

WORLD HEALTH ORGANIZATION
Regional Office
for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale



مِنْظَرَةُ الصِّحَّةِ الْعَالَمِيَّةِ
المكتب الإقليمي
لشرق البحر المتوسط

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

Thirty-third Session

Agenda item 14

EM/RC33/Tech.Disc.1
August 1986

ORIGINAL: ENGLISH

TECHNICAL DISCUSSIONS

ADOLESCENCE, HEALTH AND SOCIAL DEVELOPMENT

ADOLESCENCE, HEALTH AND SOCIAL DEVELOPMENT

Abstract

Adolescence, a transitional phase in the development continuum of man, is regarded as a dynamic period in which basic maturation and development needs go hand in hand with continuous adaptation, to produce a balanced state fitted to the accepted social order and based on a harmonious relationship with society. Considering that problems of adolescents are commonly manifestations that reflect the society in which they live, their emergence and evolution is in turn determined by the local context. A concomitant social diagnosis of underlying causes has to be made and policies and strategies addressing problems of adolescence must necessarily be envisaged and applied with respect to the individual particularities of a national situation which, in the Eastern Mediterranean Region (EMR), may be widely variable.

Maturation into adulthood from childhood is thus negotiated against a background that varies considerably in different settings. A wide range of socio-economic conditions, from the affluent to the destitute, from the evolved modern urban to the isolated traditional rural, or from the sedentary to the nomadic, often exist in one and the same country. The school, the social and community environment, peer groups and information media are the main influences, other than the family, that deeply affect the impressionable young.

Adolescents facing the progressively harsh demands of a rapidly changing, competitive, materialistic society are, on the whole, sustained by strongly rooted traditional cultures, family systems and religion. However, the roots of healthy adolescent development lie in healthy childhood. The current political strife, armed conflict and economic uncertainties in our Region are producing increasing numbers of disrupted families. The uncared-for children of refugees, migrant populations and communities traumatized by war, are seriously at risk; the healthy development, both mental and physical, of the future adolescent generation is in grave jeopardy. Thus, planning for better adolescent health and well-being must begin with the provision of all forms of care for all children, not forgetting the emotional and psychosocial.

Many of the abnormal behavioural or health problems which become manifest during adolescence can be related to identifiable causes dating back to early childhood; hence the importance of the role of the family and of maternal and child health (MCH) services in promoting the health of adolescents. The health problems that are common to this age group, as reported from EMR countries, cover high maternal morbidity, drug abuse, rising accident rates, behavioural and mental health problems and sexually transmitted diseases (STD). Physical disability and impairment, mental retardation, nutritional disorders, tuberculosis and medication abuse are less common.

Although specialized adolescent health services do not exist in EMR countries, health services manage to cope with adolescent health needs mostly within maternal and child health services. Specific problems, such as drug addiction, mental health, STD or tuberculosis, are addressed by specialized programmes. Because of their known poor health-seeking behaviour, access of

the health services to the adolescent sector of the population often poses a problem. A school enrolment that is commonly low, and a variable quality of school health services, further limit the role that such services could potentially undertake in the promotion of adolescent health.

The year 1985, which was designated International Youth Year (IYY), served to further develop, in all countries, national structures and bodies that serve youth. It is felt that, focusing as they do more on sports than on any other aspect, they do not adopt the comprehensive balanced approach that caters for the various needs of adolescence. The multi-dimensional nature of the problems of youth calls for intersectoral coordination which allows development of the capacity to meet the needs of adolescents in an integrated manner.

Development of a health dimension to an integrated youth programme, having the main function of health promotion through an information/education/communication (IEC) programme of activities, together with surveillance of identified risk groups particular to each country, would also serve to overcome the problem of access to this age group. In such a setting, adolescents themselves can, through active involvement and participation, deal with many of their own problems and at the same time contribute to the health and well-being of the community at large. Attitudes should change so that young people come to be considered as a resource rather than a problem. Harnessing the energies and idealism of young people, so that problems they face may be tackled in a creative way with their own active involvement, is strongly advocated.

TABLE OF CONTENTS

	<u>page</u>
1. INTRODUCTION	1
1.1. Conceptual framework	3
1.2. Methodology adopted for preparing the paper	3
2. SITUATION OF ADOLESCENTS IN EMR	4
2.1. A general Regional overview	4
2.2. Review of country data	6
3. ISSUES OF SPECIAL CONCERN	8
3.1. The family	8
3.2. The role of education	10
3.3. Adolescents and labour	12
3.4. Information and communications	13
3.5. Drug-related behaviour	15
3.6. Risk-taking behaviour	16
3.7. Adolescent girls	17
3.8. Sexually transmitted diseases (STD)	18
3.9. Disability during adolescence	19
3.10. Legal issues	20
4. ADOLESCENTS AND HEALTH SERVICES	21
5. INTERSECTORAL COLLABORATION FOR ADOLESCENT HEALTH	22
6. ADOLESCENTS AND SOCIAL DEVELOPMENT	23
7. RECOMMENDATIONS	24
7.1. Information and data collection	24
7.2. The family	24
7.3. Health services for adolescents	24
7.4. Intersectoral collaboration	25
7.5. Legislation	25
7.6. Research	26
7.7. Consultative body	26
REFERENCES	27
Figures 1-3	31

1. INTRODUCTION

The Regional Consultative Committee at its meeting in October 1984 agreed on the principle that subjects for technical discussion during the Regional Committee meetings should be topics which would be intersectoral in nature and would stimulate interest. From the various topics proposed, "Adolescence, Health and Social Development" was chosen for the technical discussion at the Thirty-third Session of the Eastern Mediterranean Regional Committee. The selection of this topic is opportune as it follows the designation by the UN General Assembly of 1985 as International Youth Year (IYY) with the guiding theme of "Participation, Development and Peace". During that year the eyes of the whole world focused on youth. Activities initiated in relation to IYY have served to indicate the major universal problem areas that affect young people across the global spectrum. Such activities are concerned with peace, development, education and training, work, health, housing, family life, culture and environment. Attention was drawn to the fact that the problems that youth (including adolescents) face are merely reflections of the larger problems of society. These problems should thus be analysed and addressed within the broader framework of global, regional and national social, economic and political structures.

The concept of youth, or adolescence, varies throughout the world as it is usually interpreted from a cultural point of view. Countries have different designations of, for example, the age of consent, of criminal responsibility, of compulsory school attendance, of liability for military service, of acquiring voting rights, and the right to manage one's own finances, of being permitted to drive a motor vehicle, or attaining the age for marriage. Even in the case of physiological phenomena, such as the onset of puberty in the two sexes, the age may vary from one country to another.

It is recognized that cross-cultural variations in the concepts of "adolescence" and "youth" may render the chronological definition of the stages of development socially arbitrary. In less developed societies children pass into adulthood and assume adult responsibilities with a very short or even non-existent transitional phase. Adolescence has been defined for the purpose of this paper as that period of development affecting people aged 10-19 years, i.e. from 10 up to less than 20 completed years of age. It is a transitional phase in the maturation process of the human development cycle and is characterized by growth and rapid change.

This period from the age of 10 to 19 inclusive covers early, middle and late adolescence. It includes children who are still at school as well as others who are already married and themselves have children. In this sense, the age grouping 10-19 years may seem ambiguous. A more expressive age bracket could have been, for example, 12-21 years. However, the 10-19 years' grouping has been used in this paper so as to coincide with age groupings commonly used for data analysis, e.g. in census data, morbidity and mortality statistics, vital statistics (birth, death, marriage statistics, etc.).

Growth and development of the adolescent are associated with three closely related maturation phenomena: biological growth (sexual maturation and physical growth) or puberty; cognitive advance and the arrival of abstract thought; and psychosocial development - the process of adolescence itself. The biological sequence of the events of puberty has not changed, although

evidence suggests that maturation now begins at an earlier age and that adolescents are attaining a greater ultimate size.

Adolescence is regarded as a dynamic period during which basic maturation and development needs go hand in hand with continuous adaptation, so as to produce a state of equilibrium fitted to the accepted social order and based on a harmonious relationship with society. The psychosocial process of adolescence through which a child becomes an adult is unique for each society. Emergence into adulthood for adolescents is negotiated against the background of their own worlds - family, school, peer group and self.

The parameters of health care for adolescents encompass a broad range of issues varying from the biological to the psychosocial, and from preventive to the remedial for specific health problems. These issues are often the result of complex interaction between biology, culture and society.

A WHO working group discussing the health aspects of adolescents and youth within the framework of IYY drew attention to the paucity of available information on the subject. Discussing perspectives, problems and priorities, the group categorized health and health-related problems as biological, psychosocial, sex-related, mental and emotional problems, and as disability, handicap and impairment. The need to develop an adolescence health policy, and adolescence health programmes to cope with the above, was expressed. Such a policy should, it was recommended, address linkages between the health services and services or programmes of other sectors. The multidimensional nature of the problems of youth calls for intersectoral coordination that allows development of the capacity to meet the needs of adolescents in an integrated manner.

Harnessing the energies and idealism of young people so that the problems they face can be tackled in a creative way was the background against which the WHO Study Group meeting in 1984 discussed "Young People and Health for All by the Year 2000". The study group examined the health issues faced by adolescents and the broad social repercussions of these issues in a rapidly changing world. General policy considerations addressed the subject from the perspective of active involvement and participation on the part of youth itself. As young people, given the appropriate and necessary support and encouragement as well as sensitive guidance, can deal with many of their own health problems and at the same time contribute significantly to the health and well-being of the community at large, it was stressed that attitudes must change so that young people come to be considered as a resource rather than as a problem.

Strategies for specific action in this area recommended the compilation and exchange of sound information on norms, special problems and programmes, services or institutions addressing the various aspects of health and social development for adolescents. Plans for specific action can only be based on the availability of adequate information.

The purpose of this paper is to introduce the subject and provide enough information in order to initiate discussions and guide decisions on important related issues: whether policy decisions for launching a programme or recommendations for specific action.

1.1. Conceptual framework

The subject of adolescence treats a phase in human development, the period of metamorphosis of the "man-child" into the "man-adult". A methodology based on the concept of man as a living whole is to be applied if we want to grasp the subject in its entirety, that is to say, both in its current state and throughout the whole course of its life.

As man is not confined to the limits of a physical/biological state of being but extends into a cultural and existential reality, this approach also becomes imperative as health is no more regarded within the narrow concept of the control and elimination of disease, but as a social goal and an integral part of development.

Thus, if our long-term objective is the achievement of the social goal of Health for All or, in other words, human welfare for all human beings, health policies for the welfare of adolescence(ts) have to be guided by:

- an identification of national health priorities, particularly in their relation to the phases and events of human development;
- the overall national socio-economic development policy/strategy;
- the national Health for All plan of action that fits into the framework of the national development policy/strategy.

