent Health and Development in Africa.

Figure 2: Distribution of the world's young people



2.4 ADOLESCENT HEALTH AND DEVELOPMENT AND THE MILLENNIUM DEVELOPMENT GOALS

The Bank and its partners—governments, United Nations agencies, and bilateral donors—are increasingly committed to a common set of development results, including the Millennium Development Goals (MDGs) and other goals agreed to by governments at major conferences in the 1990s. The Bank

has made achievement of the MDGs a central focus of its activities. Better adolescent health will directly or indirectly contribute to achieving almost all of the eight internationally agreed-on goals. Table 1 shows the goals that are relevant to AHD, the indicators, and the pathways through which better AHD helps achieve each goal.

Table 1: The Path to Achieving the MDGs Runs Through Adolescence

Millennium Development Goal	Indicator	Adolescent-Focused Activities to Achieve the Goal
Goal 1: <i>Eradicate extreme poverty and hunger.</i>	Proportion living on less than \$1 a day	Preventing teen pregnancy
	Proportion of people who suffer from hunger	Reducing HIV infection in youth
Goal 3: <i>Promote gender equality and empower women.</i>	Ratio of girls to boys in primary, secondary, and tertiary education	Educating girls
	Among 15–24-year-olds, ratio of literate females to literate males	Changing social norms to promote gender equity
Goal 4: <i>Reduce child mortality.</i>	Infant death rate	Preventing high-risk pregnancies to young mothers and reducing adolescent malnutrition
Goal 5: <i>Improve maternal health.</i>	Maternal mortality ratio (to the extent that young mothers are at higher risk of pregnancy-related death and disability)	Improving maternal care for pregnant adolescents
	Proportion of births attended by skilled health personnel	Expanding postabortion care for youth
	Contraceptive prevalence rate	Expanding youth access to information and services for pregnancy prevention
Goal 6: <i>Combat HIV/AIDS, malaria, and other diseases.</i>	HIV prevalence among 15–24-year-old pregnant women	Expanding youth-specific HIV prevention and care efforts
	Prevalence and death rates associated with tuberculosis and malaria	Educating youth how to identify the symptoms of TB and get care for themselves, friends, and family members
		Preventive malaria treatment for pregnant adolescents
Goal 7: <i>Ensure environmental sustainability.</i>	Proportion of population with sustainable access to an improved water source	Investing in the human capital of young people, leading to lower fertility and less pressure on natural resources
Goal 8, target 16: <i>Develop and implement strategies for decent and productive work for youth.</i>	Unemployment rate of 15–24-year-olds	Carrying out policies and programs to expand youth employment

III. GOOD PRACTICES IN ADOLESCENT HEALTH AND DEVELOPMENT PROGRAMMING

This section discusses common principles for effective youth programs, examines the types of programs and policies that are effective in improving AHD, and presents good practice examples for a range of AHD issues.

3.1 COMMON PRINCIPLES

Effective youth-focused efforts share some common general principles. Effective efforts achieve the following:

- *Recognize the diversity of the youth age group.* Programs should apply different strategies to reach subgroups of youth who vary by age, sex, employment, schooling, and marital status.
- *Involve young people.* Involving youth in the conceptualizing, planning, carrying out, and evaluating of programs saves cost and ensures ownership, success, and sustainability.
- *Address gender inequality.* Inequalities related to gender expose young girls to coerced sex, HIV infection, and unwanted pregnancy.
- *Focus on not only girls but also boys.* Adolescence presents a unique opportunity to help boys form positive notions of gender relations and raise awareness of health issues.
- *Appeal to youth.* A key to rapidly expanding access for young people is to make existing services more “youth friendly” by using specially trained health workers who are equipped with appropriate job aids and by bolstering the privacy, confidentiality, and accessibility of care.
- *Address multiple youth needs.* Comprehensive programs that provide information and services while addressing contextual constraints are more effective than narrowly focused interventions.
- *Address the many nonhealth factors that influence adolescent health.* Linking school and livelihood opportunities to adolescent health programs, at either the policy or program level, is key to helping youth avoid risky behaviors.
- *Address underlying risk and protective factors.* These factors are those that either increase (risk factor) or decrease (protective factor) the chances that a young person will have unhealthy behaviors. They operate at the individual, family, institutional, and community level and include feelings of self-efficacy, attitudes and behaviors of friends, connectedness with parents and other influential adults, and involvement in the community.

3.2 EFFECTIVE APPROACHES

The range of adolescent health interventions is broad. All approaches gain in effectiveness when they provide youth with information and services as well as create a positive context that allows young people to practice key health-promoting, interrelated behaviors. These behaviors include:

- Delaying sexual debut and practicing abstinence as well as, for sexually active youth, safer sex and increased contraceptive use;
- Postponing marriage and childbearing;
- Using safe delivery care;
- Avoiding tobacco use and substance abuse; and
- Practicing better nutrition and appropriate levels of physical activity.

The key strategies to improve AHD typically have overlapping and synergistic goals. To emphasize the interrelatedness of these strategies, Table 2 combines intermediate and final outcome indicators for a range of desired adolescent health outcomes.

3.2.1 Providing Information and Services to Young People

A number of approaches effectively give young people the information they need to make the right life choices. Where school enrollment is high, a cost-effective and important approach is to reach students through schools. For many young people, peers are a primary source of information on sexuality and health. Peer education programs are especially appropriate for young people who are not in school and for hard-to-reach, at-risk subsets of the youth population, including sex workers and street children. The mass media have enormous influence on youth in most societies and can help to normalize positive adolescent behaviors and gender roles as well as to direct young people to appropriate health services.

Access to high-quality health services is as important for youth as it is for older clients. Although some young people seek care through the formal health system, many others are deterred by the often-judgmental attitudes of health workers, particularly when seeking care and advice on sexuality-related matters. The most effective efforts to reach youth are tailored to address their specific needs and to reach young people where they live, work, and play. The subsidized sale of condoms and other health products and services through social marketing programs brings products and services to places in the community such as shops, kiosks, and pharmacies that young people frequent.

3.2.2 Creating a Positive Context for Improvements in Adolescent Health

Successful adolescent health efforts also address the political and social context in which young people make decisions that affect their health and development.

Global commitment to meeting adolescent health needs has never been higher. The 1994 International Conference on Population and Development and the 2001 UN Special Session on AIDS affirmed the rights of young people to high-quality sexual and reproductive health information and services. Similarly, the *Framework Convention on Tobacco Control* (Framework, 2003) recognizes the youth dimension of the smoking epidemic. Translating this international commitment into national policies, a supportive legal framework, and adequate budgetary support is a priority.

Improving adolescent health also requires changing the social norms that promote negative health outcomes, for example, gender discrimination, norms that promote early sexual activity or that stigmatize using condoms, cultural expectations to marry and bear children early in adolescence, tolerance of substance abuse, and poor eating habits. Mass media and community mobilization efforts that engage influential adults such as parents, teachers, community and religious leaders, as well as pop and sports stars can positively affect these norms. Multisectoral programs that meet the job and schooling needs of young people also can positively influence the factors that can either protect young people or put them at risk.

Table 2: Actions to Promote Adolescent Health and Development

OBJECTIVE: IMPROVE KNOWLEDGE, ATTITUDES, AND BEHAVIORS OF YOUNG PEOPLE		
Core Interventions	Beneficiaries/Target Groups	Indicators^a
Provide information to young people to increase their knowledge and understanding of health issues and to motivate them to practice healthy behaviors through		
Life skills and health and sexuality education in schools	In-school youth, ideally starting before puberty and before young people become sexually active	<p>Intermediate Outcome Indicators</p> <ul style="list-style-type: none"> • Percentage of sexually active youth using contraception, especially condoms for prevention of both pregnancy and HIV/AIDS as well as other STIs • Percentage of young mothers with prenatal care and trained delivery assistance • Percentage of youth having high-risk sex • Percentage of youth with anemia • Percentage of youth who use tobacco products • Age of marriage • Age at sexual debut <p>Final Outcome Indicators</p> <ul style="list-style-type: none"> • Rates of maternal death and disability for young mothers • Rates of HIV and other STIs for youth • Rates of teen pregnancy (wanted and unwanted) • Rates of unsafe abortion for youth
Peer educators deployed in a wide range of formal and informal settings such as schools and workplaces to provide role models for other youth, to share information on health, and to refer peers to health services	Out-of-school youth; youth in hard-to-reach groups such as sex workers, street children	
TV, radio, and other mass media campaigns, including popular theater and other culturally appropriate means that appeal to youth	All young people, especially those at highest risk of unhealthy behaviors	
Provide health services to young people through		
Subsidized social marketing of condoms and other reproductive health products	Sexually active young people	
Programs that reach young people at their places of work and through private channels such as pharmacies and for-profit medical services, where many youth prefer seeking care	Employed youth; youth who use private, for-profit health services	
Comprehensive adolescent health services provided by the public sector and NGOs	All young people, but especially poor and rural youth	
Community-based programs, for example those that distribute condoms and other contraceptives	All youth, but especially out-of-school youth; poor youth	
Voluntary counseling and testing for HIV/AIDS	Youth engaging in high-risk behaviors	

Expanding school and livelihoods opportunities and psychosocial support for poor youth affected by AIDS, including AIDS orphans	Poor youth living with HIV/AIDS or from AIDS-affected families; AIDS orphans and other orphans	
OBJECTIVE: CREATE A POSITIVE CONTEXT FOR ADOLESCENT HEALTH (AH) PROGRAMS		
Core Interventions	Beneficiaries/Target Groups	Indicators
Promote policy dialogue and advocacy.		
Develop national AH policies and service guidelines. Address AH in national development policies such as the Poverty Reduction Strategy Paper (PRSP). Create a supportive legal framework. Promote anti-smoking policies such as taxes and advertising bans.	Decision makers; legislators; community, religious, and business leaders; civil society	<ul style="list-style-type: none"> • Level of political support for AH • Existence of a national AH policy • Adequate budget for AH • Existence of program guidelines and regulations that support delivery of AH care • Existence and enforcement of positive legal framework (e.g., minimum age at marriage; legality of contraceptive sales to youth; ban on tobacco promotion)
Change social norms.		
Promote mass media and community mobilization efforts.	Parents, teachers, religious leaders, other influential adults	<ul style="list-style-type: none"> • Degree of family and community support for AH policies and programs
Address related youth needs through multisectoral interventions.		
Improve education opportunities, especially for girls. Link AH with other youth activities, including education and youth development programs that give young people broadly applicable attitudes and skills. Provide job training and other livelihoods programs.	All youth, particularly those at risk	<ul style="list-style-type: none"> • <i>Primary and secondary school enrollment for girls and boys</i> • <i>Youth unemployment rate</i>

Note. ^aIndicators that correspond directly to Millennium Development Goals are in italics.

3.3 GOOD PRACTICE EXAMPLES

The following sections describe examples of effective AHD efforts for a range of different topics.

3.3.1 Sexual and Reproductive Health

Pregnancy-related death and disability and other reproductive health conditions such as HIV/AIDS and other sexually transmitted infections (STIs) are among the leading causes of disability-adjusted life years (DALYs) that are lost among young people ages 10–24 living in developing regions (World Bank, 1998). Improved adolescent reproductive health also has important links to economic prosperity and poverty reduction, and it is an integral part of youth health and development. Adolescent reproductive health initiatives ultimately seek to give young people the means to

- reduce early and unwanted childbearing;
- lower their vulnerability to HIV and other sexually transmitted infections; and
- decrease their chances of dying or falling ill from pregnancy-related causes.

A number of approaches effectively give young people the information they need to make the right choices and also address the political and social context in which they make decisions about sex and reproduction. Among the most important and best-studied program interventions is school reproductive health and HIV/AIDS education. One of the many examples of well-designed and effective sex education efforts is the *Planeando Tu Vida* life-planning curriculum in Mexico. A study carried out in Mexico City found that students in the 6-week course improved their knowledge of sexuality and reproductive health and had significantly higher contraceptive use compared to students in traditional sex education courses and to those who had not attended any sex education course (FOCUS, 2001, citing Pick de Weiss & Palos, 1989). For a recent review of school-based reproductive health education programs, see YouthNet’s *YouthLens* fact sheet, “Sexuality and Family Life Education Helps Prepare Young People,” available on the YouthNet Web site at <http://www.fhi.org/en/youth/youthnet/pubs/lens.html>

3.3.2 HIV/AIDS

With young people at the center of the HIV/AIDS epidemic, youth-focused efforts are key to eventually bringing the disease under control. As with other areas of AHD, preventing HIV/AIDS requires a multipronged approach that includes information, services, and attention to the larger context within which youth make decisions on risky sex and related behaviors such as injecting drugs that increase the odds of HIV transmission.

Voluntary counseling and testing (VCT) for HIV, a proven approach for promoting safe sex and increasing the use of care and support services for adults, is now also seen as a potentially powerful tool for youth. In Kenya and Uganda, research for youth ages 14 to 21 indicates that youth would seek VCT if the services were confidential and inexpensive (Horizons, 2001). In response, program officials in Uganda are carrying out a number of enhancements to the VCT program, including the following:

- Training of health workers to counsel youth about HIV
- Use of a separate room and alternative locations to improve confidentiality
- Reduced prices
- Establishment of a referral system for young clients
- Improved outreach to schools and youth groups
- Introduction of VCT at youth reproductive health centers

- A multimedia campaign to inform youth about VCT

For more information on the Uganda program, visit the Horizons Web site (<http://www.popcouncil.org/pdfs/horizons/vctyouthbaseline.pdf>). For a synthesis of knowledge of VCT programs directed at youth, see YouthNet's recent *YouthLens* fact sheet, "HIV: Voluntary Counseling and Testing" on the YouthNet Web site (<http://www.fhi.org/en/youth/youthnet/pubs/lens.html>).

3.3.3 Nutrition

Nutrition programs in developing countries have increasingly turned their attention to addressing nutritional problems earlier in the life cycle. In part, this trend is because of the chronic problem of low birth weight, which is more common in the offspring of adolescent mothers and is associated with higher infant death rates (Treffers, 2002). Pregnant mothers' nutrition is also important for their children's long-term health. Moreover, diet and lifestyle-related chronic diseases—many with their roots in adolescence—are emerging as one of the most important health problems in the developing world.

Adolescence is a key time from a nutritional standpoint. For many adolescents—both boys and girls—the lack of adequate quality and quantity of food is a prime cause of nutrition problems. Chronic undernutrition that causes stunting among young people delays growth and physical maturation, increases risk to pregnant mothers and their newborns, and decreases the capacity to work. Folate and iron deficiency are of particular concern in adolescence, along with other micronutrient deficiencies. Moreover, evidence is emerging about the connection between poor maternal nutrition and greater risk of transmission of HIV from mothers to their infants (Piwoz & Greble, 2000). On the other end of the spectrum, in developing countries, overnutrition and obesity in adolescents is on the rise as a result of changes in diet and physical activity. Many harmful eating habits begin in adolescence and can lead to diet-related chronic illness later in life.

Adolescence offers an early chance to acquire knowledge about optimal nutrition and to contribute to the prevention or reduction of (a) problems during pregnancy and (b) diet-related illnesses. Ideally, nutrition efforts should be collaborative, integrated efforts across multiple institutions and sectors, including the food industry, agriculture and rural development, health, and education. Because anemia is a critical health problem in many countries, many efforts have focused on improving the iron intake of adult women. One program in Peru addressed poor iron status of adolescent girls. Despite other programs to supply pregnant women with iron supplements through public sector health centers, the prevalence of anemia remains high in Peru. This successful program in Peru worked through the schools to reach adolescent girls with nutrition education and iron supplementation. Over a 17-week period, girls received iron tablets at school between meals. Researchers found that daily iron supplementation effectively lowers anemia and iron deficiency. With adequate motivation and the support of their teachers, the girls had high compliance with the iron supplementation program (Elder, 2002; MotherCare, 2000).

