

Adolescents are often considered the next generation of actors on the social and economic stage; therefore all societies would benefit from harnessing their energy and skills. *A 16-year-old girl leads an adolescent girls' hygiene-monitoring group that is transforming the slum neighbourhood she lives in, Comilla, Bangladesh.*



CHAPTER 2

Realizing the Rights of Adolescents





CHALLENGES AND

Realizing the rights of adolescents and advancing their development requires a keen understanding of their current circumstances. Using the latest available data from international surveys, supplemented by national sources and research studies where appropriate, this chapter examines the state of adolescent health and education before looking at gender and protection issues.

At the international level, the evidence base on middle childhood (5–9 years) and adolescents (10–19 years) is considerably thinner than it is for early childhood (0–4 years). This relative paucity of data derives from several factors. The survival and health care of children under five years – the time of greatest mortality risk for individuals – has been at the cornerstone of international efforts to protect and care for children for more than six decades. In recent decades, vast leaps have taken place in the collection of health data, driven by the child survival revolution of the 1980s, the 1990 World Summit for Children, the Convention on the Rights of the Child and the push for the MDGs. Consequently, national and international health information systems for children mostly focus on the early years, concentrating on such indicators as neonatal deaths, infant immunization and underweight prevalence among under-fives.

Health information on adolescents, by contrast, is not widely available in many developing countries apart from indicators on sexual and reproductive health collected by major international health surveys, particularly in the context of HIV and AIDS. Where health data on adolescence are available, it is often not disaggregated by sex, age cohort or other factors that could give much-needed details on the situation of adolescents.

Education presents a similar story. The decades-long international drive for universal primary education and, more recently, for early childhood development has fostered the development of indicators and analysis of education in the first decade of life. This is most welcome, and it reflects the

growing and sustained commitment of international and national stakeholders to education, increasingly for girls as well as boys.

The evidence base at the international level on secondary education, is far narrower. Sufficient data do not exist to determine the share of secondary-school-age children who complete education at this level globally, or to assess the quality of the education they receive. And as with health, not many developing countries can provide comprehensive disaggregated data on key quantitative and qualitative indicators.

Child protection is the third field in which the availability of data is fundamental to understanding how vulnerable adolescents are to violence, abuse, exploitation, neglect and discrimination. It is heartening that since UNICEF and others began to adapt the 1980s concept of ‘children in especially difficult circumstances’ into the more holistic concept of child protection, we now have many more key protection indicators. Thanks to the USAID-supported Demographic and Health Surveys (DHS) and the UNICEF-supported Multiple Indicator Cluster Surveys (MICS) in particular – but also to national systems – data are available on child labour, child marriage, birth registration and female genital mutilation/cutting. More recently, through both expanded household surveys and targeted studies, data have emerged on other child protection concerns such as violence.

But the scope for more and better information on child protection remains vast. Many aspects of this most vulnerable of

OPPORTUNITIES

areas for adolescents are still hidden from view, partly owing to intractable difficulties associated with the collection of such information in circumstances often involving secrecy and illegality. Furthermore, the international household surveys from which much of the data on adolescents is derived do not, by definition, capture adolescent males and females living outside the household – in institutions, for example, or on the streets, in slums or in informal peri-urban settlements where records do not exist.

Often-quoted estimates of the number of children associated with or affected by armed conflict and child trafficking and of those in conflict with the law – to name but three areas – are outdated, not fully reliable and generally believed to vastly underestimate the true scope of the abuse.

This pattern of data collection is beginning to change. Enhanced national surveys and censuses, along with international household surveys such as MICS and DHS, are providing an increasingly rich vein of evidence on the situation of adolescents and young people on a wide range of issues. Recent work by the UNESCO Institute of Statistics, the Education for All Initiative and other mechanisms are providing a stronger evidence base on education than before. Analysis of this new data is enriching our understanding of the state of adolescents worldwide and will enhance the international community's ability to realize their rights.

Health in adolescence

Healthier adolescents today, despite lingering risks

Despite popular perceptions to the contrary, adolescents across the world are generally healthier today than in previous generations. This is in large measure a legacy of greater attention to and investment in early childhood, higher rates of infant immunization and improved infant

nutrition, which yield physiological benefits that persist into adolescence.

Those children who reach adolescence have already negotiated the years of greatest mortality risk. While the survival of children in their earliest years is threatened on many fronts – for example, by birth complications, infectious diseases and undernutrition – mortality rates for adolescents aged 10–14 are lower than for any other age cohort. Rates for young people aged 15–24, while slightly higher, are still relatively low. Girls have lower rates of mortality in adolescence than boys, though the difference is much more marked in industrialized countries than in developing countries.¹

Yet in 2004 almost 1 million children under age 18 died of an injury.² Risks to adolescent survival and health stem from several causes, including accidents, AIDS, early pregnancy, unsafe abortions, risky behaviours such as tobacco consumption and drug use, mental health issues and violence. These risks are addressed below, with the exception of violence, which is tackled later on in the section on gender and protection.

Survival and general health risks

Accidents are the greatest cause of mortality among adolescents

Injuries are a growing concern in public health in relation to younger children and adolescents alike. They are the leading cause of death among adolescents aged 10–19, accounting for almost 400,000 deaths each year among this age group. Many of these deaths are related to road traffic accidents.³

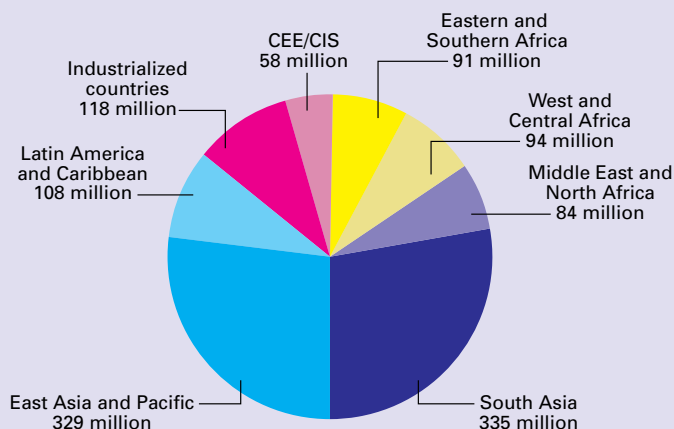
Fatalities from injuries among adolescents are highest among the poor, with low- and middle-income countries experiencing the greatest burden. Road traffic accidents

“Adolescents need the opportunity to assert themselves, express themselves, to flourish.”

Mamadou, 19, Senegal

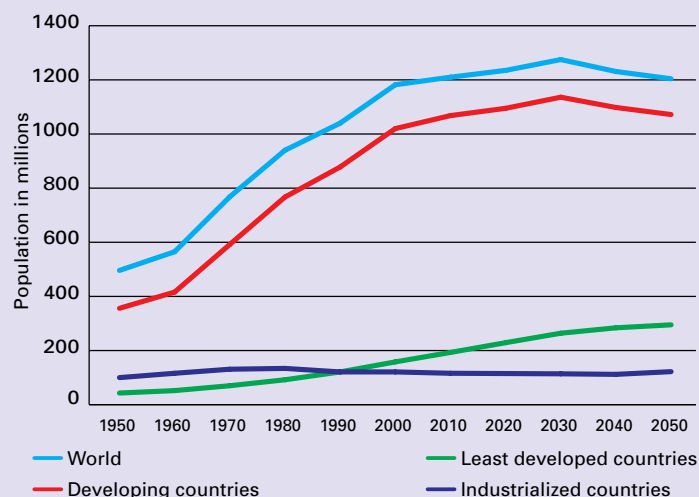
Demographic trends for adolescents: Ten key facts

Figure 2.1: Adolescent population (10–19 years) by region, 2009



Source: United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2008 Revision*, <www.esa.un.org/unpd/wpp2008/index.htm>, accessed October 2010.

Figure 2.2: Trends in the adolescent population, 1950–2050



Source: United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2008 Revision*, <www.esa.un.org/unpd/wpp2008/index.htm>, accessed October 2010.

- In 2009, there were 1.2 billion adolescents aged 10–19 in the world, forming 18 per cent of world population. Adolescent numbers have more than doubled since 1950.
- The vast majority of adolescents – 88 per cent – live in developing countries. The least developed countries are home to roughly 1 in every 6 adolescents.
- More than half the world’s adolescents live in either the South Asia or the East Asia and Pacific region, each of which contains roughly 330 million adolescents.
- On current trends, however, the regional composition of adolescents is set to alter by mid-century. In 2050, sub-Saharan Africa is projected to have more adolescents than any other region, marginally surpassing the number in either of the Asian regions.
- India has the largest national population of adolescents (243 million), followed by China (207 million), United States (44 million), Indonesia and Pakistan (both 41 million).
- Adolescents account for only 12 per cent of people in the industrialized world, reflecting the sharp ageing of Europe and Japan in particular. In contrast, adolescents account for more than 1 in every 5 inhabitants of sub-Saharan Africa, South Asia and the least developed countries.
- Adolescent boys outnumber girls in all regions with data available, including the industrialized countries. Parity is closest in Africa, with 995 girls aged 10–19 for every 1,000 boys in Eastern and Southern Africa and 982 girls per 1,000 boys in West and Central Africa, while the gender gap is greatest in both Asian regions.
- At the global level, adolescents’ share of the total population peaked in the 1980s at just over 20 per cent.
- Although adolescent numbers will continue to grow in absolute terms until around 2030, adolescents’ share of the total population is already declining in all regions except West and Central Africa and will steadily diminish all over the world through 2050.
- One trend that will continue to intensify in the coming decades is that ever more adolescents will live in urban areas. In 2009, around 50 per cent of the world’s adolescents lived in urban areas. By 2050, this share will rise to almost 70 per cent, with the strongest increases occurring in developing countries.

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are a regular threat in urban areas, and rising affluence – with attendant increases in traffic volume – may account for the higher road fatalities recently seen in Asia and the eastern Mediterranean. Boys are more prone than girls to injury and death from such accidents as well as from violence stemming from chance encounters or organized gang conflict. Because the rate of urbanization is most rapid in the poorest regions of sub-Saharan Africa and South Asia – which are also the areas with the greatest share of adolescents in the population – averting injuries in the second decade of life must become a major international health objective.⁴

Tobacco consumption and drug and alcohol use are growing health risks for adolescents

In part, injuries arise from a propensity to take risks that is a common feature of adolescence, connected with the psychological need to explore boundaries as part of the development of individual identity. Such readiness to take risks leads many adolescents to experiment with tobacco, alcohol and other addictive drugs without sufficient understanding of the potential damage to health or of other long-term consequences of addiction, such as being drawn into crime to pay for a habit.

