

2 Growing up Healthy



Youth are often portrayed as the very emblem of health: vital, robust and sparkling with natural resilience. Adolescence is indeed a time rich with opportunities for building a healthy life, but it is also a time of risk. This critical passage from childhood to adulthood has both immediate and long-term consequences for physical, mental and social well-being.

The health of young people is shaped to a large degree by the same constellation of determinants that shapes the health of children and adults: proper nutrition, good personal hygiene, cohesive social networks, and a supportive environment, including access to basic health care services.

However, forward-looking approaches to health are increasingly embracing the belief that adolescents are a unique population – as distinct as children and adults – with specific health concerns and needs that spring from their rapidly growing and changing bodies and the social, sexual and personal challenges that accompany the process of maturation. Research in industrialized and developing countries repeatedly finds that ensuring access to youth-friendly health and development interventions is cost-effective and contributes to lower morbidity and mortality in later life.

This new philosophy recognizes adolescence as an essential and formative stage of the life cycle. It also recognizes that young people have to be treated as persons in their own right and that their individual needs have to be considered case-by-case. It stresses that psychosocial determinants play as important a role in adolescent and youth health as do biomedical factors. In other words, youth health is strongly linked to youth development. However, like many youth issues, adolescent health is a relatively new field of practice, and this is most certainly so in the transition region of Central and Eastern Europe and the Commonwealth of Independent States.

There are reasons to assume that young people in this region have been endowed with particular chances for growing up healthy. Before the transition, there was widespread access to basic maternal health services, paediatric health services and nutrition programmes in nurseries and schools. Families lived in a social environment that offered few opportunities, but where basic needs were broadly met. So, the transition generation of today – those aged 15-24 – had good access to basic health services and rarely lived in poverty as children. The erosion of authoritarianism and the introduction of greater rights and responsibilities among individuals that have been associated with the transition have also presented youth with greater opportunities

related to personal development and health. For example, problems that contributed to poor adult health before the transition, such as widespread ignorance about the role and responsibility of individuals in promoting their own health, are being challenged and changed.

The transition generation is, however, also facing notable risks.

Poverty, inequality, weakening social cohesion, tensions around ethnicity and family and gender roles, discrimination, and rapid social change – conditions that have accompanied the transition to varying degrees in different countries – are widely recognized as root causes of health and development problems among youth. These problems are being manifested in poor nutrition, substance abuse, early and unprotected sexual activity, infections, depression and anxiety, suicide, and injury due to accidents and violence.

The staggering rise in adult mortality during the 1990s in many transition countries that is noted in earlier Regional Monitoring Reports underscores the huge social impact of the transition, as well as the widespread frailty of individual life styles, coping skills and social networks. Indeed, with hindsight, the individual and public health assets inherited from communist times appear to be less robust than once thought, with negative implications for today's youth. Surveys carried out in the early transition years found evidence of stunting among children aged 0-5 in Romania and problems both of stunted growth and excessive weight in Russia. More recent surveys have explored evidence of wasting from malnutrition among these same cohorts in Central Asia, even in countries relatively less affected by the transition. Studies have also pointed to the high incidence of childhood injuries throughout the region.

Chapter 1 discusses youth in the context of family formation and sexual partnerships, behavioural patterns within which young people have inherited a mixed legacy. There have been some positive, or at least adequate, changes during the transition, such as declines in the high numbers of teenage births. However, analysis also finds evidence that youth are becoming sexually active earlier than they were a few years ago and that they are spending longer periods with a series of stable partners or without committed partnerships, situations which tend to raise health risks.

Certainly, young people have shown considerable resilience, and some health indicators did improve in many parts of the region over the 1990s. At times, how-

ever, progress has been less reassuring among youth than it has been among adults. The majority of the data reviewed in this chapter reveals a stark picture of a young generation whose health has been compromised. Young people have not been sheltered from higher levels of stress, neglect, or violence in many transition societies: in 1998 about 85,000 young people died in the region, almost 20,000 more than nine years earlier. The open environment of the transition has exposed youth to new and greater risks related to sexually transmitted infections, dependence on illicit drugs and rising levels of tobacco use, which some experts regard as the most deadly trend in the long run.

These facts underline the need to understand and address the health needs of youth more effectively. While the link between health and social factors is well established in the international literature, the impact of the transition on the health of young people has been little researched, discussed or understood. Inherited health care philosophies

in the region have remained concentrated largely on the treatment of physical complaints. Despite the many health care workers and facilities, there are few services aimed at youth. A dialogue on youth health, including the perspectives of young people, could bring both a broader understanding and a particular focus to the issues.

In this chapter, Section 2.1 looks at how youth in the region view their own health and explores the incidence of mortality and illness among adolescents. Section 2.2 examines risky behaviours through the lens of substance abuse. Section 2.3 outlines the health aspects of sexual and reproductive behaviour, including the incidence of sexually transmitted diseases and unwanted pregnancies among youth. Section 2.4 presents the case for developing better responses to adolescent health by building on existing strengths in the region and adopting new approaches to support growing up healthy. ■

2.1 The Basic Parameters of Youth Health

The concept of good health promoted by the World Health Organization is defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. In focus-group research conducted for this Report, young people aged 15-24 in Romania, Russia and Uzbekistan were asked how they would define “good health”. Not surprisingly, they tended to see good health as a lack of impairment or complaint, or as the physical ability to be able to act and perform as they desire.

The notions that young people have about health are important because they influence how youth behave in regard to their health, with very real consequences – positive and negative. Interviewing young people about their knowledge, attitudes, beliefs, and practices is now an accepted research method for understanding youth issues and developing youth-friendly policies. And international experience shows that young people can be able partners in addressing their own health needs.

The sampling presented in *Voices of Youth 3* illustrates how differently young people can think about health. For example, youth in Uzbekistan often positioned their health in the context of building family and community, while young Russians and Romanians defined health in a more personal way. A number of them identified health as a sort of capital, but some, like Stefan, thought of it as a resource to be spent rather than carefully managed. His comment strikes a chord in what Natalia, age 15, of Russia, said in the focus-group discussions: “Good health is when you can do something without thinking of the consequences”.

Indeed, surveys show that a remarkably high number of young people in the transition region actually lack good health and engage in behaviour which has negative, even fatal, consequences. As Chapter 1 recounts, of the generation which was aged 5-14 in 1989 when the transition

began, more than a half-million boys and girls did not survive to become part of the 15-24 generation of 1999. This means that almost one person in every 100 of the generation of Natalia, Stefan and the others has been lost along the way.

Higher youth mortality in many countries

Adolescent health as a distinct health concern is barely on the policy radar in the region; accordingly, there is a dearth of research and evidence available on the broader aspects of youth health in many countries. However, regionwide data are available on the bluntest measure of adolescent health: the deaths of young people.

Figure 2.1 shows the mortality rates of the 15-24 populations in the 27 countries both at the beginning of the transition and in 1998 (or the latest available year). The diagram offers a comparison among countries and over time.

Overall, in 11 countries, youth mortality rates were higher in 1998 than they had been in 1989 – largely in CIS countries such as Russia, Ukraine, Belarus, Azerbaijan, Kazakhstan, and Turkmenistan. (The most recent data for Albania are from 1997 and indicate a rise in youth mortality; no data have been available for Bosnia-Herzegovina since the 1992-95 war, but it is unlikely that death rates have gone down since 1989.) More positively, youth mortality rates have declined in 16 countries, notably including the Baltic States and all of Central Europe.

Although the number of countries registering improvement was greater than the number showing deterioration, youth mortality regionwide was higher in 1998 than it had been at the beginning of the transition, meaning the improvement was minor and was occurring mostly in smaller countries, while the deterioration was more substantial and was taking place in countries with larger youth

populations. On balance, about 30 percent more young people aged 15-24 died in the region in 1998 than in 1989 – about 15,000 more young men and 4,000 more young women. Only one-third of this increase was due to population growth, while two-thirds was accounted for by the higher mortality risks.

A geographical reading of Figure 2.1 reveals considerable differences in youth mortality rates among the 27 countries of the region. Three subregions stand out with high death rates among youth: the Baltic States, the western CIS and Central Asia, accounting for most of the countries of the former Soviet Union. The Caucasus subregion is the only area of the former Soviet Union where youth mortality rates are similar to those in Central and Southeastern Europe. And, although youth mortality rates have fallen in the Baltic States, they are still almost double those in Central Europe. Across the entire region, differences in rates have become greater, so that in 1998 young people in Russia and Kazakhstan were three times more likely to die than were youth in Slovakia or Hungary.

Figure 2.2 shows the pattern of change in youth mortality rates in eight countries since 1985. It also includes the average rate in the European Union (EU) for comparison.

The figure makes clear that, in the mid-1980s, youth mortality rates in Central Europe, parts of Southeastern Europe and the Caucasus were comparable to EU rates, while rates in Russia and other parts of the USSR were significantly higher. During the transition years of the 1990s, the rates in Central and Eastern European countries (left panel) experienced some initial increases, but then subsided to levels lower than pre-transition and close to the flat line of the EU rates. (The spikes in Croatia's trend-line reflect the impact of war.) The rates in most countries of the former USSR (right panel) reveal relatively higher starting points in the mid-1980s, peaks in the mid-1990s

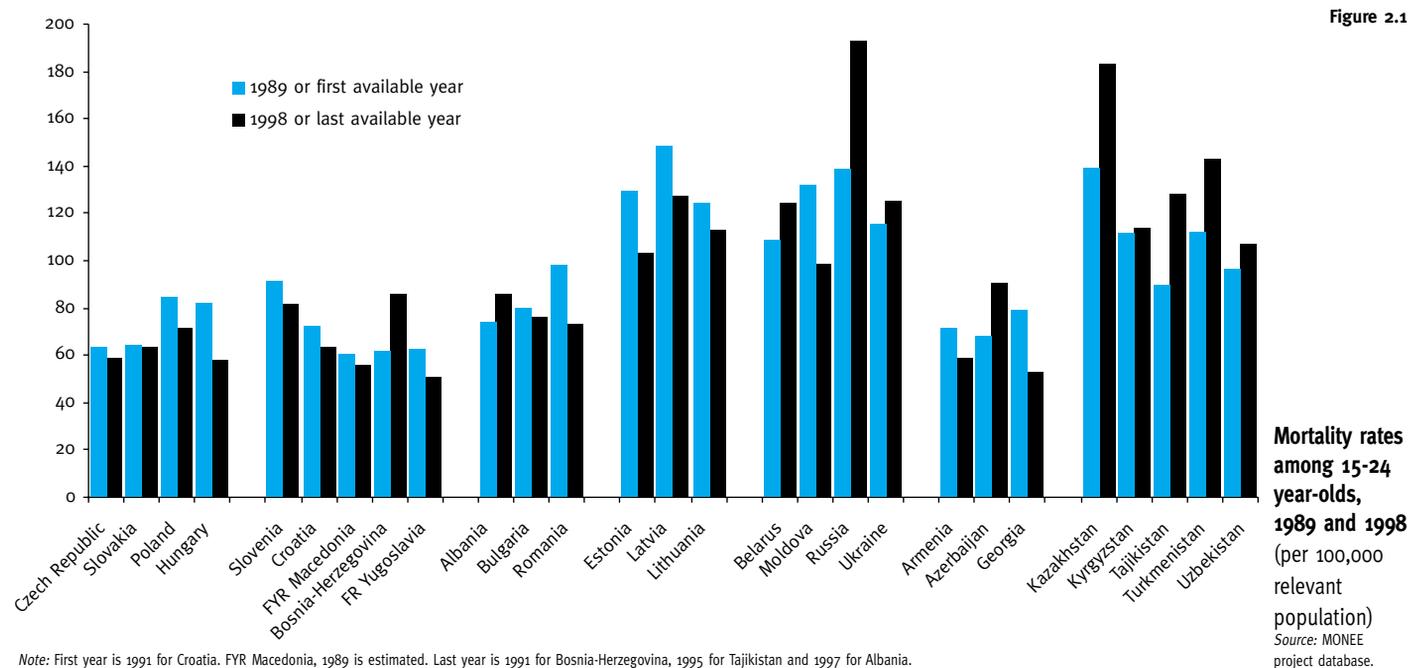
How do you define “good health”?

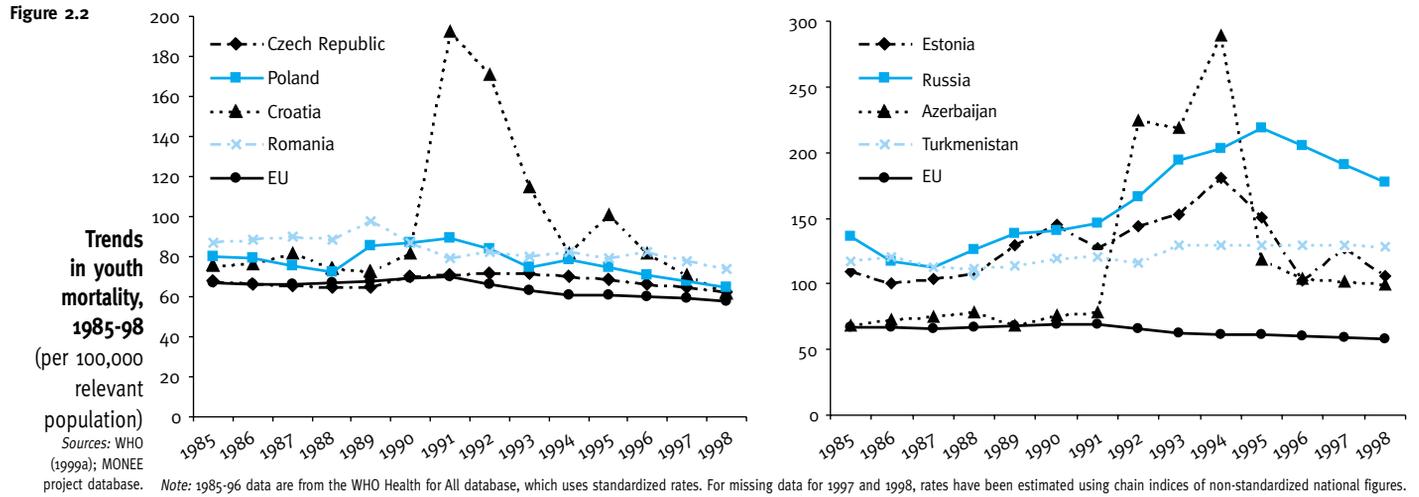
Concepts of health influence how health is defined, managed and evaluated. In focus groups organized for this Report, young Romanians, Russians and Uzbeks aged 15-24 were asked to describe what “good health” meant to them personally.