3.3.4 Mental Health

Studies of mental health in developed and developing countries show that between 10% and 25% of children and adolescents suffer from a mental health disorder (WHO, 2001b). Common problems include schizophrenia, depression, and other neuropsychiatric disorders as well as alcohol and substance abuse. Young people also suffer from the psychosocial problems caused by armed conflict and HIV/AIDS. Street children are particularly vulnerable to alcohol and drug abuse.

Many of the mental health problems of the young are both preventable and treatable. Like other health problems that begin during adolescence, inattention to mental health during the adolescent years can

result in life-long disability and consequences that continue far into the adult years. For this reason, prevention and treatment are especially critical during the adolescent years. Despite the widespread nature of mental health disorders, relatively few countries have youth-specific mental health policies or programs (WHO, 2001b).

One of the biggest killers of youth in both developed and developing countries is suicide. Worldwide, suicide ranks among the three most important causes of death for young people and suicide rates among young people are rising in China and other parts of Asia as well as in the Caribbean and Africa (WHO, 2001b).

One country with a national program to prevent youth suicide is New Zealand. Among youth ages 15–24 years, New Zealand has the highest rates of suicide for both males and females among selected industrialized nations (NZ MOH, 2002). In 1998, the government developed the *National Youth Suicide Prevention Strategy*, which is based on international experience with good practice in suicide prevention strategies. This New Zealand strategy, which includes both a component for the general population and one that focuses on the indigenous Maori community, provides a framework for understanding suicide prevention and signals the steps that government agencies, communities, and service providers must take to reduce suicide. These steps include

- school-based mental health programs to promote resiliency and reduce harm;
- early identification of youth at high risk of suicide;
- improved treatment for those who are at special risk of suicide, including those who have attempted suicide;
- effective support and response after a suicide or serious suicide attempt; and
- improved information about the rates and causes of suicide.

The national strategy is a mechanism to coordinate all suicide prevention initiatives and to identify and address service gaps. The Ministry of Youth Affairs takes the lead in promoting, coordinating, and communicating how the strategy will be carried out, with oversight from a Ministerial and Inter-Agency Committee (New Zealand Ministry of Youth Affairs. Youth Suicide Prevention Web Site. www.youthaffairs.govt.nz). Although the effect of the national strategy is still too early to adequately gauge, the youth suicide rates in 1999—the first after the strategy’s adoption—fell to their lowest levels since 1991 (NZ MOH, 2002).

3.3.5 Tobacco

Tobacco use is the prime example of a behavior begun in adolescence that has staggeringly negative long-term consequences for health. Similar to adult smokers in developed countries, most adult smokers in the developing world begin smoking in adolescence or earlier (World Bank, 1999a). Every day, worldwide, almost 100,000 young people start smoking, more than two-thirds of these in developing countries (World Bank, 1999a). Of the 300 million youth smoking today, tobacco will eventually kill half (WHO, 1998), and half of those deaths will be during productive years. By 2030, tobacco is expected to be the single biggest cause of death worldwide, accounting for about 10 million deaths per year (World Bank, 1999a). Research shows that adolescents’ knowledge of the dangers of smoking is inadequate, and thus, they face greater obstacles than adults in making informed choices. Equally important, young people underestimate the risk of becoming addicted to nicotine, and therefore, grossly underestimate their future costs from smoking. Even teenagers who know about the risks of smoking may have a limited capacity to use that information wisely (World Bank, 1999a).

Price increases are the most effective tool to reduce or deter use of tobacco products by young people. Recent efforts to reduce youth smoking in the United States have focused on raising tobacco prices

through higher taxes. Research has shown that the price of tobacco has an important influence on the demand for tobacco products, particularly among adolescents and young adults. Price increases can reduce the number of adolescents who start smoking, prevent youth who already smoke from becoming heavier smokers, and persuade some youth to abandon smoking altogether. Backed by strong public support for anti-smoking actions, several U.S. states have raised taxes on tobacco products. Moreover, through referenda, voters have directly approved tobacco tax increases in a number of states (UIC Health Research and Policy Centers, 2001).

Other proven policies and interventions to reduce tobacco use should complement tax increases that raise tobacco product prices. Policies to make public places smoke-free help change social norms about smoking and directly reduce smoking. Comprehensive bans on all advertising, including bans on the promotion of tobacco products and trademarks, can help change the social forces that encourage smoking. Prohibitions on free distribution of tobacco products and promotional products (e.g., T-shirts, school notebooks, etc) also help reduce adolescent tobacco use (World Bank, 2002b). Although bans on tobacco product sales to young people are politically popular, they are difficult and costly to enforce. Instead, policies should attempt to restrict the usual sources from which young people get their cigarettes or other tobacco products. For example, some countries have reduced youth access to tobacco products (especially cigarettes) by banning sales through vending machines. School anti-smoking programs, though widespread, have a patchy record of effectiveness. Messages to youth about the long-term consequences of tobacco use on their health are not an effective deterrent to adolescents who tend to behave with only the present in mind and who tend to rebel against the advice of adults (World Bank, 1999a). By contrast, programs that teach skills to resist peer pressure and other social pressures to smoke have demonstrated consistent and significant reductions or delays in adolescent smoking. School-based programs are also more effective when combined with community-wide, supportive efforts. Information campaigns that help young people to see how the tobacco industry tries to manipulate their behavior through advertising have been highly effective in changing behavior and attitudes to smoking among young people in the United States (American Legacy Foundation, 2002).

3.3.6 Road Safety

Road traffic accidents are among the biggest health hazards young people face. Relative to adults, adolescents are particularly vulnerable to road accidents because of their emotional and social immaturity, their lack of driving experience, their greater propensity to mix driving with alcohol and drug use, their relatively infrequent use of safety devices such as crash helmets and seat belts, and their tendency to work in often-hazardous public transport jobs (WHO, 2001a).

Effective policy and program measures to reduce the toll of death and injury to adolescents from traffic accidents include:

- Safer vehicles and roads;
- Graduated driver licensing systems that phase in young beginners to full driving privileges;
- Promotion of the use of seatbelts and crash helmets through the robust enforcement of related laws supported by intensive publicity and information campaigns;
- Restriction of alcohol use by adolescents and enforcement of stricter drinking and driving regulations;
- Road safety education, beginning with young children and continuing through adolescence; and
- Efforts to work with parents to better control use of vehicles by adolescents (WHO, 2001a).

Efforts to reduce the unacceptable health losses of road transport should be a high priority for governments and the wider society. The World Bank, the Asian Development Bank, the World Health Organization, and other international agencies are working together to improve their responses to this

public health threat, in collaboration with governments, civil society, and the private sector. One manifestation of this collaboration is the recently formed Global Road Safety Partnership (GRSP). Active in a number of “focus countries,” the partnership fosters alliances to promote road safety and has helped launch a knowledge base to help practitioners in developing nations. Road safety education is among the initiatives the GRSP supports. For example, the “Safe Ways” program in Ghana is carried out in collaboration with the National Road Safety Commission, whose mandate is to coordinate countrywide safety activities. The program provides opportunities for 11- and 12-year-old schoolchildren to learn about road safety in the classroom, on the playground, and outside near real roads to foster safer journeys to and from school. A similar program in South Africa, the “Road Safety Education Package,” assists schoolteachers to create awareness and safe behavior of children in traffic from ages 6 to 18 (GRSP, 2001).

3.3.7 Tuberculosis

Of the nearly 3 million people killed by tuberculosis (TB) each year, most are poor adults from the age of 15 to 45 who were infected as youth. Because people with HIV/AIDS have weakened immune systems, they are especially vulnerable to TB. In many African countries, the boundary is minimal between the TB and HIV/AIDS epidemics. More than 60% of tuberculosis patients are HIV positive in some sub-Saharan African nations, and the toll is enormous. TB is also on the rise in Asia and Eastern Europe. If these trends continue, approximately 10.2 million new cases are expected each year by 2005.

Youth is a time when exposure to TB increases. Young people socialize more, enter the labor market, and thus spend time in workplaces and social settings where they can be exposed. In high-burden, high-HIV countries, illness and death associated with TB is concentrated in the youth population because people are most at risk of developing the disease in the first few years after the initial infection. Reported rates of TB infection in young men are twice as high as for young women, although these rates may reflect underreporting of infection in young women (Holmes, Hausler, & Nunn, 1998).

Although TB prevention and control efforts have not traditionally focused on young people, the time is ripe for greater attention to the youth age group, particularly as government efforts turn toward rapidly expanding access and effective care based on the Directly Observed Treatment, Short Course (DOTS) strategy (World Bank, 2002a). Young people can play a unique role as a resource for detection and treatment, and educating young people on TB is crucial if they are to be effective in that role. Education efforts that are successful teach young people how to (a) recognize early on that they—or a close relative or friend—are at risk of contracting the disease; (b) know when they or others show the symptoms of TB; and (c) know what steps to take to treat the disease before it is passed to others, for example, encouraging their relatives to seek testing and treatment.

As with HIV/AIDS infection, overcoming the stigma associated with TB is one of the biggest obstacles blocking effective treatment of young people. Thus, for young people, who already are less likely than older adults to seek care, informing them that TB is a curable disease and removing the stigma is an important element of treatment programs. A key effort to expand case detection is happening through new community-based approaches and social mobilization techniques. A focus on youth could be important to achieving the new Global Plan to Stop TB. Communications strategies borrowed from the commercial sector, which have proved effective with youth in the area of HIV/AIDS and pregnancy prevention, can also potentially be applied to TB programs.

As is the case for other health messages, schools are important venues for educating young people on TB. Another intervention strategy is to link educational messages on TB testing and treatment with other health promotion, whether interpersonally or through the mass media. An example is a program in the secondary schools in one city in Uganda. In a single 1.5-hour session, instructors covered the key points

of TB control, including treatment and need for case-finding and compliance with tuberculosis treatment. In the period following the school program, the number of new TB cases diagnosed at the local clinic rose by almost one-third. Twenty percent of the new diagnosed cases were sent to the clinic by students who participated in the class or by their families (Migliori et al., 1996).

3.3.8 Malaria

Malaria is one of the biggest health problems for young people and a major cause of lost time at school or work. Furthermore, about 125,000 adolescents ages 10 to 19 die each year from the disease (Lalloo, 2002). African adolescents account for almost three-fourths of the total DALYs lost from malaria in adolescents worldwide (Lalloo, 2002).

Most adolescents experience the symptoms and physical effects of malaria in the same way as adults, although those adolescents with severe malaria may be more likely to develop anemia. Malaria in pregnant adolescent girls is a particular concern because the disease is a major cause of low birth weight in high transmission areas, and of spontaneous abortion and stillbirth in lower transmission areas. Young mothers infected with malaria, particularly those in their first and second pregnancies, are at especially high risk of poor pregnancy outcomes. Moreover, the negative effects of malaria on birth outcomes are amplified in pregnant women infected with HIV, especially during their first pregnancy—which often occurs during adolescence in many African countries.

The core strategies to fight malaria in adolescents are, in general terms, identical to those proposed in international initiatives such as the Roll Back Malaria effort. They include rapid, effective treatment along the same medical guidelines as for adults; promoting the use of insecticide-treated bednets; and prevention in pregnant adolescents using intermittent preventive treatment (IPT) (World Bank, 2001a). However, adapting these general approaches to the adolescent population is still a challenge. The few studies of adolescent-specific malaria programs show that these efforts are hampered by some of the same obstacles that prevent adolescents more generally from seeking and receiving good health care. For example, pregnant women typically receive malaria prophylaxis as one element of antenatal care. Because of the barriers adolescents face in gaining access to antenatal care, strategies to reach them with prophylaxis and other services through traditional avenues such as the antenatal care clinic may have a limited effect. In Nigeria, for instance, unmarried, pregnant adolescents were found to be far less likely than their married counterparts to use malaria prophylaxis, mainly because the stigma of being single and pregnant prevents them from seeking care at the local clinic (Okonofua, Feyisetan, Davies-Adetugbo, & Sansui, 1992 cited in Lalloo, 2002). Health promotion for adolescents that includes information on malaria is also an important strategy. To better inform these efforts, programs need to gather more information about what adolescents know about malaria, what they do for prevention, and how they behave when they fall ill.

IV. FOCUS ON POVERTY

As noted above, poverty is closely related to adolescent health. This section examines the relationship of poverty to adolescent health status and use of health services, using data from the Demographic and Health Surveys (Macro International, 1990-1998) in six countries. After the data analysis is a discussion of (a) the reasons why health services are not reaching poor youth and (b) strategies for improving access of poor youth to health care. Box 3 describes an analysis of how the Poverty Reduction Strategy Papers are addressing AHD.

Box 3: Youth and the PRSPs

The Poverty Reduction Strategy Paper (PRSP) is emerging as a key policy document guiding government decision-making and World Bank support in the poorest developing countries. In many of these nations, AHD concerns are central to achieving economic growth and poverty reduction. How well does this key policy document address these concerns? An analysis of the 21 PRSPs completed through December 2002 (Sundaram, Epp, Oomman, & Rosen, 2003) shows that these documents could improve their focus on youth. Fewer than half of the countries involved youth in the development of their strategy. Only a few address youth concerns in the assessment of poverty or discuss the relationship between poor adolescent health and poverty. On a more encouraging note, a little more than half of countries propose youth-specific strategies for poverty reduction. Nonetheless, only a few countries link these strategies to specific targets and budget outlays.

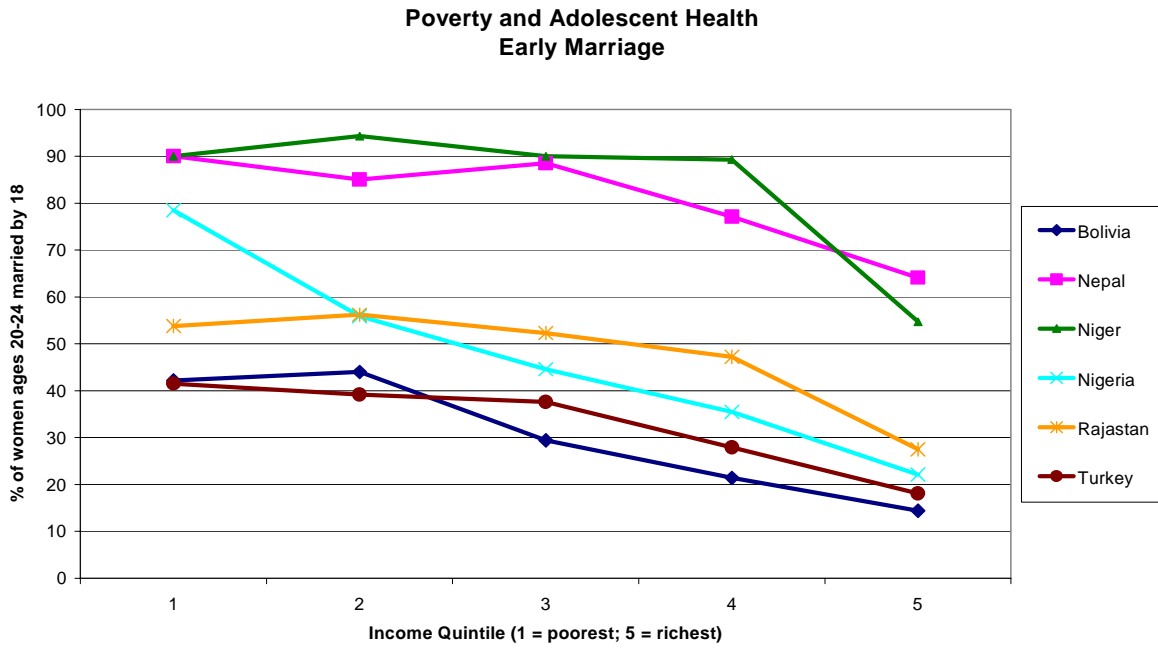
4.1 POVERTY, ADOLESCENT HEALTH STATUS, AND USE OF HEALTH CARE

Using as a model the analysis of poverty and health status pioneered by Gwatkin et al. (2000), this section presents results from six countries: Bolivia, Nepal, Niger, Nigeria, India (state of Rajasthan), and Turkey. The analysis focuses on a range of youth-specific indicators of health status and use of health services.