Guided by the above, a policy and strategy for development of the health and welfare of adolescence can be evolved. The basic general reference is that adolescence(ts) constitutes a phase in the developmental continuum of man. The goal of Health for All represents the ideal state that "All" should enjoy. Situated between the above fixed and basic general reference point and the common ultimate goal are a number of movable causes and variables that are peculiar to each country and which determine the national health profile, the health priority order, and the policies and strategies to address them. The pattern, picture or features of a particular health problem in any given country are determined by the local context in which such a problem evolves. Natural, historical, socio-economic and political factors, among others, contribute and lend a specific national identity to any health problem. Considering that problems of adolescents (health and other) are commonly manifestations which reflect the society in which these same adolescents live, the emergence and evolution of these problems are, in turn, determined by the local context; therefore a concomitant social diagnosis of underlying causes has also to be made. Policies and strategies addressing problems of adolescence must necessarily be envisaged, and applied, with respect to the individual particularities of a national situation, as the health and well-being of adolescents are truly "existential" rather than simply biological.

1.2. Methodology adopted for preparing the paper

Collection, compilation and analysis of information relevant to the multiple issues related to adolescence in a country constitute the first essential step in developing a programme for improving the health and welfare of adolescents. An attempt was made by the Regional Office to collect enough information to present an overview of the profile of adolescents in the Region and the various dimensions of the subject seen against the features particular to the Regional situation. This was a difficult task as information on the subject was scarce and not always easily accessible.

In preparation for this paper, each member country was requested to bring together, in a national workshop, all those responsible, in health and other sectors, for the health and well-being of adolescents and to report on the priority health problems and the available services that are catering for this sector of the population, including the participation of youth themselves in health care. A limited number of countries responded, as requested, with reports on such a workshop. In addition, some of the important problems and issues prevalent among this age group in EMR have been individually treated with the presentation of pertinent data. A few in-depth country reviews were initiated by the Regional Office*.

2. SITUATION OF ADOLESCENTS IN EMR

2.1. A general Regional overview

The age group of adolescents, taken to cover the period from 10 to 19 years inclusive, represents about 22% of the total population in this Region. This young age structure of the population is expected to persist, and even to be augmented due to the prevailing pattern of high birth and death rates. This means that this age group, which makes up about 71 million of the population of the Region, is expected to increase in number to reach about 83 million by the year 2000.

While at present the majority of adolescents, especially in the larger, more populous countries, may be living in rural areas, continuous migration to urban settings is taking place in all countries. In fact, in a number of countries of the Region, the main bulk of the population already lives in urban settings.

There is great variability in the conditions and modes of existence for the 10-19 year olds in the Region. This variability also holds true for different communities within the same country. Some live in traditional, relatively isolated, societies while others are exposed to the progressive life-styles of modern existence. The majority of adolescents in the Region are generally brought up in an atmosphere of relatively strong adherence to norms of traditional cultures and value systems. Religious dictums are inculcated in them early, and usually govern and guide their behaviour. This strongly traditional upbringing, where the roles of the two sexes are also well-defined, is understandably the cause of the dilemma felt by adolescents exposed to modern life-styles, and the clash between generations when some of those adolescents decide to shed their traditional values, preferring what may be regarded by them as a more prestigious mode of existence. Close family ties and a deep-rooted sense of values and ethics, still common in EMR, are some of the positive factors tiding the youngsters safely over the troubled period of adolescence. Present day media, telecommunication systems, improved communications and transportation facilities all result in a continuous invasion of the traditional life-styles by contemporary life patterns, concepts, values and ideas.

*Copies are available at the Regional Committee.

Literacy in this age group is rapidly improving, and school enrolment rates are progressively rising in all countries for both boys and girls. This is especially noticeable for girls, although for them the situation is still undermined by an elevated school drop-out rate. (See Figure 1).

The Eastern Mediterranean Region, which comprises a mixture of affluent and less economically favoured Member States, presents a wide range of national resources and, in turn, of living conditions and opportunities. With an overall average gross national product (GNP) of around US\$1350 per caput, 4.5% of the population of the Region have a per caput GNP that exceeds US\$10 000 and 46.5% of the population have a GNP of less than US\$400 per caput. Young people, adolescents included, occupy a unique social position. They are active agents of the process of social change, on the one hand but, on the other, they often suffer as a result of it. Although they may certainly be victims of adverse economic situations and social conditions, they also represent a vast development potential and their active cooperation is extremely valuable in overcoming economic and social crises.

Specific groups of disadvantaged adolescents exist in unfavourable circumstances; these include those who are members of economically underprivileged families and those living on the margins of society. Such adverse conditions may be further multiplied and magnified by the great difficulties caused by natural disasters, political unrest and armed conflict occurring in a number of EMR countries. There are 5.5 million refugees involving the population of, or seeking asylum in, no less than eight countries of the Region.

Rapid growth in urban and peri-urban areas has resulted in large numbers of adolescents living in extraordinarily precarious conditions in settlements that lack basic services, housing or security. In addition, there are adolescents among migrants, refugees or young workers who struggle on the fringe of the labour force; adolescents with disabilities who face particular difficulties as they attempt to participate fully in society; and adolescents who may be driven by social circumstances into prostitution, crime, alcohol and drug abuse and trafficking. As the high illiteracy rates in EMR countries show, there are many adolescents deprived of educational opportunities. Adolescents, even though integrated into the formal educational structure, suffer from a dysjunction between education and the practical world of work. Few statistics are available to follow the transition of the young from education to employment, or indeed from their situation as children to their new responsible roles as spouses and parents.

Some groups of adolescents in certain settings are exposed to unequal or inadequate access to opportunities, e.g. for education or employment; they may also suffer from limited understanding and support in their special position with regard to family situation and health. Girls and young women are especially likely to be victims of long-entrenched discrimination, practices and attitudes. The average adult literacy rate for males in the Region is 49% against 26% for females, and female literacy is found to be as low as 10% in two countries, representing 8.3% of the population of the Region. Often denied the same opportunities as males for education, training and paid employment, their huge contribution, both actual and potential, and both to the economy and to society, is not always recognized. Females are thus, all too frequently, not given the chance to maximize their individual development and realization of their various social roles.

Adolescence may present particular features in rural situations. Developing in different historical and social contexts, the transition from childhood into adulthood tends to be shorter in the rural than in the urban setting and is facilitated by factors such as the social support provided by extended family systems. Commonly spared the need to search for an identity, boys and girls smoothly step into the well-defined roles which their fathers and mothers played before them. The early delegation of various work tasks speeds up the development in them of a sense of responsibility. This dependence on social support and protection provided by the extended family or tribal system fosters young marriages, and the young couples are usually integrated under the wing of the "family". In accepting such an existence, they also accept the authority and control of the family elders, and personal relations cede precedence to group relations. Recreation outlets and leisure time occupations are few and are rarely sought outside family circles. Opportunities for socialization outside the family for those not attending school are usually limited.

Acute alienation and a number of other disturbances are sometimes manifested by rural adolescents, exposed to foreign cultures and value systems through the information media, or subjected to rapid social change accompanying rapid economic growth, or facing the demands of evolved urban life. On the other hand, adolescents of rural origin belonging to the new generations brought up and educated in modern societies may feel the widening generation gap between themselves and their elders, and suffer accordingly. Although this may result in a clash of generations on a number of issues, investigations have shown that there is often a certain dependence of the older generations on the educated "modernized" youth, using them as a bridge for access to the intricacies of the new modern world from which they feel estranged.

2.2. Review of country data

Requested to report on the prevalent health and social problems faced by adolescents of both sexes, and the existing programmes or activities that address them, some Ministries of Health in the Region responded with country reports. It was probably because information on the integration of adolescents into national development was also requested that, in a number of instances, it was the social welfare or services or the youth sector that supplied the information, thus mainly reporting on social issues with little information on the health profile of adolescents in the country. The general trends abstracted from the information contained in these reports are presented below.

The situation of adolescents was reported against a background of the progressively harsh demands of a fast changing, competitive society, the common features of which were shared by many countries, especially in urban situations. These features include internal and external migration movements, rapid urbanization and the ensuing social adaptation problems, invasion by Western styles of life, difficult socio-economic conditions with limited opportunities for betterment, and social inequality, all multiplied by the emergence of an affluent consumer society governed by material values. Weakening of the family and of spiritual influences were reported in the face of the new materialism.

This environment, with its tensions, confusion and lack of harmony, was thought to magnify the generation gap and foster anti-social feelings and behaviour. However, this situation, usually predominating in industrialized urban settings, often becomes diluted by the traditional mode of life with its strong family ties and religious beliefs which commonly prevail in peripheral communities.

Various degrees of legislation and measures for control of information, communication and the media - including publications - were reported. The problem of the negative, destructive influence of uncensored importation and exchange of some forms of information materials, was seen to warrant stricter measures of control to protect the impressionable adolescent.

Although educational opportunities may be available to both sexes, the contribution of the school to their health care, and the degree to which the school satisfies adolescents' needs within the scope of overall human development, vary greatly. Lower enrolment rates and higher drop-out rates are commonly observed for girls. Fostering the development of national identity, cultural activities, physical training, leisure occupations, spiritual guidance and moral values are some of the positive elements that some schools provide. National coverage by facilities for sports and physical education, opportunities for socialization, and for developing or exercising responsibility were stated as being often deficient.

All Member States seem to possess structures or bodies that are concerned with the welfare of youth. In some countries it is represented at the ministerial level by a Youth Affairs Ministry, usually also responsible for sports, or by national committees or popular youth organizations. Various forms and levels of representation exist for these youth services or bodies.

Rapport and linkage between such national sectors concerned with youth and one or more of the other sectors, e.g. social welfare, sports, education and justice (juvenile courts) were usually present. Apart from the school health services, often provided by ministries of education and serving only those adolescents attending school, liaison and coordination between the youth sector and the health services were not general features. However, the involvement of older adolescents in health care services at the community level is present, albeit in the form of isolated experiences with limited applications, in a number of EMR countries. Varying degrees of social welfare services are enjoyed by special groups in this age bracket and are usually school-based or concerned with separately identified problems. No special health service addresses the age group of 10-19 years, apart from the school health services available to those attending school.

Social and psychosocial problems commonly quoted include: weak family ties, social pressures and poor social adaptation, anti-social behaviour such as running away, delinquency (including hooliganism), drug abuse and prostitution, high school drop-out and low school enrolment rates, insufficient opportunities for vocational training and decreased employment opportunities.

The rising incidence of addiction, maternal deaths, accidents and mental health problems, as well as sexually transmitted diseases, are felt to be danger signals in the health profile of this age group. Less dramatic health issues mentioned in the reports include physical disability and impairment,

mental retardation, nutritional disorders, tuberculosis and other respiratory infections and medication abuse.

3. ISSUES OF SPECIAL CONCERN

3.1. The family

The variety of family patterns existing in EMR is wide; such patterns differ extensively in different countries and within different settings in the same country. While many peripheral, remote and relatively isolated communities have preserved their traditional tribal or extended family patterns, the nuclear family is emerging and prevailing, especially in industrialized urban settings.