- “Good health lets you physically do what you want . . . being able to go to a three-day drinking party, to run 10 kilometres, to dance in the rain.” (Dorinel, 22)
- “Good health means that your health doesn't limit your ability to work.” (Elena, 19)
- “Good health means that you have no business with the doctor, no need for medication.” (Cerasela, 16)
- “That is what healthy means – it is prestige, male pride, a healthy generation.” (Rustam, 18)
- “We are all girls. For us the main thing is to be healthy for the family.” (Nargiza, 20)
- “Health is not only about being healthy, but it is about the future. And this future is not only ours, but the next generation's, and health is the foundation for our successors. We should always try to lead a healthy life; then both we and our children will be healthy.” (Said, 18)
- “If you take care of your health when you are 15 or 16, you will enjoy good health in the future. Otherwise in 10 years you will be sick and will start blaming yourself for having ignored health issues before.” (Raisa, 15)
- “You are in good health when you can afford not to think about good health.” (Stefan, 20)

and mostly levels that were higher in 1998 than in 1989, even in the absence of armed conflict.

War and armed conflict have taken many young lives during the upheavals of the transition – in the Balkans, in





the Caucasus (including parts of Russia) and in areas of Central Asia, and certainly some portion of these deaths has gone unrecorded and is missing from the statistics.

Using official data from the first year of the hostilities in former Yugoslavia, Box 2.1 highlights the particular vulnerability of youth to ethnic tensions and conflict.

Box 2.1

Young people as the first war casualties in Croatia and Bosnia-Herzegovina

There are no reliable accounts of how many young lives have been lost during the bloody breakup of the former Yugoslavia, the most devastating war in Europe since the Second World War. However, 1991 death statistics for Croatia and Bosnia-Herzegovina offer a snapshot of the mounting casualties in the spreading hostilities. It was the first year of war in Croatia and the last year in which official statistics were gathered in Bosnia-Herzegovina as it plunged into conflict from 1992 to 1995. The numbers

are a grim reminder of the high vulnerability of young people to ethnic tensions and war.

Figure 2.3 presents two scenarios. The first graph shows male mortality rates across the life span in Croatia in 1989 when both republics were at peace. The U-shaped pattern is typical of developed countries: infant mortality is relatively contained; children and adolescents have the lowest probability of death, and mortality bottoms out before or during early adolescence and then rises with age.

The second graph shows the change in male mortality between 1989 and 1991, the year when Croatia was overtaken with conflict and Bosnia-Herzegovina was on the verge of war. In contrast to the first graph, the comparison of these two years shows an inverted U-shape, a mortality wave which crests among 20-24 year-olds in Croatia and among 15-19 year-olds in Bosnia-Herzegovina. (Many of the latter may have been conscripts aged 18-19 who were serving in the federal army as the conflict escalated.)

Estimates put the number of children killed in the conflict in Bosnia-Herzegovina at 16,000 and the number of girls and women raped at 20,000 to 50,000. By the time the Dayton Accords between Croatia, Bosnia-Herzegovina and FR Yugoslavia ended the hostilities in 1995, tens of thousands of children and youth had died and hundreds of thousands had been subjected to and involved in violence.

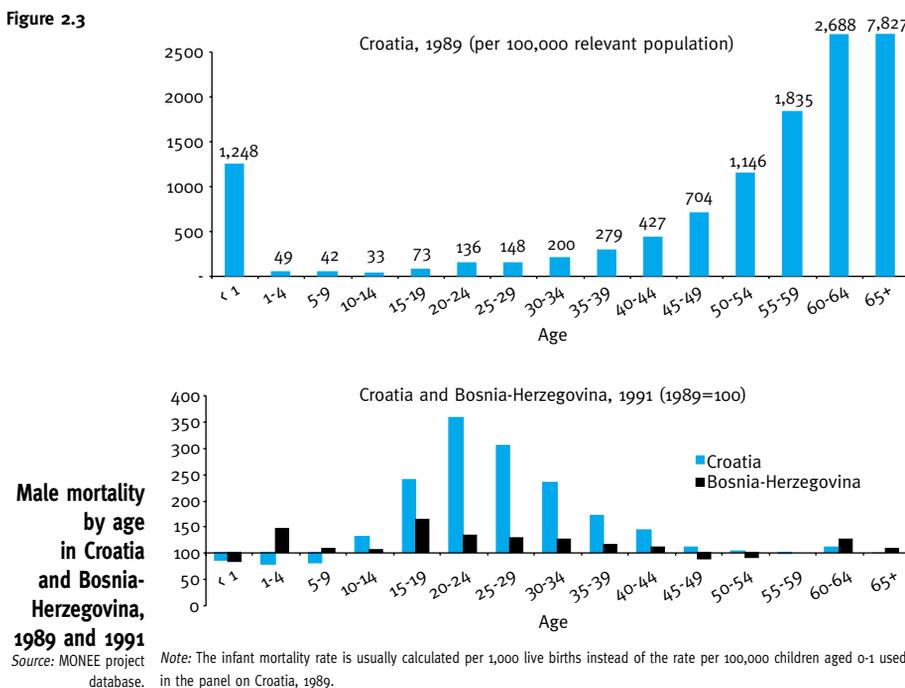
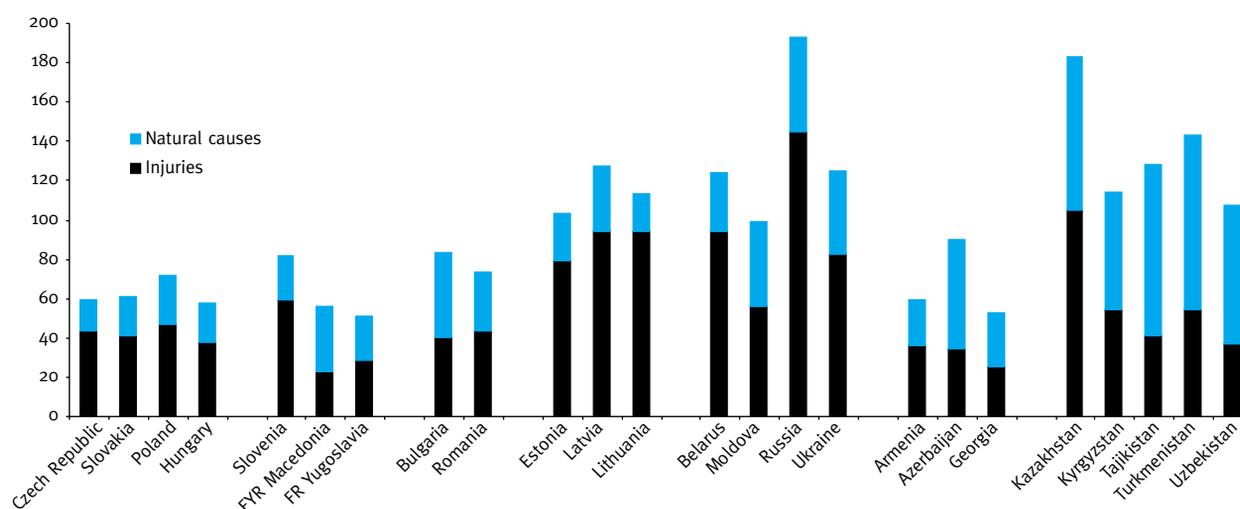


Figure 2.4



Note: Data for Slovakia and Tajikistan refer to 1995 and for FYR Macedonia and Bulgaria to 1997.

Youth mortality due to injury and natural causes, 1998 (per 100,000 relevant population)
Sources: WHO (1999a); MONEE project database.

Preventable deaths

Young people, especially males, typically see risk-taking behaviour in a different light than adults do and are also less experienced at managing risks. As a result, many youth deaths are caused by accidental injury, drowning, or poisoning and, at times, homicide and suicide, a loss which constitutes a “silent emergency” in many transition countries. These “non-natural” injuries and deaths are all, by definition, preventable. In parts of the region, “natural” causes are also significant contributors to youth mortality, mainly involving infectious diseases, but also maternity-related problems, among others. Clearly, many of these deaths are also preventable.

Figure 2.4 shows 1998 youth mortality rates in the region broken down into these two components: natural and non-natural causes. (Data are unavailable for Croatia, Bosnia-Herzegovina and Albania.) The data confirm that deaths from injuries account for much of the difference among youth mortality rates. The range in mortality rates from “natural” causes in the southern belt of the region indicates there is also plenty of room in some countries to improve preventive care in this regard.

In countries with the biggest rises in mortality rates, such as Russia or Kazakhstan, there has been an increase both in deaths from natural causes and in those from injuries. In some countries where the death rate is down, like the Czech Republic, a relatively larger decrease in deaths from natural causes outweighs and obscures an actual increase in deaths from injury.

One way to assess the number of young people who could have been saved through better prevention is to assume, for hypothetical purposes, that the risk of early death is the same for youth living in the transition region as it is for youth living in other industrialized regions. The last column of Table 2.1 shows the number of young lives that would be saved in each transition country if its youth mortality rate were the same as the rate in the European Union. Using this calculation, there are 45,000 “excess”

Table 2.1

Annual deaths among 15-24 year-olds and hypothetical numbers based on EU rates

	Actual deaths, 1998	Hypothetical deaths, using EU rate	Difference
Czech Republic	980	996	-16
Slovakia	584	556	28
Poland	4,569	3,829	740
Hungary	912	947	-35
Slovenia	239	176	63
Croatia	406	386	20
FYR Macedonia	183	197	-14
Bosnia-Herzegovina	632	309	323
FR Yugoslavia	804	958	-154
Albania	488	358	130
Bulgaria	925	729	196
Romania	2,748	2,246	502
Estonia	214	125	89
Latvia	425	200	225
Lithuania	595	315	280
Belarus	1,882	909	973
Moldova	618	376	242
Russia	42,225	13,133	29,092
Ukraine	9,089	4,365	4,724
Armenia	385	394	-9
Azerbaijan	1,226	816	410
Georgia	436	497	-61
Kazakhstan	4,939	1,620	3,319
Kyrgyzstan	1,010	531	479
Tajikistan	1,400	710	690
Turkmenistan	1,309	549	760
Uzbekistan	4,949	2,774	2,175
Total	84,172	39,002	45,170

Sources: WHO (1999a); MONEE project database.

Note: The number of hypothetical deaths is based on the 15-24 population in the transition countries and the average youth mortality rate in the EU in the mid-1990s. The actual death figures refer to 1991 for Bosnia-Herzegovina, 1996 for Albania and 1995 for Tajikistan.

East meets West: the risk of accidental death

Young men are most at risk of dying from injuries, whether accidental, or intentionally inflicted. How well are the young men of the transition region surviving this threat compared to their peers in the European Union?

Figure 2.5 compares mortality rates due to all forms of injury in individual EU countries and in nine transition countries which have applied for EU membership, as well as in Russia, the country with the highest injury rate in Europe. The figure identifies four categories of non-natural death: motor vehicle accident, accidental death from drowning, fire, poison, etc., homicide, and suicide.

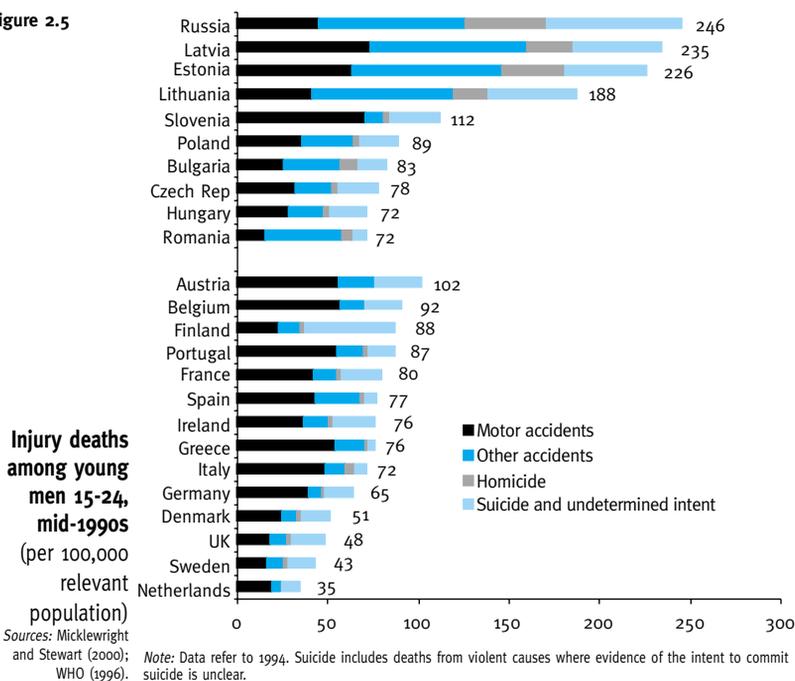
The figure shows a wide range in risk both in the

EU and in the 10 transition countries. Within the EU, young males in Austria have three times more probability of dying of injury than do young males in the Netherlands, the best EU performer. However, the Russian rate is seven times higher than the rate in the Netherlands. The figure highlights the fact that the great divide in deaths from injuries in Europe follows the borders of the former Soviet Union rather than those of the former "Iron Curtain".

Five countries – Romania, Hungary, the Czech Republic, Bulgaria, and Poland – have lower rates of death from injuries than do the worst-performing EU states, but this is largely due to lower rates for deaths from road accidents. The other five transition countries have road-accident rates which are higher than the EU average, despite their lower levels of motorization. In terms of other types of accidental deaths, most transition countries fare worse or much worse than the EU. Romania and, notably, the Baltic States and Russia have startlingly high non-road-accident death rates, and the incidence of youth suicide and homicide in the Baltic States and Russia is also shocking.

Overall, the figure suggests that there is much room for improvement within the transition region and within the EU. It is, however, encouraging to note that several EU countries (such as the Netherlands, the United Kingdom, Denmark, and Sweden) show relatively low rates of youth mortality from injuries. This progress in reducing the incidence of accidental and violent deaths among young people has taken place despite urbanization and an increase in travel, recreation and the use of vehicles, power tools and appliances. This success may provide models and best practices, such as life-skills education and targeted safety measures, that can be adopted and adapted in other countries.

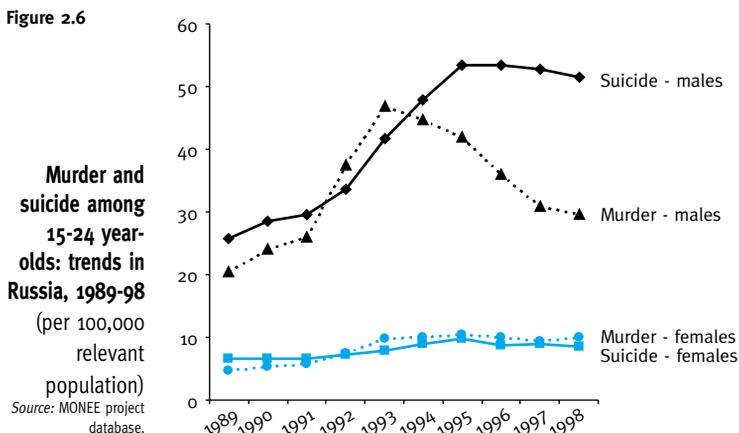
Figure 2.5



young deaths in the region each year, more than half the annual death toll among youth.