4.1.1 Early Marriage

Although the average proportion of young women who are married by age 18 varies widely across countries, the analysis shows a similar pattern in all six countries whereby adolescents are less likely to marry young the higher their income group (see Figure 3). This disparity is particularly pronounced in Nigeria, where almost 80% of the poorest young women marry early compared with just 22% of the richest young women.

Figure 3: Rates of early marriage across income quintiles

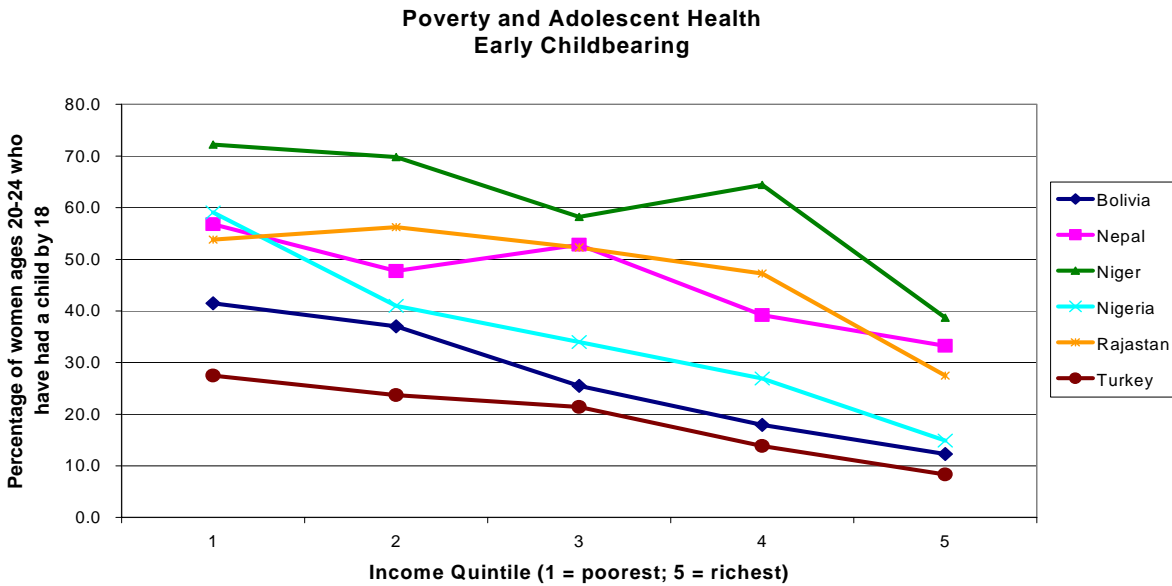


Source: Demographic and Health Surveys, 1990-1998

4.1.2 Early Childbearing

The pattern for early childbearing (see Figure 4) is similar to that seen in Figure 3 for early marriage. In Bolivia, for instance, the proportion of the poorest women who have had a child by age 18 is more than 40% compared with 13% among the wealthiest women.

Figure 4: Rates of early childbearing across income quintiles

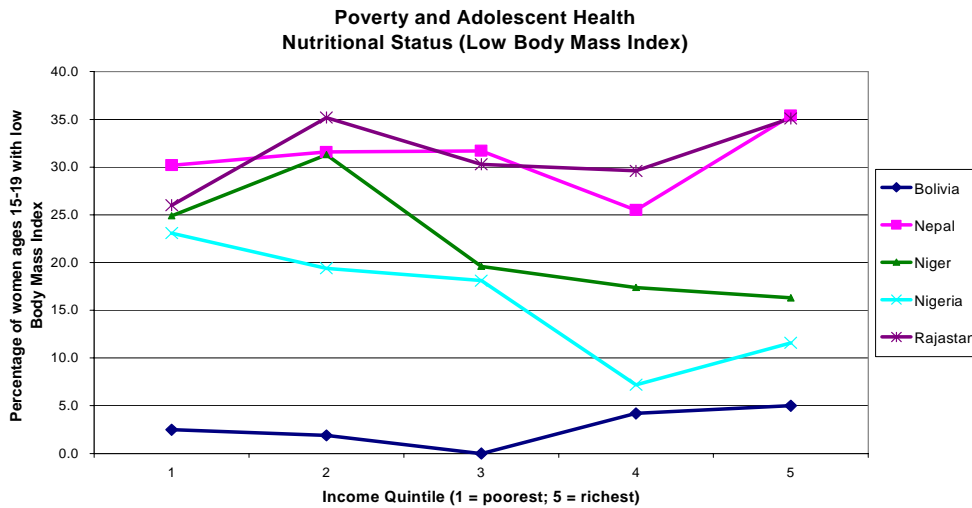


Source: Demographic and Health Surveys, 1990-1998

4.1.3 Nutritional Status

Low body mass index is one indicator of malnutrition among young women. The results from the analysis are somewhat mixed (see Figure 5). For Niger and Nigeria, one finds a clear correlation between low body mass and poverty, with the poorest girls also being the thinnest. For Nepal and Rajasthan, however, this kind of correlation is not seen. Women in Bolivia have minimal levels of low body mass index.

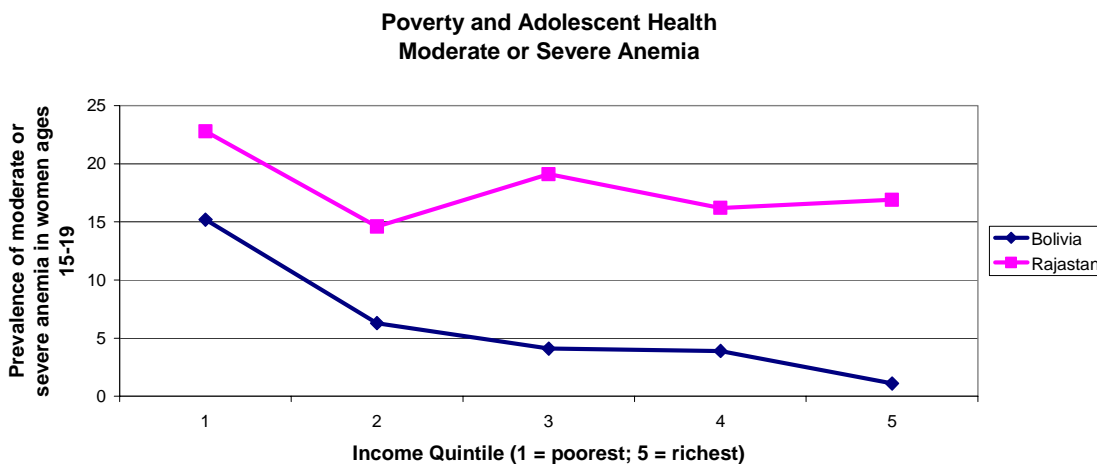
Figure 5: Rates of low body mass index across income quintiles



Source: Demographic and Health Surveys, 1990-1998

Anemia is another indicator of nutritional status. For the two countries where data are available, the results are somewhat mixed (see Figure 6). In Bolivia, where overall rates of anemia are lower than in Rajasthan, prevalence of moderate or severe anemia clearly declines as income rises. In Rajasthan, the poorest group of adolescent women has the highest rates of anemia, and rates are lower but roughly similar in the four other income quintiles.

Figure 6: Rates of moderate or severe anemia across income quintiles

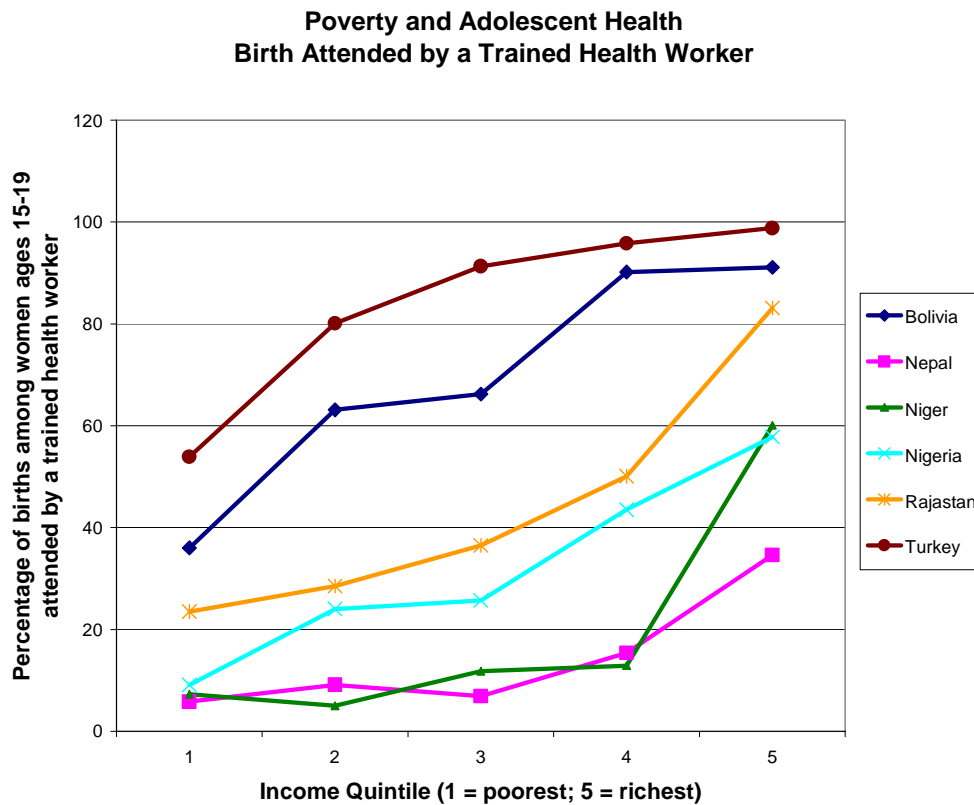


Source: Demographic and Health Surveys, 1990-1998

4.1.4 Maternal Health

Having a skilled health worker attend the birth of a child is key for promoting the health of mothers and newborns. As Figure 7 shows, access to this kind of care by adolescent mothers is closely tied to economic status. In all six countries, rates of skilled delivery attendance are two to eight times higher among the richest young women compared with the poorest.

Figure 7: Rates of skilled delivery attendance across income quintiles

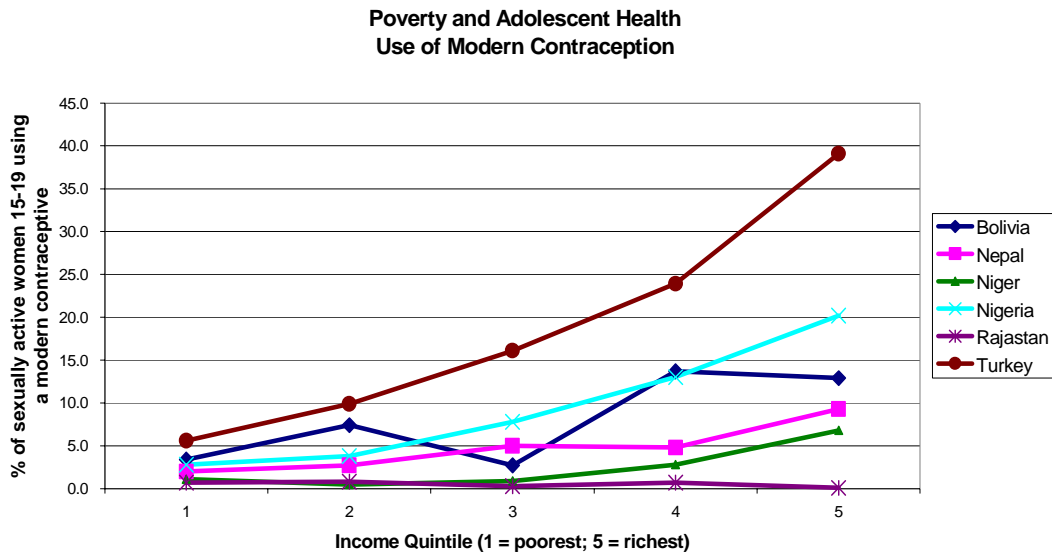


Source: Demographic and Health Surveys, 1990-1998

4.1.5 Use of Contraception

Although use of modern contraception is generally quite low among sexually active adolescent women, use tends to increase with economic status (see Figure 8). In the six countries studied, 5% or fewer of the poorest adolescents use a modern method of contraception, reflecting inequities in access to family planning services.

Figure 8: Rates of contraceptive use across income quintiles

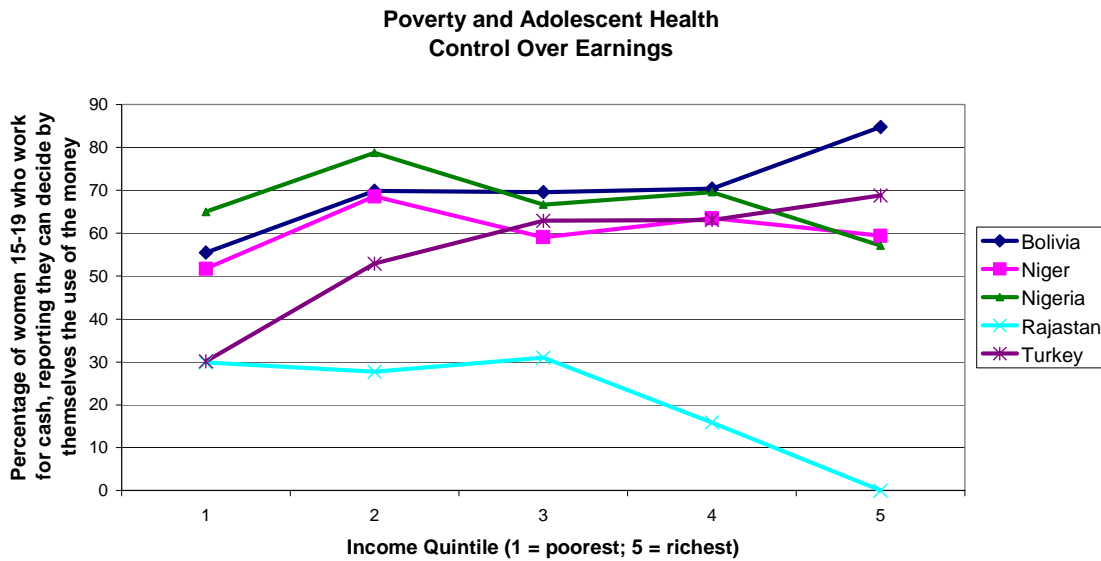


Source: Demographic and Health Surveys, 1990-1998

4.1.6 Status of Adolescent Women: Control Over Earnings

Women’s status has an important association with health and health-seeking behavior. One measure of status is the control that adolescent girls have over their earnings. As Figure 9 shows, with the exception of women in Rajasthan, the poorest adolescents tend to have less say in the use of their earnings.