The most common addiction is cigarette smoking, a habit that almost all tobacco users form while in their adolescent years.

It is estimated that half the 150 million adolescents who continue smoking will in the end die from tobacco-related causes.⁵ Risky behaviours often overlap: A 2007 UNICEF report on child poverty in Organisation for Economic Co-operation and Development (OECD) countries indicated that adolescents who smoke are three times more likely to use alcohol regularly and eight times more likely to use cannabis.⁶

Nutritional status

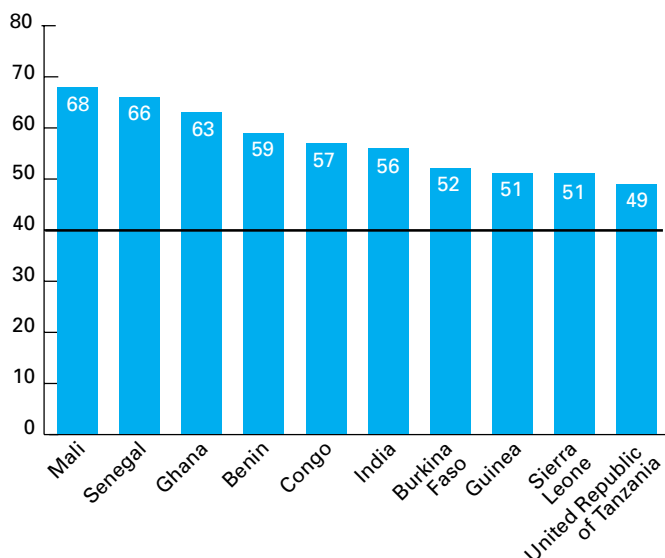
Adolescent females are more prone to nutritional difficulties than adolescent males

In early childhood (0–4 years), the available international evidence suggests that differences in nutritional status between girls and boys are statistically negligible in all regions except South Asia.⁷ As the years pass, however, girls run a greater risk than boys of nutritional difficulties, notably anaemia. Data from 14 developing countries show a considerably higher incidence of anaemia among female adolescents aged 15–19 as compared to their male counterparts in all but one country.⁸

In nine countries – all, aside from India, in West and Central Africa – more than half of girls aged 15–19 are anaemic.⁹ India also has the highest underweight prevalence among adolescent girls among the countries with available data, at 47 per cent. The implications for adolescent girls in this

Figure 2.3: Anaemia is a significant risk for adolescent girls (15–19) in sub-Saharan Africa and South Asia

Prevalence of anaemia among adolescent girls aged 15–19 in a subset of high-prevalence countries with available data

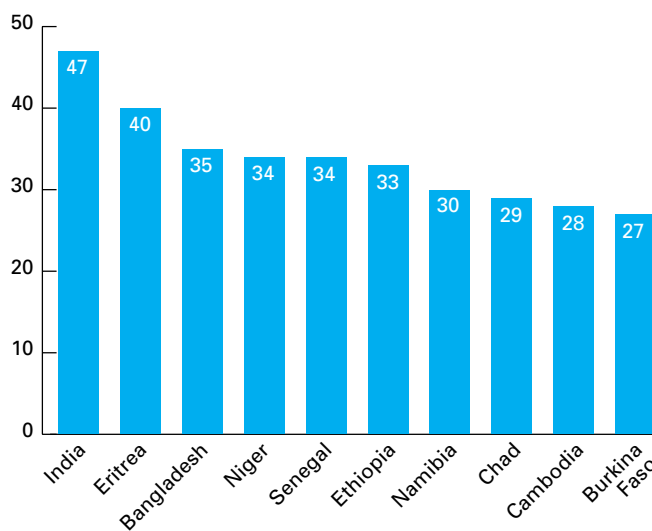


*The horizontal line at the 40 per cent mark represents the threshold at which anaemia is considered a severe national public health issue.

Source: DHS and national surveys, 2003–2009.

Figure 2.4: Underweight is a major risk for adolescent girls (15–19) in sub-Saharan Africa and South Asia

Percentage of adolescent girls aged 15–19 who are underweight* in a subset of high-prevalence countries with available data



* Defined as a body mass index of 18.5 or less.

Source: DHS and other national surveys, 2002–2007.

country are particularly serious, given that in the period 2000–2009, around 47 per cent of Indian women aged 20–24 were married by age 18.¹⁰ Adolescent pregnancy is a regular consequence of child marriage, and underweight mothers have a higher risk of maternal death or morbidity.

Obesity is a growing and serious concern in both industrialized countries and the developing world. Data from a subset of 10 developing countries show that the percentage of girls aged 15–19 who are overweight (i.e., those with a body mass index above 25.0) ranges between 21 and 36 per cent.¹¹ Among the OECD countries, the highest levels of obesity in 2007 were found in the four southern European countries of Greece, Italy, Spain and Portugal, together with the mainly Anglophone nations of Canada, the United Kingdom and the United States.¹²

Sexual and reproductive health matters

Girls are more likely to have engaged in early sex in adolescence but also less likely to use contraception

Investing in sexual and reproductive health knowledge and services for early adolescents is critical for several reasons. The first is that some adolescents are engaging in sexual relations in early adolescence; international household survey data representative of the developing world, excluding China, indicate that around 11 per cent of females and 6 per cent of males aged 15–19 claim to have had sex before the age of 15.¹³

Latin America and the Caribbean is the region with the highest proportion of adolescent females claiming to have had their sexual debut before age 15, at 22 per cent (there are no equivalent figures for young men for this region). The lowest reported levels of sexual activity for both boys and girls under 15 occur in Asia.¹⁴

The second reason concerns the alarming and consistent disparity in practice and knowledge of sexual and reproductive health between adolescent males and adolescent females. Adolescent males appear more likely to engage in risky sexual behaviour than adolescent females. In 19 selected developing countries with available data, males aged 15–19 were consistently more likely than females to have engaged in higher-risk sex with non-marital, non-cohabiting partners in the preceding 12 months. The data also suggest, however, that boys are more likely than girls to use a condom when they engage in such higher-risk sex – despite the fact that girls are at greater risk of sexually transmitted infections, including HIV. These findings

underscore the importance of making high-quality sexual and reproductive health services and knowledge available to adolescent girls and boys alike from an early age.¹⁵

Early pregnancy, often as a consequence of early marriage, increases maternity risks

The third challenge is empowering adolescent girls in particular with the knowledge of sexual and reproductive health, owing to the gender-related protection risks they face in many countries and communities. Child marriage, often deemed by elders to protect girls – and, to a much lesser extent, boys – from sexual predation, promiscuity and social ostracism, in fact makes children more likely to be ignorant about health and more vulnerable to school dropout. Many adolescent girls are required to marry early, and when they become pregnant, they face a much higher risk of maternal mortality, as their bodies are not mature enough to cope with the experience.

The younger a girl is when she becomes pregnant, whether she is married or not, the greater the risks to her health. In Latin America, for example, a study shows that girls who give birth before the age of 16 are three to four times more likely to suffer maternal death than women in their twenties. Complications related to pregnancy and child-birth are among the leading causes of death worldwide for adolescent girls between the ages of 15 and 19.¹⁶

For girls, child marriage is also associated with an increased risk of sexually transmitted infections and unwanted pregnancies. Research suggests that adolescent pregnancy is related to factors beyond girls' control. One study undertaken in Orellana, an Ecuadorian province in the Amazon basin, where nearly 40 per cent of girls aged 15–19 are or have been pregnant, found that the pregnancies had much less to do with choices made by the girls themselves than with structural factors such as sexual abuse, parental absence and poverty.¹⁷

Unsafe abortions pose high risks for adolescent girls

A further serious risk to health that arises as a consequence of adolescent sexual activity is unsafe abortion, which directly causes the deaths of many adolescent girls and injures many more. A 2003 study by the World Health Organization estimates that 14 per cent of all unsafe abortions that take place in the developing world – amounting to 2.5 million that year – involve adolescents under age 20.¹⁸ Of the unsafe abortions that involve adolescents, most are conducted by untrained practitioners and often take place in hazardous circumstances and unhygienic conditions.¹⁹

Risks and opportunities for the world's largest national population of adolescent girls



Khamma Devi, an advocate for women in the community, explains the ill effects of child marriage to girls and women in Himmatpura Village, India.

“Ensuring the nutritional, health and educational needs of its adolescent population, particularly girls, remains a key challenge for India.”

India is home to more than 243 million adolescents, who account for almost 20 per cent of the country's population. Over the past two decades, rapid economic growth – with real gross domestic product averaging 4.8 per cent between 1990 and 2009 – has lifted millions of Indians out of poverty; this, combined with government programmes, has led to the improved health and development of the country's adolescents. However, many challenges remain for India's youthful population, particularly for girls, who face gender disparities in education and nutrition, early marriage and discrimination, especially against those belonging to socially excluded castes and tribes.

India ranked 119 out of 169 country rankings in the United Nations Development Programme's gender inequality index (GII) in 2010. While the country has made significant progress towards gender parity in primary education enrolment, which stands at 0.96, gender parity in secondary school enrolment remains low at 0.83. Adolescent girls also face a greater risk of nutritional problems than adolescent boys, including anaemia and underweight. Underweight prevalence among adolescent girls aged 15–19 is 47 per cent in India, the world's highest. In addition, over half of girls aged 15–19 (56 per cent) are anaemic. This has serious implications, since many young women marry before age 20 and being anaemic or underweight increases their risks during pregnancy. Anaemia is the main indirect cause of maternal mortality, which stood at 230 maternal deaths per 100,000 live births in 2008. Such nutritional deprivations continue throughout the life cycle and are often passed on to the next generation.

Although the legal age for marriage is 18, the majority of Indian women marry as adolescents. Recent data show that 30 per cent of girls aged 15–19 are currently married or in union, compared to only 5 per cent of boys of the same age. Also, 3 in 5 women aged 20–49 were married as adolescents, compared to 1 in 5 men. There are considerable disparities depending on where girls live. For instance, while the prevalence of child marriage among urban girls is around 29 per cent, it is 56 per cent for their rural counterparts.