While Russia and some other countries show many

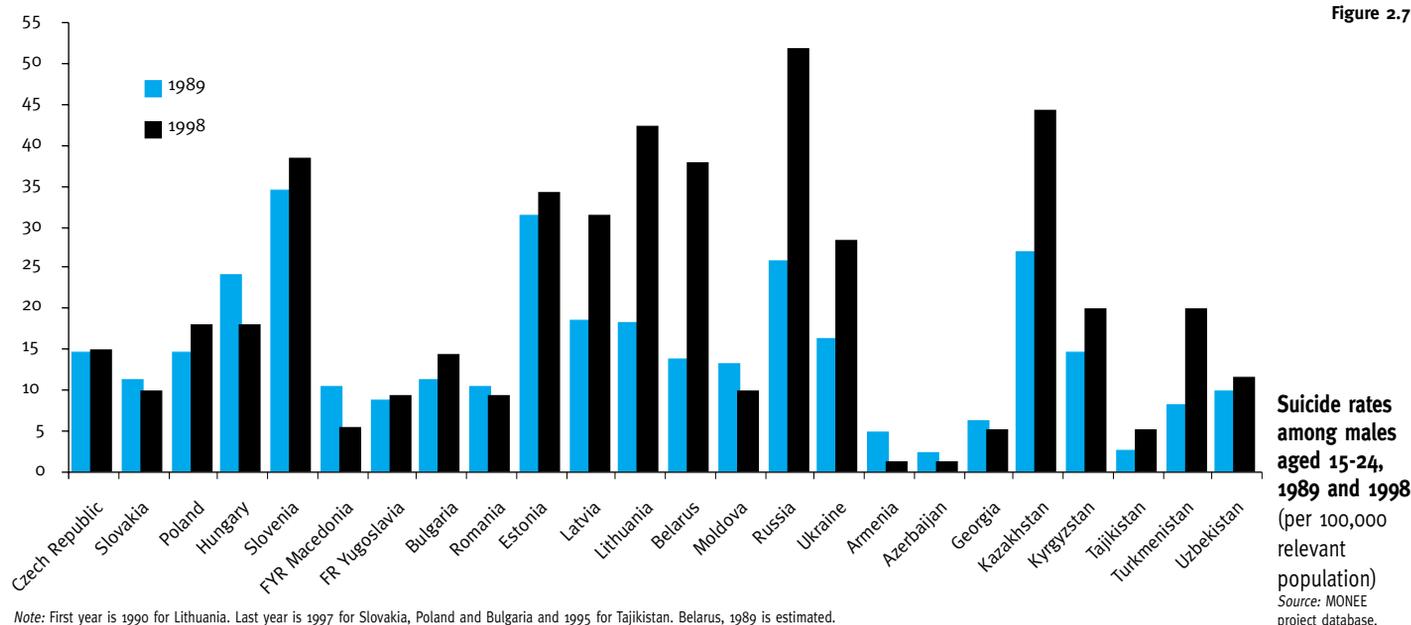
Figure 2.6



“excess” deaths, the negative figures in Table 2.1 reveal the striking fact that the youth mortality risk in several countries is actually below the EU average. However, it is important to remember that the transition region has been relatively disadvantaged materially, including in the availability of the motorized vehicles which are involved in a high share of accidental deaths. So, lower youth mortality rates in the transition countries may be favoured by less urbanization, less traffic and less access by youth to cars, motorscooters and recreation activities. As Box 2.2 illustrates, despite this factor, the accident rate is often quite high.

Earlier Regional Monitoring Reports have already called attention to increases in youth homicides and suicides in many transition countries, particularly in the early 1990s and most notably in Russia. Figure 2.6 shows murder and suicide trends from 1989 to 1998 for males and females aged 15-24 in that country. Homicide and suicide rates follow similar but not identical patterns: the number of male murder vic-

Figure 2.7



Note: First year is 1990 for Lithuania. Last year is 1997 for Slovakia, Poland and Bulgaria and 1995 for Tajikistan. Belarus, 1989 is estimated.

tims rose sharply in the early 1990s, then declined, while male suicide rates climbed quickly and settled at a much higher level; the rates for women have increased less during the transition, with deaths by homicide overtaking suicides.

Suicide is a bigger killer of young people across the region than is violence by others, especially since homicide rates have subsided in recent years, while suicide rates have not. Murder takes the lives of an estimated 5,000 males and 1,500 females aged 15-24 in the region every year – 15 males and 5 females per 100,000 population. (War deaths are not included in these numbers.) Suicide annually takes the lives of 10,000 males and 2,000 females – 30 males and 6 females per 100,000 population.

Figure 2.7 compares 1998 and 1989 suicide rates for males aged 15-24 in 24 transition countries. In 1998, rates were higher in 16 countries and particularly high – and rising – in Slovenia, Estonia, Latvia, Lithuania, Russia, Ukraine, and Kazakhstan; among those countries with relatively lower incidence in 1989, the rates more than doubled in Belarus and Turkmenistan. Some countries experienced rate increases in the mid-1990s that have since subsided (Statistical Annex, Tables 3.13 and 3.14). The incidence of suicide has also gone up among girls and young women in several countries. The Caucasus appears to be an exception to the overall patterns in the region, presenting not only low but declining rates, though recent data may be compromised by reporting problems.

Suicide is a public health issue in the broadest sense, associated with problems such as personal and family troubles, early pregnancy, bleak employment prospects, and a lack of a sense of purpose or belonging. If youth suicide rates can be seen as a warning flare of the general state of youth, then even the smallest increases should command the attention of governments and communities, and large increases should raise alarm.

The deteriorating general health of young people

At a time of life when young people are increasingly pursuing activities and making decisions on their own, they are also encountering a growing number of challenges and choices related to nutrition, healthy life styles, exposure to accidents and violence, high-risk behaviours like substance abuse, sexually transmitted disease, early and unwanted pregnancy – and the associated stress and psychosocial problems. It is important to gather information about and respond to the related broader health needs facing youth.

One way of exploring the general health status of youth is to find out how young people rate their own health. A major survey in 26 industrialized countries that asked young people the question “How healthy do you think you are?” found that adolescents in transition countries systematically offered less positive assessments than youth in Western Europe or North America. The 1997-98 Health Behaviour in School-Aged Children (HBSC) survey found that 84-89 percent of Czech, Slovak, Polish, and Hungarian adolescents and 81 percent of Russian youth described themselves as “very” or “quite” healthy. In Western countries, the ratio was more than 90 percent, and in some Scandinavian countries, over 95 percent.

Findings were similar in the 1993-94 HBSC survey, though the question was worded somewhat differently. Young people from the transition region were systematically less positive about their overall health status than their Western peers. The surveys also revealed a marked association between “feeling healthy” and “feeling happy”, and adolescents from the transition countries reported themselves happy less often than did Western youth.

Table 2.2 presents evidence on two physical complaints frequent among youth: headache and stomach ache. Interestingly, neither the 1993-94, nor the 1997-98 survey discovered a close relationship between self-assessed overall

Reported incidence of headache and stomach ache
(15 year-olds experiencing headache/stomach ache at least once weekly, percent)

Table 2.2

	Headache					Stomach ache				
	Female		Male		Total, 1997-98 (1993-94=100)	Female		Male		Total, 1997-98 (1993-94=100)
	1993-94	1997-98	1993-94	1997-98		1993-94	1997-98	1993-94	1997-98	
Slovakia	41	47	20	29	124.6	25	31	15	20	127.5
Poland	33	40	14	21	129.8	13	19	6	11	157.9
Hungary	41	48	19	29	128.3	17	28	11	16	157.1
Estonia	31	41	19	23	128.0	18	27	13	17	141.9
Latvia	36	41	14	19	120.0	22	24	9	13	119.4
Lithuania	42	48	22	22	109.4	22	25	10	12	115.6
Russia (regions)	41	45	19	28	121.7	14	23	11	16	156.0
7 transition countries	38	44	18	24	122.7	19	25	11	15	136.9
15 other countries/regions	38	41	20	23	109.3	19	22	11	12	113.3

Sources: Based on HBSC data in King et al. (1996) and Currie et al. (2000).

Note: For Russia in 1993-94, only students in St. Petersburg and the surrounding district were interviewed; the 1997-98 round also surveyed young people from Krasnodar kraj and Chelyabinsk oblast. Regions within France and Germany represented these countries. For the UK, constituencies in England, Wales, Scotland, and Northern Ireland were surveyed and reported separately.

health status and reported physical symptoms or related medication use: those young people who said they felt unhealthy were seldom the same ones who expressed these symptoms.

Table 2.2 shows data for the 22 countries and regions included in both surveys, including seven industrialized transition countries. It is striking that the 1993-94 data show almost the same percentage of 15-year-old girls and boys reporting headache and stomach ache in the transition countries and in the Western countries. This appears to indicate that young generations in Eastern Europe were no sicker than their Western peers.

However, the 1997-98 data show that, while the reported incidence of headache and stomach ache had climbed in all countries since 1993-94, it had climbed more steeply in Central and Eastern Europe. Western research identifies higher symptom rates within given countries with a higher incidence of distress, anxiety and unstable psychosocial environments. Figures on medication incidence (which may reflect symptom severity, as well as the better availability of medicines) seem to confirm that physical

complaints among youth in the transition region are on the rise: the survey found a slight overall increase in medication incidence in the 26 countries covered, but sharp increases in the seven transition countries examined.

Therefore, the conclusion cannot be dismissed that the 1993-94 and 1997-98 surveys captured a rapid transition from a low to a high prevalence of symptoms of ill health among the youth of Central and Eastern Europe. This troubling shift in self-reported health problems and assessments merits further investigation.

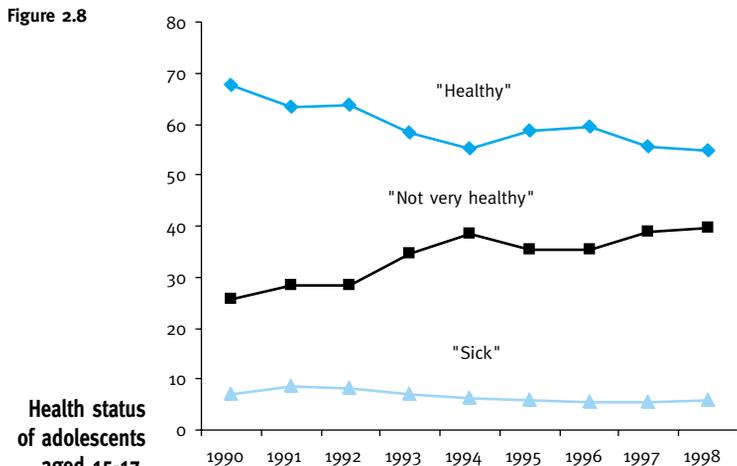
A valuable source of health-management information is the tradition in the region of medical check-ups at school and even sometimes in the workplace. Certainly, the nature and quality of the data vary, but overall the records confirm the above trend and add a further important finding: the disparities in the health status of youth are growing in the region.

Even in Slovenia, where the impacts of transition have been relatively moderate and evenly experienced throughout society, polarization in health has taken place; for example, school doctors found a greater share of both very well-nourished and poorly nourished students in 1996 than they had in 1987. Yet, many countries exhibit greater economic disparities than those in Slovenia, as well as poorer access to food. For instance, average annual meat consumption is 65 kilograms per capita in Slovenia, but only 37 kilograms in Bulgaria and 23 kilograms in Georgia; much of this variance is the outcome of the transition.

Another snapshot of changes in young people's health over the 1990s is presented in Figure 2.8, which is based on check-up records maintained on adolescents aged 15-17 by the Latvian Medical Statistics Bureau. Only 55 percent of the teenagers examined were found to be "healthy" in 1998, considerably lower than the share in 1990. The proportion regarded as "not very healthy" had grown from 25 to 40 percent.

A final insight gained from the records in various countries is that health conditions and health standards differ widely in the region. This appears to be true even among the countries that once all took part in the Soviet health system.

Figure 2.8



Health status
of adolescents
aged 15-17,
Latvia, 1990-98
(percent)

Source: CSBL (1999).

Note: "Healthy" corresponds with "Group-1" in the registers. "Not very healthy" represents "Group-2" (often ill, illnesses are lasting, and after-illness periods are characterized by tiredness, irritability, sleep disorders, appetite loss, etc.). "Sick" refers to young people with congenital malformations and chronic pathologies ("Group-3").

In Azerbaijan, for example, around 40 percent of the drinking water has been found to be contaminated with bacteria. Likewise, infectious diseases have greater impact where people are poor or are refugees and where there is a lack of money or

access to preventive measures, treatments and medications. In such conditions, health problems which get attention in more affluent countries may simply go unnoticed or unchecked. ■

2.2 The Risks of Substance Abuse

Adolescence is typically the time of life when people first confront choices related to intoxicating and potentially addictive substances like tobacco, alcohol and drugs. Certainly, tobacco and alcohol use was common in the region before the transition and was even widespread in a number of countries. Drug abuse was rare in these closed and highly controlled societies.

The transition has opened up borders, values and opportunities, a process that has been accompanied by stress and turmoil. One of the unfortunate impacts of this change is an increased willingness on the part of many young people to experiment with controlled and illegal substances at the same time that these substances are becoming more readily available and are being more aggressively marketed.

Higher rates of smoking

With privatization and economic liberalization, the tobacco industry in the region has become dominated by large transnational firms. This shift has meant that the marketing of cigarettes has become more sophisticated. For example, branding now associates smoking with an affluent and advantaged Western life style or with other images which no doubt appeal directly to young people.

Based on data from the two HBSO surveys carried out during the 1990s, Figure 2.9 shows the share of 15-year-old students who say they smoke at least once weekly. The overall picture is that smoking has been increasing among both girls and boys across Europe, East and West. The figures show that smoking is now just as common among boys in Central and Eastern Europe as it is among their Western European peers, and in some countries even more common. In Western Europe, the share of adolescent girls who smoke is now often

greater than the corresponding share of adolescent boys.