Figure 9: Rates of control over earnings across income quintiles

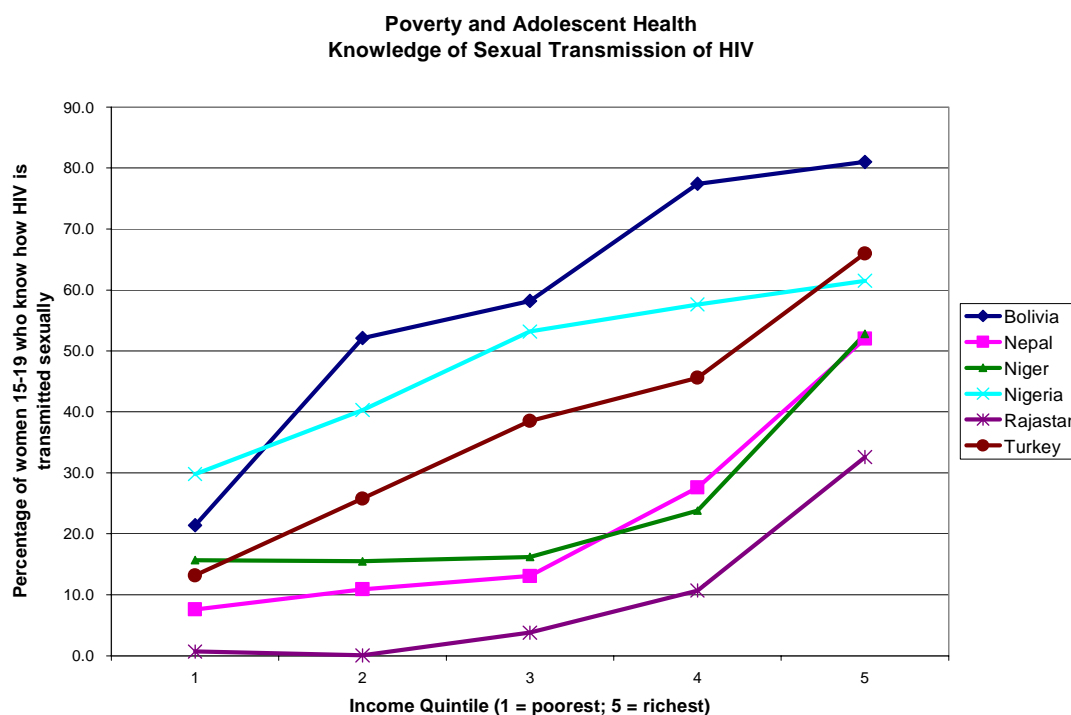


Source: Demographic and Health Surveys, 1990-1998

4.1.7 Knowledge of HIV/AIDS Transmission

Knowledge about how HIV/AIDS is transmitted sexually tends to be alarmingly low among adolescent women, even in countries such as Nigeria with relatively high rates of HIV infection. Furthermore, large disparities across income groups exist, with the richest young women between 2 and 46 times as likely as the poorest young women to know about sexual transmission of the disease (see Figure 10).

Figure 10: Rates of knowledge of sexual transmission of HIV across income quintiles



Source: Demographic and Health Surveys, 1990-1998

4.2 REACHING POOR YOUTH

Poor people of any age face formidable barriers to achieving good health. For the young, several unique obstacles present themselves:

- **Low status of girls and women**—Even more than older women, girls and young women lack access to resources such as land, credit, and education, thus limiting their engagement in productive work and ability to seek health care. Low status denies poor young women the power to make decisions about sex and childbearing as well as use of contraception and other health services. Socioeconomic dependency makes poor young women more vulnerable to physical and sexual abuse, harmful traditional practices such as female genital cutting, unwanted pregnancy, and HIV/AIDS and other STIs.
- **Cultural norms and practices**—Cultural norms and practices that perpetuate poor health are even more harmful to young people. These norms and practices include gender inequalities, limited access to education, community acceptance of harmful practices such as female genital cutting, and early childbearing and marriage.

- **Affordability**—The cost of health care poses a barrier for poor youth, who are likely to have less money than adults to pay for care and who are more dependent on families to absorb the cost of health care.
- **Accessibility**—Like all poor people, poor youth tend to be concentrated in rural areas, where coverage of health facilities remains limited. Clients in rural areas often walk more than an hour to the nearest health facility. Bad roads and lack of public transport make access difficult, especially when complications arise.
- **Quality of care**—Poor quality of care and deficient services are the most common reasons that women and their families give for not using available health services. Poor people often receive the worst treatment and wait long hours because they have no voice and no alternatives. Bad treatment and judgmental attitudes are often compounded for unmarried youth, particularly when they seek sexuality-related care such as contraception.

Strategies to improve access to health services for poor youth encompass a broad range of efforts, including those described in the following sections:

Targeting out-of-school youth. Out-of-school youth are likely to be more marginalized than those who are in school and are often the youth most in need of critical services such as pregnancy prevention and prevention of HIV/AIDS and other STIs. A number of countries, including Paraguay, South Africa, and Zimbabwe have launched effective programs targeting out-of-school youth, which combine mass media, peer education, and community-based efforts. For instance, the *Arte y Parte* project targeted out-of-school youth in three cities in Paraguay, using a booklet about adolescent sexuality, street drama, radio programming, newspaper columns, and distribution of promotional items (Magnani, Robinson, Seiber, & Avila, 2000).

Improving education for girls and young women. Poor girls are least likely to be able to attend school. Better access to school helps delay early marriage and childbearing and empowers young women to better negotiate sex and condom use. Literacy programs and other nonformal education for young adult women are also important. Although disparities between enrollment rates for girls and boys remain, targeted efforts to improve girls' education have been effective in a number of countries, and overall schooling for girls is rising. The Better Life Options project in India illustrates the effect of education on adolescent health. Combining nonformal education, family life education, and health services, the project significantly improved the reproductive health, employment, and formal schooling of girls who participated (Levitt-Dayal & Motihar, 2000).

Focusing efforts on vulnerable youth. Youth who have been orphaned or left vulnerable by AIDS typically rely first on their extended families and communities for support. Efforts to help these youth should strengthen these safety nets. One example is the COPE program in Malawi, an NGO-sponsored effort that works through existing government structures to help orphans and other vulnerable children (Phiri, Foster, & Nzima, 2001).

Tailoring subsidized programs to poor youth. Social marketing of reproductive health products and services, for example, condoms for pregnancy and disease prevention or promotion of iron supplementation, often targets young consumers. Nonetheless, these efforts should ensure that they reach the desired clients—those who are poor and less likely to afford paying market prices. The Social Marketing for Adolescent Sexual Health (SMASH) project in four African countries combined mass media with peer education to encourage youth to practice safer sex, including condom use (Agha, 2000).

Strengthening postabortion care. Poor youth are more likely to resort to unsafe abortions than older women; less likely to seek early care; and thus, more likely to need postabortion care. Strengthening this kind of care should include special training for health personnel, particularly the nurses and nurse-

midwives who typically staff rural and marginally urban health facilities. In one of these programs, adolescents seeking postabortion care at a maternity hospital in Fortaleza, Brazil, are treated and then referred to the hospital's Adolescent Center for group and individual counseling on reproductive health (Herrick, 2001).

V. THE WORLD BANK'S ROLE

Recognizing the urgent need to translate the aspirations of young people into reality, the World Bank is supporting AHD in a variety of ways that are described in the following sections.

5.1 PROVIDING RESOURCES FOR PROVEN APPROACHES

The Bank is increasingly working with client governments to look at new and innovative ways to use its financial resources to improve AHD outcomes.

Health, Nutrition, and Population (HNP). Through its HNP lending, World Bank support for AHD has increased rapidly in recent years:

- Twenty-nine of the 43 HNP loans made in fiscal years 2001 and 2002 have an adolescent health component (see Table 3).
- The \$227 million in lending for adolescent health since the beginning of fiscal year 2001 represents 12% of all HNP commitments.
- The increased emphasis on adolescent health stems largely from the priority put on young people in the Bank's loans to combat HIV/AIDS under the Multicountry AIDS Program (MAP) in Africa and the Caribbean.

HNP loans support a broad range of strategies and approaches, including advocacy and policy development; reproductive health education for in-school and out-of-school youth; social marketing of condoms; youth-friendly health services; care and support for AIDS-affected youth and orphans; and behavioral and other research. For more detailed information on AHD loan commitments, see Appendix H.

Table 3: World Bank Loan Commitments for Adolescent Health and Development, 1999–2002

Fiscal Year	Total No. of HNP Loans	No. Loans With AHD Component	Commitments for AHD (\$U.S. million)	AHD as a Percentage of All HNP Commitments
1999	22	7	\$24.4	2%
2000	21	3	\$23.7	2%
2001	21	13	\$151.5	15%
2002	22	16	\$75.9	9%
1999–2002	86	39	\$275.2	7%

Note. Figures obtained from various World Bank documents.

Education. The World Bank continues to be the largest external source of financing for education in the developing world:

- Lending for the education of adolescents and young adults totaled about \$4 billion between fiscal years 1996 and 2001.
- For fiscal year 2001, lending for education of youth was \$274.5 million, or 35% of all education lending.
- Recognizing the importance of schools as a venue for improving health, the Bank currently works in partnership to carry out the Focusing Resources of Effective School Health (FRESH) approach as part of more than 20 projects in Africa, with plans to expand to other regions.

Social protection. The focus of lending in the Social Protection sector has been on poor, at-risk youth, with an emphasis on youth development, livelihoods, violence, and drug prevention:

- About 1 of every 10 Social Protection loans over the past 5 years has had a youth component.
- Loans in Macedonia and Colombia support stand-alone, multisectoral youth development projects.

5.2 ADVOCATING FOR CHANGE THROUGH POLICY DIALOGUE

Through research, analysis, and policy dialogue, the Bank is increasing its efforts to help client governments take youth concerns into account when setting their development priorities:

- In response to Bank efforts, some countries, in designing poverty reduction strategies, already have explicitly recognized the need to address head-on the youth dimension of the HIV/AIDS epidemic and the human capital needs of their populations.
- A key focus of the Bank is on strengthening political commitment for education and supporting the macroeconomic reforms needed to address the problem of youth unemployment and underemployment.
- Bank-sponsored research on topics such as youth at risk in the Caribbean (Cunningham & Correia, 2002) and assessing the economic benefits of youth investment (Knowles & Behrman, 2003) help to bolster attention to the specific needs of young people and to appropriate policy and program responses.
- Regional policy-oriented meetings such as on Youth in South Eastern Europe, held in May 2002 in Rome, and the June 2002 and March 2003 videoconferences on AHD in Africa have promoted high-level policy dialogue and follow-up actions.

5.3 WORKING IN PARTNERSHIP

In all these efforts, the Bank highly values working in partnership with a broad range of individuals, organizations, and governments. Recent examples of Bank partnerships to promote AHD include the following:

- Collaboration on a number of public health initiatives, including (a) the Safe Motherhood Initiative and (b) Curbing the Tobacco Epidemic
- Membership on the board of the Global Alliance for Workers and Families, which is part of the International Youth Foundation
- Support for UNAIDS and participation in its two Inter-Agency Working Groups on Youth and on Schools and Education
- Support for the Children and Youth at Risk on the Streets Program, a program of the World Bank Institute in partnership with the George Soros Foundation and the King Baudouin Foundation

(See Appendix D for more information on key partners in AHD.)

5.4 STRENGTHENING THE WORLD BANK'S COMMITMENT TO ADOLESCENT HEALTH AND DEVELOPMENT

The Bank is currently taking a number of steps to build on these important initiatives and to increase the scope and effectiveness of its work to promote AHD, including the following:

- The creation of a Children and Youth Advisor¹ position to take leadership on youth issues within the Bank and to head up the Children and Youth Cluster, the internal Bank group that serves as a catalyst to bring together staff people, thematic group members, and technical areas from across different sectors of the Bank
- The development of a Children and Youth Strategy plan, scheduled to be completed in 2003

¹ The Bank's Children and Youth Advisor is Viviana Mangiaterra (vmangiaterra@worldbank.org).

Appendix A: Case Examples of World Bank Loans to Support Adolescent Health and Development

The World Bank has supported adolescent health and development efforts through a variety of lending operations (see Appendix H for a listing of recent loans). The following examples highlight selected youth-focused activities within the Bank's lending portfolio.

Country: Uganda
Project: STI Prevention; District Health Services Project (DHSP)
Year: 1995
Loan Amounts: \$50 million (STI) and \$45 million (DHSP)

The Sexually Transmitted Infection (STI) project was carried out in parallel with the District Health Services Project (DHSP) as part of broader health-sector reform in Uganda. Because of the high incidence of HIV/AIDS and other sexually transmitted infections in youth, both projects included a focus on adolescent health. The STI project targeted youth for prevention of STI/HIV infections at both the district and central levels. Activities included the following:

- Development of an information, education, and communication (IEC) strategy tailored to different age groups
- Support for NGOs to work on youth issues, including skills-based training to avoid pregnancies and STIs/HIV; counseling; IEC workshops; livelihoods opportunities; sensitizing youth on rights and responsibilities; life-skills training in schools; HIV/AIDS prevention among street children; and condom distribution to youth
- Development of guidelines for teachers on how to teach HIV/AIDS prevention and the mainstreaming of reproductive health into the school curriculum
- Training of school nurses in the syndromic management of STIs
- Sensitizing of community leaders on the importance of adolescent reproductive health (ARH)

The District Health Services Pilot Project, a broad, health-sector reform effort, supported a number of adolescent-specific activities, including

- development of national policy guidelines on ARH;
- district management of ARH programs;
- training of health workers in counseling skills for adolescent health;
- training of science teachers in ARH;
- development and dissemination of IEC materials;
- health education for women and youth councils; and
- integration of reproductive health issues in STI/HIV/AIDS management.

The projects helped contribute to the success Uganda has had in reducing HIV incidence among youth. At the project's completion, more than 90% of the target population could cite two methods of protection from HIV, and condom use increased by more than 200%. Reported casual sex partnerships declined by 43%, and the median age at first sexual intercourse increased from 14 to 16 years.

Source. Adapted from Toolanen, 2001.

Countries: Barbados and the Dominican Republic
Project: HIV/AIDS Prevention and Control
Year: 2001
Loan Amounts: \$15 million (Barbados) and \$25 million (Dominican Republic)

The HIV/AIDS Prevention and Control Projects for Barbados and the Dominican Republic are part of the First Phase, Multicountry HIV/AIDS Prevention and Control Adaptable Program Lending (APL) for the Caribbean region, a lending program that provides loans, credits, or both to governments in the region to finance their HIV/AIDS programs. Projects in both countries identify youth as being a high-risk group, and the prevention components include a strong emphasis on adolescents. In Barbados, the project will support the following activities:

- Improving how Health and Family Life Education Programs are carried out
- Integrating HIV and STI issues into adolescent programs, including reproductive health programs
- Ensuring the availability and accessibility of condoms to youth
- Advocating for the provision of youth-oriented health services and facilities
- Promoting innovative peer counseling models for youth, parents, and teachers
- Ensuring the access of out-of-school youth to HIV/AIDS prevention and services

In the Dominican Republic, efforts will include the following tasks:

- Advocacy campaigns to supportive and key policy makers, religious leaders, and the press
- Incorporation of HIV/AIDS and STI prevention into education policies and programs
- The carrying out of sex education programs, including HIV/AIDS and STI prevention, through a face-to-face methodology
- Design and production of IEC materials on sex education that are directed specifically at target population groups
- Training of teachers to act as facilitators in school sex education programs

Source. World Bank, 2001b

Country: Bangladesh
Project: Integrated Nutrition Project
Year: 1995
Loan Amount: \$59.8 million

Launched in 1995, the Bangladesh Integrated Nutrition Project is a community-based nutrition services delivery project, covering areas representing 12% of the country's total population. The project emphases include community mobilization and deployment of locally based community nutrition promoters; universal growth monitoring and promotion of children under 2 years; and weight-gain and nutrition-status monitoring for pregnant and lactating women, complemented by targeted supplementary feeding. A specific concern with respect to severe maternal malnutrition in the country prompted experimental work with newlywed women—many of whom are adolescents—to address this problem and the high incidence of low birth weight infants born in Bangladesh. Services are provided from marriage through the firstborn child's second birthday. Intensive counseling efforts with newlywed couples and the mother-in-law, combined with iron-folate supplementation of the new wife beginning at enrollment form the cornerstones of the intervention, with monthly weight monitoring and supplementary feeding of malnourished pregnant women. Unmarried adolescent girls are also targeted to receive life cycle information, with specific messages designed to improve subsequent maternal health and pregnancy

outcomes. Building on the project's experience, the new World Bank-supported National Nutrition Program is scaling up many of these activities.