The Government of India, in partnership with other stakeholders, has made considerable efforts to

improve the survival and development of children and adolescents. One such effort is the adolescent anaemia control programme, a collaborative intervention supported by UNICEF that began in 2000 in 11 states. The main objective of the programme is to reduce the prevalence and severity of anaemia in adolescent girls through the provision of iron and folic acid supplements (weekly), deworming tablets (bi-annually) and information on improved nutrition practices. The programme uses schools as the delivery channel for those attending school and community Anganwadi Centres, through the Integrated Child Development Services programme, for out-of-school girls. The programme currently reaches more than 15 million adolescent girls and is expected to reach 20 million by the end of 2010. Attention has also been given to child protection issues. In 2007, the Government enacted the Prohibition of Child Marriage Act, 2006 to replace the earlier Child Marriage Restraint Act, 1929. The legislation aims to prohibit child marriage, protect its victims and ensure punishment for those who abet, promote or solemnize such marriages. However, implementation and enforcement of the law remain a challenge.

Non-governmental organizations such as the Centre for Health Education, Training and Nutrition Awareness (CHETNA) work closely with the Government and civil society to improve the health and nutrition of children, youth and women, including socially excluded and disadvantaged groups. CHETNA also works to bring awareness of gender discrimination issues to communities, particularly to boys and men, and provides support for comprehensive gender-sensitive policies at state and national levels.

Ensuring the nutritional, health and educational needs of its adolescent population, particularly girls, remains a key challenge for India. Widening disparities, gender discrimination and the social divide among castes and tribes are also among the barriers to advancing the development and protection rights of young people. Increased investment in the country's large adolescent population will help prepare them to be healthy and productive citizens. As these young people reach working age in the near future, the country will reap the demographic dividend of having a more active, participatory and prosperous society.

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Gathering accurate data on adolescent abortions is almost impossible given the level of secrecy and shame surrounding the procedure, but the number has been estimated at 1 million–4 million per year.²⁰ Many of the girls and women who seek abortions do so because they have had insufficient control over their own fertility, whether because of poverty, ignorance, problems with male partners or lack of access to contraception.

HIV and AIDS

HIV and AIDS are life-threatening challenges for adolescents in high-prevalence countries

Preventing the transmission of HIV is one of the most important challenges for adolescent survival and health. Although AIDS is estimated to be only the eighth leading cause of death among adolescents aged 15–19, and the sixth leading cause among 10–14-year-olds, it takes a disproportionately high toll in high-prevalence countries.²¹ It is the sheer scale of the AIDS epidemic in Eastern and Southern Africa that

makes this disease a prominent cause of death for women aged 15–29 worldwide, as well as one of the leading causes of death for men in this age group.²²

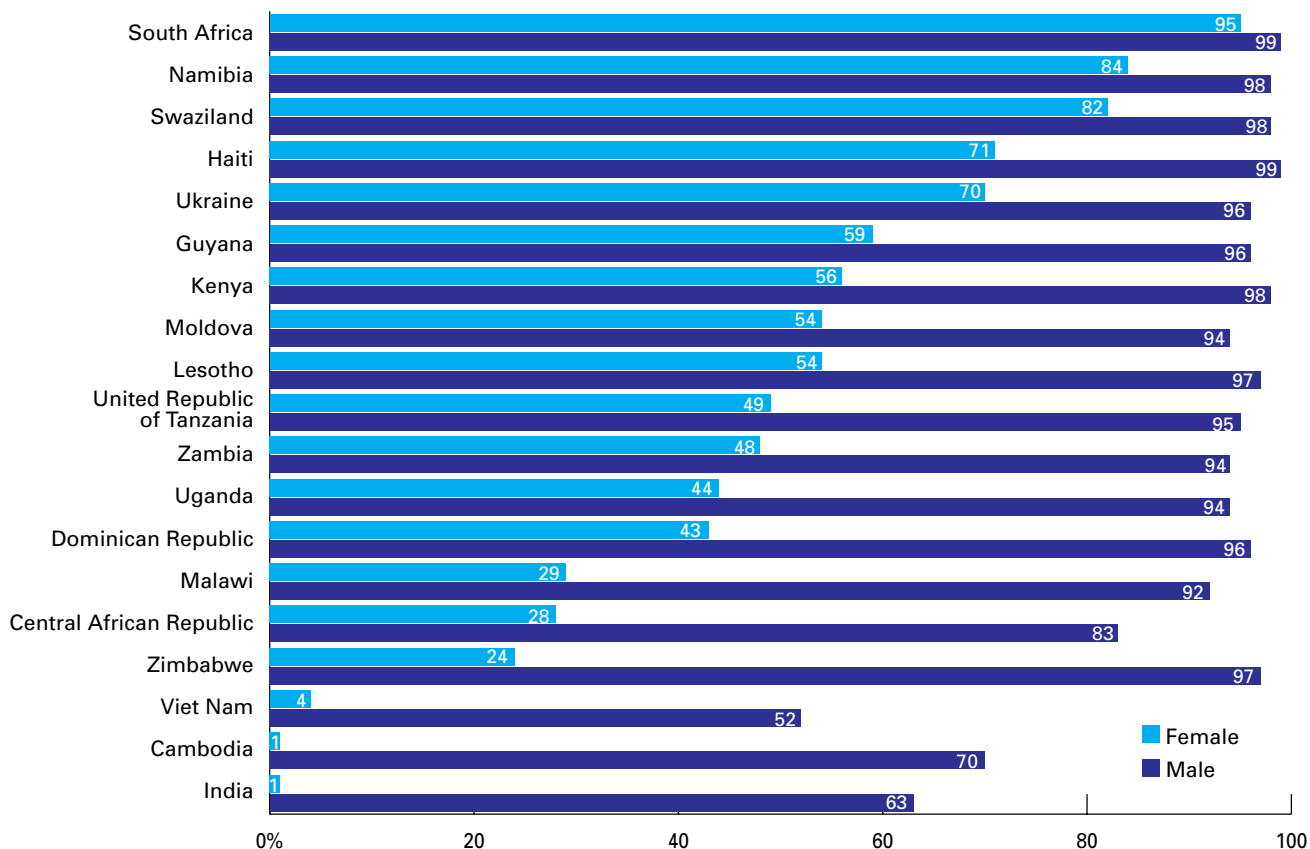
Many new HIV cases worldwide involve young people aged 15–24. In four of the world’s seven regions, young females are more likely to be living with HIV than young males – around twice as likely. In Eastern and Southern African countries with adult HIV prevalence of 10 per cent or higher, prevalence among girls and women aged 15–24 is two to three times higher than it is for their male peers.²³

The risk of HIV infection is considerably higher among adolescent girls than adolescent boys

Adolescent girls are at far greater risk of contracting HIV than boys, as data from six countries in Eastern and Southern Africa show. In Lesotho, for example, population based survey data show that HIV prevalence among males aged 15–19 was around 2 per cent in 2004, compared with 8 per cent for girls of the same age. The risks of HIV preva-

Figure 2.5: Young males in late adolescence (15–19) are more likely to engage in higher risk sex than females of the same age group

Percentage of young people aged 15–19 who had higher-risk sex with a non-marital, non-cohabitating partner in the last 12 months in selected countries



Source: DHS, MICS and national surveys, 2003–2009.

lence for both sexes continue to rise for the following two five-year cohorts (20–24 years and 25–29 years).²⁴

The higher incidence of the virus among girls and women is not solely a result of their greater physiological susceptibility. In many settings, adolescent girls and young women face a high risk of sexual violence and rape, both inside and outside of marriage. Child marriage, though often intended by families to shield girls and young women from physical and sexual risks, often fails to protect them from HIV and other sexually transmitted diseases because condom use tends to be lower in long-term relationships. Moreover, the available evidence indicates that adolescent girls in child marriages, and women in general, have less say than their partners over the use of contraception or over whether sex takes place at all.

Enhancing HIV services and knowledge is essential to empowering and protecting adolescents

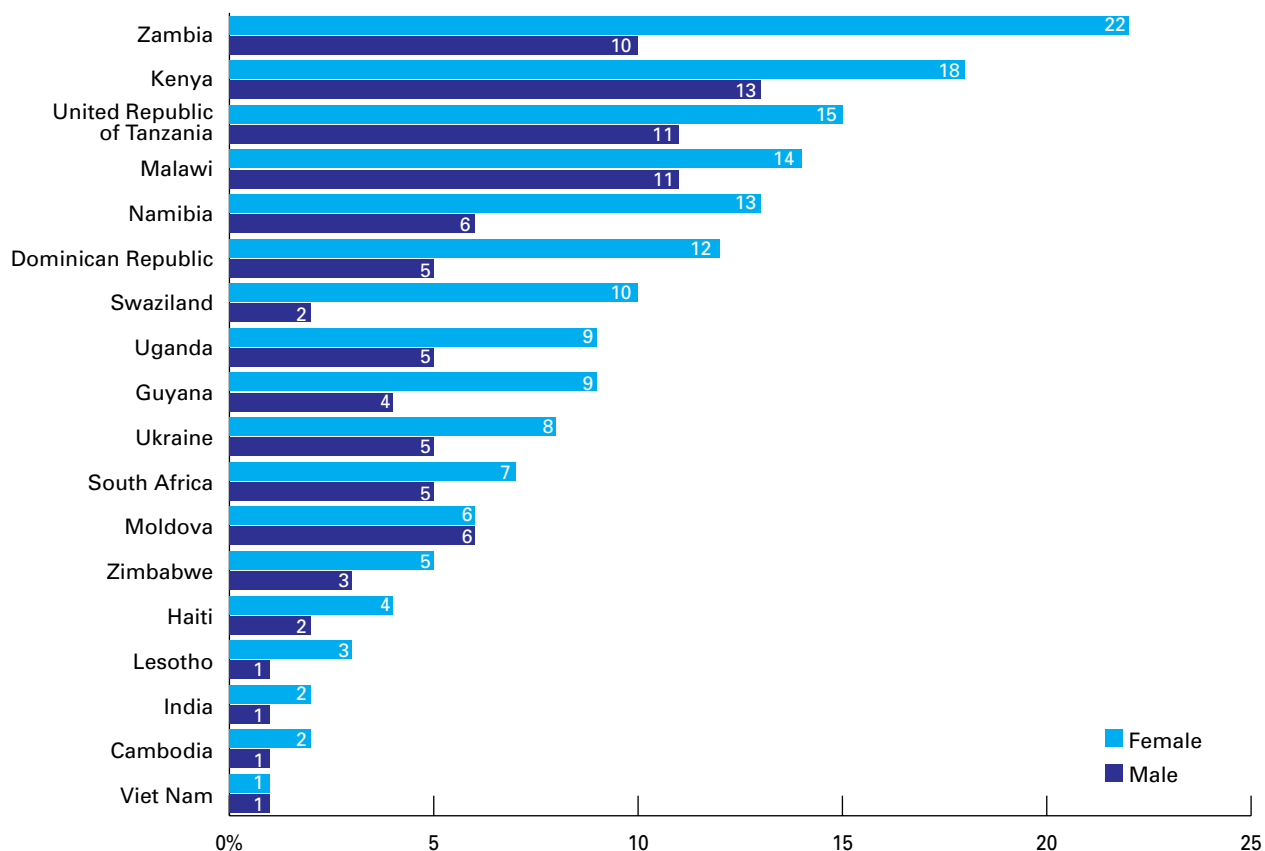
Investment in HIV prevention and treatment is critical to reversing the spread of HIV in adolescence. Offering

adolescents and young people high-quality reproductive health services, and ensuring that they have sound knowledge of sexually transmitted infections, empowers them in their choices and behaviours. Making such services and knowledge available in early adolescence, particularly for girls, is imperative; by late adolescence, the risk of infection for young people in high-prevalence countries is already considerable.