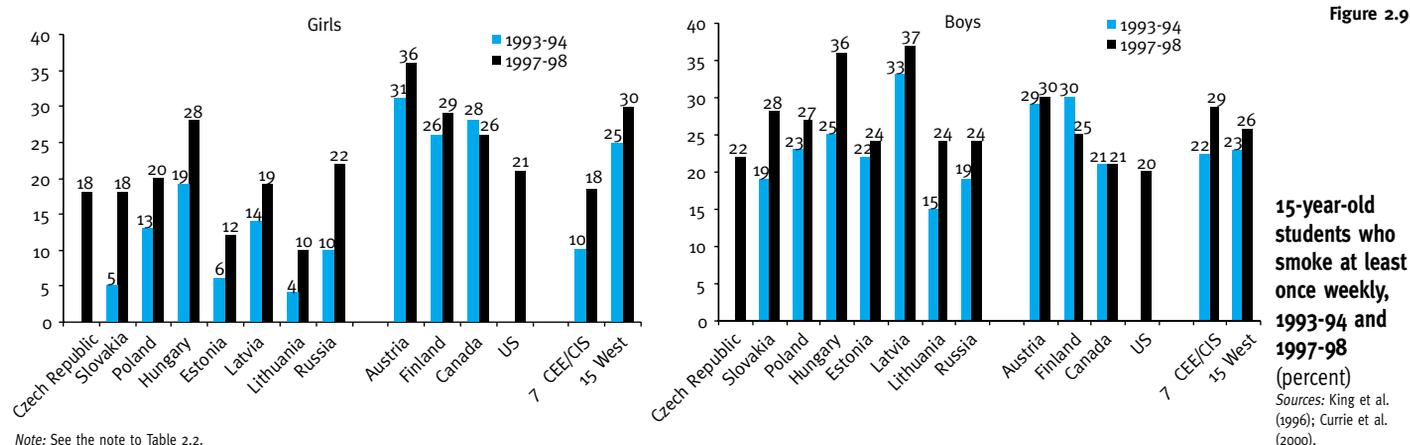
Pre-transition, girls in Central and Eastern Europe smoked much less than did either boys in the region, or girls in the West. During the transition, the incidence of smoking

Voices of Youth 4

Young people talk about smoking

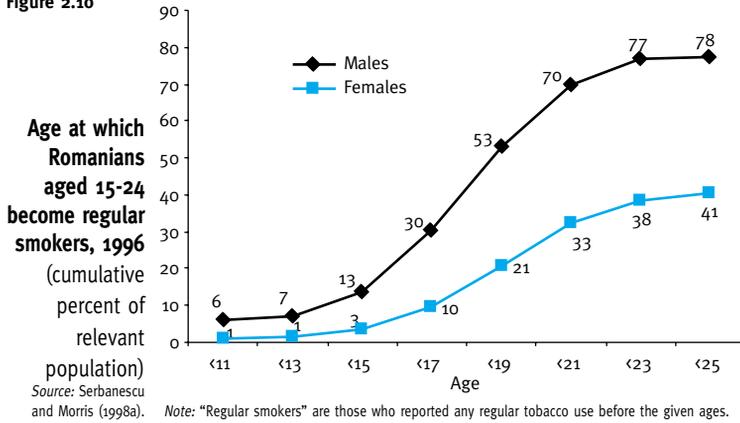
Smoking is becoming more prevalent more quickly among young women than among young men in many countries of the world, including transition countries. Listening to what young people say about smoking can be an aid in the development of effective prevention and intervention strategies. The quotes below are from interviews with Russian, Romanian and Latvian youth.

- "I just feel scared. I'm 16 now. I smoke, and I do anything I want. What will happen to my children? I would not watch my kid start smoking at the age of 12. But I started at that age." (Klavdia, 16)
- "I started smoking when I was 12, and it was considered early . . . and now I see 9-year-old kids smoking everywhere." (Natalia, 15)
- "It all depends on your peer group: if more than 50 percent of your friends smoke, you will start smoking as well. If I am nervous, I can't help smoking." (Klavdia, 16)
- "We only had one class on [healthy living] – about the dangers of smoking." (Gianina, 16)
- "One cigarette per day could even lower the risk of cancer." (Elena, 19)
- "I can't say for sure that smoking is bad for my health or not. I don't have enough information to make this decision." (Tatiana, 22)
- "[My friends] find it normal to smoke and do not consider it a bad habit. They know I don't support their smoking, but I don't try to put any pressure on them to give up. I believe that it's a personal decision of every human being and that I don't have the right to impose my opinion on them." (Guntar, 22)



Note: See the note to Table 2.2.

Figure 2.10



has gone up among all groups, but more quickly among girls. On average, in the 15 Western countries surveyed, 20 percent more girls reported smoking daily or weekly in 1997-98 than in the same survey four years earlier. In the seven transition countries surveyed, 82 percent more girls smoked. In countries like Slovakia or Russia, where rates were still relatively low in 1993-94, the incidence of smoking doubled or tripled during this short period. In other countries, like Hungary, where a higher percentage of girls smoked in 1993-94, the increase was less steep, but still very significant.

The "catching up" trend among young women has many dimensions. A 1996 survey in Romania found that urban females of reproductive age were almost twice as likely to smoke as were non-urban women. It also found that the share of smokers among women climbed with education level. However, data on younger adolescent girls showed much less differentiation in terms of locale or education. Some surveys suggest that girls are more likely than boys to take up smoking and more likely to quit. In Estonia, for example, of the generation born between 1971 and 1980, more than 60 percent of the males surveyed said they had never been smokers, while only one-third of the women said this.

Smoking still appears relatively less common and largely confined to males in the Caucasus and Central Asia. In Azerbaijan, for instance, recent household surveys report

that one-third of adult men and only 1 percent of women say they smoke. However, the share of young women who smoke in these regions is rising. In Georgia, the National Centre against Smoking estimates that currently about one-third of pregnant and breastfeeding women smoke, up from 14 and 22 percent, respectively, in 1995. Tobacco use by pregnant and nursing women has health implications for newborns, including higher rates of stillbirth, low birth-weight and congenital anomalies. Although many women stop smoking while pregnant, a survey in Armenia found that every second pregnant smoker did not.

Adolescence is a critical time to prevent smoking and to promote quitting because it is the moment in life when most people start the habit – a habit that is notoriously difficult to break once it is established and extremely detrimental to health, especially in the long term. A 1994 representative survey of Hungarian adults found, for instance, that, among smokers, 75 percent of men and 60 percent of women had begun smoking before age 20.

Figure 2.10 reports on how young people interviewed for the 1996 Romanian reproductive health survey recalled starting smoking. Among males, 6-13 percent recalled smoking regularly by age 10-14. After age 15, the share of people who had begun smoking rose steeply and then levelled out. This means that by age 25, 78 percent of men had a history of regular smoking, and two-thirds of them were still smokers. Girls are slower than boys to take up smoking and do so to a much lesser degree, as the figure shows. However, comparison with a similar survey carried out three years earlier confirms that relatively more girls are taking up smoking in this country, too.

Alcohol abuse: an old habit with new followers

Alcohol use and abuse are well established in all countries of the transition region. Alcohol is implicated in the region's high mortality rates and is a significant factor in accidents, domestic abuse and violence, emotional, mental and social ills, and crime.

"Alcohol is dangerous: most problems start off when you are drunk," commented Mikayel, a 16-year-old

Figure 2.11

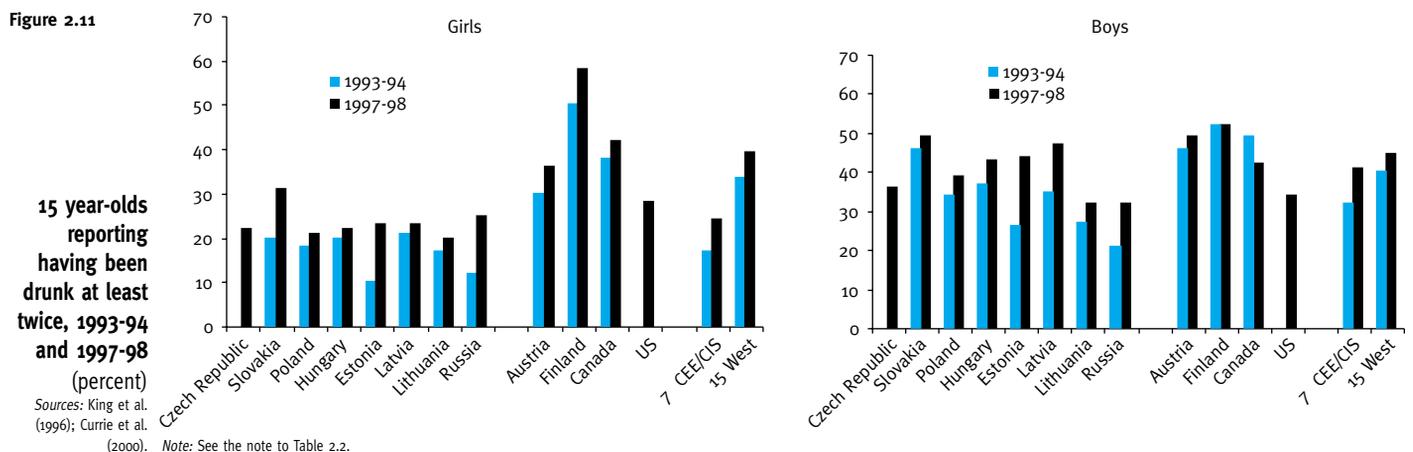


Table 2.3

Registered cases of alcohol abuse and addiction (per 100,000 population age 15+)

	1989	1995	1998
Czech Republic	911	585	527
Slovakia	791	1,338	1,287
Poland	532	538	–
Hungary	1,245	971	901
Estonia	2,577	1,020	1,182
Latvia	3,380	2,698	2,580
Lithuania	2,880	3,691	3,454
Belarus	2,859	2,160	2,352
Moldova	285	227	245
Russia	353	288	201
Ukraine	–	228	187
Armenia	428	238	233
Azerbaijan	450	420	439
Georgia	–	333	288
Turkmenistan	890	802	811
Uzbekistan	–	710	640

Source: MONEE project database.

Note: End-year cumulative totals, except Moldova, Russia and Ukraine, for which data refer to cases newly registered during the year.

Russian, in focus-group research carried out for this Report.

Figure 2.11 uses data from the 1993-94 and 1997-98 HBSC surveys to show the share of 15 year-olds who said they had been drunk at least twice. The graph tells much the same story as the data on smoking: the rates of alcohol use in the CEE/CIS are significantly higher among boys than among girls, but girls are catching up in many countries.

Given the generally high levels of alcohol consumption in the transition countries, it is surprising that the share of Central and Eastern European teenagers who admitted having been drunk was smaller than the share among their Western peers. However, there may be a methodological problem, since teenagers in different countries or cultures may interpret "being drunk" differently. Indeed, significantly more Russian pupils reported having drunk some alcohol than did the Finnish, Canadian or US students interviewed.

Various sources suggest that, in parts of the region, young people start drinking at younger ages, that drinking throughout adolescence is more common and that the intensity of drinking (the frequency and the quantities) is rising. The data presented in Figure 2.11 show that alcohol abuse has been mounting more quickly in the transition countries than it has in Western countries. The Romanian survey mentioned above found that one-third of 11-year-old boys had consumed alcohol and that most males are occasional or regular drinkers (especially in rural areas) by age 16.

Table 2.3 shows the number of persons in the region registered for treatment for drunkenness and addiction to alcohol. Most belong to the mature adult population. Available sporadic data indicate that less than 10 percent of registered abusers are aged 15-24, in keeping with sources that suggest that "hard" drinking habits usually become established in the early 20s.

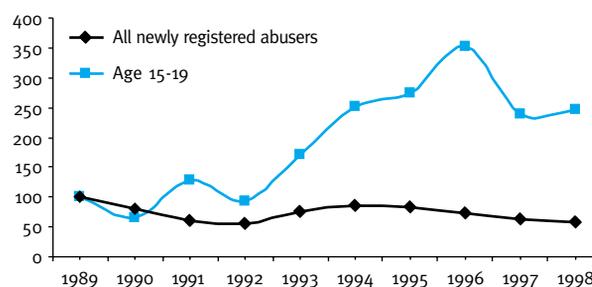


Figure 2.12

Newly registered alcohol abusers in Russia, 1990-98 (1989=100)
Source: MONEE project database.

Though chronic alcoholism may be rare among adolescents, there is a worrying trend in some countries, as Figure 2.12 illustrates with data from Russia. There has been a significant increase in the number of adolescents being taken to dispensaries dealing with alcohol-related problems even when the total number of registered abuse cases is stable or declining. It is reasonable to believe that these formal registers capture only a fraction of the actual alcohol abusers of any age.

Drug use: a new risk for youth

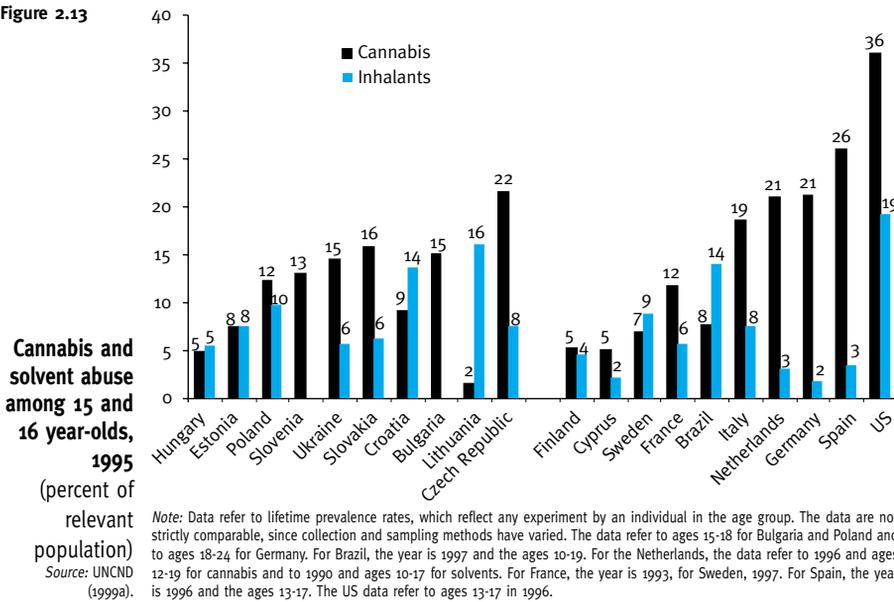
In countries around the world, the issue of drugs touches the lives of young people across the socio-economic spectrum: from youth experimenting with the latest "party" drug to vulnerable and marginalized populations, including refugee and displaced children, young sex workers and soldiers, street children, and institutionalized youth, who use drugs to cope with a stressful existence. Teen populations in the transition region are expanding at both ends of this continuum, and they are facing a drug issue that was unknown in their parents' time.