Source. Adapted from Elder, 2002.

Country: China
Project: Health VII Project
Year: 1996
Loan Amount: \$162 million

The China Health VII project was carried out from 1996 to 2003. The project goals were to increase capacity for health promotion to prevent and control noncommunicable diseases, STIs/HIV, injuries, and vaccine-preventable diseases. The total budget was \$162 million of which \$19 million was for a health promotion pilot component in seven cities where tobacco control was a main focus.

The tobacco control interventions include the following:

- **Citywide strategies**
 - Enacting policies to ban smoking in public areas and to ban sales of cigarettes to youth
 - Conducting a mass media campaign
 - Coordinating World No Tobacco Day activities
 - Coordinating international quit and win competition
- **Strategies for neighborhoods, schools, hospitals, and workplaces**
 - Setting up a tobacco control office
 - Developing no smoking regulations
 - Encouraging cessation (especially among role models such as teachers or doctors)
 - Conducting tobacco control education
 - Holding anti-smoking meetings and training classes
- **School interventions**
 - Soliciting student pledges to refuse the first cigarette
 - Encouraging students to advise their parents to quit smoking

The effect of the project on youth behavior appears to be significant: Behavioral Risk Factor Surveillance Surveys in the seven cities, each with samples of at least 2,400 people, found an overall decline from 19% to 10% of smoking prevalence among young men aged 15–20 (small declines were also reported for adult men and women, and small increases were reported in knowledge about the health risks of smoking).

Source. World Bank Project Appraisal Documents and supervision reports.

Country: Colombia
Project: Youth Development
Year: 1998
Loan Amount: \$ 7.8 million

Colombia, like many other countries in Latin America, struggles with rising levels of youth violence, high rates of teenage pregnancy, and drug addiction. The Youth Development Project for Colombia is designed to test and evaluate alternative multisectoral and participatory approaches to developing and delivering services and to providing activities for low-income youth. The ultimate goal is to improve and expand educational and employment opportunities. The national-level component of the project supports

technical assistance for the design and follow-through of subprojects, and it supports efforts to develop and carry out a learning network to support follow-through of subprojects and to disseminate subproject findings. A municipal-level component supports service delivery, subproject follow-through, and local learning networks.

Two principles guided the development of subprojects: (1) a multisectoral and integrated response to a perceived youth problem and (2) use of a participatory framework to develop, carry out, and evaluate the project. Using a participatory process, each municipality selected an issue to address. These issues included youth employment in two rural and two urban settings; family violence; juvenile delinquency and youth violence; and school dropout patterns. Committees composed of youth, local NGOs, universities, the private sector, and local government entities participated in the design, follow-through, and oversight of each subproject. For example, in one of the cities, the project worked with youth to convert two recreational areas that were under gang control into safe and constructive spaces. Young people defined the layout of the park, the activities it would support, and participated in its “reclaiming.” The project included the participation of the ministries of health, education, urban development, and sports as well as a number of NGOs. For each of the interventions, the projects are collecting baseline and end-line data to measure effects and outcomes.

Source. World Bank Project Appraisal Documents and supervision reports.

Country: Macedonia
Project: Children and Youth Development
Year: 2001
Loan Amount: \$2.5 million

In Macedonia, important youth issues include addressing inter-ethnic conflict; high unemployment rates resulting from the transition to a free-market economy; gender disparities in education that disadvantage girls; teen pregnancies; and drug addiction. The project aims to significantly increase social cohesion by integrating at-risk youth from different sociocultural backgrounds. Community-based approaches to work with young people and techniques to build institutional capacity are the two main strategies being used to empower youth. Activities include scaling up the program of life education for youth, which includes training in:

- Conflict prevention
- Computers and information technology
- English language
- Business development
- Life education skills
- Art, music, drama
- Environment awareness
- Sports

In addition, the project will support expanding the drug abuse prevention program of the Agency of Youth and Sports to all secondary schools and youth centers. The institutional development component of the project includes (a) setting up a project management unit to provide technical assistance; (b) developing a Participatory Youth Strategy and Action Plan; and (c) coordinating a Public Communication and Outreach campaign. The program will emphasize targeting rural areas; focusing on girls who have dropped out of school; extending current efforts to reach youth in the 18–24 cohort; and increasing youth and community participation.

Sources. World Bank, 2001c; La Cava, 2002.

Appendix B: Key Readings and Web Resources

The literature on adolescent health and development is vast. Similarly, Web sites with information on the topic abound. This appendix lists some of the best available publications and Web sites.

Investing in Youth

Publications

- Birdsall, N., Kelley, A. C., & Sinding, S. W. (Eds.). (2001). *Population matters: Demographic change, economic growth, and poverty in the developing world*. New York: Oxford University Press.
- Burt, M. (1998). *Why should we invest in adolescents?* Paper prepared for the Conference on Comprehensive Health of Adolescents and Youth in Latin America and the Caribbean, July 9–12, 1996, Washington, DC. Washington, DC: Pan American Health Organization and the W. K. Kellogg Foundation. Available on the World Wide Web: http://165.158.1.110/english/hpp/adol_burt.htm#what
- Buvinic, M. (1998). The costs of adolescent childbearing: Evidence from Chile, Barbados, Guatemala, and Mexico. *Studies in Family Planning*, 29(2), 201–209.
- Cunningham, W., & Correia, M. (2002). Caribbean youth development: Issues and policy directions. Washington, DC: World Bank, Caribbean Country Management Unit, Poverty Reduction and Economic Management Unit, Latin America and the Caribbean Region.
- Knowles, J. C., & Behrman, J. R. (2003). Assessing the economic benefits of investing in youth in developing countries (Health, Nutrition, and Population Discussion Paper). Washington, DC: World Bank.

General Adolescent Health and Development

Publications

- International Center for Research on Women. (2001). The critical role of youth in global development (Issue Brief, December 2001). Washington, DC: Author.
- Population Reference Bureau. (2000). *The world's youth 2000*. Washington, DC: Author.
- World Health Organization. (1999). *Programming for adolescent health and development: Report of a WHO/UNICEF/UNFPA study group on programming for adolescent health*. Available on the World Wide Web: [http://whqlibdoc.who.int/trs/WHO_TRS_886_\(p1-p144\).pdf](http://whqlibdoc.who.int/trs/WHO_TRS_886_(p1-p144).pdf)
- World Health Organization. (2001). *The second decade: Improving adolescent health and development*. Geneva: Author.
- United Nations Population Fund. (2003). *State of world population 2003. Making 1 billion count: Investing in adolescents' health and rights*. New York: Author.

Web Sites

Pan American Health Organization (Paho)

www.adolec.org

World Health Organization, Department of Child and Adolescent Health and Development

<http://www.who.int/child-adolescent-health/>

HIV/AIDS

Publications

- Horizons Program, Kenya Partners Project, & Uganda Partners Project. (2001). *HIV voluntary counseling and testing among youth ages 14 to 21: Results from an exploratory study in Nairobi, Kenya and Kampala and Masaka, Uganda*. New York: Population Council. Available on the World Wide Web: <http://www.popcouncil.org/pdfs/horizons/vctyouthbaseline.pdf>

- Kiragu, K. (2001). *Youth and HIV/AIDS: Can we avoid catastrophe?* (Population Reports, Series L, No. 12). Baltimore, MD: The Johns Hopkins University Bloomberg School of Public Health, Population Information Program. Available on the World Wide Web: <http://www.jhuccp.org/pr/112edsum.shtml>
- UNICEF, UNAIDS, & World Health Organization. (2002). *Young people and HIV/AIDS: Opportunity in crisis*. Available on the World Wide Web: <http://www.unicef.org/pubsgen/youngpeople-hivaids/index.html>
- World Bank. (2002). *Education and HIV/AIDS: A Window of Hope*. Washington, DC: Author.
- World Bank. (2003). *Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs*. Washington, DC: Author.

Education

Publications

- World Bank. (1999). *Education sector strategy*. Washington, DC: Author.

Livelihoods/Employment

Publications

- ICRW. (2001). *Making it work: Linking youth reproductive health and livelihoods* Available on the ICRW Web site: <http://www.icrw.org/docs/Makingitwork.pdf>
- International Labour Office. (2001). *Youth and work: Global trends*. Geneva: Author.
- World Bank. (2000). *Trinidad and Tobago: Youth and social development: An integrated approach for social inclusion* (Report No. 20088-TR). Washington, DC: Author.

Malaria

Publications

- Laloo, D. G. (2002). Issues in adolescent health and development: Malaria in adolescence. Geneva: Department of Child and Adolescent Health and Development, World Health Organization.
- World Bank. (2001). *Malaria at-a-glance*. Washington, DC: Author.

Male Involvement

Publications

- Alan Guttmacher Institute. (2003). *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide*. New York: Author.
- Inter-Agency Gender Working Group. (2003). *Involving men in sexual and reproductive health: An orientation guide*. Available on CD ROM and on the World Wide Web: www.igwg.org
- Rivers, K., & Aggleton, P. (2002). *Working with young men to promote sexual and reproductive health*. Southampton, United Kingdom: DFID, Safe Passages to Adulthood Program. Available on the World Wide Web: <http://www.socstats.soton.ac.uk/cshr/pdf/guidelines/workingwithmen.pdf>

Mental Health

Publications

- World Health Organization. (2000). *Preventing suicide. A resource for teachers and other school staff*. Geneva: Author.
- World Health Organization. (2001). *World health report 2001: Mental health: New understanding, new hope*. Available on the World Wide Web: <http://www.who.int/whr/2001/main/en/pdf/index.htm>

Nutrition

Publications

- Delisle, H., Chandra-Mouli, V., & de Benoist, B. (2001). *Should adolescents be specifically targeted for nutrition in developing countries? To address which problems, and how?* Washington, DC: World Health Organization. Available on the World Wide Web: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/Adolescent_nutrition_paper.pdf
- World Bank. (in press). *Adolescent nutrition at-a-glance*. Washington, DC: Author.

Road Safety

Publications

- Insurance Institute for Highway Safety & National Highway Traffic Safety Administration. (2000). *Q&A: Teenagers: Graduated driver licensing*. Available on the World Wide Web: http://www.iihs.org/safety_facts/qanda/gdl.htm#1
- World Bank. (2002). *Road safety at-a-glance*. Washington, DC: Author.

Web Sites

- The Global Road Safety Partnership.
www.grsproadsafety.org

Sexual and Reproductive Health

Publications

- FOCUS on Young Adults. (2001). *Advancing young adult reproductive health: Actions for the next decade*. Washington, DC: FOCUS on Young Adults. Available on the World Wide Web: http://www.pathfind.org/site/PageServer?pagename=Publications_FOCUS_Publications
- Greene, M. E., Rasekh, E., & Ahset-Amen, K. (2002). *In this generation: Sexual and reproductive health policies for a youthful world*. Washington, DC: Population Action International. Available on the World Wide Web: <http://www.populationaction.org/resources/index.htm>

Web Sites

- FOCUS on Young Adults
http://www.pathfind.org/site/PageServer?pagename=Publications_FOCUS_Publications
- Reproductive Health Outlook
<http://www.rho.org/html/adolescent.htm>
- UNESCO's Web site on adolescent reproductive and sexual health in Asia
<http://www.unescobkk.org/ips/arh-web/index.htm>
- United Nations Population Fund
<http://www.unfpa.org/adolescents/index.htm>
- YouthNet
<http://www.fhi.org/en/youth/youthnet/ynetindex.html>

School Health

Publications

UNESCO, UNICEF, the World Health Organization, & the World Bank. (2000).
School health: Focusing resources on effective school health: A FRESH start to enhancing the quality and equity of education. Paris: Authors.

Web sites

FRESH Initiative
<http://www.schoolsandhealth.org>

Substance Abuse

Publications

Jernigan, D. (2001). *Global status report: Alcohol and young people*. Geneva: World Health Organization. Available on the World Wide Web:
http://www.who.int/substance_abuse/PDFfiles/globsta_alcoyoung%20people.pdf
United Nations Economic and Social Council (ECOSOC). (1999). *Youth and drugs: A global overview*. New York: Author. Available on the World Wide Web: http://www.undcp.org/document_1999-01-11_2.html

Tobacco

Publications

U.S. Department of Health and Human Services. (1994). *Preventing tobacco use among young people: A report of the surgeon general*. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Available on the World Wide Web: <http://www.cdc.gov/tobacco/sgr2.htm>
Landman, A., Ling, P. M., & Glantz, S. A. (2002). Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. *American Journal of Public Health, 93*(6), 917–930.
University of Illinois at Chicago & Health Research and Policy Centers. (2001). *Cigarette taxes and kids* (Policy Briefs, volume 1, April 2001). Chicago: Author. Available on the World Wide Web: www.impactteen.org
Woollery, T., Asma, S., & Sharp, D. (2000). Clean indoor-air laws and youth access restrictions. In P. Jha & F. Chaloupka (Eds.), *Tobacco control in developing countries* (pp. 273–286). New York: Oxford. Available on the World Wide Web: <http://www1.worldbank.org/tobacco/tcdc.asp>
World Bank. (1999). *Curbing the epidemic: Governments and the economics of tobacco control*. Washington, DC. www.worldbank.org/tobacco
World Health Organization. (1999). *International consultation on youth and tobacco: What in the world works?* (Final report of a conference held September 28–30, 1999, Singapore). Geneva: Author. Available on the World Wide Web:
<http://www5.who.int/tobacco/page.cfm?sid=54>
World Bank. (2002). *Tobacco Control at-a-glance*. Washington, DC. www.worldbank.org/tobacco

Web Sites

Campaign for Tobacco Free Kids, Global Initiatives

www.tobaccofreekids.org/campaign/global/
Global Youth Tobacco Survey
<http://www.cdc.gov/tobacco/global/GYTS.htm>
World Health Organization, Tobacco Free Initiative
<http://www5.who.int/tobacco/>

Tuberculosis

Publications

Holmes, C. B., Hausler, H., & Nunn, P. (1998). A review of sex differences in the epidemiology of tuberculosis. *International Journal of Tuberculosis and Lung Disease*, 2(2), 96–104.