Encouragingly, efforts to enhance knowledge of HIV across the developing world are beginning to bear fruit. Analysis of 11 developing countries with available trend data shows that in 10 countries adolescent girls were more likely to know where to go for an HIV test in the latter half of the 2000s than they were in the early years of the decade.²⁵ Testing remains low, however, among both sexes. In contrast to testing, when it comes to comprehensive knowledge about HIV prevention, adolescent males consistently edge ahead of their female counterparts; and closing this divide is a particular challenge. For both

Figure 2.6: Young women in late adolescence (15–19) are more likely to seek an HIV test and receive their results than young men of the same age group

Percentage of young people aged 15–19 years who have been tested for HIV in the last 12 months and received results in selected countries



Source: DHS, MICS and national surveys, 2003–2009.

sexes, there is still a considerable gap between knowing about HIV and actually changing practices; this stems partly from the difficulty of addressing social and cultural mores.

Disability in adolescence

Nobody knows how many adolescents are affected by physical or mental disability. Adolescents with disabilities are likely to suffer forms of discrimination, exclusion and stigmatization similar to those endured by younger children. Disabled adolescents are often segregated from society and regarded as passive victims or objects of charity. They are also vulnerable to physical violence and abuse of all kinds. They are substantially less likely to be in school, and even if they are, they may suffer below-average transition rates. This lack of educational opportunities may contribute to long-term poverty.

An equity-based approach to disability – together with the assertive campaigning of disability-rights organizations – has led to a sharp change in perceptions. This approach, founded on human rights, emphasizes the barriers and bottlenecks that exclude children and adolescents living with disabilities. Such barriers include retrograde attitudes, government policies, the structure of public institutions and lack of access to transport, buildings and other resources that should be available to all.

This evolution of attitudes is having an increasing effect on policy and practice in almost every country of the world. A seal was set on it by the Convention on the Rights of Persons with Disabilities, which was adopted by the United Nations General Assembly in December 2006.²⁶

Nevertheless, adolescents with disabilities still all too often suffer discrimination and exclusion. Disability issues cannot be considered in isolation but must factor into all areas of provision for adolescents.

Adolescent-friendly health services

Adolescents face health challenges that paediatric and adult physicians alike are often ill-equipped to handle. Rapid physical and emotional growth, as well as the frequently conflicting and influential cultural messages they receive from the outside world, account for the unique nature of their health concerns. Without proper education and support, adolescents lack the knowledge and confi-

dence to make informed decisions about their health and safety – decisions that may have life-long consequences. In order to protect young people from health threats such as disease, sexually transmitted infections, early and unwanted pregnancy, HIV transmission and drug and alcohol abuse, communities must address their particular needs, and governments must invest in establishing adolescent-friendly health care services in hospitals, clinics and youth centres.

Studies show that adolescents avoid health care services – effectively nullifying preventive care – and distrust staff. They can be put off by the long waits, distance to health facilities or unwelcoming services, or they may feel too ashamed to ask for the money to cover the cost of their visit. Creating a welcoming, private space, where adolescents feel comfortable and are able to obtain prescriptions and counselling, is crucial to realizing their right to adequate health care services. Adolescent-friendly health facilities should be physically accessible, open at convenient times, require no appointments, offer services for free and provide referrals to other relevant services. In addition, cultural, generational and gender-specific barriers must be broken down to make way for an open dialogue between adolescents and trained staff who can provide effective treatment and counselling.

Education in adolescence

In most countries with universal or near-universal primary education and well-developed education systems, many children make the transition to secondary education in early adolescence. At the global level, however, universal primary education has not yet been achieved, despite significant progress towards it over the last decade. Achieving higher rates of primary education is fundamental to strengthening the numbers of early adolescents who are ready to make the jump to secondary school at the appropriate age.

Net primary enrolment in developing countries stood at 90 per cent for boys and 87 per cent for girls in the period 2005–2009, with much lower levels of 81 per cent and 77 per cent respectively in sub-Saharan Africa, the most disadvantaged region.²⁷ Many millions of adolescents across the world have not completed a full course of quality primary education that would prepare them to participate in secondary education.

Adolescent mental health: An urgent challenge for investigation and investment

It is estimated that around 20 per cent of the world's adolescents have a mental health or behavioural problem. Depression is the single largest contributor to the global burden of disease for people aged 15–19, and suicide is one of the three leading causes of mortality among people aged 15–35. Globally, an estimated 71,000 adolescents commit suicide annually, while up to 40 times as many make suicide attempts. About half of lifetime mental disorders begin before age 14, and 70 per cent by age 24. The prevalence of mental disorders among adolescents has increased in the past 20–30 years; the increase is attributed to disrupted family structures, growing youth unemployment and families' unrealistic educational and vocational aspirations for their children.

Unassisted mental health problems among adolescents are associated with low educational achievement, unemployment, substance use, risk-taking behaviours, crime, poor sexual and reproductive health, self-harm and inadequate self-care – all of which increase the lifetime risk of morbidity and

premature mortality. Mental health problems among adolescents carry high social and economic costs, as they often develop into more disabling conditions later in life.

The risk factors for mental health problems are well established and include childhood abuse; family, school and neighbourhood violence; poverty; social exclusion and educational disadvantage. Psychiatric illness and substance abuse in parents, as well as marital violence, also place

adolescents at increased risk, as does exposure to the social disruption and psychological distress that accompany armed conflict, natural disasters and other humanitarian crises. The stigma directed towards young people with mental disorders and the human rights violations to which they are subjected amplify the adverse consequences.

In many countries, only a small minority of young people with mental health problems receive basic assessment and care, while most suffer needlessly, unable to access appropriate resources for recognition, support and treatment. Despite the substantial progress in developing effective interventions, most mental health needs are unmet, even in wealthier societies – and in many developing countries, the rate of unmet need is nearly 100 per cent.

Mental health problems in young people thus present a major public health challenge worldwide. Preventive efforts can help forestall the development and progression of mental disorders, and early intervention can limit their severity. Young people whose mental health needs are recognized function better socially, perform better in school and are more likely to develop into well-adjusted and productive adults than those

whose needs are unmet. Mental health promotion, prevention and timely treatment also reduce the burden on health-care systems.

Greater public awareness of mental health issues and general social support for adolescents are essential to effective prevention and assistance. Safeguarding adolescent mental health begins with parents, families, schools and communities. Educating these critical stakeholders about mental health can help adolescents enhance their social skills, improve their problem-solving capacity and gain self-confidence – which in turn may alleviate mental health problems and discourage risky and violent behaviours. Adolescents themselves should also be encouraged to contribute to debates and policy-making on mental health.

Early recognition of emotional distress and the provision of psychosocial support by trained individuals – who need not be health workers – can mitigate the effects of mental health problems. Primary health-care workers can be trained to use structured interviews to detect problems early on and provide treatment and support. Psycho-educational programs in schools, supportive counselling and cognitive-behavioural therapy, ideally with the involvement of the family, are all effective in improving the mental health of adolescents, while the complex needs of young people with serious mental disorders can be addressed through stepped referrals to specialist services.

At the international level, a number of instruments and agreements are in place to promote the health and development of adolescents, most notably the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. The integration of mental health into primary health-care systems is a major endeavour to reduce the treatment gap for mental health problems. To that end, the World Health Organization and its partners have developed the 4 S Framework, which provides a structure for national initiatives to gather and use strategic information; develop supportive, evidence-informed policies; scale up the provision and utilization of health services and commodities; and strengthen links with other government sectors. Such integration will increase the accessibility of services and reduce the stigma attached to mental disorders.

One of the most urgent tasks in addressing adolescent mental health is improving and expanding the evidence base, particularly in resource-constrained countries. Systematic research on the nature, prevalence and determinants of mental health problems in adolescents – and on prevention, early intervention and treatment strategies – will be pivotal to ensuring adolescents' rights to health and development in these settings.

See References, page 78.

Facing the challenge: Reproductive health for HIV-positive adolescents



by Nyaradzayi Gumbonzvanda,
General Secretary, World
Young Women's Christian
Association

"Most adolescents living with HIV struggle for recognition, rights, protection and support."

In recent years, the global community has also made great strides to protect children and facilitate access to education and health services for HIV-positive children and orphans. Organizations such as UNICEF, faith-based organizations and women's networks such as the World Young Women's Christian Association (YWCA) have directed resources to train caregivers in social protection policies and to defend children's rights to information and dignity.

Many of those living with HIV are adolescents. These young people do not fit any one model: They are in school, out of school, living with foster parents, in stable families, heading families or seeking employment. But all of them deserve a nurturing environment and coherent support to make informed decisions about their particular condition. In the last two years, the World YWCA conducted a series of dialogues with HIV-positive adolescent girls on the particular issues they face. We discovered three key challenges that adolescents living with HIV contend with: disclosure, education and developing relationships.

First, in terms of disclosure, many children and young people are not informed of their HIV-positive status. Caregivers may not be prepared to tell them for a variety of reasons. Parents may feel an overwhelming guilt for unintentionally 'infecting' their child, for example, or they may dread answering questions about how HIV is transmitted. They may also wonder whether their child will be able to live a 'normal' life, knowing she or he is HIV-positive, or have fulfilling relationships (sexual or otherwise) in the future. Counselling for both caregiver and child is indispensable when handling disclosure.