Illicit drugs, especially in the narcotic family, were relatively absent under communism. Travel was restricted; borders were tightly controlled, and local currencies were without value on the international market. Certainly, there was some abuse of available substances, including the practice of sniffing solvents. The changes triggered by the transition have, unfortunately, opened up the region not only to more democratic values and market forces, but to the trafficking, production and use of drugs.

Figure 2.13 shows rates of marijuana and solvent use among young people aged 15-16 in 10 transition countries and, for comparison, 10 countries outside the region. (The data typically refer only to students and so tend to exclude some higher risk populations, such as young people who have left school.) It is clear from the figure that, by the mid-1990s, there was already a drug problem among youth in the transition countries: roughly 10 percent of the secondary school-age population had used cannabis, and a similar ratio had abused solvents. These rates compare to the middle range of the industrialized countries represented. Telltale is the significant use of cannabis in the transition countries, where five years ago use was almost nil.

Given the burgeoning reliance on drugs in Eastern

Figure 2.13



Europe following the fall of communism, it is pertinent to ask whether rates have stabilized, declined or continued to rise since the mid-1990s. Unfortunately, in most countries in the region, only sparse information is available on drug-use incidence and patterns.

However, the evidence that is available through international surveys, opinion polls and rapid-assessment surveys does suggest that drug use is increasingly accepted by youth and is now widespread in Central and Eastern Europe. In Hungary, for example, recent data point to a serious rise in illicit drug-use rates in the late 1990s. An international survey carried out in 1999 by the European Schools Project on Alcohol, Tobacco and Other Drugs (ESPAD) found that 25 percent of 16 year-olds in Hungary were using drugs. This compared to 19 percent in 1995, with the increment mainly involving marijuana and hashish. Prescription medications, such as sedatives and sleeping pills, combined sometimes with alcohol, remain a problem, especially among young girls, 12 percent of whom were relying on these legal drugs, while 11 percent were using illicit drugs.

In general, drug use seems to be less frequent and even strongly rejected among “mainstream” youth in the CIS

countries. However, there are indications that significant pools of drug users have appeared both among the newly affluent and among socially marginalized youth in many cities and other areas in these countries. The dramatic rise in HIV infections among young adults in Ukraine and Russia has called attention to the scope of the drug problem, and outreach programmes aimed at syringe users report a mounting number of cases among young adolescents. A considerable part of these drugs are trafficked through Central Asia, a region which itself is experiencing growing drug use among youth. Surveys in Bishkek, Kyrgyzstan, found that 2 percent of secondary school students in 1994 had experimented with psychoactive substances and that the share jumped to 12 percent over the next two years. Rapid assessment surveys carried out in 1998

found that 7 percent of secondary school students in Tashkent, Uzbekistan, had used drugs.

Table 2.4 shows the number of registered drug addicts in the region. The rates are highest in Central Europe and the Baltic States and lower in the CIS, although not in every case. Certainly, these data capture only a fraction – according to some estimates, one-tenth or less – of the actual number of drug users; on the other hand, the increases in the number of registered users could reflect those longer time users who have only recently come into contact with the health care system. As Figure 2.14 illustrates through the situation in Russia, in many countries during the transition there has been an exponential growth in newly registered cases.

Doctors in FR Yugoslavia say that children and teenagers there make indiscriminate use of the available intoxicants, including glue, petrol, acetone, asthma spray, poppy-cocoon tea, hashish, marijuana, medications prescribed for mental illness – often combined with alcohol, which multiplies the effects of the substances. In parts of the Balkans, Caucasus and Central Asia, various and sometimes converging factors – remote mountain location, a tradition of using the opium poppy in folk medicine, armed conflict, and persistent ethnic tension – facilitate drug production and trafficking.

The ESPAD survey found evidence of growing multiple-drug use and increasing reliance on LSD, crack, amphetamine-based ecstasy, and heroin. Other surveys in the region confirm the spread of heroin, a highly addictive and expensive drug (Voices of Youth 5). Various sources point to the rapid rise in the use of injected drugs, which represent a heightened risk of the transmission of infectious disease, including the HIV virus which causes AIDS. The ESPAD survey found that the use of injected drugs in Hungary was three times

Figure 2.14

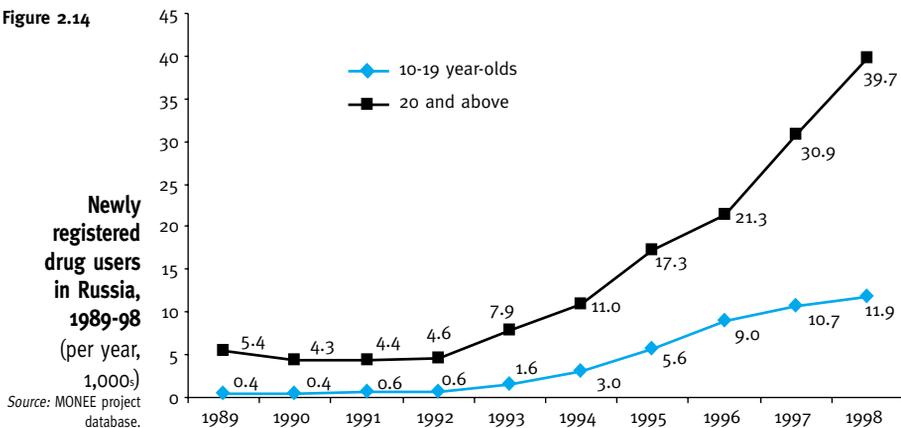


Table 2.4

Registered cases of drug addiction, 1995-98

	1995	1996	1997	1998
Total (per 100,000 population)				
Czech Republic	32.3	57.6	72.9	73.9
Slovakia	23.1	29.7	38.5	40.8
Hungary	–	–	78.2	88.6
Estonia	24.7	51.4	72.6	82.2
Latvia	32.0	36.3	40.2	44.1
Lithuania	46.0	63.4	77.5	77.5
Belarus	14.8	21.4	26.4	29.9
Moldova	7.1	9.6	24.2	36.9
Ukraine	24.0	25.4	21.1	21.7
Armenia	25.5	23.2	34.0	39.6
Georgia	48.2	52.5	50.3	55.3
Kyrgyzstan	15.0	20.0	18.8	15.4
Uzbekistan	29.0	32.9	37.2	41.2
Share of 15-19 year-olds among the total (%)				
Czech Republic	28.5	33.2	37.6	35.3
Slovakia	49.1	40.7	32.0	29.2
Hungary	–	–	17.4	17.7
Latvia	3.1	8.8	15.6	15.1
Belarus	1.8	2.3	1.4	1.2
Moldova	5.8	10.1	17.4	24.4
Kyrgyzstan	5.2	4.7	4.7	3.6
Uzbekistan	0.5	0.5	0.3	0.4

Source: MONEE project database.

Note: End-year. The data in the lower panel refer to people under 17 in Hungary and Latvia and 15-17 year-olds in Belarus and Uzbekistan.

more frequent in 1999 than it had been in 1995. In Ukraine, screening among 13,385 drug users during the first three months of 1999 found that more than 1,000, about 8 percent, were infected with HIV. UNAIDS reported 2,700 new cases of HIV among drug users in Moscow in the first nine months of 1999 alone.

Rapid assessment surveys in Central Asia have found that drug users are graduating more quickly from ingesting or inhaling drugs to injection and that many drug users start out with injections. Sharing needles and drugs aggravates health risks, particularly HIV transmission. Several sources also indicate that the age of first contact with drugs has become lower as the drug trade and drug use have spread in the region.



Vladimir's story: living with drug abuse

Vladimir is a 23-year-old drug user from Moscow. He was the subject of an individual interview associated with focus-group research carried out for this Report. At the time of the interview, Vladimir had been using drugs, including marijuana, hashish and heroin, for six years. He had stopped using heroin eight months earlier. This was his fourth attempt to get clear of drugs. However, he appeared to be under the influence of sedatives during the interview.

Vladimir recalled that, when he first came into contact with drugs, he was on the street with friends. "Nobody pushed me or tried to get me involved. I did it voluntarily."

According to him, it is easy to buy drugs. "In most cases, young people buy drugs on the street. There are special places in every district where you will always find someone you can buy drugs from. . . . Most young people steal to get money for drugs. Of course, it's expensive, but there's no way out."

The high health risks of drug injections were not lost on Vladimir. "Taking drugs is a risk to one's life. You always risk dying of overdose. It's easy to get infected with hepatitis and HIV."

Asked why he used drugs, Vladimir claimed psychological and physical dependence. "You simply cannot live without them." He had turned to his parents and medical clinics for help. "It was not possible to live that life any more. I simply could not go on like that."

Vladimir complained about his experience at the drug treatment clinic, however. He said doctors were polite, but cool and distant, and he often felt he was being treated like a "second-class human being", even as a criminal behind barred windows. He also said there was a lack of medications, especially those used to ease early physical withdrawal symptoms.

People who advised him to quit drugs were unable to follow through with appropriate psychological support, Vladimir said. He would only listen to a former drug user who knows what it's like to be addicted. Vladimir said he had heard from a friend in the drug scene about the effectiveness of 12-step programmes and had seen a presentation at the clinic, but he couldn't afford the \$1,400 programme-fee. Interestingly, in the West, where the self-help recovery movement started and remains very popular, such programmes are run by the clients themselves, are inexpensive and are strictly non-profit.

The research interviewer made these observations about Vladimir: "The respondent was very indifferent towards everything. His eyes were empty; no expressions on his face; he did not care about anything, including his health and life. He seemed to be living in his own 'desert'. There are no people he cares about; there are no people who care about him; he has no interests, no plans for the future and no stories about the past."

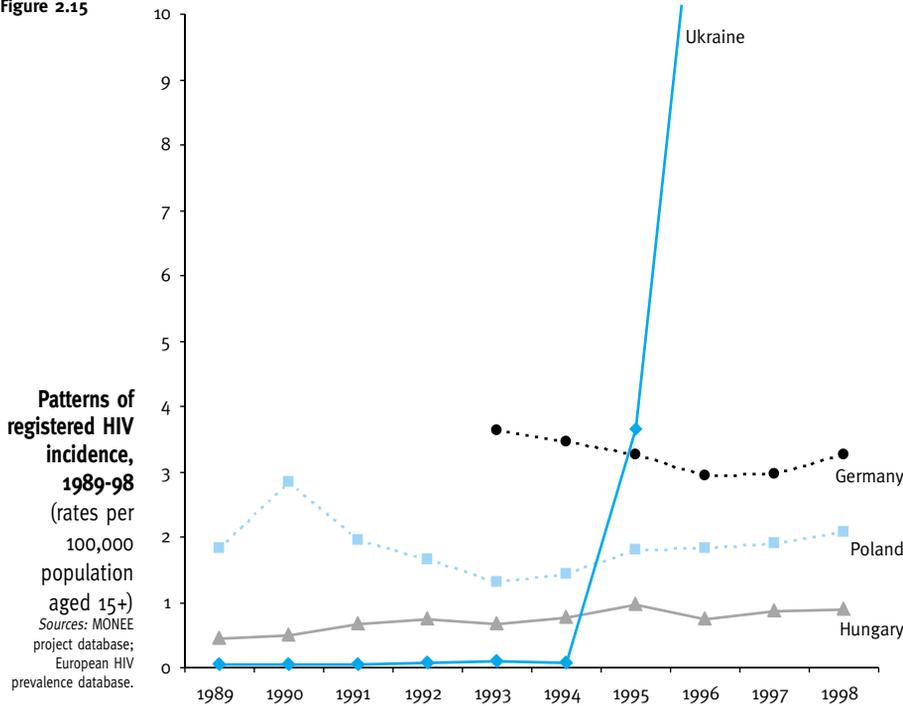
2.3 Changes in Reproductive and Sexual Health

Attaining sexual maturity and becoming sexually active are hallmarks of adolescence and young adulthood. These dramatic changes in physical health and social behaviour are, naturally, accompanied by risks. Before the transition youth in the region tended to marry young and have a first child relatively young. During the transition years, the picture has changed substantially: youth are less likely to marry, but

more likely to have sex at a younger age; teen birth rates have fallen across the region overall, but more of these births are occurring outside marriage and to very young teenage mothers.

The two most acute health problems associated with the reproductive and sexual health of young people in the region are sexually transmitted infections (STIs) and

Figure 2.15



unwanted pregnancies ending in abortion. Before the transition, abortion rates were notoriously high in many countries, while the incidence of serious STIs was low. What has happened since?

Voices of Youth 6

Talking about the threat of sexually transmitted disease

Evidence shows that the incidence rates for sexually transmitted infections have gone up during the transition, affecting young people as well as older adults. These voices from Russia and Romania reveal the uncertainty and worry generated by this problem.

- “Using condoms is very important!” (Oana, 17)
- “Safe sex is essential. But it depends on the partner.” (Cristian, 16)
- “The atmosphere in the [STI] clinic is uncaring. You should feel protected, like at home. The doctors should inspire more confidence. A smile and a few words of support are very important.” (Andrei, 24)
- “I once went for a blood test, and there were a lot of young people doing an AIDS test. I was worried because you never know about the needles they use.” (Karina, 15)
- “There are some infected people who mess around and infect as many people as they can, deliberately. . . . that’s scary.” (Ira, 16)
- “It would have been impossible to involve my parents. If only they understood, but usually they just start shouting at me, and I get even more scared.” (Lena, 16)
- “I feel alone with this problem [gonorrhoea]. I no longer feel like a normal human being. I am really worried; nobody helps me. I’m going through it on my own.” (Ksenia, 22)

The spread of HIV/AIDS

In many countries of the region prior to the transition, not a single young person was registered with HIV. Even in the early 1990s, the region was among the parts of the world least affected by AIDS. In recent years, however, there has been a frightening surge in HIV cases, particularly in the CIS. There were about 12,000 known cases in the region in 1995, and five times that number in 1999.

Taking into account that known cases represent only a fraction of the probable infections, UNAIDS estimated at the end of 1999 that 360,000 persons in the 27 countries of the region were infected with the virus. This implies a prevalence rate of 0.14 percent among the 15-49 population in the region, compared to 0.07 percent in East Asia and the Pacific, 0.25 percent in Western Europe, 0.56 percent in the Americas, 0.69 percent in Southeast Asia, and 8.0 percent in sub-Saharan Africa.

No immunization or cure exists for HIV-AIDS, and effective treatments which slow the progress of the disease are expensive and largely unavailable in transition countries. HIV transmission occurs mainly through the use of infected blood products, needle-sharing and sexual activity. Box 2.3 traces the epidemiology of HIV in the CEE and CIS. Understanding the routes of HIV infection among populations is important in the development of prevention and intervention strategies. In Western countries, experience shows that efforts to promote safer sex and safer drug use among high-risk populations reduce the infection rate not only in these communities, but in the general population as well.