Uplekar, M., Rangan, S., & Ogden, J. (1999). *Gender and tuberculosis control: Towards a strategy for research and action* (Draft strategy paper prepared for Communicable Disease Prevention, Control and Eradication, World Health Organization, Geneva, Switzerland). Available on the World Wide Web: http://www.who.int/gtb/publications/Gender/Gender_paper.doc

Youth Development

Publications

World Bank. (2002). *Youth development in the Caribbean*. Washington, DC: Author. Available on the World Wide Web:
http://wbln0018.worldbank.org/LAC/lacinfoclient.nsf/Date/By+Author_Country/8612CE20DEB D4D6285256BCF004E097E?OpenDocument

Web Sites

Inter-American Development Bank Youth Program
<http://www.iadb.org/exr/mandates/youth/index.htm>
International Youth Foundation
www.iyfnet.org

Bibliographies

World Health Organization. (2001). *Guide to WHO documents concerning adolescent health and development*. Geneva.

Annotated bibliography of more than 100 documents, organized according to the steps in the frame for programming adolescent health (building political commitment; assessing priorities for action; maintaining implementation; monitoring and evaluation). Available on the World Wide Web:
http://www.who.int/child-adolescent-health/New_Publications/ADH/Guide_to_WHO_documents_Final_files/Guide_to_WHO_documents_Final.htm

Appendix C: World Bank Staff Members Working on Adolescent Health and Development

World Bank Staff Members Working on Adolescent Health and Development October 2003

Unit	Name	Telephone	E-mail	Interests/Expertise
HDNED	Aya Aoki	202-458-2197	Aaoki@worldbank.org	Literacy
EASHD	Jayshree Balachander	202-473-9798	Jbalachander@worldbank.org	Youth at Risk, Out-of-School Youth
EASHD	Rosemary Bellew	202-473-4836	Rbellew@worldbank.org	Education
WBIHD	Anthony Bloome	202-473-2282	Abloome@worldbank.org	Internet, HIV/AIDS
HDNED	Don Bundy	202-473-3636	Dbundy@worldbank.org	School Health
ECSSD	Carine Clert	202-458-4913	cclert@worldbank.org	Social Policy and Social Exclusion
LCSHD	Lorena Cohan	202-473-0880	lcohan@worldbank.org	Reproductive Health
HDNVP	Steve Commins	202-473-3470	Scommins@worldbank.org	Head, Children and Youth Cluster
LCSPG	Wendy Cunningham	202-473-2384	Wcunningham@worldbank.org	Youth at Risk
DECRG	Monica Das Gupta	202-473-1983	Mdasgupta@worldbank.org	Gender, Reproductive Health
HDNHE	Joy de Beyer	202-473-1887	Jdebeyer@worldbank.org	Tobacco
LCSES	Maria Donoso Clark	202-458-4645	Mdonosoclark@worldbank.org	Youth at Risk/Inclusion
AFTH1	Marito Garcia	202-473-5385	Mgarcia1@worldbank.org	Orphans and Vulnerable Children
ECSSD	Gloria La Cava	202-458-7646	Glacava@worldbank.org	Youth at Risk/Inclusion
HDNHE	Elizabeth Lule	202-473-3787	elule@worldbank.org	Reproductive Health
AFTH2	Seung-Hee Frances Lee	202-458-0504	Slee4@worldbank.org	School Health
ECSHD	John Innes	5242+246 (Turkey)	Jinnes@worldbank.org	Education, Economics
AFTH3	Eva Jarawan	202-473-4028	Ejarawan@worldbank.org	Road Safety
HDNED	Ruth Kagia	202-473-3314	Rkagia@worldbank.org	Education
HDNVP	Maureen Lewis	202-473-9080	MLEwis1@worldbank.org	Economics, Reproductive Health
HDNSP	Viviana Mangiaterra	202-473-4502	vmangiaterra@worldbank.org	Children and Youth Advisor
AFTH2	John May	202-458-7797	Jmay@worldbank.org	Reproductive Health
HDNHE	Milla Mclachlan	202-458-5954	mmclachlan@worldbank.org	Nutrition
WBIHD	Tom Merrick	202-473-6762	Tmerrick@worldbank.org	Reproductive Health
HDNHE	Nandini Oomman	202-473-2278	noonman@worldbank.org	Maternal Health; Reproductive Health
HDNED	Robert Prouty	202-473-7532	Rprouty@worldbank.org	Literacy
AFTHD	Khama Rogo	202-473-6117	krogo@worldbank.org	Reproductive Health

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LCSHH	Sandra Rosenhouse	202-473-2747	Srosenhouse@worldbank.org	Youth Development, Reproductive Health
EASHD	Fadia Saadah	202-458-2022	Fsaadah@worldbank.org	Reproductive Health, Maternal Health
WBIHD	Rashmi Sharma	202-473-0546	Rsharma1@worldbank.org	Reproductive Health
Staff Exchange IYF	Leigh Sontheimer	410-951-1569	Lsontheimer@worldbank.org	Youth Development
AFTH2	Tshiya Subayi-Cuppen	(Benin)	Tsubayi@worldbank.org	FGC
HDNHE	Kimberly Switlick	202-458-1827	kswitlick@worldbank.org	Male Involvement
LCSHS	Maurizia Tovo	202-473-7579	mtovo@worldbank.org	Orphans and Other Vulnerable Children
LCSHS	Andrea Vermehren	202-458-0657	avermehren@worldbank.org	Youth at Risk
SASHD	Maj-Lis Voss	202-458-9043	Mvoss@worldbank.org	Reproductive Health
HDNED	Carolyn Winter	202-473-1281	Cwinter@worldbank.org	Girls' Education
HDNHE	Ayda Yurekli	202-473-3749	Ayurekli@worldbank.org	Tobacco
HDNVP	Debrework Zewdie	202-473-9414	Dzewdie@worldbank.org	HIV/AIDS

Appendix D: Partners on Adolescent Health and Development

The World Bank often works in partnership on adolescent health and development issues. Some of the Bank's principal partners include the organizations listed in table below.

Agency	Focus Area	Web Site
The UN System		
International Labour Organization (ILO)	Youth Employment	http://www.ilo.org/public/english/employment/skills/targets/youth/
UNAIDS	HIV/AIDS	http://www.unaids.org/youngpeople/index.html
UNDCP	Substance Abuse	http://www.undcp.org/youthnet/
UNESCO	Education, Youth Development	http://www.unesco.org/youth/
UNFPA	Sexual and Reproductive Health, HIV/AIDS	http://www.unfpa.org/adolescents/index.htm
UNICEF	Health, Education	www.unicef.org
UNIFEM	Gender, Empowerment of Girls and Women	http://www.unifem.org/
UN Youth Unit	UN Focal Point on Youth	www.un.org/esa/socdev/unyin/
World Health Organization (WHO)	Health	http://www.who.int/child-adolescent-health/
Regional Organizations		
Inter-American Development Bank (IDB)	Youth Development, Employment	http://www.iadb.org/exr/topics/youth.htm
Pan American Health Organization (PAHO)	Health	www.paho.org
Bilateral Agencies		
USAID (US)	Reproductive Health, HIV/AIDS, Education	www.usaid.gov
DFID (UK)	Reproductive Health, HIV/AIDS, Education, Employment	http://www.dfid.gov.uk/
GTZ (Germany)	Youth Development	http://www.gtz.de/youth/english/
CIDA (Canada)	Youth Development, Employment, HIV/AIDS	http://www.acdi-cida.gc.ca/Youth
Private Foundations		
Kaiser Family Foundation	Sexual and Reproductive Health, HIV/AIDS	http://www.kff.org/
MacArthur Foundation	Population & Reproductive Health	http://www.macfound.org/
Rockefeller Foundation	Reproductive Health, Education	http://www.rockfound.org/
Turner Foundation	Sexual and Reproductive Health, HIV/AIDS	http://www.turnerfoundation.org/
UN Foundation	Sexual and Reproductive Health, HIV/AIDS	http://www.unfoundation.org/

Appendix E: Spotlight on Adolescent Health and Development in Africa

Who Are the Young People of Africa?

At the beginning of this millennium, 210 million Africans—one-third of the population—are between the ages of 10 and 24. This, the largest group ever to enter adulthood, is also the fastest growing of any region. By 2025, more than one of every five young people in the developing world—some 380 million people—will live in sub-Saharan Africa. African youth are increasingly concentrated in cities, making this generation the most urbanized generation in history.

In Africa, as elsewhere around the world, puberty is occurring earlier and the age of marriage is rising. This expanded “bio-social gap” means that young people are facing a longer period of time during which they are sexually mature and may be sexually active before marriage. This phenomenon is new to most traditional cultures and has brought new and unfamiliar challenges. Even with these profound cultural changes, boys in Africa continue to experience adolescence very differently from girls, and enormous diversity exists among and within countries.

What Are the Challenges and Opportunities for Young People in Africa Today?

African youth are growing up in a time of both heightened peril and unprecedented opportunity. More than ever before, adolescents—particularly those in cities—are connected to the world at large through communication, information, and transportation technologies. Yet, the cycle of poverty, inadequate education and work opportunities, and civil unrest stunts the development of too many millions of young people.

African youth face a number of threats to their health:

- More than 50% of the new HIV infections in Africa occur in young people, with girls disproportionately affected.
- Many millions of youth suffer from other sexually transmitted infections, which can leave young women infertile and, thus, often stigmatized by their communities and families.
- Half of women in Africa marry and give birth before age 20, many while they are still legally children.
- A large proportion of these pregnancies are unplanned, and many end in unsafe abortion.
- Teen mothers are twice as likely as older women to die of pregnancy-related causes, and their own children are at higher risk of illness and death, largely because of widespread nutritional deficiencies such as anemia.
- Approximately 2 million African girls undergo female genital mutilation each year.
- Millions of African youth die tragically or suffer because of other preventable health hazards, for example, road accidents, smoking, substance abuse, suicide, and infectious diseases such as malaria and tuberculosis.
- Political and ethnic violence disrupts the lives of many youth, either by drawing them into the fighting or by leaving them bereft of hope.

As they struggle to stay healthy, most adolescents in Africa have limited opportunities for formal education:

- Many young people never attend school or fail to achieve basic literacy before dropping out, in large part because of the poor quality of education.
- Outdated curricula leave students with skills that are largely irrelevant to the modern market economy.

- For the region as a whole, educational progress has generally stalled since 1990, failing to reverse the setbacks of the 1980s.
- Africa has the lowest enrollment rate at every level, and it is the only region where the numbers of children who are out of school continue to rise.
- In 26 countries, boys are enrolled at higher rates than girls, thus perpetuating gender inequalities.
- As school systems struggle to keep up with rapidly increasing numbers of school-age children, the HIV/AIDS epidemic is draining the supply of education, eroding the quality of the educational system, weakening demand and access, drying up countries' pools of skilled workers, and raising the cost of schooling.

Youth face an uphill battle to gain the skills and experience they need to compete in the job market:

- Many of the youngest adolescents are forced to work too young, thus cutting off opportunities for education and healthy development.
- Older youth who want jobs are having an increasingly difficult time finding employment. Unemployment rates for youth are typically in the range of 30% to 40%—two to four times higher than for adults.
- A large and increasing number of African young people live on the fringes of societies that neither listen nor care about their plight. Lacking opportunities to make a positive contribution, too many youth turn to crime and violence and feed existing civil unrest.

The Poverty Connection

In part because many youth fail to acquire the skills needed either to compete in the job market or otherwise make a living through self-employment, youth tend to be poorer than the rest of the population. Poverty and inadequate health systems compound the vulnerability of adolescents to sickness and possible death:

- Poor youth are particularly vulnerable to sexual violence and exploitation. In some African countries, up to two-thirds of girls who reported having sexual intercourse were accepting money or gifts for sex.
- On average, a poor African teen is more than twice as likely to give birth as a wealthy teen.
- Youth from AIDS-affected homes, including the 12 million under the age of 15 who are already orphaned by the disease, often have to forgo schooling and other opportunities, thus threatening their livelihoods prospects, forcing them deeper into poverty, and increasing their own chances of contracting HIV.

At the same time, poor health exacerbates poverty, either by weakening and killing young people in the prime of their working lives, by disrupting and cutting short school opportunities, or by placing heavy financial and social burdens on families.

Box E1. Africa's Youth and the Millennium Development Goals

The majority of the Millennium Development Goals (MDGs) are highly relevant to the health and welfare of African youth. Better adolescent health will directly contribute to achieving five of the eight internationally agreed-on goals: reversing the spread of HIV/AIDS; reducing maternal deaths; reducing infant and child deaths; developing and implementing strategies for youth livelihoods; and reducing poverty. For African countries to reach these goals by 2015, concrete commitments and actions are needed to support countries to get on track.

Can We Make a Difference? Yes. Despite the enormous challenges they face, young people in Africa—when supported by their families, schools, and communities—can make the right life choices as shown in the following examples:

- In Uganda, Tanzania, and Zambia, HIV prevalence among young people has recently declined by half or more, together with changes in behavior such as delay in first sexual experience and increased condom use.
- Although sub-Saharan has the highest adolescent fertility of any region, rates of teenage childbearing are declining in many African countries, and use of effective contraception is rising.
- Millions of youth defy the odds and go on to live productive and fulfilling lives, participating fully in the civic and cultural life of their communities and nations.

A Strategy for Action

Collectively, we know effective and affordable actions that can protect adolescents from ill health and set them on a course for healthy development. These actions can generally be organized as those that create a positive context for adolescent health and those that provide youth with good information and services.

Creating a positive context for adolescent health. Governments must, at every level, create an enabling political and social environment in which adolescents can truly and freely access programs that address their needs. These efforts should include the following:

- Promoting positive laws and regulations to legitimize efforts in societies where some aspects of adolescent health—for example, sex education and access to condoms—are controversial
- Establishing adequately funded national adolescent health programs
- Enacting policies to achieve universal primary education and expanded access to secondary education as well as to eliminate the gender gap in education
- Crafting and carrying out policies to expand economic opportunities for young people
- Working to change social norms that allow health problems to fester, for example, gender discrimination and cultural expectations to marry and bear children early in adolescence

Providing youth with good information and services. By virtue of their age, level of physical and emotional development, and life circumstances, young people require a special approach to their health needs. Successful efforts must do the following:

- Recognize the diversity of the youth age group. Programs should apply different strategies to reach subsets of youth that vary by age and sex, as well as by employment, schooling, and marital status. In particular, health systems need to do more to serve married adolescent women, a neglected majority in many countries. Special outreach is also needed for marginalized groups such as street children and displaced youth.
- Involve young people. Involving the youth in conceptualization, planning, follow-through, and evaluation of programs saves money and ensures ownership, success, and sustainability.
- Address gender inequality. These inequalities expose young girls to coerced sex, HIV infection, and unwanted pregnancy.
- Focus not only on girls but also on boys. Adolescence presents a unique opportunity to help boys form positive notions of gender relations and raise awareness of health issues.
- Make services appealing to youth. A key to rapidly expanding access for young people is to make existing health services more “youth-friendly” by (a) using specially trained health workers who are equipped with appropriate job aids and tools and (b) bolstering the privacy, confidentiality, and accessibility of care.
- Address multiple youth needs. Comprehensive programs that provide information and services while addressing contextual constraints are more effective than narrowly focused interventions.

- Address the many nonhealth factors that influence adolescent health. Linking school and livelihood opportunities to adolescent health programs, either at the policy or program level, is key to helping youth avoid risky behaviors.

The World Bank's Role

The World Bank's work on adolescent health and development follows naturally on its efforts to help children. The Bank uses its institutional strengths to complement the ongoing efforts of African governments and other aid organizations, specifically, to provide resources for proven approaches, to advocate for change through policy dialogue, and to work in partnership with governments and organizations.