Some adolescents know their status but do not disclose it to others because they fear rejection or exclusion. Both circumstances put young people at risk of transmitting HIV to others. In order to stop the spread of this virus, we must counteract prevailing stigma. It is imperative that policies and programmes – especially those established by governments – provide safe spaces for adolescents to feel comfortable disclosing their status, secure in the knowledge that they will be supported.

The second challenge is that comprehensive information on reproductive health for HIV-positive

adolescents is still scarce. Health-care systems and family support networks lack the means to break down such information to show its relevance to a particular age group or gender. "Aunt, should I stop taking the medicine now that I have started my period?" asks 15-year-old Tendai from Zimbabwe. Tendai was born HIV-positive and worries that taking medication during her period could result in side effects or adversely affect the chance of her having a child later in life. Local health-care workers and caregivers need training to provide answers to such questions about the fertility risks for HIV-positive adolescents. Providing education and accessible information to people living with HIV is pivotal to eliminating the epidemic.

The third challenge is developing relationships. Whether with friends or family, relationships are fraught with difficulty for young people living with HIV. UNICEF recently organized a dialogue with HIV-positive adolescents in Zimbabwe. These wonderful, bright voices brought painful and piercing messages. Conscious of their HIV status, adolescents fear they may never experience a sustainable romantic relationship. If they are blessed with a loving and understanding partner, will the partner's family accept them? If so, how do they go about conceiving a child? In such resource-poor countries, what are the risks and options?

It is the duty of governments to make sure medication and services such as counselling are available to all those living with HIV, including young people. International organizations such as Save the Children and community groups such as Rozaria Memorial Trust must join hands to enable HIV-positive adolescents to enjoy all their rights, especially their right to sexual and reproductive health. Most adolescents living with HIV struggle for recognition, rights, protection and support. They seek advice and information, not judgement. The sooner these adolescents' questions are answered, the sooner they will be empowered with the confidence that only knowledge can provide.

As World YWCA General Secretary, Nyaradzayi Gumbonzvanda leads a global network of women in 106 countries, reaching 25 million women and girls. She previously served as Regional Director for the United Nations Development Fund for Women (UNIFEM) and as a human rights officer with UNICEF in Liberia and Zimbabwe.

More than 70 million adolescents of lower secondary age are out of school, with sub-Saharan Africa the most affected region

The overwhelming focus on achieving universal primary education by 2015 may have led to the educational challenge for adolescents being understated. Reports repeatedly talk about the ‘number of children out of school’ but refer only to the number of children of primary age who are out of school – currently 69 million.²⁸ Yet there are virtually equal numbers of adolescents of lower secondary age – almost 71 million,²⁹ which is around one in five of that total age group – who are also out of school, either because they have not completed their primary schooling or because they have been unable to make the transition to lower secondary school – or because they have simply dropped out of secondary education. Taking account of adolescents, therefore, doubles the worldwide problem of children out of school. Of these out-of-school adolescents, 54 per cent are girls. The region most affected in this respect is sub-Saharan Africa, with 38 per cent of adolescents out of school.³⁰

There is a growing need to focus on the transition from primary to lower secondary school, which often proves particularly difficult in developing countries. Some children are not transitioning to secondary school at typical ages while other children drop out entirely. For example, of lower-secondary-age adolescents in sub-Saharan Africa, 39 per cent are still in primary school, repeating earlier grades or catching up after a late start. In sub-Saharan Africa, 64 per cent of primary school students transition to secondary school.³¹ Of those adolescents who do transition to secondary school, many do not make it to the upper secondary. For developing countries, the upper secondary gross enrolment ratio stood at just 48 per cent in 2007, compared with 75 per cent at the lower secondary level.³²

As more sub-Saharan African countries are reaching universal primary education, they are expanding their education goals to universal basic education, which includes an element of lower secondary as well as primary schooling. Ghana, for example, in 2007 established basic education to include 11 years of schooling, including two years of kindergarten, six years of primary school and three years of junior high school.³³

The barriers to school attendance at secondary level are largely similar to those at the primary level, but often even more entrenched. The cost of secondary schooling is often

higher than the cost of primary schooling and therefore more difficult for families to afford; secondary schools are further from home, often requiring transportation; and the conflict between educational aspirations and the potential income that could be earned by a working adolescent is greater.

Across the developing world, girls still lag behind boys in secondary school attendance

At the global level, girls still lag behind boys in secondary school participation, with net enrolment at 53 per cent for boys and 48 per cent for girls for the period 2005–2009. Although girls lag behind boys generally, their disadvantage is not wholesale. Girl disadvantage is highest in the least developed countries, particularly in sub-Saharan Africa and South Asia. However, in the East Asia and Pacific and the Latin America and Caribbean regions, net attendance in secondary school is higher for girls than boys.³⁴

Adolescent girls and boys face different challenges to school attendance. Girls, especially poor girls, are less likely to attend secondary school due to the compounding forms of disadvantage and discrimination they face, including domestic labour, child marriage, ethnic or social exclusion and early pregnancy.³⁵ Boys may face psychosocial challenges to school attendance. Adolescent boys tend to report lower satisfaction with school than girls.³⁶ Studies show that teenage boys tend to spend less time in academic activities than girls, while lack of family involvement and the influence of their peer group may also adversely affect boys’ levels of satisfaction and adjustment to school.

Secondary education is critical to adolescent empowerment, development and protection

Girls’ secondary education remains critical to their development. The existence of secondary schools tends to improve not only enrolment and completion in primary schools but also the quality of the education they provide. Secondary education contributes to greater civic participation and helps to combat youth violence, sexual harassment and human trafficking. It results in a range of long-term health benefits, including lower infant mortality, later marriage, reduced domestic violence, lower fertility rates and improved child nutrition. It functions as a long-term defence against HIV and AIDS, and also acts to reduce poverty and foster social empowerment.³⁷

Many countries in the developing world have made significant progress in enrolling more girls in secondary school since 1990, though the goal of gender parity remains

Inequality in childhood and adolescence in rich countries – *Innocenti Report Card 9: The children left behind*

In comparison with those in the rest of the world, children in the wealthiest countries enjoy a very high standard of living – but not all benefit equally from the relative prosperity of their nations.

Over the past decade, the UNICEF Innocenti Research Centre's Report Card series on child well-being in the Organisation for Economic Co-operation and Development (OECD) countries has emphasized the importance of measuring the well-being of children in industrialized countries. The latest in the series, Report Card 9, asks, *How far behind are the least advantaged children being allowed to fall?*

Analysing three dimensions of the lives of adolescents – material well-being, education and health – the report ranks 24 OECD countries according to how successfully they practice the 'no child left behind' ethos. Denmark, Finland, the Netherlands and Switzerland appear at the top of the league table, while Greece, Italy and the United States are shown to have the highest levels of inequality for children.

By measuring economically advanced countries against one another, the Report Card creates a meaningful comparison, revealing the real potential for improvement to reach the standards of other OECD countries.

“Poverty and disadvantage in childhood are closely and consistently associated with many practical costs and consequences.”

The cost of inequality

Allowing a child to suffer avoidable setbacks in the most formative stages of development is a breach of the most basic principle of the Convention on the Rights of the Child – that every child has a right to develop to his or her full potential.

According to the report, poverty and disadvantage in childhood are also closely and consistently associated with many practical costs and consequences. These include poorer health outcomes, including a greater probability of low birthweight, obesity, diabetes, chronic asthma, anaemia and cardiovascular disease. Early disadvantage is linked to inadequate nutrition and compromised physical development as well as impaired cognitive and linguistic progress.

The least advantaged children are also more likely to experience food insecurity and parental stress (including lack of parental time), and to have higher allostatic loads due to recurrent stress. Further on in life, there is a greater probability of behavioural difficulties, lower skills and aspirations, lower levels of education and reduced adult earnings. Other risks include a higher incidence of unemployment and welfare dependence, teenage pregnancy, involvement with the police and courts, and alcohol and drug addiction (see adjacent column for full list).

Risks and consequences of inequality in the OECD

Efforts to prevent children from falling behind are right in principle, as they meet the basic tenet of the Convention that every child has the right to develop to her or his full potential. But they are also right in practice; based on hundreds of studies in OECD countries, the costs of young children and adolescents falling behind are grave, and include the greater likelihood of:

- low birthweight
- parental stress and lack of parental time
- chronic stress for the child, possibly linked to long-term health problems and reduced memory capacity
- food insecurity and inadequate nutrition
- poor health outcomes, including obesity, diabetes, chronic asthma, anaemia and cardiovascular disease
- more frequent visits to hospitals and emergency wards
- impaired cognitive development
- lower educational achievement
- lower rates of return on investments in education
- reduced linguistic ability
- lower skills and aspirations
- lower productivity and adult earnings
- unemployment and welfare dependence
- behavioural difficulties
- involvement with the police and courts
- teenage pregnancy
- alcohol and drug dependence.

Source: UNICEF Innocenti Research Centre, *Report Card 9, The children left behind – A league table of inequality in child well-being in the world's rich countries*, UNICEF IRC, Florence, 2010, p. 26.

Many families succeed in overcoming the odds and raising children who do not fall into any of the above categories. But Report Card 9 demonstrates that, on average, children who fall far behind their peers in their early years are likely to find themselves at 'a marked and measurable disadvantage' – through no fault of their own. And a society that aspires to fairness 'cannot be unconcerned that accidents of birth should so heavily circumscribe the opportunities of life'.

Principle and practice argue as one, concludes Report Card 9. Preventing millions of individual children from falling behind in different dimensions of their lives will not only better fulfil their rights, but also enhance the economic and social prospects of their nations. Conversely, when large numbers of children and young people are allowed to fall well below the standards enjoyed by their peers, both they and their societies pay a heavy price.

See References, page 78.

elusive. The gender gap is widest in sub-Saharan Africa and South Asia.³⁸

The global economy's increasing emphasis on knowledge-based skills means that the educational experience of adolescents in the developing world is coming more under the microscope. The foundation for providing young people with the skills they need to make the most of the opportunities in the modern economy remains basic education. Such education, however, needs to teach students how to think and how to solve problems creatively rather than simply passing on knowledge. Technical and vocational education also needs to be improved, and not treated as a second-best option for the less academic. It is also vital to extend the opportunity to participate first in basic education and subsequently in technical and vocational courses to adolescents from marginalized groups within society. Flexible 'catch-up' programmes can often reach these adolescents, especially if these are incorporated into national poverty reduction initiatives.³⁹

This equitable dimension is fundamental. The most vulnerable adolescents – those affected, for example, by poverty, HIV and AIDS, drug use, disability or ethnic disadvantage – are unlikely to be reached by the 'standard' offer of secondary schooling.⁴⁰ They will need to be approached through a range of strategies, including non-formal education, outreach and peer education, and the sensitive provision of education within a context of treatment, care and support.