The influence of the family environment, total in early childhood, is succeeded by the first social contacts outside the immediate family, then by the school - where the influence of teachers and peers comes into play. Accepting that adolescents may be subjected to unfavourable influences from peer groups, the media and the environment, it must be recognized that it is the family that provides the understanding, support and protection to tide the adolescent safely over this difficult period of adjustment.

The family is recognized as the basic institution and environment directly influencing the progress and outcome of the phase of adolescence. Most valuable to the adolescent is a correct balance between love and discipline, stability, harmony between the parents and the projection of a good example for role-modelling. Behaviour and life-styles, whether good or bad, are often copied from the parents; for example, studies have shown that the majority of adolescents who smoke come from homes where one of the parents is a smoker. Anti-social behaviour and delinquency during adolescence are, in many cases, a manifestation or an effect of factors in the home environment that go back as early as the preschool age - mainly lack of love and discipline and weak personalities of the parents. The stability of the family structure is eroded and impaired by a number of factors and under various circumstances existing in several EMR countries. Extreme economic stress, urbanization, male labour migration, political unrest, warring conditions, refugee states and displacement of families can all undermine family unity and cohesion.

3.1.1. The absent father

Prolonged absence of the father, common to several of the above conditions, has led to an increase in women-heads-of-households struggling to cope on their own. This is also often followed by a disruption of the traditional family pattern with dissolution of the extended and joint families and the emergence of nuclear families. The volume of migrant labour between countries of EMR involves some several million males while the total number of refugees and displaced persons is over 5.5 million.

The absence of the paternal influence during the critical formative years of adolescence affects both boys and girls. It may influence the growth of their sense of values, identity, ethical behaviour, psychosocial development and socialization, especially in those nuclear families where there is no uncle or grandfather to assume the role of a father substitute. Although, theoretically, the teacher and the school can play important parts in bridging this gap, unfortunately the numbers of these unfavoured children attending

schools is usually small and the educational institutions themselves are not always of a calibre rendering them capable of influencing adolescents in this respect.

Adolescence is the age when it is important to develop a sense of responsibility, to establish an identity separate from that of the parents, and to establish relations outside the family environment. Excessive mothering and protection - vital to newborns and toddlers - will, during this age, have adverse effects, especially for boys, as it can result in dependence and identification with the mother and delay in psychosocial maturation. However, paternal influence and control are important to both boys and girls, as they convey and instil a code of ethics, values and morals, all of which are positive values and strong ramparts that protect and tide them over the period of adolescence.

3.1.2. Role of elders

Family elders, as the guardians of cultural heritage, traditionally have an important role to play in propagating beliefs, knowledge patterns and value systems. Adolescents of today are progressively less exposed to their elders and are often deprived of this input into their upbringing. Erosion of the family institution, weakening of the inter-generation bond and loss of dialogue between the generations are all contributory factors. This situation needs to be more fully understood and compensated for by inputs from the immediate family. The school, the information media and religious guidance can also contribute in this respect.

3.1.3. Women's work - or maternal deprivation?

The main pressing problems that individuals, families, communities or nations are currently facing are economic in nature. The tendency to overlook the fact that overall development has to reach - and involve - all human aspects and not only the purely economic aspect, has given rise to a number of social problems in the wake of isolated trials and attempts to improve the economic situation. Such social problems have had grave repercussions on the family. One of these is women having to work.

As optimal realization of all aspects of the adolescence phase can only take place against a background of a balanced presence of both the father and the mother, and the family as a unit, the important issue is how to achieve social development while keeping the family unit intact. Recognizing that development cannot be conceived without an involved society, each member of which has a role to play, the problem that should be tackled is, therefore, how to divide work between men and women so that there is no interference with women's family-related obligations. Each society, according to its structure, traditions and value systems, has to find and define the system and the conditions for women's work that (a) protect and preserve the existence of the family and its unity (or cohesion); (b) define the conditions of woman's work that do not interfere with her essential role in the appropriate development of her children; (c) protect the institution of the family, this being the nucleus of society; and (d) encourage women's best contribution to national development.

Work for women poses a problem inasmuch as it undermines the maternal presence in a family. This may, in turn, affect the unity and welfare of the

family and its members, weaken the society concerned and drag on the wheel of development. The peasant woman in EMR countries who toils from sunrise to sundown preserves her presence with her family, and at the same time fulfils her obligations towards her children, husband and home. Conditions of work for women in modern industrialized settings may seriously interfere with their family-related responsibilities and obligations.

3.2. The role of education

3.2.1. Developments in education

Education and learning in our Region, in the past, was for the privileged few. For the majority of people, informal and generally religious classes were available to answer simple local needs in literacy and numeracy.

Interaction with the Western world was followed by gradual introduction of formal educational systems and curricula based on imported Western models, and devoted to the development of examinable academic and intellectual skills. Education thus underwent a process of formalization and secularization. But the new model has never quite seemed to fit the conditions of the "developing" societies which it was intended to serve and disparities often continue to persist between what is taught and the practical demands of adult life in such societies. Moreover, this stereotyped form of education was usually unrelated to countries' specific needs.

Rapid quantitative expansion of formal education has, in most countries, proceeded without careful planning or coordination with other aspects of the country's life and resources. It seemed to thrive at the expense of the quality and standards of education. Standards of selection and training of teachers were often seriously relaxed in order to staff the fast-multiplying schools.

In spite of the general economic recession, education programmes in countries of EMR still enjoy a certain priority in national plans. Formal school systems that provide education (obligatory in most countries) for children at the primary or basic level exist in all countries of EMR. A number of countries in the Region have, over the past years, reached universal or quasi-universal coverage by education for the primary level. While educational opportunities are equally available to both sexes, it is still observed that school enrolment for girls lags behind that for boys. Differences in enrolment rates between boys and girls are progressively diminishing for the primary level with the overall increase in the number of girls going to school. The gap widens again at higher levels of education, where the drop-out rate for girls becomes high and where cultural and other factors interfere with the further pursuit of education for girls. (See Figure 1).

3.2.2. Adolescents and education

The age group for adolescents, as used in this paper, does not coincide neatly with the age groups in the different levels of education. It covers the end of the primary level, the whole of the secondary level and the beginning of higher education. Technical schools and vocational training, when present, mainly address the adolescent population.

Of the total adolescent population in EMR a great many do not receive the benefits of education because of lack of access to the school system for one reason or another. This uneducated group will have limited employment opportunities and will be less able to contribute to the overall development of society. Special programmes and measures will need to be directed towards their re-education/training for integration into national development. They represent a wastage of human resources described as a "social pathology" whose "shadow" extends into the future of a country as the attainment of Education for All and the development of human resources is regarded as a major social objective, with a view to enhancing particularly the capacity of developing societies for economic and social progress.

The relatively low literacy rates for several EMR countries, being lower still for women especially in rural areas (10 to 30%), means continued undermining of progress and social development. The uneducated will have limited opportunities for productive contribution to national development. For women, there is documented evidence that literacy (and education) is the one single factor that can improve child survival and the care and welfare of the family.

Many countries are re-examining their education plans to render them more realistic and relevant to the training, professional and manpower demands of national development. An increase in technical and vocational training opportunities is slowly replacing indiscriminate expansion in higher education. Yet vocational education, which could provide a practical solution to the problem, does not appear to be making headway in several of our countries as it is still regarded as a second-rate type of education, leading to manual occupations traditionally looked down upon. Governments in countries with limited resources are often unable to provide the modern technical institutions which would render such training attractive and satisfying to the young. However, such training is vitally needed to cope with the high technological advances of modern life.

Education policies and employment opportunities are often not coordinated in national plans, with the young in mind, expansion in education not being met by cadre or job opportunities in national development plans or ambitious development programmes not being backed by the training and professional education necessary for developing the required manpower. Good planning in this respect will primarily benefit the younger generations.

A peculiarity of modern culture, as far as adolescents are concerned, are the extremely complex, interactive relationships existing between various factors affecting this sector of the population. These factors are: family, religion, school, media and peer groups. Both separately and collectively they exert influences, in the fields of ideals, values and ethics; this may well be a cause of the moral confusion experienced by the young of today. These young people often find themselves the target of instruction or faced with examples from the family, school and media that pursue widely disparate goals which are often inconsistent and uncoordinated: while, for instance, the school and the family may encourage honesty, integrity, altruism and respect for others the mass media may promote violence, aggressive behaviour, relentless pursuit of material wealth and self-indulgence. There is a renewed universal drive for schools to assume greater responsibility for moral education. It may be opportune to initiate programmes to prepare teachers for such a role.

3.3. Adolescents and labour

Adolescents - and children - represent a defined group as a labour force and breadwinners in several countries of EMR. Generally, the engagement of children in labour is a part of underdevelopment, and it has been noted that it persists in an inverse relation to a country's degree of economic advancement. (See figure 2). Children have often traditionally worked alongside their parents, but what is newly emerging is the systematic exploitation of the young outside the family environment.

The child's wage, however meagre, may for poverty-stricken families mean simply "to eat or not to eat". Parents who send their children out to work do not see themselves as being exploitative, since the family has always been viewed as a single economic unit to which each member contributes. Child labour serves to increase the family income, its purchasing power and the nutritive value of the family diet and thus improves the health of the family. Information in many countries of the Region on the nature and extent of the engagement of children and adolescents in different occupational settings and economic sectors, as well as on their related health conditions, leaves much to be desired. The fact that child labour in most countries is a clandestine activity makes it difficult, if not impossible, to obtain figures that correctly represent the actual situation.

Available legislation on child labour in some countries of the Region is sound, and is certainly a necessary first step. On review of labour laws in 12 countries in the Region, it became evident that child labour is not totally banned. All these countries prohibited employment of children below a certain age, that ranged between 12 and 15 years, except if employed within the environment of the family and under supervision. All countries required every child to be medically examined and certified as physically fit for the required work; to be employed on written consent from his guardian; to be medically examined at one-year intervals; to have completed his basic education; not to be employed more than six hours a day; to be allowed one or more breaks for rest, prayer and meals; not to work overtime or on holidays and weekends; not to be employed in night work; and not to be employed in strenuous and hazardous operations or jobs harmful to his health.

Legislation has virtually eradicated child labour in the formal manufacturing sectors (larger industries). Yet children continue to be employed in the "informal" sector, composed for example of small enterprises that are often not registered and thus escape all forms of government inspection and control in terms of safety regulations, hygiene standards, etc. Indeed, one problem of legislation prohibiting child labour is that it drives it underground. These children are not covered by any benefits, receive no sick leave or indeed any leave at all, could be subjected to maltreatment, and are not protected by any on-the-job injury provision. The working conditions are entirely arbitrary and depend on the benevolence of the employer. As for children working on the streets, the authorities often turn a blind eye.

Long hours and days of uninterrupted, monotonous, exhausting or hazardous work have a negative effect on the child, narrowing his horizons and often crippling him emotionally. They deprive him of his chances for education, leisure and recreation which are essentials for normal healthy psychosocial development as well as being unalienable human rights.