Providing resources for proven approaches. Through its lending to combat HIV/AIDS under the Multicountry AIDS Program (MAP) and by means of traditional lending for health, nutrition, and population, the Bank has greatly increased its focus on young people in recent years. Currently, lending in 19 African countries supports a range of proven approaches, including advocacy and policy development; reproductive health education for in-school and out-of-school youth; social marketing of condoms; youth-friendly health services; care and support for AIDS-affected youth and orphans; and behavioral and other research. Recognizing the importance of schools as a venue for improving health, the Bank currently works in partnership to carry out the Focusing Resources of Effective School Health (FRESH) approach as part of more than 20 projects in Africa. The World Bank has been a long-standing partner to African countries in their efforts to educate their people and, to date, is the largest external source of financing for education in the region.

Advocating for change through policy dialogue. The Bank is increasing its efforts to help African countries take youth concerns into account when setting the countries' development priorities. In designing their poverty reduction strategies, many countries already have explicitly recognized the need to address head-on the youth dimension of the HIV/AIDS epidemic and the human capital needs of their populations. The Bank also helps strengthen political commitment for education and to support the macroeconomic reforms—with careful attention to their social implications—that are needed to address the problem of youth unemployment and underemployment.

Working in partnership. In all these efforts, the Bank highly values working in partnership with client governments, beneficiaries, nongovernmental organizations, the private sector, bilateral donors, foundations, and other UN agencies, including the WHO, UNICEF, UNAIDS, and UNFPA.

The Way Forward

Governments across Africa increasingly recognize and are addressing the needs of young people *before* they spiral downwards into a cycle of poor health, risky behaviors, violence, and poverty. Yet, powerful cultural, religious, and political groups in many countries continue to stifle forward movement, thus limiting resource allocation and the quality of programs for young people. African governments, supported by the international community and working in partnership with the private sector, must seize the opportunities at hand to promote the health and development of their young people. They cannot afford the cost of inaction.

Appendix F: Guideline on Adolescents for the Multicountry AIDS Program (II)

Adolescents form one-quarter of the world's population. Over 80% are in the developing world. The proportion of young people involved in high-risk activities is increasing globally. Many are migrating to urban areas where traditional social support and sanctions are lacking. The majority is not in school. Most of them are unemployed or hold menial jobs that make them economically vulnerable. Some are in refugee camps or act as child soldiers. Many are or live in the streets. They lack organized means of recreation and are easily attracted to high-risk behavior, including drug abuse and alcohol use. They have limited access to youth-friendly health care. Many with STIs are not treated in time or are inadequately treated.

Young people bear a special burden in the HIV/AIDS pandemic. Over 10 million young people (age 15–24) have HIV/AIDS—nearly one-third of all the people infected. In some countries, the rates of infection in girls (ages 15–19) are 4 to 5 times higher than in boys of the same age. A total of 13 million children under the age of 15 have now lost one or both parents to this epidemic. The children of yesterday are the young adults of today. Because of poverty and lack of parental support they may not be prepared for responsible adulthood. Many are forced by circumstances to become heads of households and earn a living at a very young age.

Key Actions:

- Create awareness among leaders on the magnitude of HIV/AIDS epidemic and implication for the youth and community;
- Initiate dialogue in order to enact appropriate policies, legislation and programs;
- Provide comprehensive and effective sexual and reproductive health information, education and services for youth in and out of school;
- Involve youth in program design and implementation;
- Promote and protect the sexual and reproductive rights of all adolescents;
- Explicitly address issues of gender in the epidemic generally and specifically within this age group;
- Promote and initiate programs that empower girls to be in control of their lives and sexual relations;
- Invest in programs to reduce poverty in and disadvantaged communities and in young people;
- Explicitly ensure that young people, including pregnant teenagers, have equal access to condoms, STI treatment and drugs;
- Support programs for AIDS orphans;
- Ensure that health systems and education departments are fully engaged and are playing central and effective roles in scaling up HIV/AIDS programs for the youth;
- Consider issues of long term sustainability of programs through community involvement and multi sector approaches; and
- Build partnerships and networks to avoid duplication and build on lessons learnt.

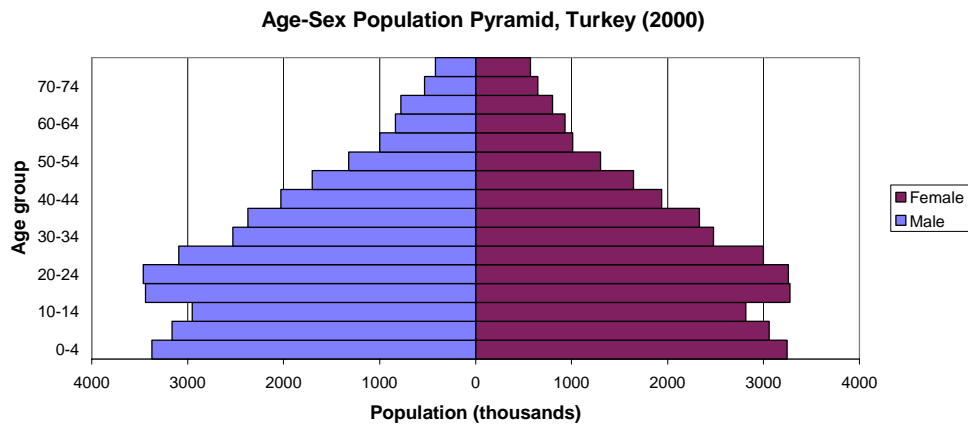
Source. Memorandum and Recommendation of the President of the International Development Association to the Executive Directors on a Proposed Credit of SDR 24 Million (US\$30 Million Equivalent) to the Republic of Senegal in Support of the US\$500 Million Second Multi-Country HIV/AIDS Program (Map2) (Apl) for the Africa Region (Report No. P 7497. AFR, pp. 65–66) by The World Bank, December 20, 2001. Available on the World Bank's Intranet at http://imagebank/servlet/WDS_IBank_Servlet?pcont=details&eid=000094946_02011904014578

Appendix G: Poverty and Adolescent Health: Turkey Case Example²

Poverty and Adolescent Health:

Figure G1 shows that young people ages 10–24 account for almost 30% of the country’s total population. This information suggests that Turkey will benefit immensely by investing now in the health of this emerging productive work force, particularly for those low-income youth who are less healthy and use services less often than wealthier youth.

Figure G1. Population pyramid by age and sex for Turkey in 2000

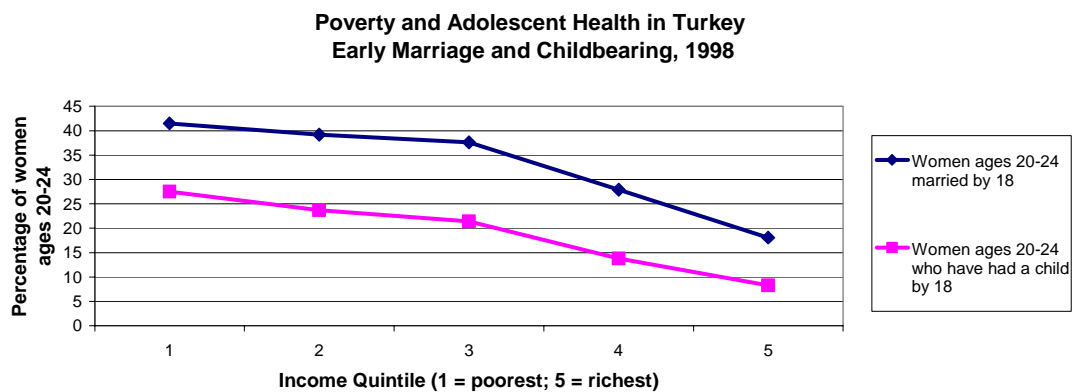


Source: Turkey Demographic and Health Survey, 2000

Marriage and Childbearing

Overall, 1 in 3 young women marry by age 18, with the poorest young women more than twice as likely to marry early compared to their wealthiest peers. Almost 20% of women have had a child by age 18, with early childbearing more than three times as likely to happen to young women in the poorest quintile compared with the richest quintile (see Figure G2).

Figure G2. Rates of marriage and childbearing in 1998 among women in Turkey ages 20–24

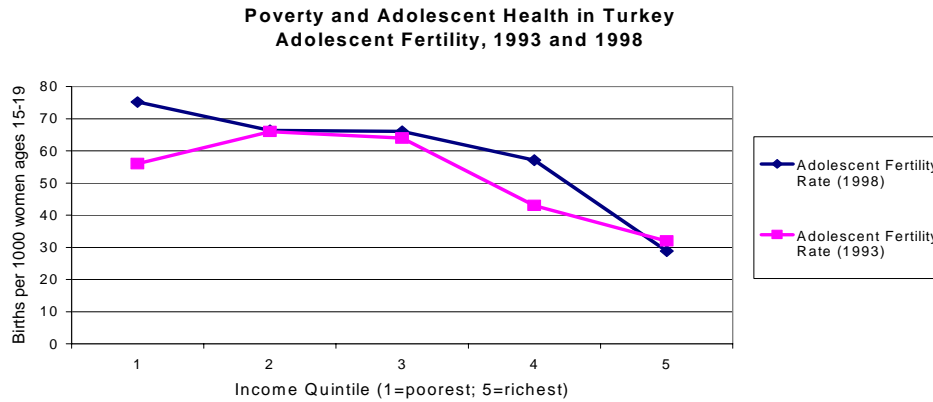


Source: Turkey Demographic and Health Survey, 2000

² Data for these analysis are derived from a secondary analysis of the 2000 Demographic and Health Survey carried out in Turkey.

Fertility rates for adolescent girls show a similar pattern across wealth quintiles. The birth rate for the poorest girls is almost three times as high as for the wealthiest girls (see Figure G3). Alarming, although adolescent fertility rose 8% between 1993 and 1998, fertility rates for the poorest groups rose by a disturbing 33% during the same period.

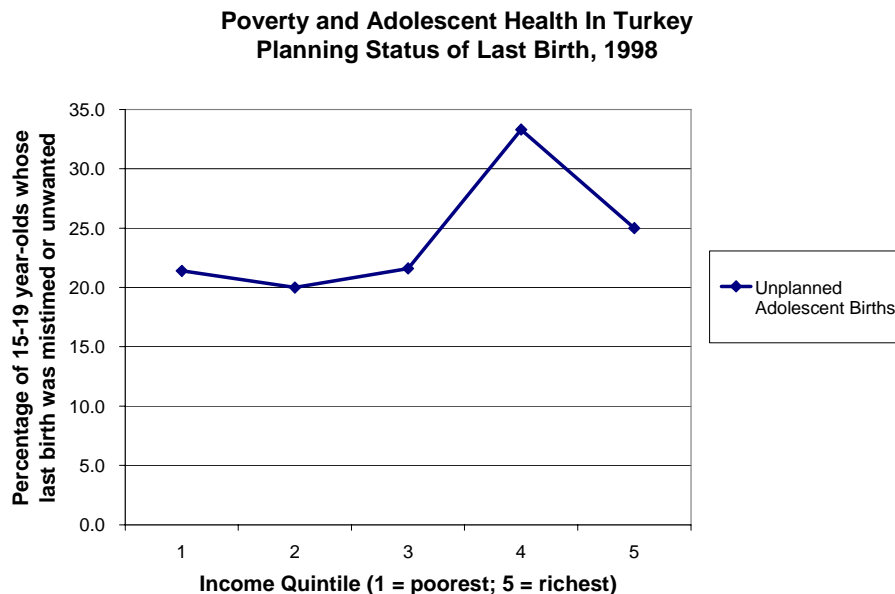
Figure G3. Rates of fertility among adolescent women in Turkey in 1993 and 1998



Source: Turkey Demographic and Health Survey, 2000

Disparities in the fertility rate across income groups (shown in Figure G3) do not appear to be related to large differences in a desire to bear children. As Figure G4 shows, the percentage of births to adolescents that were mistimed or unwanted—on average, about one in four—did not vary greatly across income groups and was even slightly higher for wealthier teens.

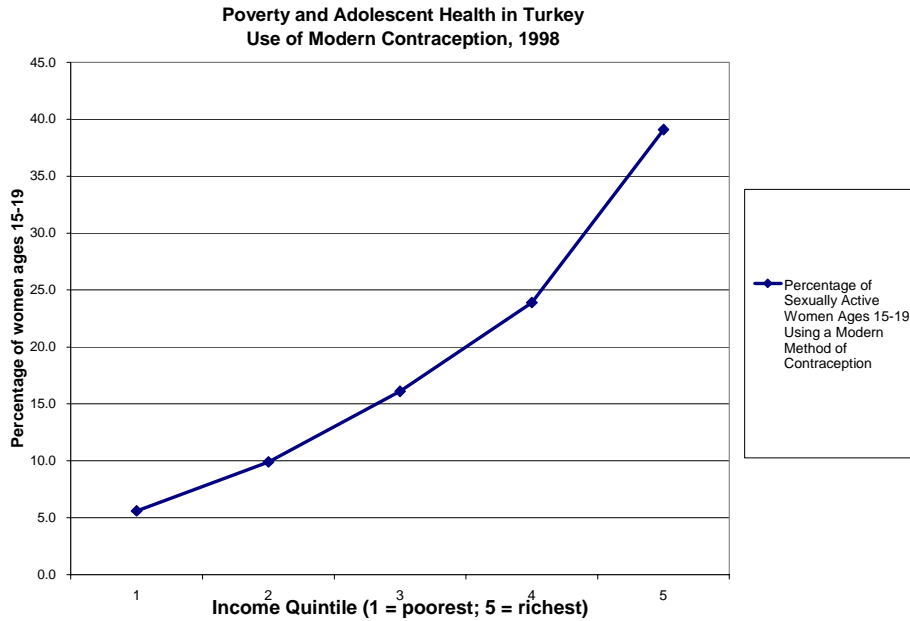
Figure G4. Planning status of last birth in 15–19-year-olds.



Source: Turkey Demographic and Health Survey, 2000

Rather, large differences in the use of contraception by sexually active youth may explain the disparity in births. As Figure G5 shows, wealthier teens are almost seven times more likely to use contraception than the poorest teens.

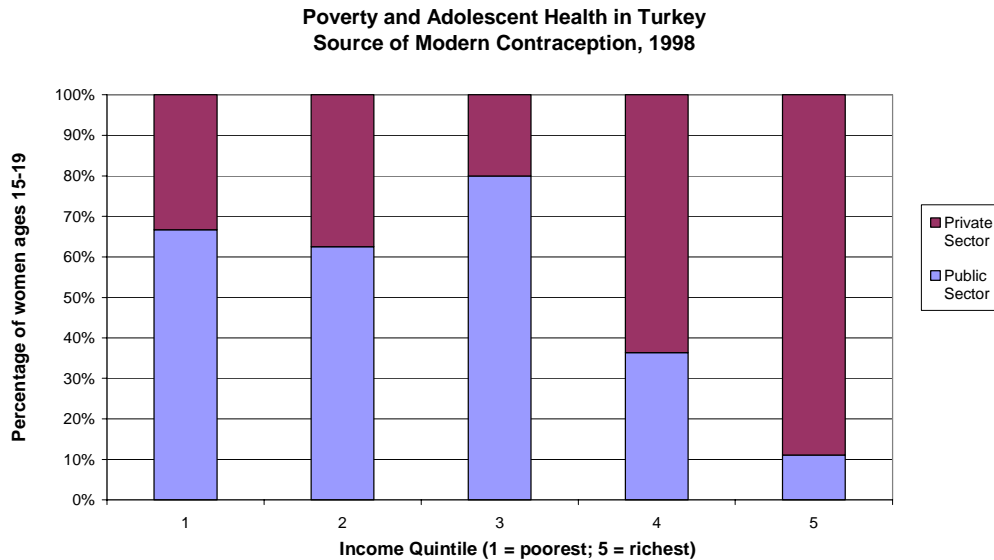
Figure G5. Rates of contraceptive use in sexually active 15–19-year-olds



Source: Turkey Demographic and Health Survey, 2000

Overall, slightly less than half of teens use the public sector as their source of modern contraceptive methods, although the proportions are much higher for poorer teens and much lower for wealthier teens (see Figure G6).