Gender and protection in adolescence

Many of the key threats to children from violence, abuse and exploitation are at their height during adolescence. It is primarily adolescents who are forced into conflict as child combatants, or to work in hazardous conditions as child labourers. Millions of adolescents are subjected to exploitation, or find themselves in conflict with criminal justice systems. Others are denied their rights to protection by inadequate legal systems or by social and cultural norms that permit the exploitation and abuse of children and adolescents with impunity.

Threats to adolescent protection rights are exacerbated by gender discrimination and exclusion. Genital mutilation/cutting, child marriage, sexual violence and domestic servitude are four abuses estimated to affect a far greater number of adolescent females than adolescent males. But there are also human rights abuses that largely befall adolescent boys because of assumptions about their gender; it

is primarily boys, for example, who are forcibly recruited as child combatants or who are required to perform the most physically punishing forms of child labour.

Any examination of, or action on child protection – particularly in relation to the adolescent years – must consider the gender dimension. The other side of the coin is that addressing violence, abuse and exploitation of adolescents is vital to promoting gender equality and challenging the underlying discrimination that perpetuates it.

Violence and abuse

Violence and sexual abuse, particularly against girls, are commonplace and too frequently tolerated

Acts of violence take place within the home, at school, and in the community; they can be physical, sexual or psychological. The full scale of violence against adolescents is impossible to measure, given that most abuses occur in secret and remain unreported. Data from 11 countries with available estimates show a wide variation in levels of violence against adolescent females aged 15–19; in every country assessed, however, it remains an important problem.⁴¹

In addition to enduring violence from adults, however, adolescents are also much more likely to encounter violence from their peers than at any other stage in life. Acts of physical violence reach a peak during the second decade of life, with some adolescents using it to gain the respect of their peers or to assert their own independence. Most of this violence tends to be directed towards other adolescents.

For many young people, the experience of physical violence, whether as victim or as perpetrator, is largely confined to the teenage years and diminishes as they enter adulthood. Certain groups of adolescents are particularly vulnerable to physical violence, including those with disabilities, those living on the streets, those in conflict with the law, and refugee and displaced children.

Sexual violence and abuse occur in many different forms and may happen anywhere: at home, in school, at work, in the community or even in cyberspace. Although boys are also affected, studies show that the majority of the victims of sexual abuse are girls. Adolescents may be lured into commercial sexual exploitation under the pretence of being offered education or employment, or in exchange for cash. Or they may become involved due to family pressure, or the need to support their families, themselves, or both.

Act responsibly: Nurse our planet back to health



by Meenakshi Dunga,
16, India

“We have to wake up and realize that we are accountable not only to ourselves but also to Mother Nature and future generations.”

What can I say about climate change that hasn't already been written, read or discussed? In school we learn about global warming daily from our textbooks; we attend lectures and presentations. The earth is a sick patient whose temperature is slowly rising. Her condition is worsening. So what can I – a 16-year-old who can't decide what to have for lunch – say or do to make a difference? You might be surprised.

Although we are the caretakers of the planet, we have become too engrossed in our personal lives and our desire to succeed. Oblivious to the wounded world around us, we neglect our duties and responsibilities to the environment. We are quick to remember money owed to us and easily recall when the teacher was away, but we can't be bothered to unplug appliances to save energy or plant a tree. We can climb Mount Everest, cure illnesses and land on the moon, but we can't remember to turn off the light when we leave a room or to throw trash in the bin or separate it for recycling.

Many wake-up calls later, we remain asleep – or perhaps we choose not to be roused, thinking that other people will deal with the problem. But they won't. Gandhi said, “We need to be the change we wish to see in the world.” This is our planet, and it is up to us to care for it. Nursing our planet back to health is our responsibility, for the greater good.

My brother and I fight every morning because I insist he take a five-minute shower, using 10–25 gallons of water, instead of a 70-gallon bath. As in the butterfly effect, our daily actions – even minute ones – have far-reaching consequences. They determine whether life on Earth will perish or flourish. Closing the tap while we brush our teeth saves up to 30 litres of water per day. Biking or walking just twice a week can reduce CO₂ emissions by 1,600 pounds per year. Properly insulating our houses, thereby using less energy to heat and cool them, also makes a tremendous difference.

These small steps will help the earth, a patient who is struggling and who, I think, is eager to get well soon. We have to wake up and realize that we are accountable not only to ourselves but also to Mother Nature and future generations. Adolescents: Be more alert, active and engaged. I will continue to spread awareness to family members, friends and neighbours. We must respect our environment and keep it clean and safe. Who knows? One day, our patient might be cured, begin to thrive and become a greener, more beautiful place to live.

Meenakshi Dunga lives in Dwarka, New Delhi. Following her graduation, she plans to study medicine in India and become the best surgeon she can be. Meenakshi also enjoys singing, listening to music and caring for the environment.

Poverty, social and economic exclusion, low educational level and lack of information about the risks attached to commercial sexual exploitation, increase adolescents' vulnerability to sexual abuse. The driving factor behind commercial sexual exploitation of children, however, is demand. While foreign tourists are often involved, research shows that the vast majority of the demand is actually local.

The gender dimension of protection abuses in adolescence is pronounced

The gender dimensions of violence and abuse – physical, sexual and psychological – against adolescents are critical. Girls experience higher rates of domestic and sexual vio-

lence than boys; these abuses reinforce male dominance in the household and community, and concurrently impede female empowerment. Evidence from 11 developing countries with available data show a broad spread of experience of sexual or physical violence against adolescent females aged 15–19, reaching a height of 65 per cent in Uganda.⁴²

The widespread acceptance of spousal violence as a normal feature of life, particularly by young women, is a grave cause for concern. The latest international household data for 2000–2009 show that on average more than 50 per cent of adolescent females aged 15–19 in the developing world (excluding China) consider that a

husband is justified in hitting or beating his wife under certain circumstances, such as if she burns the food or refuses to have sex.⁴³

Similar attitudes are prevalent among adolescent males of the same age cohort. In two thirds of the 28 countries with available data on this indicator, more than one third of adolescent males aged 15–19 considered a husband justified in hitting or beating his wife under certain circumstances.⁴⁴ Prevailing notions of masculinity and femininity reinforce these attitudes.

Adolescent marriage

Most adolescent marriages take place after age 15 but before age 18

Adolescent marriage – defined here as a marriage or union where one or more of the spouses is age 19 or younger – is most common in South Asia and sub-Saharan Africa. New figures from 31 countries in these two regions show that most adolescent marriages take place between the ages of 15 and 18. In three countries – Bangladesh, Chad and the Niger – around one third of women aged 20–24 were married by the age of 15.⁴⁵

While the impact of child marriage on girls' health and education has been noted earlier in this report, the psychosocial effects are also enormous. Girls are likely to find themselves in a position of powerlessness within the household of their husband's family, with no clear access to friends of the same age or other sources of support. This powerlessness means they are more vulnerable to abuse and may also have to bear an excessive burden of domestic work.

Female genital mutilation/cutting

The prevalence of female genital mutilation/cutting (FGM/C), though declining, is still widespread in 29 countries

More than 70 million girls and women aged 15–49 have undergone female genital mutilation/cutting (FGM/C), usually by the onset of puberty.⁴⁶ Of the 29 countries where FGM/C prevalence is higher than 1 per cent, only Yemen is outside the African continent.⁴⁷ Such cutting is extremely dangerous, especially when – as is common – it takes place in an unsanitary environment. It can do significant long-term damage and heightens the risk of complications during childbirth for both mother

and baby. It also reduces girls' capacity to enjoy normal, healthy sexual development.

The prevalence of FGM/C is declining – it is measurably less common among younger women than older, and among daughters compared with their mothers. But progress is slow, and millions of girls remain threatened by the practice.

Child labour

Child labour is declining, but still affects a large number of adolescents

Around 150 million children aged 5–14 are currently engaged in child labour, with incidence highest in sub-Saharan Africa.⁴⁸ Adolescents who work excessive hours or in hazardous conditions are unlikely to be able to complete their education, severely curtailing their ability to escape from poverty. The evidence shows that the prevalence of child labour has been falling in recent years, and that the incidence of hazardous child labour is declining sharply.⁴⁹ But it continues to blight the life chances and well-being of adolescents in much of the developing world.

Better data have revealed the extent to which lower rates of school enrolment and attainment in the developing world relate to child labour. The data also show the gender discrimination prevalent in child labour, especially domestic labour by adolescents. Although aggregate numbers suggest that more boys than girls are involved in child labour, it is estimated that roughly 90 per cent of children involved in domestic labour are girls.⁵⁰

Adolescents are also victims of trafficking

The extent to which adolescents, especially females, are vulnerable to protection abuses is being increasingly documented through household surveys and targeted studies. Nonetheless, many forms of protection risk remain largely invisible, owing either to their clandestine nature or to the difficulty encountered by adolescents in reporting these issues.

Trafficking is such an illegal and clandestine activity that statistics purporting to show the number of children and adolescents affected are likely to be unreliable. Adolescents may be trafficked into forced labour, marriage, prostitution or domestic work. They may be transported across borders, though it is more common for the trafficking to take place within countries. The number of countries with specific anti-trafficking laws has more than doubled over the

past decade, though not all of them have actually brought prosecutions against offenders.⁵¹

Initiatives on gender and protection

Experience shows that programmes that cut across sectors, promote discussion, debate and broad participation and successfully, over time, generate consensus around human rights principles and corresponding social change, can lead to a decrease in harmful practices that predominantly affect women and girls. This directly results in greater equality between men and women, reduced child mortality and improved maternal health.