Though it is clear that much of the upturn in the known cases of HIV infection is linked to the emergence of significant pools of users of injected drugs, there remains a considerable degree of uncertainty about the extent of heterosexual transmission and, particularly, about the future impact of the epidemic on youth.

Figure 2.15 illustrates the three prevailing patterns in HIV-incidence rates in the region: low but steadily rising rates, which are typical in most Central and Eastern European countries and which are represented in the diagram by Hungary, rates which peak then remain at low-medium levels, as in Poland (or Germany, which is included as an aid for comparison with rates close to the EU average), and rates which skyrocket, as in Ukraine.

Although the rates in the first two groups of countries are still relatively low, the rising trend is troublesome and strengthens the suspicion that the number of unreported cases is considerable. In some countries, like Bulgaria, official data are scanty. As experience has shown in other parts

The HIV epidemic in the CEE/CIS

HIV infection rates were low in the region before the onset of the transition, though transmission was occurring in several countries through the use of blood products. In Romania, for example, an alarmingly high number of infants and children became infected in 1987-89 through blood transfusions and reliance on unsterilized syringes in children's institutions.

Routine screening of high-risk populations, such as patients with STIs, incarcerated people and drug users in contact with health or justice authorities, meant that the number of registered cases of HIV infection grew throughout the late 1980s and early 90s. Voluntary confidential testing is available, but so far has played a minor role in the detection of HIV infections.

About 12,000 cases of HIV infection, of which more than 3,000 were accounted for by Romanian children, were recorded in the region between the mid-1980s and the end of 1995. Just three years later, by the end of 1998, over 50,000 cases were known.

The distribution of the registered cases largely involves populations in the western CIS. Half of all reported cases are found in Ukraine, where the number of registered HIV infections has soared exponentially since 1995. The proportion of young people 15-24 among those known to be infected ranges from one-third in Latvia and the Czech Republic to two-thirds in Belarus.

Table 2.5 shows three-year aggregates of newly registered HIV cases in 26 countries since 1990. Although the number of registered cases is still relatively low, the table suggests that in most instances the incidence of the disease is accelerating. In 1996-98, 32,000 new cases were registered, up from 4,000 new cases in 1993-95. Preliminary figures produced by UNAIDS show that another 95,000 new cases were registered in 1999 alone.

There is ample evidence that much of the dramatic surge in registered HIV infections in Ukraine and other western CIS countries is accounted for by users of injected drugs. The sharing of needles and injected drugs is a primary route for the spread of HIV. Experts estimate that three or four of every five newly diagnosed infections in Russia and Ukraine occur among users of injected drugs.

Sex workers, most of whom are young, are another group vulnerable to HIV infection, and their numbers have been growing rapidly since the transition began. However, this population seems relatively less affected so far. In Moscow, for example, a recent test of 550 sex workers at an STI clinic found three persons infected. In Odessa, a focal point of HIV infection in the Ukraine, one-third of arrested drug users had the virus, but screenings of prostitutes in 1998 revealed that only

2-3 percent were HIV-positive. There is little information available on the sexual networking patterns of various high-risk populations; existing sporadic studies suggest, however, that drug users often have unprotected sex with non-drug users, which could create bridges for the virus to the general population.

In areas where HIV rates are still relatively low, such as Southeastern and Central Europe, the main route of transmission appears to be sexual, including male-to-male transmission. There is relatively little information about male-to-male HIV infection, because homosexual contact was outlawed before the transition and remains severely stigmatized and therefore concealed, especially in the CIS.

Table 2.5

Newly registered cases of HIV, 1990-98 (absolute numbers)

	1990-92	1993-95	1996-98
Czech Republic	143	105	144
Slovakia	10	24	34
Poland	1,041	1,346	1,768
Hungary	156	202	210
Slovenia	12	21	26
Croatia	–	153	146
FYR Macedonia	2	7	6
FR Yugoslavia	205	251	156
Albania	–	23	16
Bulgaria	12	16	95
Romania	–	–	690
Estonia	1	4	14
Latvia	10	34	205
Lithuania	14	24	88
Belarus	47	23	2,228
Moldova	3	14	859
Russia	609	453	9,871
Ukraine	174	1,499	22,868
Armenia	–	3	73
Azerbaijan	3	3	79
Georgia	10	3	51
Kazakhstan	4	7	772
Kyrgyzstan	–	–	27
Tajikistan	–	–	4
Turkmenistan	–	–	1
Uzbekistan	–	9	15

Sources: MONEE project database; Dehne (1999).

Note: Data show new cases registered during each of the three-year periods. Czech Republic, 1990-92: all cases known by year-end 1992, based on Dehne (1999). Slovakia, 1996-98: Dehne (1999). Croatia, Albania and Uzbekistan, 1993-95: all cases known by year-end 1995. Bulgaria, 1993-95: refers to 1993-94; 1996-98: Dehne (1999). Romania, 1996-98: refers to cumulative number of AIDS cases by year-end 1998. Russia, 1990-92: refers to 1987-92. Ukraine, 1990-92: all cases known by year-end 1992, includes AIDS cases. Armenia: Dehne (1999). Kyrgyzstan: includes foreigners.

of the world, openness, energetic monitoring and public debate on the related, often sensitive, issues are very important for effective prevention.

Where the increases in the incidence of HIV are gradual, transmission is likely occurring primarily through sexual activity rather than through the use of injected drugs. Some experts are forecasting that Ukraine and the other countries now experiencing the swift, drug-related expansion of HIV will follow the Polish model, eventually stabilizing, but at higher levels. In Poland, the HIV-incidence pattern is relatively well documented: the quick initial surge followed by stabilization is attributed to a rapid spread among drug users and a subsequent rise in awareness about risky practices. However, the registered number of new cases has been growing in Poland over the last few years, too, despite prevention initiatives targeting high-risk groups and more public awareness of sexual and reproductive health issues.

While HIV typically first affects high-risk individuals such as homosexual males, sex workers and injecting drug users, in many parts of the world the disease has radiated to other populations, especially where the general health of people is already compromised or stressed because of poverty, poor nutrition and inadequate care. In particular, young people are at higher risk of HIV-AIDS because of their behavioural patterns and because, according to the evidence, unsafe sexual practices are widespread in the region.

The incidence of gonorrhoea and syphilis is increasing

The list of sexually transmitted infections is long, and, although syphilis, gonorrhoea and trichomoniasis can be treated effectively with timely intervention, other infections such as genital herpes or human papillomavirus remain in the body, leaving open the possibility of recurrent acute outbreaks. Some of these diseases may contribute to

cancer in reproductive organs, especially among women, while syphilis and genital herpes, for instance, facilitate other infections, including HIV.

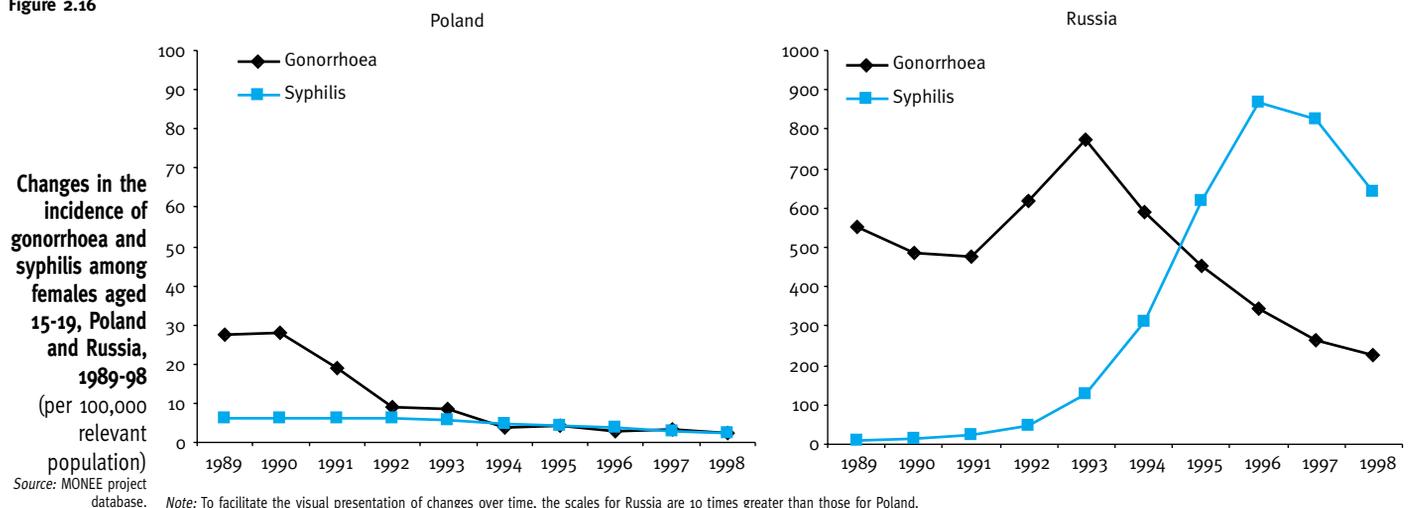
The transition has been accompanied by a serious advance in STIs like syphilis and gonorrhoea among adults and young people. Two observable patterns in the incidence of these infections among young people are illustrated by the cases of Poland and Russia. Figure 2.16 shows the registered infection rates for gonorrhoea and syphilis among young women aged 15-19 in these two countries. (Note the different scales for each country.)

In Poland, altogether, 10,400 new cases of sexually transmitted disease were recorded in 1989, the lowest population incidence in Central Europe. About 10 percent of the cases occurred among 15-19 year-olds. The figure shows that the vast majority of infections before 1992 involved gonorrhoea rather than syphilis and that diagnosis of gonorrhoea has plunged since 1990, so that the two diseases are now present at similarly low levels. The Polish pattern is similar to the patterns in other Central European nations and in the countries of the former Yugoslavia; however, Bulgaria and Romania have significantly higher incidence rates, and the number of registered cases has risen in recent years.

In Russia in 1989, the registered incidence of syphilis among females aged 15-19 was similar to that in Poland. However, gonorrhoea rates were 20 times higher: five adolescents in every 1,000 were infected annually. A similar situation prevailed in other parts of the USSR. Only in the republics of the Caucasus and Central Asia (with the exception of Kazakhstan and Kyrgyzstan) was the incidence of gonorrhoea relatively low.

It appears that even before the transition sexual behaviour and sexual hygiene practices were particularly ill matched in Russia and the countries which now make up the western CIS. However, under communism, the combination of a highly controlled society and rigorous disease-management systems kept rates contained. When social

Figure 2.16



and medical restraints were relaxed after 1991, it was only a matter of time before STI rates shot up. As the diagram on Russia in Figure 2.16 demonstrates, first the incidence of gonorrhoea increased, and then, in 1992-94, syphilis began spreading. The incidence rate for syphilis surpassed that for gonorrhoea in 1995.

Many infections are discovered during pregnancy testing and health check-ups for military service among older adolescents. During 1996-98, gynaecologists, dermatologists and other specialists found that more than nine of every 1,000 young Russian women aged 18-19 were infected with syphilis. This serious disease, even when treated promptly and properly, can impair long-term health, including the reproductive ability of women and the health of babies born to infected mothers.

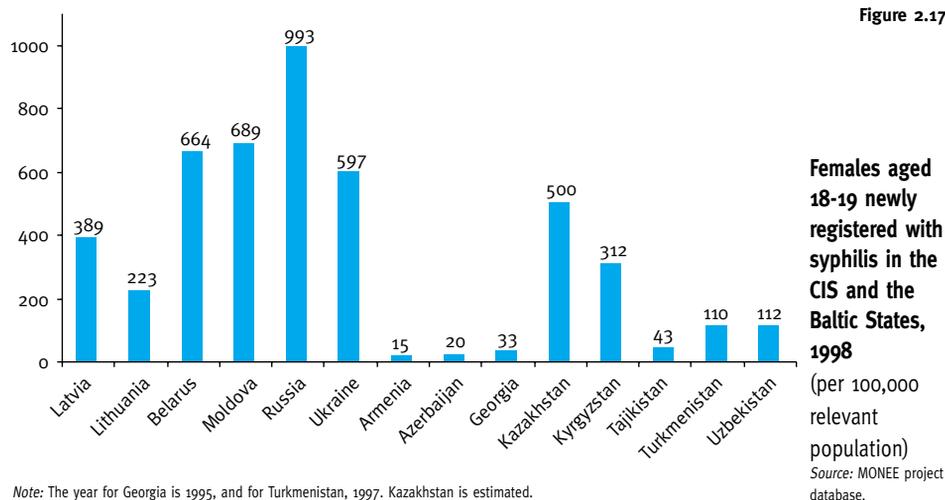
Figure 2.17 shows the most recent figures for the incidence of syphilis among women aged 18-19 in those countries of the former Soviet Union for which data are available. It is worth noting that even relatively low figures often reflect an increase because the disease had almost been eradicated before the transition.

In the entire region in 1998, there were a half-million newly registered cases of syphilis, of which 15-17 year-olds accounted for an estimated 40,000 and 18-24 year-olds for another 200,000. Doctors found about 3,000 cases of syphilis among 10-14 year-olds. Given the difficulty of detecting this insidious disease, which often presents no obvious symptoms, the real size of the problem is presumably even bigger.

The climbing trend in sexually transmitted infections in the region is disturbing both for what it now represents and for what it may portend. Most troubling is the pattern in countries where an initial wave of gonorrhoea infection has been succeeded by a surge in the more destructive syphilis, and, more recently, the incidence rates for the deadly HIV have started to move up. This raises the spectre that, unless there is a substantive change in sexual behaviours and health practices, AIDS may yet stake a large claim on the youth of the region.

Youth pregnancy and abortion rates

Before the transition, the adolescent fertility and abortion rates in the region were very high in international comparisons. During the transition adolescent birth rates have declined, but marriage rates have declined even more quickly, and in many countries more births are occurring among unmarried



teen mothers. So, what then has been happening with adolescent pregnancy and abortion rates over the same period?

Figure 2.18 illustrates the main patterns through the cases of Russia and the Czech Republic. Birth and abortion rates among adolescents have fallen in both countries, as they have in the majority of transition countries. However, in the Czech Republic, abortion rates have decreased less than birth rates, with the result that the number of abortions per 100 live births has climbed. The same scenario has taken place in 11 of the 20 countries for which data are available, mostly those in Central and Eastern Europe (Statistical Annex, Table 2.11). Meanwhile, as the figure shows for Russia, the ratio between adolescent births and abortions has changed little in the western CIS, and the abortion rate fell more than did the birth rate in the Caucasus and Central Asia.

Although the absolute number of abortions has gone down among youth and adults alike in all countries (except Romania) for which data are available, the decline among teenagers has typically been weaker than that among adults.