3.4. Information and communications

Modern communications have become a potent force for social change. Developments in mass media, telecommunications and informatics - and indeed in the swiftness and ease of moving people and goods - are having such far-reaching effects in such a short time that it is difficult to comprehend or even describe their cumulative impact. Most difficult to grasp is the facility with which societies have absorbed the resulting quantitative and qualitative changes, have adjusted to a complete upheaval of established ways of doing things in work and leisure, or social and family life, and have become totally dependent on products and systems which were only concepts - if that - half a generation ago; in some cases, only half a decade ago.

The effects of such sweeping changes varied, according to country, social group and activity. The balance of advantages is in favour of those who possess the greatest capacity to make use of information - as distinct from those who merely have access to it. This means that, with regard to countries, those with established education systems, scientific traditions, extensive facilities and development experience will be in a much better position to benefit from modern communication systems.

All countries face the problems that are triggered by the technical capacity for near-instant worldwide diffusion of all forms of information, opinions and comments, in a world of immense diversity of social realities and traditions. Given the predominance of developed-country organizations in the shaping of what is diffused as information, there is a natural apprehension that one particular and not necessarily representative view of the world, of issues and of events, will tend to dominate all others. On present indications, this danger, while real, may be contained by the fact that the recipients' interpretation of information is also important. The present diversity and varying social realities of communities will continue to act as effective barriers to cultural encroachments.

The reach of the mass media, especially the electronic media, has been vastly extended in recent years. More people now have regular access to radio than can read and write. Near-universal access to both radio and television will be achieved, if current trends continue, well before universal literacy.

3.4.1. Adolescents and the media

Adolescents are among those who are most influenced by the media. They are considered an impressionable target group of the population for media programmes, especially the audiovisual. The adolescent is continuously looking for resources, apart from his active imagination and creative fantasy, to draw on for images and forms for role-modelling his new identity.

While childhood can be called the dependent age as regards needs to be satisfied, adolescence is generally identified as the age of change with problems to overcome. Acutely living his own problems, the heightened learning capacity of an adolescent and his avidity for knowledge and information on matters of primary personal concern guarantee the impact of media programmes that address such problems. These programmes will serve to foster his emotional, mental and social growth and maturation.

Programmes dealing with health and health-related problems suffered by adolescents, treated from the angle of their felt needs, providing solutions and answers to the ignorance/anxiety/fear caused by otherwise incomprehensible physical and emotional changes, and informing about nutritional and exercise needs and other topics demonstrating healthy life-styles, are certain to be well received and "absorbed" by adolescents. However, such an approach to adolescents' health rarely figures in media programmes.

Review of media programmes in general reveals that they are usually not oriented toward satisfying the felt information needs of adolescents. Being a double-edged weapon and a potentially powerful tool for this age group, a general critique of media programmes in EMR countries in their bearing upon adolescence is attempted hereunder:

- A varying volume of imported programmes portraying images usually of Western modern life-styles provides an unopposed continuous source of alien imagery to adolescents.
- Programmes addressing youth issues may be imported and therefore do not relate to the local setting, whether social, cultural, psychosocial or political. Thus they have a poor impact and only serve to further alienate youth.
- They do not reflect the whole range of problems experienced by this age group. A few problems chosen to be dealt with are repeated over and over again, no attention being given to other areas of information needs felt by the adolescents themselves. This "unbalanced" approach to information, with programmes excessively weighted in certain areas, may only lead to frustration, and even to a reactionary, resistant attitude.
- As the media are usually State-controlled, efforts should be made to reach the politicians, decision-makers and opinion-formers and raise their awareness as to the needs of adolescents and to the appropriate means of communicating with them.
- The unscientific approach, commonly resulting in irrelevance of content and poor impact of media programmes meant for adolescents, is due to the fact that no qualified specialists contribute to the structuring, design and realization of such materials. A positive role in adolescent development can only be assumed by the media if they are handled by competent qualified specialists and not left to media technicians alone.
- Few programmes are of a preventive nature, adopting a risk approach for an identified problem of adolescence and dealing with it before it becomes manifest. They usually follow such crises as may arise.
- Adolescence is labelled a "danger age" and media usually identify a few "danger" manifestations of interest to the authorities and public, such as addiction and delinquency. Not adopting the scientific approach, these subjects are not treated as manifestations of an underlying cause. The media often take a short-cut approach and openly portray examples of deviant behaviour. There is a common erroneous belief that this frank portrayal, accompanied by a strong commentary, will provide adolescents with enough information and exert a corrective influence. On the contrary, this may only result in a stimulation of the adolescent's fantasy and supply it with ready-made "forms" for his imagination and can thus often produce negative or destructive outcomes.
- Censorship and legislative control over the media commonly exist. This is governed by different codes and is observed to varying degrees.

- Illicit uncontrolled importation, sale and distribution of videotape cassettes represent an alarming trade that is quickly spreading in many countries and is especially popular among adolescents and youth.
- While considerably widening young people's horizon of experience, which is now no longer limited to the immediate surroundings, the media often erode the roles of the family and the school as the main agents influencing the young on moral issues accepted by society. TV, films, modern ("pop") music, and other elements of mass culture exert greater appeal for the young and are thus new sources of influences and persuasion for the adolescent.

3.5. Drug-related behaviour

Although the use of well-known dependence-producing drugs, such as opium and cannabis, has been known in countries of the Region for a long time, a new dimension to this problem has been added in recent years by the rapid increase in their misuse by the introduction of many more refined and synthetic products backed by vested interests of a powerful illicit trade. One of the most distressing aspects of this new phenomenon of drug misuse is the involvement of more and more youth and adolescents. Whereas in the past use of such drugs on certain occasions was socially condoned, their gross abuse was confined to only a small section of society, mostly in the middle and older age group. In recent years, there has been a great upsurge of this phenomenon in the middle social classes, in the urban areas, particularly affecting youth, and instead of single-drug use poly-drug abuse is becoming more frequent.

There is at present a large number of substances which have the common property of altering brain functions, and which are generally known as psychoactive substances. They may be depressants, stimulants or hallucinogens. However, all of them alter brain functions, have a tendency toward producing dependence and are thus health hazards.

In spite of great concern expressed by various community leaders and health authorities in many countries about the health and socio-economic consequences of drug abuse, reliable epidemiological data are still very scanty. Most information is based on the impression of doctors seeing many more cases than before, or on the amount of a drug confiscated in an occasional customs raid. Reliable epidemiological surveys are very few. No proper information system has yet been established, at either country or Regional level, to collect and provide regular information about the size of the problem and the adequacy of services, and also to monitor changes in the patterns of drug abuse.

In 1982, a study done on a sample of 5530 male pupils (age range 15-21 years) representing all secondary school pupils of a major city in this Region, revealed that approximately 18% of the total sample smoked tobacco. Regarding the use of drugs without prescription, 5.3% had tried tranquillizers, 5.7% stimulants, 4.7% hypnotics and 10.5% narcotic drugs (90.7% cannabis, 7.4% opium and nearly 2% other narcotics). The percentage of pupils of the total sample who had ever tried beer was 43.3%, wine 13.6%, whisky 13.9% and other alcoholic beverages 6.7%. In one major psychiatric hospital in a country of the Region, the number of drug-dependant persons admitted in 1982 was only eleven. In 1985, the number had gone up to over six hundred. Part of the increase is due to change in admission policy: whereas in the past cases were admitted only on court order, now they are being admitted on a voluntary basis. The majority of the cases were of

heroin addiction which was virtually unknown before 1980. About one quarter had picked up this habit in their teens. A similar dramatic increase has been reported in recent years in a few other countries in the Region.

Another feature of the current drug scene is the rapidity and unpredictability of the spread in drug abuse and the potential for the rapid emergence of new patterns of misuse. The mescaline and LSD popular during the 1950s were soon replaced by cannabis during the '60s, then by heroin in the '70s. In the West the use of heroin has now declined, but it has been followed by an even bigger wave of cocaine. Waiting in the wings are the new, synthetically produced "designer" drugs, volatile inhalants and who knows what else.

While considering the dangers posed by the increasing use of illicit drugs, we often tend to forget the havoc wrought by tobacco on the health of young people. Tobacco use begins mostly in adolescence, and in many countries a quarter to half of the college-going male population use it regularly. An increase in women smokers is also now noted in many countries of EMR. In this context a recent report from Australia is worth keeping in mind. Some 20 500 deaths during 1983 were attributable to drug misuse. Of these 81% were due to tobacco, 16% to alcohol, 1% to barbiturates and 2% to all other drugs.

It is difficult to give a straight answer to the question: "Why has such a large number of youth taken up the self-destructive behaviour of drug-taking?" Obviously what we are seeing in our Region is part of a larger, global phenomenon. Psychologically, drug abuse is a complex interaction between the personality of the individual, social pressures and the chemical nature of the drug used. Weakening of family and cultural ties, westernization of lifestyles, influence of TV and media, easy availability of money among the newly rich, youth's rebellion against authority and many other factors have all been blamed from time to time. The enormous margin of profit in this illicit trade has attracted many criminal groups who have become a powerful vested interest in its propagation. Most of the countries of our Region, unfortunately, lie on the main routes of drug traffic from East to West and often unwillingly become victims of this scourge. The political conflicts in many parts of the Region further add to the demand.

3.6. Risk-taking behaviour

In recent years much has been written on the "risk-taking" behaviour of adolescents and youth, which very often turns into health-damaging behaviour, such as rash driving or experimenting with drugs or promiscuous sex or street violence, etc. However, it must also be realized that risk-taking is a very essential part of the growing up process and an essential component of maturation. The self-esteem and admiration of peers resulting from risk-taking is more important than the approval of the senior generation. Hence, there is a need to keep some kind of a balance between, on the one hand, adolescents' search for identity and their desire to be independent and, on the other, society's need to preserve its rich traditional cultural heritage. This is particularly likely to be so in societies which are in transition, as is the case in countries of this Region.

Combatting drug dependence is a complex process, requiring simultaneous action on many fronts. Perhaps the most vitally needed is prevention by curtailing the demand, by proper health education for adolescents and their families. The emphasis should be more on positive aspects; education should

avoid the "thou shalt not" approach, and rather focus on enhanced health and personal fulfilment. Such efforts must also be supported by education and social welfare planning which enlarges the opportunities open to young people for learning, employment and active and rewarding leisure pursuits. The background values and norms, which society as a whole promulgates and enshrines, are vital barriers against drug-taking.

Along with the programme of prevention by education and control of illicit traffic of drugs, it is equally important to have adequate provision of facilities for treatment and rehabilitation of drug-dependent cases. Keeping in view the limited resources in trained manpower and materials of most of the countries of the Region, such services should be developed and integrated with mental health and general health services at the primary health care level.

3.7. Adolescent girls

In view of the separation of roles of the sexes commonly existing in the traditional communities of EMR, certain issues particular to adolescent girls are dealt with separately.