In Uganda, for example, Raising Voices and the Centre for Domestic Violence Prevention supported community initiatives designed to challenge gender norms and prevent violence against women and children. Their activities included raising awareness on domestic violence, building networks of support and action within the community and professional sectors, supporting community activities such as discussions, door-to-door visits and theatre, and using media such as radio, television and newspapers to promote women’s rights.⁵²

In Senegal, a community empowerment programme supported by Tostan, a non-governmental organization that engages local facilitators to lead sensitization and awareness-raising sessions in villages, led to a 77 per cent decrease in

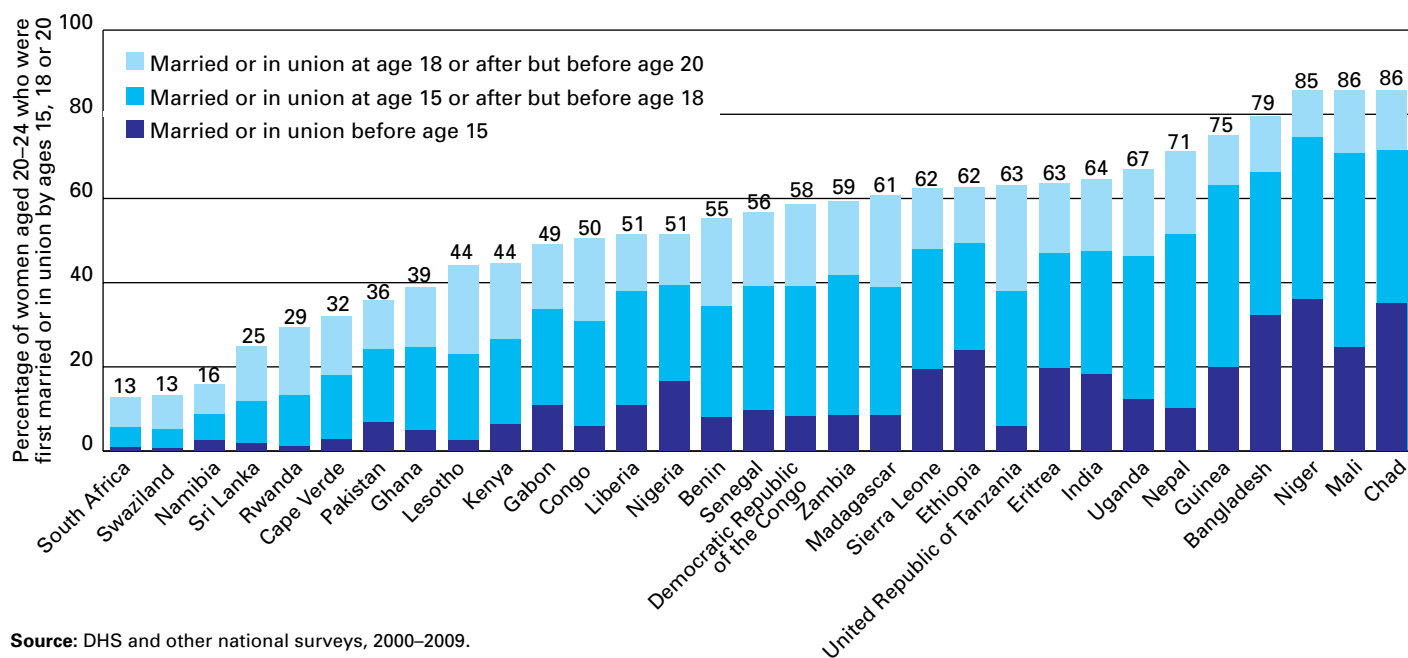
the prevalence of FGM/C. The community sensitization initiative also involves raising awareness of the negative implications of child marriage.⁵³

In Ethiopia, as a result of the Kembatta Mentti Gezzima-Topo (KMG) programme, which facilitated community dialogue and collective community decisions around FGM/C and alternatives, most families in the zone abandoned FGM/C. Whereas before the programme, which took place in 2008, 97 per cent of villagers were in favour of FGM/C, after it 96 per cent accepted that it should be abandoned. Just as vitally, 85 per cent of villagers believed that uncut girls were no longer “despised” in their communities.⁵⁴

Around 60 per cent of programmes combating child marriage are based on community sensitization of this kind. Other programmes aim to educate girls directly about the disadvantages of early marriage and offer incentives not to engage in it. The Government of Bangladesh, for example, has since 1994 been offering secondary school scholarships to girls who postpone marriage,⁵⁵ while in the Indian state of Maharashtra, girls’ participation in a life-skills education course has been demonstrated to delay their marriage by a year.⁵⁶

In other Indian states – Andhra Pradesh, Haryana, Karnataka, Madhya Pradesh, Punjab, Rajasthan and Tamil Nadu – both girls and their families are offered financial incentives to delay marriage until the age of 18.⁵⁷

Figure 2.7: Marriage by age of first union in selected countries with available disaggregated data



Source: DHS and other national surveys, 2000–2009.

Gender, poverty and the challenge for adolescents



A woman carrying her baby daughter on her back stands in her home, Ethiopia. Nurse Midwife Association and health extension workers are integrating the abandonment of FGM/C into existing maternal and child health clinics and programmes.

“Ethiopia’s population is young; over 50 per cent was under 18 in 2009.”

Although Ethiopia remains one of the poorest countries in the world, its economy has been growing, and many programmes to improve the health and education of children have shown success. The country is on track to reach Millennium Development Goals 4 and 5 to reduce child mortality and improve maternal health. Enrolment rates in primary school increased from 2008 to 2009, and girls’ participation in education has improved. In the global economic recession, the Government has taken steps to maintain budget allocations for the benefit of the poor. Yet environmental challenges such as drought and subsequent water shortages, along with poverty and violence against girls and women, present obstacles to development and threaten to reverse the progress that the nation has made.

Ethiopia’s population is young; over 50 per cent was under 18 in 2009. It is one of seven countries worldwide that account for half of all adolescent births (the others are Bangladesh, Brazil, the Democratic Republic of the Congo, India, Nigeria and the United States). In a country where most people survive on subsistence agriculture, children are valued for their labour as well as for the emotional and physical support they give parents, and many rural communities perceive large numbers of children as a social and religious boon. In urban areas, however, fertility levels have dropped due to a number of factors including decreasing poverty and improved access to medical services, including contraception.

The Population Council has found that 85 per cent of adolescents in Ethiopia live in rural areas, where education levels tend to be much lower, particularly for girls. Some regions have very high rates of early marriage, and almost 70 per cent of young married girls interviewed in the Amhara region had experienced sexual debut before they began menstruation. A substantial number of adolescents do not live with their parents, especially in urban areas; one third of girls between 10 and 14 in cities live with neither parent. Nationally, there are between 150,000 and 200,000 children living and working on the streets, where the girls among them face sexual abuse by adults, rape, unwanted pregnancy, early motherhood and the risk of HIV infection.

Programmes tend not to reach the most vulnerable children – rural youth, married girls and out-of-school adolescents. Rather, older, unmarried boys who live in

cities and attend school are the most likely to benefit from development initiatives. A survey conducted in Addis Ababa in 2004 that asked boys and girls aged 10–19 about their use of reproductive health programmes found that boys in the city’s poorer sections were significantly more likely than girls to be in school or to live with one or both parents; they also enjoyed greater mobility and better access to services. Although older boys and girls were more likely to use programmes than their younger counterparts, younger boys were more likely than older girls to use them, showing that age did not correct for gender disparity. A major obstacle for girls was their heavier workload, particularly in domestic settings, as compared to boys who worked in manual labour or trades.

The Ethiopian Ministry of Youth and Sport, working with regional and local governments as well as international partners, initiated the Berhane Hewan (‘Light for Eve’ in Amharic) programme in 2004 to prevent early marriage and support married adolescent girls by focusing on three areas: mentorship by adult women, continuation of school, and livelihood training for out-of-school girls. Over the course of two years the programme, which targeted girls aged 10–19 in the Amhara region, increased girls’ friendship networks, school attendance, age at marriage, knowledge of reproductive health and contraceptive use. The intervention owed its success in large part to its attention to the complex social and economic drivers of girls’ isolation and disadvantage. Following an 18-month pilot period, the project is being expanded to other parts of the region.

Further programmes need to be designed with an understanding of local cultural perceptions and social dynamics, especially those that create multiple forms of disadvantage for Ethiopia’s adolescent girls and rural youth. Many of the basic needs and rights of adolescents are not being met, and when economic and environmental constraints combine, the situation worsens. A recent study of food insecurity in the Jimma region, for example, found that girls in food-insecure households suffered more than boys. It is clear that investments must be targeted and should begin with efforts to ensure a decent standard of living for all the country’s girls and boys, no matter their ethnic origin, place of residence or class.

See References, page 78.

Yet other initiatives against child marriage take a legal route. In Ethiopia, for example, the organization Pathfinder International takes action against proposed child marriages that come to its notice, employing a network of local partners to try to persuade the parents concerned not to go ahead. If this strategy is unsuccessful, the organization joins with the Ethiopian Women Lawyers' Association in launching legal action aimed at stopping the ceremony.⁵⁸

Initiatives to counter violence and sexual abuse cannot confine themselves to legal protection. Much of the sexual violence experienced by adolescent girls is at the hands of their male partner and may not therefore come to the notice of the police or other authorities. In addition, tak-

ing punitive legal action without addressing the underlying causes of the violence may have unintended consequences, such as pushing the problem further underground.

For this reason it is essential to take steps to raise the awareness of boys and men about gender relations and power. Program H, developed by four Latin American non-governmental organizations, trains facilitators to help young men consider the drawbacks attached to traditional gender roles and the unhealthy behaviour attached to them. The aim of the programme is to foster more equitable relationships between men and women, and an evaluation of its effects in Brazil indicated that it had been successful in encouraging such gender-equitable behav-

TECHNOLOGY

Young people, mobile phones and the rights of adolescents

by *Graham Brown,*
Co-founder, mobileYouth

With only five years left to meet the Millennium Development Goals, much remains to be done to ensure equitable access to technological advances in underserved and hard-to-reach communities, especially among young people. Working at mobileYouth, I have seen how adolescents are using mobile technology in new and groundbreaking ways. Emerging markets dominate the growth of this technology. Alongside the throng of street urchins and trinket sellers in Chennai, India – to take just one example – local schoolchildren surround a makeshift stall. You might mistake it for an ice cream vendor, but this stall is actually selling mobile phones. In a country where the average gross domestic product per capita is around \$225 a month and Internet access via personal computers (PCs) is the exception, it is no coincidence that youth (defined here as those aged 5–29) have gravitated towards mobile phones, which cost as little as \$10 and offer call rates that approach zero.

Three of the five markets with the highest numbers of mobile accounts among young people are developing countries: Brazil, China and India (Japan and the United States are the other two). By 2012, the number of subscribers below the age of 30 in South Asia is projected to rise by 30 per cent, to 380 million, sub-Saharan Africa is expected to have 108 million subscribers under 30, and Latin America, 188 million. This increased connectivity offers an opportunity for young people to access knowledge and fulfil their right to information.