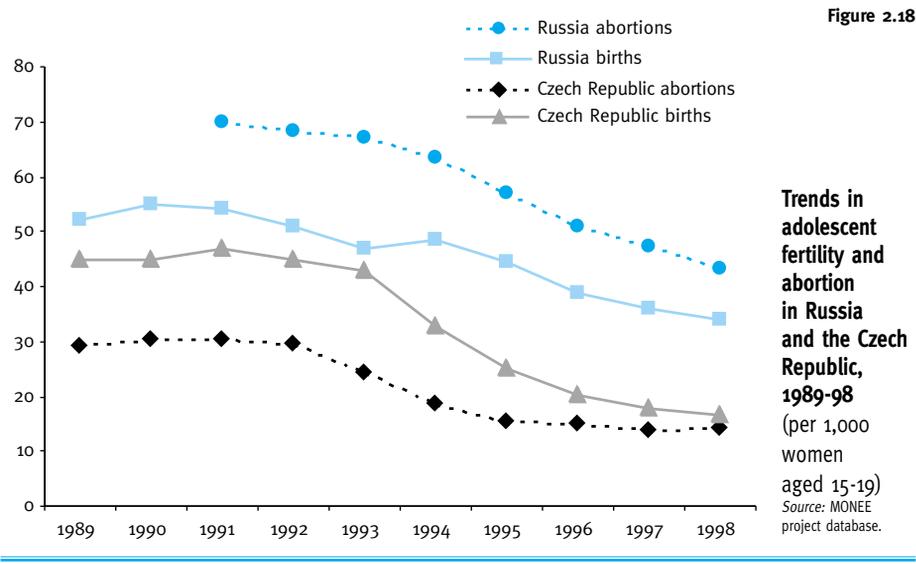
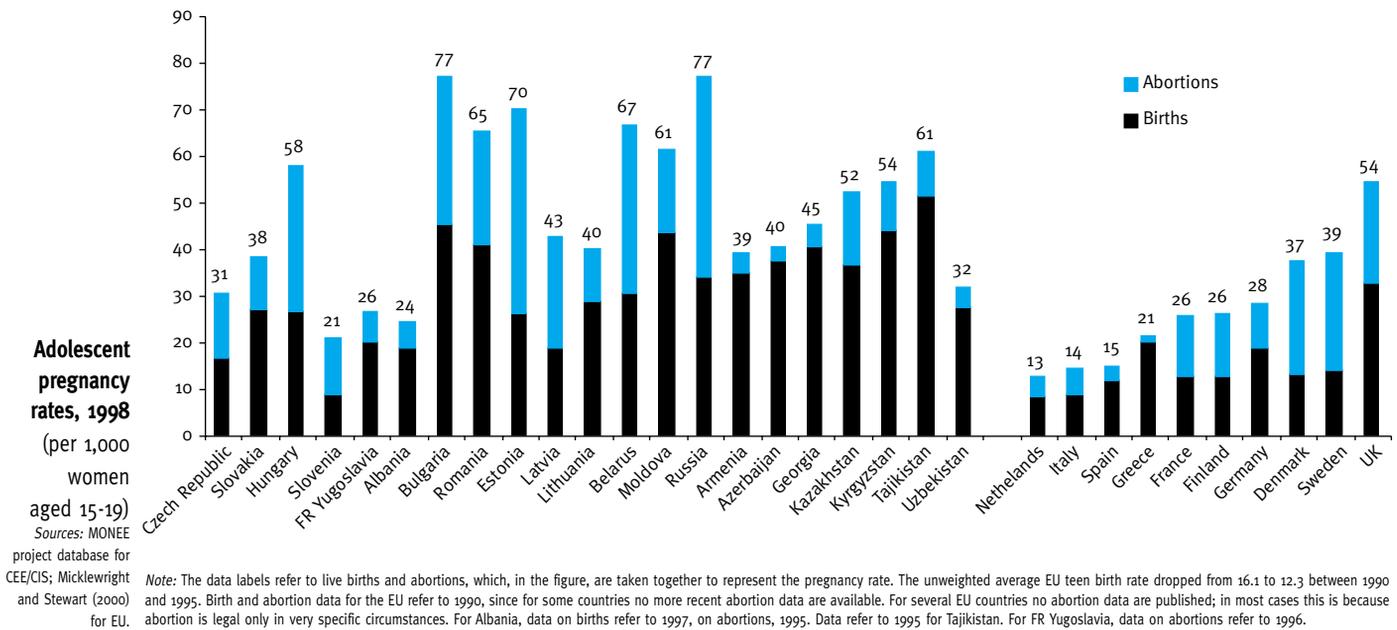


Figure 2.19



Box 2.4

Safer sexual practices among youth

“They should not look at us like criminals for buying condoms!” 15-year-old Natalia, of Russia, burst out in a focus group conducted for this Report. This single voice captures the exasperation that teenagers often feel in dealing with sexual issues and the gap that exists between healthy sexual behaviour and the realities of sexual life for young people in the region. The increasing presence of HIV/AIDS in the region underlines the need for safer sexual practices among youth. Safer practices include, among others, sexual abstinence, a delay in the onset of sexual activity, fewer sexual partners, and the use of condoms. As the previous chapter notes, abstinence or monogamy may have become more prevalent in some countries. However, the majority of the data reviewed in this and the earlier chapters are clear about the higher risk of unprotected sex among adolescents in the region.

How common is unprotected sex among youth in the region? In the Czech Republic, a 1993 survey found that 27 percent of girls aged 15-19 were relying on condoms during their first experience of sexual intercourse. In Russia, a 1996 survey found that 31 percent of unmarried women aged 15-24 employed any available modern method of contraception. According to the 1998 Romanian narrative survey, young people think that adolescent couples typically do not use condoms or other forms of contraception during their first experience of intercourse together, even though one of the partners may already be sexually active and, perhaps, exposed to sexual disease. This supported a 1996 Romanian reproductive survey which found that only 15 percent of the unmarried women aged 15-24 who were interviewed said they used contraceptives at first intercourse.

International fertility and family surveys show that,

while in France, Spain, or Belgium three-quarters of 20-24 year-olds used contraceptive methods at first intercourse, only about 55 percent did so in Poland, Hungary, or Latvia. The surveys also reveal that French women report their first use of contraception at an average age of 18.7, only five months older than their average age at first intercourse. Meanwhile, in Hungary the difference was eight months, and in Poland, Latvia and Lithuania it was 2.5 to 3.5 years. This indicates that many Central and Eastern European women only start using contraceptive techniques a relatively long time after they have initiated their sexually active lives.

The surveys also found that younger generations are more likely than older generations to practice safe sex at first intercourse. The 1998 Romanian narrative survey asked sexually active youth which contraceptive method they had used in the past month. About 20 percent of women aged 18-24 had relied on condoms, and a similar share, oral contraceptives; condom use was slightly higher among 18-19 year-olds, but more than half adopted unreliable methods or no method at all.

Surveys have found that established couples in Central and Eastern Europe depend on condoms more frequently than do couples in the West, where oral contraception is more prevalent. In Latvia, for example, half of 18-19 year-olds with stable partners and more than a third of couples aged 20-24 who rely on contraception employ condoms. Even in Poland, where 27 percent of couples depend on periodic abstinence or withdrawal as contraceptive techniques, 10 percent of sexually active couples aged 20-24 use condoms, a similar share as those relying on other methods like birth control pills and intrauterine devices.

In Romania, adolescent pregnancy rates soared after the 1989 revolution when abortion was legalized, but fertility and abortion rates have been falling more recently. In Poland, registered abortion rates have been plummeting since changes in legislation in March 1993, but there is little information available on how adolescents have been affected. Similarly, no data are available on teen abortion rates in Croatia, where total abortion numbers receded sharply in the 1990s.

Figure 2.19 presents teen pregnancy rates for the CEE/CIS and EU countries for which data are available. The diagram shows that rates are still high in most transition countries relative to Western countries. In Estonia, for example, of every 1,000 girls aged 15-19, 26 gave birth and 44 had an abortion in 1998. The figure shows that, following declines in the 1990s, teen pregnancy rates in Central Europe and parts of the Balkans are now in the higher range of the EU countries. It should be added that, in Western Europe, abortion is more concentrated among adolescents, while, in Eastern Europe, women over age 20 have about 90 percent of the abortions.

The findings of this Report on partnership formation patterns and sexual behaviour among young people, on the one hand, and sexually transmitted infections and adolescent abortion, on the other, underscore the importance of safer sexual practices among youth. However, various surveys in the region confirm that adolescents depend on contraception and safer sex practices in only a minority of cases (Box 2.4).



What do young people do to keep healthy?

Behaviours revolving around health vary widely among youth and are shaped by the environment, by the models young people look to and by individual attitudes, as these voices from the focus groups conducted for this Report show. Here, young people in Russia, Romania and Uzbekistan talk about what they do to stay healthy.

- "I eat whatever is available." (Kiril, 18)
- "I don't think I eat healthy food now, but I depend financially on my parents, and I can't afford to get things I would like." (Nikita, 16)
- "In Romania one can only rely on a heavy diet." (Gabriel, 17)
- "I'd never swap an apple for a sweet." (Carla, 24)
- "It's not that I'm trying to avoid [accidents and violence]; I am trying to find them." (Vova, 15)
- "Sometimes girls are too embarrassed to change into sports gear and go to sport lessons." (Dono, 18)
- "Not everyone feels up to going to the pharmacy to buy condoms. . . . you simply feel embarrassed. . . . I've heard that in other countries there are condom machines in every school. That's discreet." (Klavdia, 16)
- "I didn't think about the possibility of being infected [with a sexually transmitted disease]. I trusted my partner completely." (Ksenia, 22)
- "If you find a person who normally follows all the rules, that person will feel bad and will be excluded from his/her peer group. Later on, she will certainly understand that she was doing everything properly, but at the age of 15 she would feel handicapped." (Natalia, 15)

2.4 Designing Health and Development Interventions for Youth

One of the underlying principles of the Convention on the Rights of the Child is that children and youth must be active participants in matters that affect them; they must be free to express their opinions, and they must be heard. By participating in the design, development and administration of youth health services, youth can contribute not only to their own health today, but to their own health as adults and to the health of their children. Likewise, they can contribute to a more cost-effective and efficient health care system.

Listening sincerely to young people is a skill. As Voices of Youth 7 illustrates, it can be enlightening. Learning how to act on what one hears so that listening can become a policy-making tool is the next important step.

Changing the settings for health among youth

Certainly, as the determinants approach to health holds, the environments of the family, school and work are highly influential on the health and behaviour of young people, and they are therefore important settings for health promotion and intervention.

Data from the HBSC surveys confirm that, if the

communication in their families is good, young people, especially girls, are more likely to perceive themselves as healthy, while older adolescents are less likely to smoke frequently or use alcohol. If adolescents are at ease talking to their parents, they will also find it easier to talk to older siblings and to acquaintances of both sexes and to have close friends. From 16 to 36 percent of 15-year-old students in the 1997-98 HBSC survey said that they find it difficult or very difficult to talk with their mothers; slightly more girls than boys felt this way. Altogether, Central and Eastern European teenagers were in the same range as their Western peers.

The survey included questions on the socio-economic background of the family, and the responses confirmed that there is a generally positive relationship between perceived family wealth or the socio-economic status of parents and the health of youth. Responses in the three transition countries covered in the survey produced two interesting findings. First, in the case of Russia, the survey found particularly strong associations between family wealth and feeling healthy. Second, in Russia, Hungary and Latvia – unlike in any Western country in the survey – fam-

ily affluence was also linked with higher rates of risk-taking behaviour such as smoking and alcohol abuse.

The family is important not only because it provides the home environment that is such a major determinant of

youth development. It also offers care and conveys social norms and beliefs. Thus, the family is a crucial purveyor of health among youth. Moreover, the family also plays an important role in youth development through its interac-

Box 2.5

The weakening contact between primary health care and youth in the CEE/CIS

The link between young people and health services has become fragile for a variety of reasons during the transition.

Among youth, women typically make greater use of primary health care services, acting not only for themselves, but on behalf of children and male partners. The sharp decline in fertility in the region means this important population group now has less opportunity to come into contact with health screening and other health services.

Before the transition, childbearing generally peaked between ages 20 and 24 (as Figure 2.20 shows with 1990 data from Romania), and most women had given birth to at least one child by age 25. Though gynaecological check-ups should certainly not be restricted to pregnant women, the 1996 reproductive health survey in Romania found that only a quarter of young females who were sexually active had benefited

from annual gynaecological check-ups, while 60 percent had never visited a gynaecological clinic. For young men, declining military recruitment means that there has been a drop in the associated medical check-ups.

Figure 2.21 demonstrates that existing monitoring systems aimed at sexually transmitted disease increasingly fail to reach adequately those infected, including youth. At the beginning of the transition, slightly more males than females were registered with treatment services for syphilis or gonorrhoea. This is consistent with the available information on sexual behaviours and the fact that the disease symptoms can be less explicit in women. Since the onset of the transition, the male-female ratio has increased for gonorrhoea and decreased for syphilis, a divergence which suggests that there are widening gaps in the coverage of the registers and, by implication, in treatment. These gaps highlight the need for new types of services which offer support, confidentiality and cooperation

rather than shame, isolation and compulsory partner identification.

The contact between health service providers and youth is particularly troubled in the area of the prevention and treatment of drug use. Rapid assessment reports prepared in several CIS countries have concluded that the practice of close collaboration between law enforcement officials and health care institutions is destroying the trust between health care providers and drug users and that drug users are being treated in a rigid and repressive manner by authorities.

More multifaceted health care systems have been emerging in many countries. These include public and private services for pay. However, adolescents often exhibit little ability or willingness to pay for services.

Overall, the health care system which existed before the transition gave scant attention to the specific area of the health of youth. Unfortunately, the health care reforms undertaken since the beginning of the transition can claim little more. The declining frequency and effectiveness of youth contacts with health care systems warrant concern. Further investigation is needed into the development of health services which reach out to and invest in this important segment of society.

Figure 2.20

Childbirth in Romania according to the age of the mother, 1990 and 1998
(live births per 1,000 females of the relevant age)

Source: Ivan-Ungureanu et al. (1999).