Health issues related to adolescent girls are mainly those that concern their reproductive and child-rearing roles. Special programmes and activities are needed to promote the optimal realization of these roles, to counteract and neutralize traditional health-damaging practices, e.g. female circumcision, still common in a few of the EMR countries, and to prevent practices and attitudes which discriminate against females. Programmes that serve to control or modify certain traditions and customs, e.g. very early marriages; that foster girls' knowledge about their own bodies and the normal physiological changes of maturation; that educate them about reproductive health and family life, mothercraft and care of the newborn; and that lay the foundation for healthy personal habits and practices in preparation for womanhood, are all specific to adolescent girls.

Adolescent girls come into contact with the health services, or some form of health care, usually in relation to their reproductive life. Because of the rather low school enrolment and high school-leaving rates for girls, a varied percentage of girls in EMR benefit from school health services. Great numbers of girls may pass into the care of traditional health practitioners for problems related to their reproductive role without ever having been attended to or screened by the formal health system.

The reproductive role starts early for girls of the EMR - about 19-55% of total marriages take place when the bride is below the age of 20 years and 3-15% of children are born to mothers before they reach 20 years. The minimum age for marriage is usually set by legislation at 16 to 18 years for some countries, but custom and tradition often tend to foster marriages below this age. (See Figure 3).

Pregnancies occurring during adolescence expose young mothers to a number of risks, as has been established by several studies. The commonly poor coverage by antenatal services and the low percentages of births attended by trained personnel further endanger the life and health of both the mothers and their children. For the Region, an overall average of less than 30% of pregnant women are attended during pregnancy and delivery by trained personnel. Institution deliveries constitute less than 12% of all deliveries in the Region. Figures for maternal mortality rise appreciably during

adolescence and result in an increase in the overall death rate for girls over that for boys in the same age group. This is a feature particular to developing countries where teenage pregnancies are common, as opposed to the pattern in developed countries where death rates for young males exceed those for girls. Although maternal mortality is known to be usually under-reported (because of known reasons especially the avoidance of legal implications) it is found to occur in more than 2 per thousand live births in five countries that, alone, account for about 60% of all live births in the Region. Complications of childbirth are responsible for one of the commonest causes of death for girls below 20 years of age in EMR.

Analysis of figures for school enrolment for the different phases of schooling shows that more girls are being educated and some continue to vocational or higher education. As more girls stay longer at school, there has emerged a noticeable trend of decrease in the percentage of marriages below the age of 20 years over the past decade. This is observed in a number of countries in EMR. Education has implications for girls' health and fertility, since it delays the age of marriage and childbearing to an age when reproductive health problems are less likely to occur. The correlation of female education and child survival has been proven beyond doubt by numerous studies and the education of girls is regarded as the only one single factor that can alone influence child survival. (See Figures 1 and 3).

3.7.1. Monitoring the health situation of adolescent girls

Differentials in health status are a reflection of the way in which human ecology affects one sex more than the other. Sex differentials may be primarily due to broad socio-cultural factors and practices that discriminate against females and interfere with their survival chances. Or they can be a reflection of the low priority accorded to the special health care that females need in their reproductive years. Or, again, they may arise from individual health-related behaviour or practices.

In general, given a neutral social environment, females will enjoy better survival chances than males owing to the superior genetic endowment of females. But in cases where the socio-cultural environment is characterized by the practice of discriminating against females, death rates for females at certain ages may be equal to or even exceed those of males. This is illustrated by the reversal in the ratio of infant mortality rates during the first years of life. The increase in mortality rates for females over those for males during the 15-19 year age bracket in developing countries is a result of the increase in maternal deaths in adolescent girls.

3.8. Sexually transmitted diseases (STD)

Sexually transmitted diseases during adolescence were mentioned as a health problem in some of the country reports received. Increase in expressed awareness of the public health danger of sexually transmitted diseases (STD) seems to be triggered by the world-wide anxiety generated by acquired immune deficiency syndrome (AIDS). Accurate figures are not available as there is generally gross lack of information on the incidence of the whole range of STD in EMR countries. Available information usually covers the two reportable diseases, syphilis and gonorrhoea, and is not broken down by age. Secrecy and reluctance to admit the existence of such types of maladies are strongly operative in most Regional countries, a feature that is common to the patients, their families and sometimes even the authorities. This only serves to increase the infection reservoir and raises the resistance of the infectious agent through inadequate, self-administered treatment.

Management of the problem in adolescence faces several difficulties because of the conservative traditional societies of the EMR, with their strict codes governing the sexual activity of the young. The potential adverse effects of diagnosis of these diseases on self-image, reputation, family interactions, and/or sexual relations need to be recognized and appropriate counselling, sympathy and support provided.

To render pertinent information available to adolescents is of prime importance as a first step in the management and control of STD in adolescence. STD programmes currently have a unique opportunity to benefit from the prevailing frank and open attitudes adopted vis-à-vis AIDS by the public media and authorities and have much to gain by riding the crest of the public information wave.

Adolescents considered at risk should be screened routinely for STD. This risk group mainly includes: all adolescents suspected of being victims of rape, sexual abuse or incest; adolescent prostitutes or male homosexuals; imprisoned adolescents of both sexes; and adolescents who have had contact with persons having STD.

The limited availability of services, the associated social stigma, the difficulties encountered by adolescents when seeking health care on their own, such as their right to confidentiality (away from their parents), their lack of financial resources and the attitude of the health personnel themselves, as well as the absence of STD screening in any of the routine screening examinations carried out on adolescents, can all contribute towards the unchecked spread of STD among the adolescent population.

While, as mentioned above, a number of EMR countries recognize STD among adolescents as a health problem which requires intervention, available reports indicate that some EMR countries are receiving WHO assistance for assessment of the situation or for organization of programmes for the training of health personnel in the prevention and management of STD.

3.9. Disability during adolescence

With world figures of one in ten for disabled persons, the prevalence of disability among adolescents aged from 10 to 19 years is estimated to be within the range of 5-8%. In the EMR this may amount to a total of about 3.5 - 4 million disabled persons among the 71 million that make up this age group in the Region. Better care and management have resulted in more persons with disabilities caused by congenital factors, nutritional disorders or communicable diseases reaching adolescence. Accidents and trauma related to traffic, work, sport, physical violence and war are among the commonest causes of disability during adolescence, especially among males.

Disability does not figure high on the list of health priorities in countries of EMR as acute and pressing national health problems commonly overshadow it. Yet awareness of the problem and its magnitude is progressively gaining importance. Various national programmes for the disabled exist in several Member States, some of which are backed by community-based rehabilitation programmes. In a recent survey in an EMR country it was estimated that about 70% of rehabilitation needs can be achieved by home-based rehabilitation programmes. Such programmes serve to develop the family and community responsibility and capacity to cope with rehabilitation needs. Although national programmes may not provide full coverage, input and

contributions from international agencies and from benevolent or voluntary organizations often contribute appreciably towards rehabilitation of the disabled in countries of the Region.

Reporting on disability in adolescence, it was estimated in a country of the Region that only 25% of disabled adolescents benefited from some form of educational or rehabilitative care. Disability during adolescence poses special problems as it interacts with the developmental issues (both physical and psychosocial) characteristic of this period. Failure to provide proper management and support during the critical years may result in maladaptive behaviour, reactive psychopathology and even maturational arrest. Management and care of the disabled during adolescence necessitate introducing a developmental dimension that caters for the special needs of this phase of maturation.

The family - and the community - who are closely affected by an adolescent's disability need resources and supportive measures for the optimal adaptation of a disabled young person. Resources include special programmes for education, rehabilitation, vocational training, recreation and socialization as well as specific-disease support groups and aid to the crippled and the handicapped. Laws ensuring education and employment opportunities and social security will further help the integration of the disabled into society.

In the face of the generally low priority and limited resources available in most countries, a practical solution would lie in further developing family and community capabilities to deal with the disabled adolescent, giving special attention to the developmental issues related to sexuality, psychosocial maturation and vocational training.

3.10. Legal issues

Legislation, looked upon as a means to facilitate the realization of the health and social development of adolescents, extends to and covers several of the diverse aspects of the subject. Often the required legislation does exist, but is not enforced or practised. Already existing legislation, addressing adolescence and related issues, needs to be identified and made known to potential users and other interested parties through appropriate information/education programmes. Areas requiring new legislation can then be easily diagnosed and appropriate action initiated.

From the protective health viewpoint, legislation exists that covers the availability, quality and practice of services, the categories of trained personnel manning them, or obligatory interventions such as vaccinations and routine medical screening or examinations, also legislation that serves to control, preserve and/or protect the environment in the home, school, street, community, workplace, natural resources, etc. It may guarantee the quality of products and consumer goods, and control their sale and distribution, banning or prohibiting the use of some of them to adolescents, such as cigarettes and alcoholic beverages. Special legislation covers juvenile delinquents, their trial and rehabilitation. Legislation may also guarantee education and employment opportunities, and the provision of care to special groups such as the disabled. Safety legislation aiming to minimize or prevent accidents, and legislation for control and censorship of harmful information that may injure adolescents and youth, serve two important areas in relation to the welfare of adolescents.

Legislation, organizational or administrative decrees and statutes control the area of legal issues related to consent and confidentiality in the health care of adolescents, who are treated usually as minors. This may come up in situations dealing with sexuality, drug abuse and mental health as well as in emergencies. Parental consent requirement may impose important psychological and pragmatic barriers upon needed timely care. Statutes may give adolescents the right to consent to diagnosis, treatment and prevention of certain diseases. This may be an especially important issue, from the point of view of adolescents, in relation to sexually transmitted diseases, drug abuse and mental illness. It is often found that the issue does not pose much of a problem to health services when a national programme for the diagnosis, treatment and control of endemic or epidemic diseases or even STDs is being implemented.

4. ADOLESCENTS AND HEALTH SERVICES

Specialized adolescent health services do not exist in countries in the EMR although they are found in some Western societies. This is not to say, however, that health services in the Region are not able to respond to particular health needs of adolescents. They do, but not well enough. Existing health services lack the special knowledge and skills necessary to treat adolescent health problems with due care and attention.

It is, however, the contention of this paper that an adolescent health speciality or service is not needed. Emphasis should be placed instead on strengthening the capabilities of all medical specialties of relevance, i.e. general practice, nursing and other front-line health capabilities, to cope with this group. Medical specialties of central relevance are mental health, nutrition, venereology and dermatology, obstetrics, paediatrics, rehabilitation, accident and emergency medicine, internal medicine and community medicine. Strengthening of these services implies better training, both pre-service and in-service, better diagnostic instruments and skills, especially in obtaining psychological and sociological data, a more attractive image to encourage adolescents to seek medical services, and properly designed hospital services and facilities to cater for adolescents.

This "adolescent dimension" in the health service can be created through the establishment of appropriate training courses, or adolescents' centres, in universities to orientate health personnel toward adolescents' health problems and their management. It is commonly agreed that the family health physician, the primary health care physician and front-line health worker are the most appropriate persons to deal with adolescents' problems and they particularly should be prepared to do this.