Although it was long thought that low-cost laptops would unlock the world of cheap mass communications for youth in developing markets, the mobile phone has become the de facto access channel to the Internet in places where there is low PC penetration. In South Africa, for example, mobile phone subscriptions among youth outstrip PC ownership by as much as 123 per cent.

Back in 1996, nobody imagined that Short Message Service (SMS), a format that limits messages to 160 characters, could be of any use apart from receiving a simple test signal from your mobile carrier. How wrong we were. By experimenting with and exploiting the medium, young people evolved the format before returning it to the commercial world. While we struggled to conceive of a successor to SMS, investing heavily in picture messaging (MMS) and similar services, youth once again arrived at the answer without industry intervention. They adopted, adapted and converted services originally intended for business – such as BlackBerry Messenger – into their own medium, not only to communicate among themselves but also to advance social campaigns.

Young people are keen to take up new content formats, with adolescents in particular having the time to explore and exploit new technologies. SMS, in turn, is being challenged by mobile Instant Messaging (IM), which is becoming the platform of choice owing to the increasing number of users,

their behaviours and attitudes in young men aged 14–25 as compared with a control group.⁵⁹

As this suggests, gender equality is not only about women and girls. Adolescent boys and young men are often at risk of protection abuses on the basis of gender. Gender equality requires the committed participation of all – men and boys, women and girls – to eradicate discrimination based on sex and age. A world in which adolescent girls and boys are adequately protected will also be a world that has seriously confronted the entrenched gender discrimination that is at the root of so much abuse.

lower costs, popularity in emerging markets and the widespread growth of mobile Internet everywhere. Brazil has 18 million mobile IM users, representing 23 per cent of the country's mobile youth. In India, 87 million – 31 per cent of mobile youth – claim to be mobile IM users.

In the slums of Cape Town, South Africa, against a backdrop of gang violence, social entrepreneurs like Marlon Parker – founder of the non-profit Reconstructed Living Labs (RLabs) – show how technology can empower adolescents to change their lives. For example, Jason, aged 19, has spent the last four years transforming himself from petty thief to community role model using mobile chat, Facebook and texting. In conjunction with Drug Awareness Week in South Africa, RLabs and Mxit – South Africa's leading mobile social network – recently launched a live Drug Counselling Portal called Angel, which offers young people 24-hour mobile access to information and support. Since its inception, the portal has attracted more than 23,000 users, filling a gap in social services important for young people and children.

The landscape has shifted significantly in less than a generation. We can no longer rely on specific organizations to be the sole agents of change; the speed at which issues arise and crises strike requires that we supplement more traditional modes of organizing with the kinds of youth-led grass-roots movements

made possible through mobile phone technology. Directed onto the right track, such movements could create cost-effective and easily deployed platforms for social change. Imagine, for example, the millions of girls under 18 living in rural India: How many of them – if armed with a mobile phone and supported by youth non-governmental organizations – have the potential to become advocates who proclaim an alternative message of hope? The world's mobile youth will not only change the nature of mobile markets; they will also transform the development community's outreach to promote social change and realize adolescents' rights.

Graham Brown is one of the founders of mobileYouth <www.mobileyouth.org>, the world's largest aggregator of data on youth mobile phone use. He hosts the youth marketing stream on Upstart Radio and mobileYouth's own TV channel. A widely published writer on issues related to young people and mobile technology, Mr. Brown is also a judge on the Mobile Marketing Association's Award Panel and an advisor to the Global Youth Marketing Forum held in India in 2010.

“ The mobile phone has become the de facto access channel to the Internet in places where there is low PC penetration.”

Chernobyl 25 years later: Remembering adolescents in disaster



*by Maria Sharapova,
professional tennis
player and Goodwill
Ambassador for
the United Nations
Development Programme*

“We believe in your ability and your right to realize your full potential, and we pledge our support as you move into adulthood.”

In 2011, the world marks the 25th anniversary of the disaster at Chernobyl, the worst nuclear power plant accident in history. The region, however, has yet to fully recover from this catastrophe. While adolescents currently living in Belarus, Ukraine and the Russian Federation – the three countries most affected by the fallout – were not yet born when parts of the nuclear power station exploded, they bear the scars of the tragedy.

Although we may never know the full extent of the harm done, approximately 5,000 cases of thyroid cancer have since been diagnosed among those who were under 18 years old at the time of the blast, and around 350,000 people – including my family – were uprooted from their towns and villages. Emergency workers risked their lives in responding to the accident, and millions were left traumatized by lingering fears about their health and livelihood. Young people, in particular, now face limited opportunities and suffer from mental health problems that threaten their social and economic welfare.

Even 25 years later, the psychological impact manifests itself in the residents’ belief in a shortened life expectancy, in radiophobia (fear of radiation as a psychological consequence of a traumatic experience) and in a lack of initiative resulting from their designation as ‘victims’ rather than ‘survivors’. In turn, young people lead unhealthy lifestyles, resort to drugs and alcohol and suffer from a lack of confidence in their ability to succeed and excel.

I have always wanted to contribute to the recovery of this region – a place to which I have a deep and personal connection. As a global community, we must provide the region’s young people with the tools they need to reach their full potential, and we must help its communities get back on their feet and overcome the stigma that hangs over the area. Providing adolescents with educational and social opportunities and positive reinforcement is one way to move forward.

Organizations such as the International Atomic Energy Agency, the World Health Organization, UNICEF and the United Nations Development Programme (UNDP) have teamed up with the

International Chernobyl Research and Information Network to provide the affected population with information on how to pursue healthy and productive lives. Psychosocial support has been particularly important for young people. In my capacity as UNDP Goodwill Ambassador, I have focused on seven UNDP initiatives in the three Chernobyl-affected countries, aiming to improve young people’s self-confidence, to restore a sense of hope and to encourage them to take control of their lives.

We opened music schools in rural areas of Belarus. Children from the city of Chechersk took up community activities such as cleaning springs, making bird feeders and planting bushes. A newly established ‘Fairytale Room’ at the Chechersk Central Rayon Hospital now provides therapy in the form of healing and inspirational activities like interactive games and mini-circuses. In the Russian Federation, a modern sports facility was built at the Novocamp summer camp to boost the physical and mental well-being of adolescents. A network of rural youth centres was established in Ukraine to bring computer skills to rural teens. We also launched a Scholarship Programme in Belarus that enables students to pursue higher education at the Belarusian State Academy of Arts and the Belarusian State University.

I have great faith in the young people of this area. My goal is to impart a message of optimism to adolescents who suffer from the consequences of the Chernobyl fallout and to help restore a healthy and productive environment. I would also like to tell young people in this and other regions affected by disasters, whether natural or human-made – such as Hurricane Katrina, the Indian Ocean tsunami, the earthquake in Haiti and, most recently, the oil spill in the Gulf of Mexico – that the world has not forgotten you or your struggle. We believe in your ability and your right to realize your full potential, and we pledge our support as you move into adulthood.

Maria Sharapova is a professional Russian tennis player who has won 3 Grand Slam titles. She was named Goodwill Ambassador for UNDP in 2007 and has focused specifically on the Chernobyl Recovery and Development Programme.

Protecting unaccompanied migrant adolescents



A Mexican immigration officer questions a repatriated migrant child in Tijuana, Mexico.

“Protecting adolescents from discrimination based on nationality or migration status and from administrative detention will be pivotal.”

Mexico is the fifth largest country in the Americas and ranks eleventh in the world in terms of population. Given its location between the United States of America and the rest of Latin America, it is a point of origin, transit and destination for migrants, experiencing both internal (rural to urban) and external (cross-border) migration. In 2009, around 78 per cent of Mexicans were living in urban areas. Increased urbanization has been spurred by migration to the northern border states, where the rapid growth of the maquila industry has attracted workers, and to tourist centres such as Cancun on the Caribbean coast. Large numbers of Mexicans have also crossed borders, most notably to the United States, where an estimated 10.3 million first-generation Mexican immigrants were living in 2004.

Recently, ensuring the rights of young people in the context of migration has become a challenge for Mexico. Children and adolescents migrating alone make up one of the least visible faces of migration. These young people, the majority of whom are adolescents aged 12–17, are on the move for various reasons, seeking to reunite with their families, to earn income or to escape violence and exploitation. During their journeys, adolescents are vulnerable to exploitation by unscrupulous persons and may fall prey to trafficking for labour or sexual purposes or be subjected to physical and sexual abuse. They are regularly exposed to humiliating and confusing situations that can leave deep scars. Within the last two years, over 58,000 adolescents and children – close to 34,000 of whom were unaccompanied – were repatriated from the United States to Mexico. Mexico, in turn, repatriated almost 9,000 adolescents and children to their countries of origin.

The Government of Mexico has taken determined steps to address issues related to migrant adolescents and children. The Inter-Institutional Panel on Unaccompanied Child and Adolescent Migrants and Migrant Women, set up in March 2007, has been instrumental in advancing this agenda. The panel brings together some 17 institutions, ranging from public authorities such as the National Family Development System, the Ministry of Foreign Affairs and the National Migration Institute, to international agencies such as UNICEF, the Inter-

national Organization for Migration (IOM), the United Nations Development Fund for Women and the United Nations Refugee Agency. It develops public policies and coordinates programmes oriented to the protection of this highly vulnerable population.

Such efforts have resulted in the development of a new model for the protection of unaccompanied migrant adolescents and children, and in 2009 the Mexican Congress increased the national budget allocation for its implementation. The Government, in partnership with UNICEF and other stakeholders, has also made considerable efforts to ensure that the rights of adolescents and children in migration are taken up in international forums. Consequently, regional guidelines for the protection of unaccompanied migrant children were approved in 2009 at the Regional Conference on Migration. The guidelines are applicable in 11 countries of North and Central America as well as the Dominican Republic.

Specific actions have also been taken to respond to the immediate needs of repatriated adolescents and children, such as setting up special care units in the northern border areas of Mexico. Bilateral efforts are also under way between Mexico, as the transit and destination country, and countries of migrant origin, such as Guatemala.

Globally, considerable challenges still remain in the endeavour to ensure the rights of migrant adolescents and children. Overall, a fundamental challenge is the general absence of a child perspective within migration laws and policies and the corresponding lack of a migrant perspective within childhood policies. Specific issues such as access to justice, family reunification and international special protection still need to be addressed. Protecting adolescents from discrimination based on nationality or migration status and from administrative detention will be pivotal. Lastly, the migratory circuit must be dealt with in a more comprehensive way in order to tackle the root causes of migration and to ensure that adolescents do not see themselves as forced to migrate, but instead are able to make choices that serve their best interests.

See References, page 78.