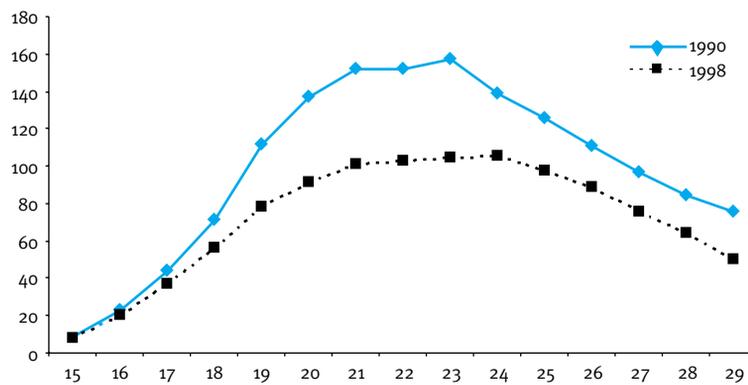
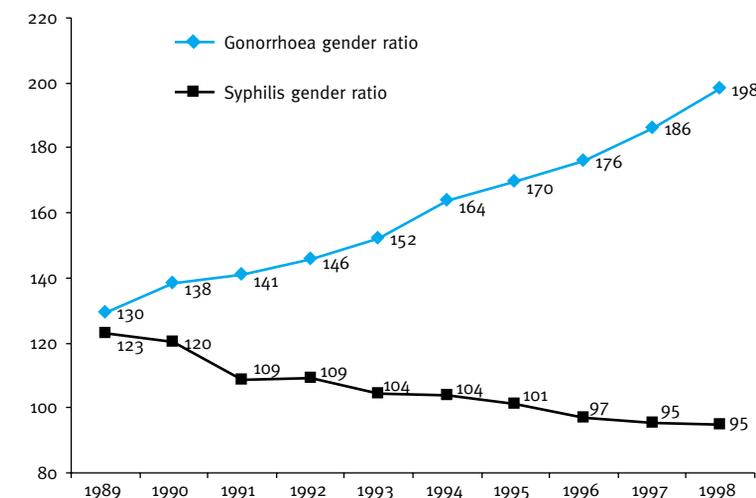


Figure 2.21

The gender ratio in registered sexually transmitted infections in the CEE/CIS, 1989-98
(males per 100 females)

Source: MONEE project database.



tions with other significant environments such as the school, the workplace and the community.

To be effective, youth health interventions need to take into consideration this broader environment around youth development, rather than focusing exclusively on narrow medical health outcomes. Research in the West has demonstrated convincingly that the mere availability of health care services does not guarantee that youth will rely on the services, in the same way that the mere provision of information is not sufficient to ensure a reduction in high-risk behaviours. Development factors such as the possession of positive goals in life, the presence of adults with whom young people feel close, and access to places where they feel safe make a difference by helping youth avoid risks and find positive responses to stress and to negative pressure from peers and adults, as well as to other health challenges.

The transition has also had implications for the health care systems in the region. Before the transition, there were many universal proactive health programmes covering young people through services such as regular check-ups at school and in the workplace, dental care, prenatal care for young pregnant women, the medical screening of young men for compulsory military service, and rigorous monitoring systems for infectious diseases. During the transition, these services have been considerably weakened, and therefore so have their linkages with youth, as Box 2.5 illustrates.

Student health screenings, which used to be universal, have been cut back in all countries for which information is available and, in some cases, have been eliminated. In Slovenia, for example, following the introduction of a family-doctor system in 1993, the number of secondary students receiving medical check-ups had halved by 1996, which led to remedial changes in health legislation the following year. In FR Yugoslavia, the frequency of medical screenings and dental-care visits among youth plunged over the 1990s. Even in countries which have maintained student health screenings, lower school enrolment rates and higher dropout rates have meant that more youth are being missed by the system, and these youth are now at particular risk, as the following chapters confirm.

Provision and partnership must be broadened

The growing health risks among youth in the region and the weakening links with health care systems call for a broad-based response from families, schools, civic society, providers of public health care, and youth themselves. As earlier Regional Monitoring Reports have pointed out, a wide range of preventive care, community and social services is lacking in the region. Pre-transition systems focused largely on the two ends of the service continuum: elementary and late interventions. This was true also in health care. Public health issues were narrowly interpreted, and there was a great void in the middle ground that must now

Young people see barriers in health care services

Discussing health issues in focus groups arranged for this Report in Russia, Romania and Uzbekistan, young people comment on the barriers they face when they come into contact with the health care system.

- “If you don’t have any friends or contacts among doctors, it is better not to consult them at all and try to cure yourself.” (Galina, 19)
- “Since one has to pay anyway, I prefer to pay a private doctor.” (Trajan, 17)
- “The equipment in the private sector is very good. But access is expensive, so that not everyone can afford it.” (Laurentiu, 20)
- “You have to queue up for more than four hours to get in there.” (Natalia, 15)
- “A girl who goes to see a gynaecologist risks being seen by locals in the queue and being considered no longer a girl.” (Oigul, 19)
- “They [STI therapists] claim they maintain absolute confidentiality, but, at the same time, they ask for my identity card. I cannot trust them.” (Ksenia, 22)
- “Doctors impose and prescribe, but we don’t listen to them.” (Kiril, 18)
- “Doctors are shocked when they discover that a kid has just come for a regular check-up.” (Klavdia, 16)

be met through the provision of services and information: public education, preventive care, health promotion, support networks, counselling, hotlines, shelters, and other participatory and empowering initiatives.

In the past, health care workers and services tended to embrace a biomedical philosophy that was little concerned with human behaviour and development or the social determinants of health. There has been no special attempt to understand the health problems of youth. Youth organizations which participated in health campaigns have all too often been motivated by objectives identified from above rather than by genuine engagement with youth.

A challenge and an opportunity now exist to estab-

Box 2.6

Criteria for youth-friendly services

The concept of youth-friendly services is relatively new in public planning. Emerging experience finds that young people are more likely to use services if the services are perceived as:

- Respectful of confidentiality.
- Involving youth participation in design, implementation and administration.
- Culturally appropriate to the needs and perceptions of youth.
- Offered by health care workers who relate to the concerns and life styles of youth.
- Affordable.
- Comprehensive “one-stop” services.

lish a range of health strategies that addresses not only the specific health needs of youth, but also the broader environments which shape the well-being of young people.

The creation of health care services which appeal to youth has been extensively researched in many parts of the world through listening to youth and learning from what they say. This body of research confirms that young people do have preferences for specific characteristics in health care services (Box 2.6).

Youth need confidentiality, particularly when they seek advice or care involving their sexual health. They want affordable services and health care workers who understand their concerns, beliefs, anxieties, and desires. Voices of Youth 8 presents a sample of youth reactions to health care systems.

Communication is an important skill in the promotion of good health among adolescents and in building services that relate to the needs of youth and that youth can relate to in turn. Meaningful dialogue also enhances the

health care provider's expertise and fosters a smooth provider-client relationship. Box 2.7 illustrates how communication can enable and reinforce health-promoting behaviour among young people.

Relying on peer promoters, educators and counsellors represents another effective way to involve youth in health strategies and the delivery of effective services aimed at youth. As Ksenia, a 22-year-old women from Russia, said in the focus-group research carried out for this Report, "We are reluctant to listen to our parents or other people much older than us. On the contrary, if we get information or advice from friends, they realize that this could happen to them, too. Young people do not judge or moralize; they live a similar life and are able to understand me."

Box 2.8 lists key lessons learned from peer-promotion projects outside the region. Although peer interventions have their limitations, experience shows that there are significant long-term benefits when the interventions are carefully planned and implemented. For example, a

Box 2.7

Communicating with young people about health issues

An important part of health promotion and protection among young people is an understanding among providers of the significance of effective communication with youth. For example, Table 2.6 presents the opinions of young people on the use of contraceptive methods at first intercourse.

Understanding these perceptions can play a crucial role in designing, communicating and delivering health strategies that inform, motivate, enable, and reinforce. What do these four key elements entail?

- *Inform.* To provide information that can be understood by the target audience in a way that is meaningful in the circumstances and the setting. For example, in Kyrgyzstan, the "Safe Sex, City of Bishkek" project distributed 50,000 leaflets which had been

designed by local artists and which supplied information on an STI/HIV hotline.

- *Motivate.* To help sustain interest in developing, continuing, or changing programmes, activities, or behaviour. For instance, in Albania, Population Services International has developed a social marketing programme which seeks to motivate young people to buy and use condoms. It relies on radio talk shows with youth to reduce the social stigmas associated with condoms. It also encourages the sale of condoms to men by male staff rather than female staff in order to lessen embarrassment.
- *Enable/Facilitate.* To furnish the tools, instruments, mechanisms, skills, or other means by which the target audience can proceed with the desired programme, activities, or behaviours. For instance, Tootsi

Table 2.6

Reasons for not using contraceptives at the first sexual encounter (percent of respondents)

Romania, 1993 (girls 15-24)	Moldova, 1997 (girls 15-24)	Ukraine, 1999* (girls 15-18)	Bulgaria, 1996** (both genders 15-25)
Lack of knowledge (27.2)	Wanted to get pregnant (41.3)	I don't want to (56.3)	I didn't think of contraception (21.2)
Wanted to become pregnant (22)	Didn't think about using a method (20.1)	I'm too young for this (37.5)	I don't wish to use contraception (18.1)
Didn't expect to have sex (21.6)	Sexual intercourse was unexpected (19.8)	My partner doesn't want to (25)	I don't know how to use contraception (9)

Sources: Serbanescu and Morris (1998a, 1998b); UNFPA et al. (1999); MOHB, Phare Programme and ASSA (1996).

Note: *Respondents could select more than one answer. **Among respondents not choosing the rhythm method.

Tuba and the Estonian Union for Child Welfare run day centres for vulnerable youth in locations that are familiar and easily accessible to young people.

- *Reinforce.* To support the continuation of a programme, activity, or behaviour, or to change a process. For example, a number of non-governmental organizations in Bratislava are helping drug-addicted youth organize positive activities such as competitive sports.

major study of 21 Family Health International projects found that the majority of peer educators had made changes in their own lives and behaviour as a result of their involvement: 31 percent were practising safer sex and using condoms; 20 percent had reduced the number of their sexual partners, and 19 percent had changed their own attitudes.

Peer programmes are often strikingly cost-effective as well. For example, a study conducted in Mexico by the US Population Council found that the Community Youth Programme, which employed a peer strategy, was able to reach young adults with sex education and family planning information at one-third the cost per active contraceptive user of the integrated youth centres, which relied on a non-peer strategy. ■

Lessons learned from peer programmes

- Many young people prefer to receive reproductive health information from peers rather than from adults.
- The involvement of peer promoters significantly increases referrals for contraceptive services at a fixed site.
- Peer promoters need to be selectively recruited and adequately trained, supervised and supported.
- Interactive training improves project outcomes.
- Peer counselling requires more complex training and supervision than does peer education.
- Turnover is a common problem in peer programmes, but this problem can be partially addressed by careful selection, by the use of contractual agreements and by good support, reinforcement and compensation or other rewards.

2.5 Conclusions

Growing up healthy, in the fullest sense of the term, is a right of all children and the privilege of too few young people in Central and Eastern Europe and the CIS. The evidence reviewed in this chapter suggests that youth in the region feel worse and engage in unhealthy behaviours more often than did youth before the transition.

It is important to stress that in several countries – including those leading in the reform process – the mortality rates among youth have improved and, overall, are not far from those in the West. However, the evidence on suicide and substance abuse and self-assessments of health indicate that there is reason to be concerned about the general health of youth in these countries. At the same time, in many countries young people are facing a greater risk of dying than they did before the transition, as well as a greater risk of dying from either accidents, or natural causes than their peers experience in more affluent industrialized countries.

There appear to be two dominant storylines in the history of the health of youth during the transition. One revolves around the appearance of greater numbers of disadvantaged youth due to fewer opportunities in education, high youth unemployment and growing social inequality. The other revolves around the greater openness generated by the rapid removal of state controls on society and the emergence of new values and opportunities, especially relative to youth, who, however, are not always being supported by an adequate adjustment in care systems and policies. Wherever these two storylines cross – where unsupported youth find themselves in a frontier environment – the outcome can be devastating, as soaring HIV rates in parts of the region underline.

Clearly, there are considerable overlaps and important linkages among unhealthy behaviours such as adolescent drinking and smoking habits, high teenage pregnancy and abortion rates, alcohol or drug

use and accidents, injuries and infections. While it may be tempting to focus primarily on those young people most at risk, one must remember that they are only the tip of the iceberg. A much larger and growing swath of the youth population in the region has also been engaging in unhealthy behaviours. Health policies therefore need to operate through broad programmes, as well as targeted interventions.

Under communism, life styles and the social environment were not adequately focused on youth, as the relatively high rates of injury and unwanted teen pregnancies demonstrate. In terms of psychosocial health, the environment was oppressive towards young people. Although basic public health care was widely available, youth were not identified as a distinct health population or treated with the respect and warmth so important in a client-provider relationship at this age.

As exemplified by the rising rates of sexually transmitted infection among youth, the pre-transition health care legacy is being undermined by the changes brought about by the transition. New approaches to youth health are required. However, while market forces are leading to the privatization of health care, often with positive results, the health of youth remains a public health issue to a large degree and must be addressed through public measures.

Certainly, some of the most serious new health risks facing young people are a result of the rapid collapse of state control and public order. Armed ethnic conflicts are ravaging parts of the region; the sex trade is growing alarmingly, and drug trafficking and use are a new and burgeoning problem. At the other extreme, some of the positive outcomes in the more open environment of the transition, such as more freedom to travel and more choice in leisure activities, can likewise expose young people to greater risks.

There is also evidence, however, that young people are taking advantage of the greater opportunities for

healthy behaviour and individual accomplishment that the transition offers. In several areas of health in which youth in the region had a particularly weak standing in international comparisons before the transition, young people are now faring better. Mortality rates due to accidents have fallen in 13 countries, including the Baltic States, where they were notoriously high. Youth suicide rates have gone down in some countries, including Hungary, where the rates were always high. The strikingly high birth rates among teenage mothers have declined in Romania and Bulgaria, and the number of abortions among young women has diminished in Russia (although it is still the highest in Europe).

These positive results need to be strengthened, and the negative trends must be confronted. Youth-friendly health and development interventions clearly have great potential in this region, where general health service availability is good, but is also far from effective in appealing to and reaching young people. The variety of evidence presented in this chapter and confirmed in the focus-group

research carried out for this Report points to a significant gap between the perspectives of health care providers, parents and teachers on the health needs of youth and the perspectives of the youth themselves. Forward-looking approaches are attempting to close this gap by involving youth in the design and implementation of appropriate and cost-effective health strategies. One of the key tools is encouragement for the participation of youth in efforts to address youth health issues, but this also means that there is a responsibility to listen to what youth have to say.

The analysis in this chapter has focused largely on health outcomes and behaviours. However, the overall well-being of youth involves many other issues that merit further investigation in terms of the realities in the region and the potential of young people. These issues, including education, employment, conflict with the law, and the participation of youth in civil society, all have implications for health and are important aspects of growing up healthy in the richest and broadest sense. ■