One part of the health service especially relevant to adolescents' health is school health. It may operate effectively in dealing with adolescents in screening them, at least once during puberty and if possible more regularly. Arguments from Western society about the cost-effectiveness of general screening services do not apply in most countries of our Region, and certainly do not apply in the least developed countries. However, the vast majority of adolescents in EMR countries, especially the girls, are not in school, hence strengthening of school health services, particularly as a venue for health screening, will not be sufficient. Screening upon admission to the military services, to industry and other vocational pursuits is also recommended. The school health service may also take a lead in health-promotional activities

for the adolescent, such as sport, recreation and health education in schools. It is particularly in this area that linkages can be made with services other than health which are important to the promotion of the health of adolescents, including the education and social services.

Support should be given to strengthening special health programme areas such as anti-smoking, alcohol and drug abuse, sex and reproductive health and abnormal risk-taking. These services must take special notice of the "ways" of the adolescents and appeal to them on a level which they understand.

Adolescents can be involved in self-care and in the pursuit of the health of their peers. This is an example of community participation. The adolescent, with his enthusiasm and abilities, can be channelled into providing basic health care services if he is led and encouraged to do so. This area is neglected in countries of EMR where health services do not take advantage of these possibilities.

The health services may do well to collect more data on adolescent health problems through their epidemiological services and to share these data with other sectors. Conversely, the health service should seek information from other, health-related, sectors and incorporate it into planning and management. Health services seldom, if ever, undertake research into adolescents' concerns. Examples of areas of research which may be of particular relevance include pubertal growth problems, psychosocial developmental problems of adolescents, nutritional status and habits, and physical and mental handicaps in this age group.

In summary, therefore, it is recognized that the health services in the countries of our Region do cater to some extent for adolescents' health, in the dimensions of both care and prevention. However, in most areas, dramatic improvement is needed.

5. INTERSECTORAL COLLABORATION FOR ADOLESCENT HEALTH

Observance of recommendations of IYY have resulted in the presence, in all countries, of national structures or bodies that address youth, usually under the banner of Ministries or High Councils for Youth and Sports or People's Youth Organizations. They commonly address adolescents' needs in sports and, to a lesser degree, in leisure pursuits. Activities for development of national identity, group spirit, and sometimes cultural activities also figure in the programmes of such institutions and their outlets. National coverage is often planned, yet these activities are not always found in communities that are in dire need of them, such as urban and peri-urban slums and squatter areas, or camps and settlements of migrated or displaced persons. The latter tend - under present conditions - to lead a semi-permanent existence so that not only the temporary needs of food, shelter and health care have to be catered for, but also the social needs of adolescents must be satisfied.

In view of the varied and multiple needs of adolescents, no one service or sector is considered adequate to satisfy them. Collaboration in developing a multiservice strategy to address adolescent needs is required. A glance at the wide range of adolescent needs and/or responsible persons, institutions or services that answer them, shows (a) that they involve more than one discipline; (b) that the health sector has but a limited role or input; and (c) that there is much overlapping. Although the role of the health sector seems relatively small for the "normal" adolescent, its importance for this

age group lies in the fact that a health dimension has to be ensured for all other services and by all other sectors. Furthermore, this should be regarded as a particularly "at-risk" or "vulnerable" age and health surveillance needs to be assured. Such a youth centre, preferably at community level, would solve the important problem of access of health services to youth for programmes dealing with the promotive and preventive aspects of their health care. Adolescents are generally reluctant to seek medical attention except for acute or emergency conditions. In view of the poor coverage, and sometimes inefficiency, of the school health services because of low school enrolment, intersectoral collaboration guaranteeing a health dimension in such a community youth service is a vital basic step in any plans for improving adolescent health. It should complement and complete a school health service and health education programme. It can also serve as a front-line unit or centre, referring adolescents needing specialized care. Depending on existing priorities, strategies and programmes can be conceived and planned to suit identified problems and resources. The form for such an activity or centre should be flexible enough to accommodate different adolescent needs in different areas or communities.

An important input of the health sector, together with other sectors involved in a multidisciplinary type of programme for adolescents, is in the training and orientation of workers in health and other related sectors. Such a training will also provide them with new perspectives, knowledge and skills which are specific to intersectoral action in the field of health. Teachers and media producers, who are considered as important communicators setting or projecting role models and life-styles for adolescents, belong to two disciplines with which the health sector should closely collaborate for the information/education activities on all health-related matters.

6. ADOLESCENTS AND SOCIAL DEVELOPMENT

Promoting the health and welfare of adolescents and youth means investment in the human resources needed to yield economic and social benefits on a national scale. Policies and programmes addressing the young as part of overall development plans must meet basic needs; recognize the role of youth in national development; help to combat unemployment and underemployment among young people; and enable these same young people to give service to their communities, thus making of youth, in developing areas, both the agents and the beneficiaries of development, rather than the victims. Optimally, youth development programmes aim to raise the basic health, education, employment and welfare levels of young people. They also assist governmental youth authorities and organizations to collaborate in promoting the interests and in meeting the needs of the young, and foster self-help and participation by the young people themselves.

Programmes for youth cannot be separated from family, health, education, or housing programmes or employment projects in the national plan, as youth policies have relevance for most, if not all, aspects of development. More consideration should be given to the needs of the young which are related to all sectors. A comprehensive intersectoral approach thus becomes essential if the significance of young people in national development is to be fully recognized and integrated with those aspects of the economic sector dealing with youth, such as industry, agriculture, commerce and transport.

As the needs of the young vary with age and with circumstances, they must be precisely identified before planning to meet them can be undertaken. This

is considered important as unmet needs of youth can become a danger that could seriously hamper progress, if there is no adequate provision for them in the national development plan.

Adolescents and youth usually suffer from the influences and far-reaching consequences and cultural implications of industrialization and urbanization, and are vulnerable to the profound effects of political change. Their problems may only be manifestations, or symptoms, of such suffering. Yet it is often noted that when subjected to culture conflict, stresses and insecurities of urban and industrial life, the young have a greater capacity for resilience and adaptation than their elders.

Meeting the needs of youth may provide striking opportunities for social advance, a factor which can be used profitably in the process of development. Development plans need to find and strike the happy medium between attention to the needs of youth and to the demands for national development in general.

7. RECOMMENDATIONS

The subject of adolescence is characterized by a number of features that determine the approaches to be used in promoting the health of adolescents and their roles in social development.

It will have been seen from the previous pages that the main features of adolescence in EMR include: the paucity of information on the subject; the strong influence of ecology and socio-economic factors on the profile of adolescents in a country; the wide range of multifaceted and interrelated needs of adolescence, that involve more than one service or sector; the importance of the parents and the family in laying the solid foundations that determine the outcome of adolescence; and, lastly, the growing numbers of families and their children exposed to risk conditions in the Region.

The following recommendations are made with a view to encouraging and promoting the development of approaches suited to Regional particularities.

7.1. Information and data collection

7.1.1. Identify variables, and the related specific indicators, for assessment of the current situation which are needed for developing a national policy and strategy for adolescent health and well-being, and for monitoring progress in implementation of that strategy and its evaluation within HFA/2000.

7.1.2. Ensure the collection of sex-differentiated data in all areas.

7.2. The family

7.2.1 Encourage Governments to explore and undertake all possible measures to reinforce and support the role of the parents and the family in providing the necessary guidance and appropriate family environment conducive to healthy psychosocial development during the period of adolescence.

7.3. Health services for adolescents

7.3.1. Sensitize the authorities concerned about the wide range of health and health-related needs of adolescence.

7.3.2. Encourage countries to review national HFA strategies with a view to ensuring that the needs of the adolescent age group are properly reflected.

7.3.3. Develop an "adolescent dimension" in existing health services and programmes related to adolescent health problems, e.g. drug abuse, STD or MCH, through appropriate training and orientation of the health personnel concerned.

7.3.4. Strengthen school and university health services and improve their capacity to handle the special needs of adolescents, especially in the area of psychosocial problems, e.g. emotional and behavioural disturbances, drug abuse or problems related to sexuality.

7.3.5. Establish an adolescent counselling service to be made available to all students and prepared to cater for identified adolescent needs, with provision of appropriate referral support.

7.3.6. Encourage the establishment of a network of community-based multifunctional youth and adolescent centres that address the young of both sexes and expand their scope of activities to cover health and psychosocial concerns of adolescence.

7.3.7. Organize outreach activities with the participation of the young themselves, and targeted towards the adolescents of the community, especially those identified as being at risk.

7.4. Intersectoral collaboration

7.4.1. Ministries of Health should establish rapport and coordinate with the national machinery serving youth issues existing in each country, so as to benefit from the mobilization of resources and achievements gained through programmes and activities initiated during the International Youth Year, with the aim of developing a multiservice strategy to address the wide range of adolescents' needs and involving all sectors concerned including health.

7.4.2. Encourage Ministries of Health to collaborate closely with the education sector, in order further to develop its important contribution to adolescent health and social development.

7.4.3. Promote and foster the constructive and developmental roles the media can play in support of the health and well-being of adolescents through involvement of the specialists concerned in the planning and execution of national information strategies and media programmes.

7.5. Legislation

7.5.1. Encourage governments to review existing legislation relating to the health and well-being of adolescents and fostering the realization of their potential roles in national development.

7.5.2. Promote the enactment of existing relevant legislation and identify constraints impeding its application.

7.5.3. Identify areas requiring new legislative support so as better to safeguard the health and well-being of adolescents.

7.6. Research

7.6.1. Encourage health service and operational type research to determine the optimal use of current resources, human and material, for the improvement of the health and well-being of adolescents.

7.6.2. Encourage Ministries of Health to undertake research to define the profile of the adolescent population at risk and develop a simple tool for its identification to be used by health workers at the primary health care level, teachers in schools, and/or social workers.

7.7. Consultative body

7.7.1. Establish a multidisciplinary Regional advisory panel for promoting and guiding Regional activities concerned with the health and social development of adolescents.

REFERENCES

1. United Nations General Assembly resolution 34/58 (1979).
2. World Health Assembly resolution 33.24 (1980).
3. Constitution of the World Health Organization. Basic Documents, WHO, Geneva, 1986.
4. Global Strategy for Health for All by the Year 2000, "Health for All Series No. 3", WHO, Geneva, 1981.
5. Adolescent and Youth Health; Perspectives, problems, priorities. Discussion Paper for WHO, MCH/IYY/SG/84.3a. WHO, Geneva, 1984.
6. Young people's health - a challenge to society. Report of a WHO study group on young people and "Health for All by the Year 2000". Technical Report Series No. 731, WHO, Geneva, 1986.
7. The conception of the psychic life as a whole, in: Jasper, K. General Psychopathology, English translation, 1963. The University of Chicago Press.
8. Human development WHO Technical Report Series No. 485, 1972. World Health Organization, Geneva.
9. Evaluation of the Strategy for Health for All by the Year 2000 - Seventh report on the World Health Situation. Vol. 6. Eastern Mediterranean region, WHO EMRO, Alexandria 1985 and latest statistical data available in the Regional Office.
10. United Nations Demographic Yearbook. United Nations, New York, 1984.
11. Adolescent Medicine, Ed. Hofmann, D. Addison-Wesley Pub., 1983 (California, USA).
12. Physicians taking adolescent medicine from the benches to the trenches, Glasbrenner, K. American Medical Association, Vol. 255, no. 4, January 1986.
13. The child and adolescent in society. Report of a Meeting, WHO Regional Office for Europe, Athens, 26-30 September 1978.
14. Social Development. Situation of youth in the 1980s. Report of the Secretary-General, Fortieth session of the General Assembly Economic and Social Council, A/40/64, E/1985/5, 10 January 1985.
15. International Youth Year: Participation, Development, Peace. Report of the Secretary-General, Fortieth Session of the United Nations General Assembly, A/40/256, 6 May 1985.
16. Preparations and observance of the International Youth Year: Participation, Development, Peace. Report of the Secretary-General, Fortieth Session of the General Assembly, A/40/701, 11 October 1985.