Figure G6. Ratios of private sector and public sector sources of contraception

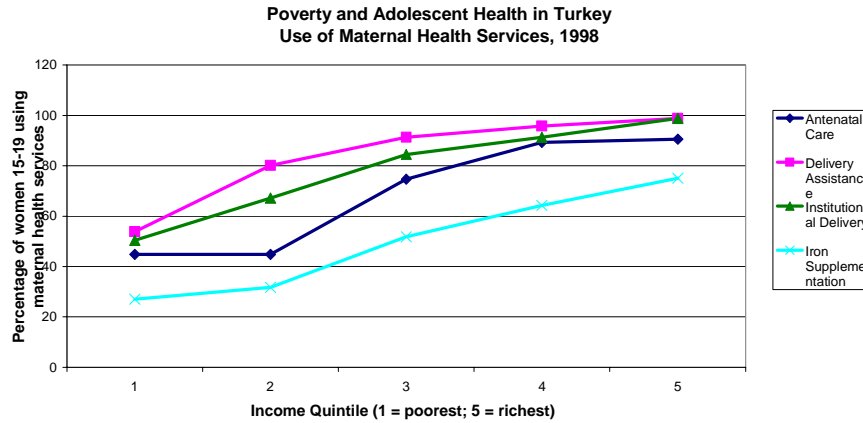


Source: Turkey Demographic and Health Survey, 2000

Maternal Health

Information is available from the Demographic and Health Survey (DHS) on adolescent use of four key maternal health services: antenatal care; assistance at delivery by a trained health worker; delivery in a health institution; and use of iron supplements. Although, on average, use of these kinds of services by adolescent mothers in Turkey is high, large disparities exist across income groups. In general, poor young mothers are half as likely (or less) to use maternal health services, as are their wealthier peers (see Figure G7).

Figure G7. Use of maternal health services by women ages 15–19

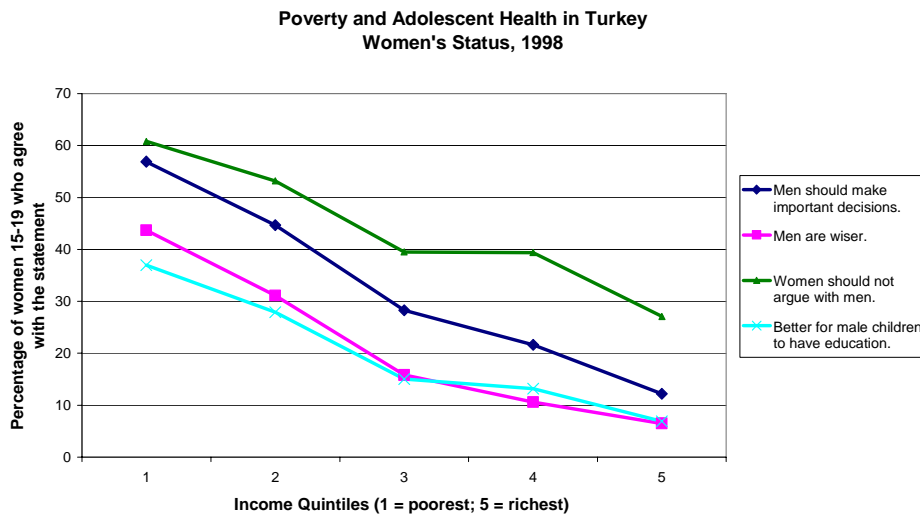


Source: Turkey Demographic and Health Survey, 2000

Women's Status

Poor adolescent girls are much more likely than their wealthy peers to agree with statements that indicate acceptance of women's inferior status relative to men. For example, almost 40% of the poorest girls compared with less than 10% of the wealthiest adolescent girls agree with the statement that it is better for male rather than female children to have education (see Figure G8).

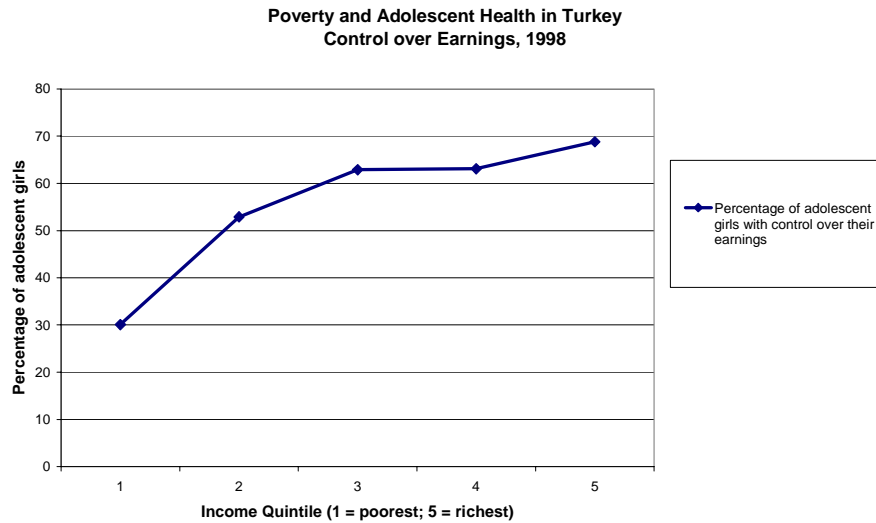
Figure G8. Rates of indications of agreement with women's inferior status relative to men among women ages 15–19



Source: Turkey Demographic and Health Survey, 2000

A similar pattern emerges in the analysis of control that adolescent girls have over their earnings. The percentage of girls who earn cash and report that they have control over how they can use the money they earn is more than twice as high among the richest girls than among the poorest—69% compared with 30% (see Figure G9).

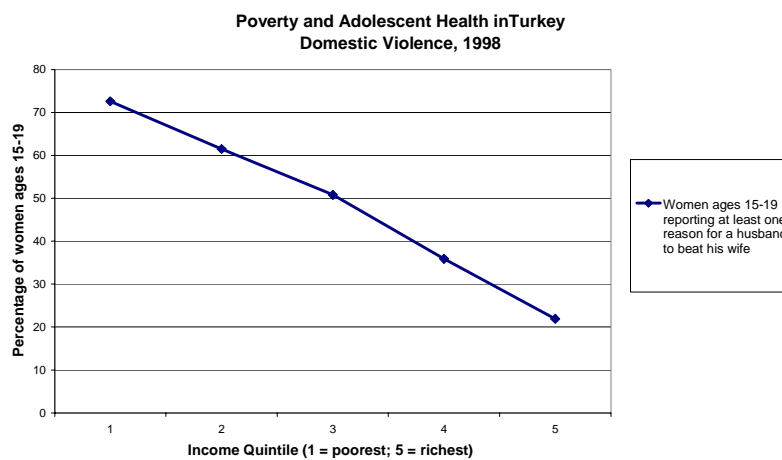
Figure G9. Rates of control over earnings among adolescent girls



Source: Turkey Demographic and Health Survey, 2000

Another indicator of how poverty affects the status of young women is their attitudes toward domestic violence. Almost three-quarters of the poorest adolescent girls report at least one reason that would justify a husband beating his wife, compared with only one in five of the wealthiest adolescent girls (see Figure G10).

Figure G10. Attitudes toward domestic violence

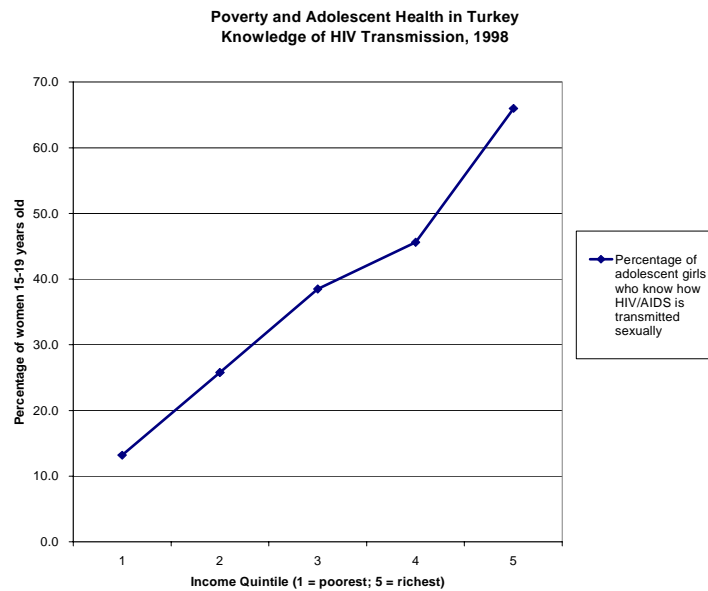


Source: Turkey Demographic and Health Survey, 2000

Sexually Transmitted Infection

The relative vulnerability of poor young women as suggested by the data on women's status is further highlighted by inequities in knowledge about how HIV/AIDS is transmitted. Only 13% of the poorest girls know how HIV/AIDS is transmitted sexually compared with 66% of the richest girls (see Figure G11).

Figure G11. Knowledge of HIV transmission among women ages 15–19.



Source: Turkey Demographic and Health Survey, 2000

Appendix H

**World Bank HNP Loan Commitments for Adolescent Health and
Fiscal Year 2002 (July 1, 2001, to June 30, 2002)**

Region*	Country	Project	Sub-sector**	Approval Date	Loan Amount	Adolescent Health Topic					
						Total	RH/AIDS	General	Nutrition	TB	Drug Prev
AFR	Benin	HIV/AIDS Multisectoral	A	1/4/2002	23	5.8	5.8				
LCR	Brazil	Family Health Extension Project	HS/PH	3/14/2002	68	0.9		0.9			
AFR	Burkina Faso	HIV/AIDS Disaster Response	A	7/6/2001	22	4.4	4.4				
AFR	Burundi	HIV/AIDS Control and Orphans	A	6/27/2002	36	9	9				
AFR	Cape Verde	HIV/AIDS	A	3/28/2002	9	2.3	2.3				
AFR	Central African Rep.	Multisectoral HIV/AIDS	A	12/14/2001	17	3.4	3.4				
AFR	Chad	2nd Pop. and AIDS	A	7/12/2001	24.6	6.2	6.2				
LCR	Costa Rica	Health Sector Strengthening and Modernization	HS	7/12/2001	17	1.7		1.7			
LCR	El Salvador	Earthquake Emergency	HS/PH	12/4/2001	142.6	0.4	0.4				
LCR	Honduras	Health System Reform	HS	5/7/2002	27.1	0.5		0.5			
LCR	Jamaica	HIV/AIDS Prevention and Control Project	A	3/29/2002	15	5.6	5.6				
AFR	Madagascar	STI/HIV/AIDS Prevention	A	12/13/2001	20	1	1				
AFR	Nigeria	Health Systems Development 2	HS	6/6/2002	127	1.6	1.6				
AFR	Nigeria	HIV/AIDS Prevention	A	7/6/2001	90.3	18.1	18.1				
AFR	Senegal	HIV/AIDS Prevention and Control Project	A	2/7/2002	30	10	10				
AFR	Sierra Leone	HIV/AIDS Response	A	3/26/2002	15	5	5				
Totals:					683.6	75.9	72.8	3.1	0	0	0

Fiscal Year 2001 (July 1, 2000, to June 30, 2001)

Region*	Country	Project	Sub-sector**	Approval Date	Loan Amount	Adolescent Health Topic					
						Total	RH/AIDS	General	Nutrition	TB	Drug Prev
SAS	Bangladesh	HIV/AIDS Prevention	A	12/12/2000	40.0	4.0	4.0				
LCR	Barbados	Caribbean Regional Initiative HIV/AIDS	A	6/28/2001	15.1	3.7	3.7				
AFR	Cameroon	Multisectoral HIV/AIDS	A	12/18/2000	50.0	37.5	37.5				
LCR	Dominican Rep.	Caribbean Regional Initiative HIV/AIDS	A	6/28/2001	25.0	7.4	7.4				
AFR	Eritrea	HIV/AIDS, Malaria, STDs, & TB Cont.	A	12/18/2000	40.0	14.8	10.4			4.40	
AFR	Ethiopia	Multisectoral HIV/AIDS	A	9/12/2000	59.7	19.9	19.9				
AFR	Gambia	HIV/AIDS Rapid Response	A	1/16/2001	15.0	10.0	10.0				
AFR	Ghana	AIDS Response	A	12/28/2000	25.0	8.3	8.3				
AFR	Kenya	HIV/AIDS Disaster Response	A	9/12/2000	50.0	12.5	12.5				
AFR	Kenya	Decentralized RH and HIV/AIDS	A	12/12/2000	50.0	15.0	15.0				
ECA	Kyrgyz. Republic	Health 2	HS	5/8/2001	15.0	0.5	0.5				
ECA	Moldova	Health Investment Fund	HS	8/22/2000	10.0	1.1	1.0			0.05	
AFR	Uganda	HIV/AIDS Control	A	1/18/2001	47.5	15.8	15.8				
LCR	Venezuela	Caracas Metro. Health Services	HS	6/26/2001	30.3	1.0	1.0				
Totals:					472.6	151.5	147.0	0.0	0.0	4.45	0.0

Fiscal Year 2000 (July 1, 1999, to June 30, 2000)

Region*	Country	Project	Sub-sector**	Approval Date	Loan Amount	Adolescent Health Topic					
						Total	RH/AIDS	General	Nutrition	TB	Drug Prev
SAS	Bangladesh	National Nutrition	PH	5/25/2000	92.0	18.4			18.4		
AFR	Madagascar	2nd Health Sector Support Prog.	HS	12/2/1999	40.0	1.3	1.3				
LCR	Peru	Health Sector Reform	HS	12/16/1999	80.0	4.0		4.0			
Totals:					212.0	23.7	1.3	4.0	18.4	0.0	0.0

Fiscal Year 1999 (July 1, 1998, to June 30, 1999)

Region*	Country	Project	Sub-sector**	Approval Date	Loan Amount	Adolescent Health Topic					
						Total	RH/AIDS	General	Nutrition	TB	Drug Prev
LCR	Argentina	Integrated Drug Prevention	PH	5/5/1999	4.8	4.8					4.8
EAP	China	Health Nine	PH	4/14/1999	60.0	1.6	1.6				
AFR	Ethiopia	Health Sector Development Program	HS	10/27/1998	100.0	1.0	1.0				
AFR	Guinea	Population and Reproductive Health	PH	12/1/1998	11.3	4.7	4.7				
SAS	India	2nd National HIV/AIDS	A	6/15/1999	191.0	9.6	9.6				
AFR	Malawi	Pop. and Family Planning	PH	9/23/1998	5.0	1.7	1.7				
AFR	Mali	Health Sector Development	HS	12/17/1998	40.0	1.0	1.0				
Totals:					412.1	24.4	19.6	0.0	0.0	0.0	4.8

* **Region Codes:** AFR = Africa; ECA = Europe and Central Asia; EAP = East Asia & Pacific; LCR = Latin America and the Caribbean; SAS = South Asia

** **Subsector Codes:** A = AIDS; HS = Health Sector Reform; PH = Public Health

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