17. Report of the United Nations Economic and Social Council (A/40/3). Economic and Social Council Resolution: Youth in the Contemporary World, 1985/23.
18. 1985 Report on the World Social Situation, United Nations, New York, 1985. (ST/ESA/165 - E/CN.5/1985/2/Rev.1).
19. Refugees in 1985. The geography of exile. UNHCR, "Refugees", No. 24, December 1985.
20. The health of adolescents and youth, a global overview. Friedman, Herbert L., World Health Statistics Quarterly, vol. 38, No. 3, 1985, WHO Geneva.
21. Health of Adolescents and Youth in the Americas, PAHO Scientific Publication No. 489, 1985.
22. Statistical Indicators on Youth, International Youth Year, United Nations 1985.
23. Impact of male migration on the structure of the family and the roles of women. Khattab, Hind A.S. and El-Daeif, Syada G. Proceedings of the Meeting on the Role of Legislation in the Protection of the Egyptian Family, Faculty of Law, Alexandria University, Alexandria, December 1985.
24. Moral offences affecting the family, Al-Awwa, M.S. Proceedings of the Meeting on the Role of Legislation in the Protection of the Egyptian Family, Faculty of Law, Alexandria University, Alexandria, December 1985 (original Arabic).
25. Psychologies de la délinquance juvénile, dans: Psychologie du Crime par Hesnard, H. Payot, Paris, 1983.
26. Study of the relationship between the development process and the family in Qatar. L. Milikian. Reviewed in: Social Development News, vol. 20. Centre for Social Development and Humanitarian Affairs (UN), Vienna 1984 (original Arabic).
27. Statistical Yearbook. UNESCO, Paris, 1985.
28. A process evaluation study of peer leaders in health education. Perry, C.L.; Klepp, K-I; Helper, A.; Hawkins, K.G. and Murray, D.M. Journal of School Health, vol. 56, No. 2, February 1986.
29. Health of school age and adolescents, Maternal and Child Health Program, Pan-American Health Organization/World Health Organization. Annotated Bibliography No. 2, 1985.
30. Growing up in a changing world, Parts I and II, Youth organizations and family life education. International Planned Parenthood Federation.
31. Child labour. A threat to health and development, 2nd (revised) edition, Defence for Children International, Geneva, 1985.
32. Child labour and health. Report on a meeting, WHO, Geneva, 1982.

33. Children at work, ILO, Geneva, 1979.
34. Developing Information Media in Arab States: Needs and priorities. Abou-Bakr, Y., Labib, S., Kandil, H. Reports and Papers on Mass Communication No. 95, UNESCO, Paris (Arabic) 1982 (original Arabic).
35. WHO Executive Board resolution ES19.R23 (influence of TV on Mental Health of Children and Young Adults) 1963.
36. Abuse of narcotic and psychotropic substances. Progress report by the Director-General of the World Health Organization; Geneva, A39/10, 17 March 1986.
37. Abuse of narcotic and psychotropic substances. Progress report by the Director-General; Geneva, A39/10 Add.1, 5 May 1986.
38. Young people and the struggle against drug abuse in the Arab countries. Okasha A. Bulletin of narcotics, Vol XXXVII, Nos.2 and 3, April-September 1985.
39. The extent of non-medical use of psychoactive substances among secondary school students in Greater Cairo. Soueif M.I., Drug and Alcohol Dependence, vol. 9, 1982.
40. Changing patterns of drug dependence among persons admitted to drug centre in Maamoura Psychiatric Hospital, Alexandria. By El Fawal, K., Member of WHO Expert Advisory Panel for Drug Dependence and Alcohol Problems. Unpublished Report.
41. Drug Dependence, Dr Mubbashar M.H., Pub. Psycho-publishers, Rawalpindi, Pakistan, 1984.
42. Adolescents and drugs in Arab Countries of the Gulf, Musaiqar, A.R., Al-Rabeen'an Pub., Kuwait, 1985 (original Arabic).
43. Compiling social indicators on the situation of women. Studies in Methods, Series F No. 32, United Nations, New York 1984. (ST/ESA/STAT/SER.F/32).
44. Health needs of young girls, Wassef, H. Paper presented at the UNICEF Workshop on Young Girls, Amman, Jordan, March 1986.
45. Sex differentials in mortality: An enquiry with reference to the Arab countries and others, Hammoud, E.I. World Health Statistics Report, vol. 30, No. 3, 1977.
46. Pregnancy and abortion in adolescence. Technical Report Series, No. 583, 1975, WHO, Geneva.
47. Health implications of sex discrimination in childhood. WHO/UNICEF/FHE 86.2. A review paper and an annotated bibliography. WHO, Geneva, 1986.
48. Control of Sexually Transmitted Diseases. WHO, Geneva, 1985.
49. Health needs of adolescents. Technical Report Series, No. 609, 1977. WHO, Geneva.

50. La Santé des adolescents algériens. Détermination des besoins de santé et réponses dans le système sanitaire. Soulimane, A. Thèse de Doctorat en Sciences médicales, 1986. Institut national d'Enseignement supérieur en Sciences médicales d'Oran.
51. Intersectoral action for Health. Technical Discussions, Geneva, May 1985, World Health Assembly. Background document. A39/Technical Discussions/1, WHO, Geneva.
52. Report of the Technical Discussions on the Role of Intersectoral Cooperation in National Strategies for Health for All. A39/Technical Discussions/4, 15 May 1986.

COMPARISON OF THE PROPORTIONS (%) OF PUPILS IN FIRST AND LAST GRADES (FIRST-LEVEL EDUCATION)
 IN 1970 AND AROUND 1982; FOR BOTH SEXES AND FOR FEMALES ALONE, IN SELECTED COUNTRIES OF EMR

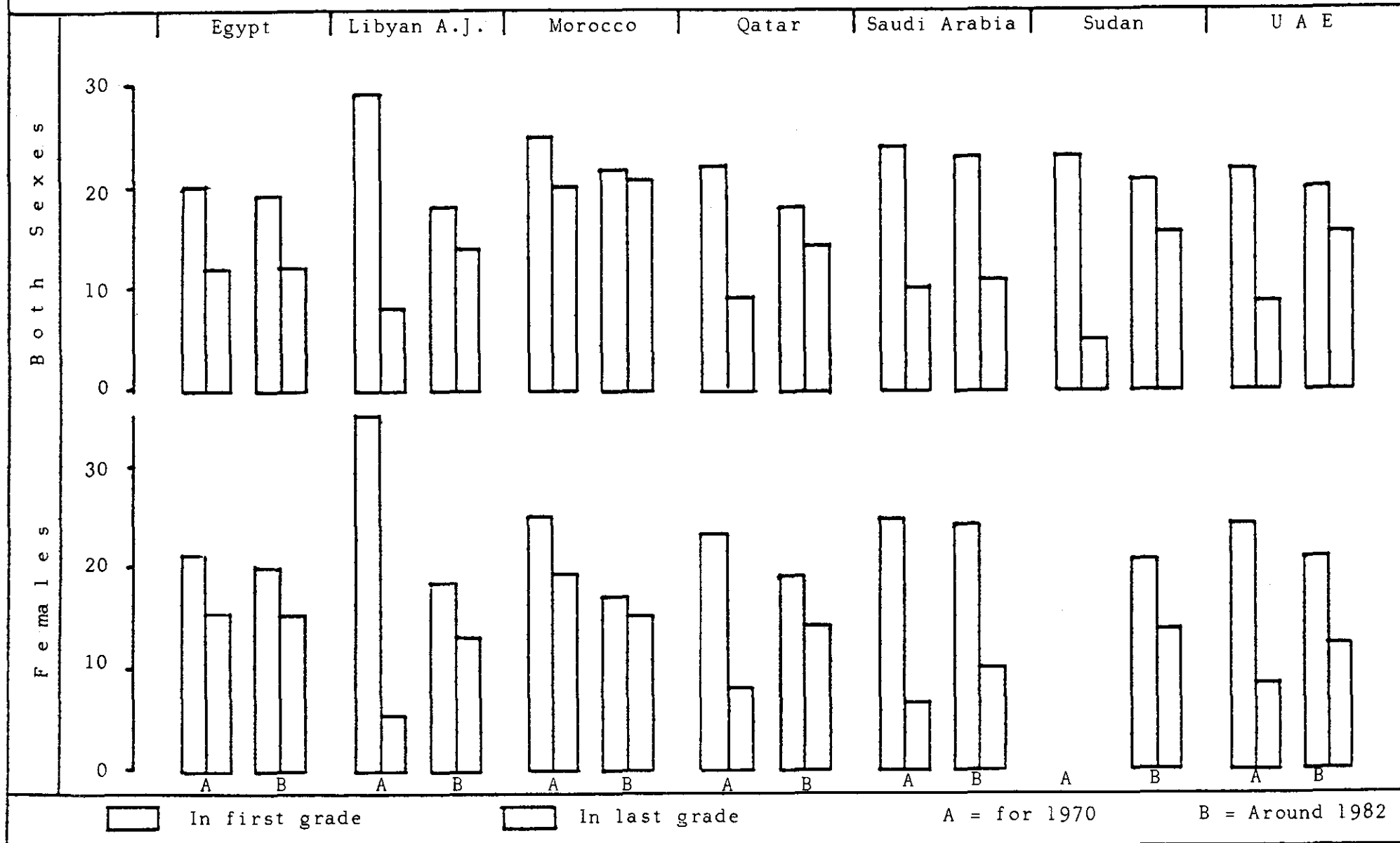
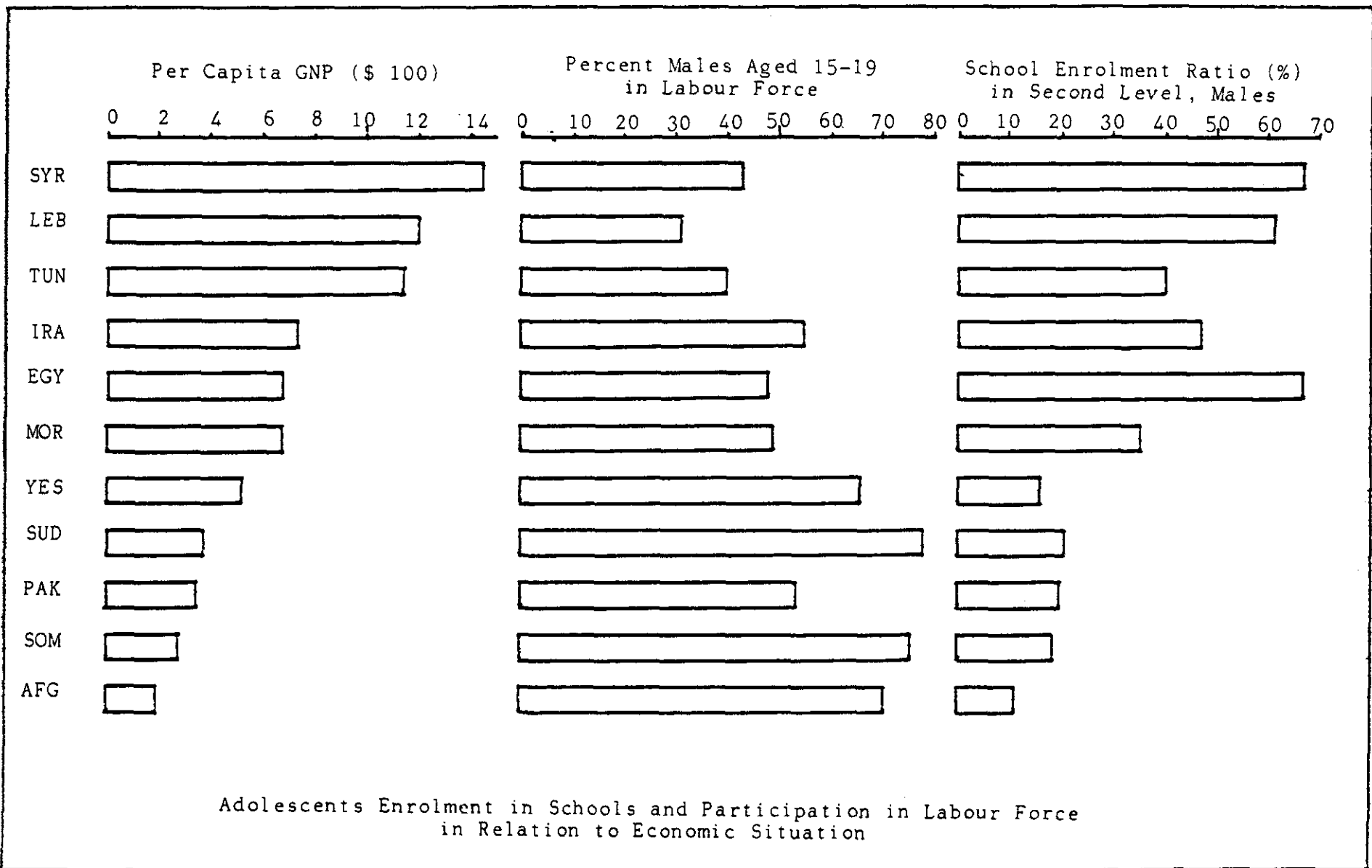


FIGURE 1



Adolescents Enrolment in Schools and Participation in Labour Force
in Relation to Economic Situation

FIGURE 2

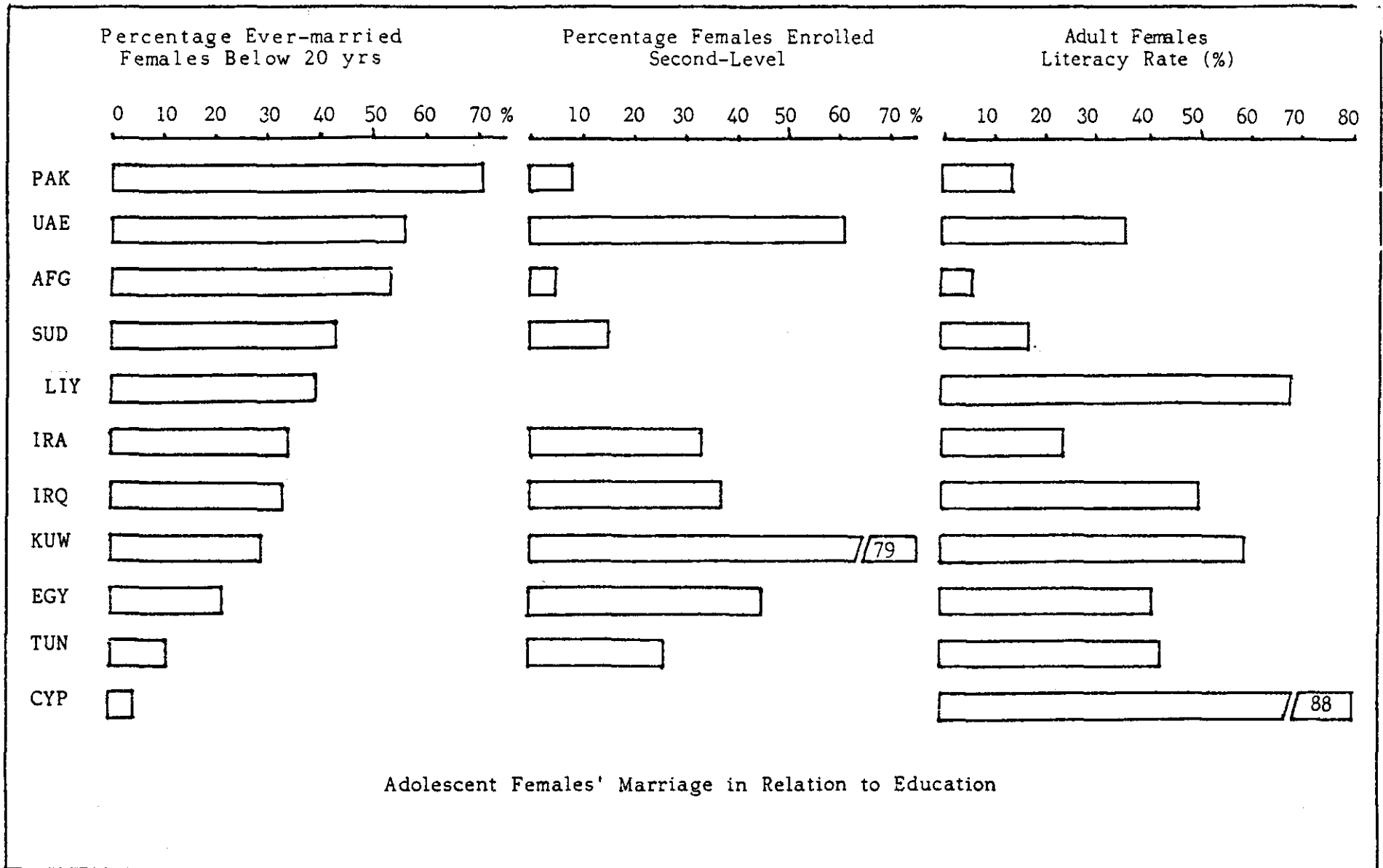


FIGURE 3

Thirty-third Session

ORIGINAL: ENGLISH

Kuwait, 4-7 October 1986

Agenda item 14

ADOLESCENCE, HEALTH AND SOCIAL DEVELOPMENT

SUMMARY OF RECOMMENDATIONS

The subject of adolescence is characterized by a number of features that determine the approaches to be used in promoting the health of adolescents and their roles in social development.

It will have been seen from the paper presented that the main features of adolescence in EMR include: the paucity of information on the subject; the strong influence of ecology and socio-economic factors on the profile of adolescents in a country; the wide range of multifaceted and interrelated needs of adolescence, that involve more than one service or sector; the importance of the parents and the family in laying the solid foundations that determine the outcome of adolescence; and, lastly, the growing numbers of families and their children exposed to risk conditions in the Region.

The following recommendations are made with a view to encouraging and promoting the development of approaches suited to Regional particularities.

1. Information and data collection

- 1.1. Identify variables, and the related specific indicators, for assessment of the current situation which are needed for developing a national policy and strategy for adolescent health and well-being, and for monitoring progress in implementation of that strategy and its evaluation within HFA/2000.

1.2. Ensure the collection of sex-differentiated data in all areas.

2. **The family**

2.1. Encourage governments to explore and undertake all possible measures to reinforce and support the role of the parents and the family in providing the necessary guidance and appropriate family environment conducive to healthy psychosocial development during the period of adolescence.

3. **Health services for adolescents**

3.1. Sensitize the authorities concerned about the wide range of health and health-related needs of adolescence.

3.2. Encourage countries to review national HFA strategies with a view to ensuring that the needs of the adolescent age group are properly reflected.

3.3. Develop an "adolescent dimension" in existing health services and programmes related to adolescent health problems, e.g. drug abuse, STD or MCH, through appropriate training and orientation of the health personnel concerned.

3.4. Strengthen school and university health services and improve their capacity to handle the special needs of adolescents, especially in the area of psychosocial problems, e.g. emotional and behavioural disturbances, drug abuse or problems related to sexuality.

3.5. Establish an adolescent counselling service to be made available to all students and prepared to cater for identified adolescent needs, with provision of appropriate referral support.

3.6. Encourage the establishment of a network of community-based multifunctional youth and adolescent centres that address the young of both sexes and expand their scope of activities to cover health and psychosocial concerns of adolescence.

3.7. Organize outreach activities with the participation of the young themselves, and targeted towards the adolescents of the community, especially those identified as being at risk.

4. Intersectoral collaboration

4.1. Ministries of Health should establish rapport and coordinate with the national machinery serving youth issues existing in each country, so as to benefit from the mobilization of resources and achievements gained through programmes and activities initiated during the International Youth Year, with the aim of developing a multiservice strategy to address the wide range of adolescents' needs and involving all sectors concerned including health.

4.2. Encourage Ministries of Health to collaborate closely with the education sector, in order further to develop its important contribution to adolescent health and social development.

4.3. Promote and foster the constructive and developmental roles the media can play in support of the health and well-being of adolescents through involvement of the specialists concerned in the planning and execution of national information strategies and media programmes.

5. Legislation

5.1. Encourage governments to review existing legislation relating to the health and well-being of adolescents and fostering the realization of their potential roles in national development.

5.2. Promote the enactment of existing relevant legislation and identify constraints impeding its application.

5.3. Identify areas requiring new legislative support so as better to safeguard the health and well-being of adolescents.

6. Research

- 6.1. Encourage health service and operational type research to determine the optimal use of current resources, human and material, for the improvement of the health and well-being of adolescents.
- 6.2. Encourage Ministries of Health to undertake research to define the profile of the adolescent population at risk and develop a simple tool for its identification to be used by health workers at the primary health care level, teachers in schools, and/or social workers.

7. Consultative body

- 7.1. Establish a multidisciplinary Regional Advisory Panel for promoting and guiding Regional activities concerned with the health and social development of adolescents.