Young people: not as healthy as they seem

Over the past 25 years, there have been major shifts in causes of mortality and morbidity among young people (aged 10–24 years). HIV/AIDS was essentially unknown 25 years ago, and other infectious diseases, such as pulmonary infections, were leading causes of death in this age-group. Suicide was less common than it is today, and deaths from motor vehicles were much less frequent in many countries of the world than they are now. Additionally, in 1985, more young women married at an earlier age than they do today, fewer young people went to school, and increased numbers lived in rural areas. All of these trends have affected mortality and morbidity in young people.1

Other patterns of change, specifically present and anticipated demographic changes, are worth considering when we explore adolescent mortality. Today, almost a third of the world’s population is aged 10–24 years, and in many developing nations 30% or more of the population fall into this age-group (compared with about 13% in Europe, Japan, the USA, and Canada). Just below 90% of the world’s young people live in developing countries, and during the next 20 years that proportion will increase. By 2025, the 140 million young people in Europe in 2006 will decline to 111 million, whereas in Africa the proportion of young people will rise from a 2006 figure of 305 million to 424 million (an increase greater than the entire population of young people in Europe).2

Other global patterns affect the health of young people, such as transnational migration, rural-to-urban migration, increased migration of young women, delay in age of marriage, and rises in rates of education, especially of girls. All these changes affect behaviours (eg, premarital intercourse) that predispose to other consequences, such as sexually transmitted infections (including HIV) and out-of-wedlock pregnancy and abortion—all of which are reflected in mortality data.3

Although adolescence is often referred to as the healthiest stage of life, the report by George Patton and co-workers4 in The Lancet today makes clear that young people are at substantial risk of mortality. They have shown that risk of mortality rises with age, that two-thirds of deaths in this age-group take place in two regions of the world, and that the causes of adolescent death vary greatly by geographical region and national and personal resources.

What distinguishes the causes of death of young people is that most deaths have behavioural causes exacerbated by national policy or failures of health-service delivery systems, or both. In industrialised countries, young men are two to four times more likely to die than are young women, and homicide, suicide, and injury account for between 50% and 80% of adolescent mortality. However, because of deaths from HIV/AIDS and maternal mortality, the same gender disparity in mortality patterns is not seen in Africa, south Asia, and southeast Asia where most of the world’s young people live and where most juvenile mortality clusters.3

WHO estimates that more than 250 000 pregnancy-related deaths happen worldwide. Early childhood marriage contributes greatly to this mortality figure as does the practice of female genital cutting, which significantly adds to morbidity. Where abortion is illegal and clandestine, abortion-related mortality is as high as 60 per 100 000 women, compared with 0·6 and 1·0 per 100 000 women, respectively, for the USA and Cuba, where it is legal. Worldwide, more than a quarter of maternal mortality stems from national abortion policies, and when those policies are reversed maternal mortality plummets. We need only to look at South Africa’s greater than 90% reduction in maternal mortality that took place when abortion became legal to see the consequences of restrictive abortion policies.

Another difference in mortality patterns worldwide relates to HIV and its transmission. In Europe and North America transmission is still mainly between men who have sex with men, and two-thirds of those who are infected are men. In much of southeast Asia, intravenous drug use is the predominate mode of transmission for HIV infection, and as a result a sex parity is observed. In
Africa, which has three-quarters of all HIV infection in young people, young women are twice as likely as their male counterparts to be infected. Factors that contribute to female risk include poverty, early marriage, gender inequality, myths and beliefs about HIV, and biological factors (eg, cervical immaturity, and a greater surface area of exposure for young women than for young men).3

Suicide is also a major cause of death in young people. Worldwide it is the fifth leading cause—in much of Europe and North America it ranks second or third, and in China and India it is the main cause of death in this age-group.6 Historically, rates have been low in countries in Latin America, sub-Saharan Africa, the Mediterranean, and in Muslim nations; however, there is reason to anticipate changes. Specifically, when Diekstra and Hawton7 explored secular trends in suicide in Europe throughout much of the 20th century, they reported a set of factors not dissimilar to much of the developing world today, including a rise in unemployment, divorce, homicide, alcohol use, secularisation of society, overcrowding, urban stress, and social disruption.7

As Patton and co-workers note, injury for young men remains the leading cause of death in every region of the world, with most deaths associated with motor vehicles. Although injury-related deaths account for more than half of all male deaths in the second decade of life, mortality in many countries has fallen by 30% or more in the past 20 years.3 Factors that have contributed to that reduction include an increased minimum age for purchasing alcohol, establishment of graduated driver’s licences, improved road safety (eg, break-away light poles, redesign of median dividers), improved car safety (eg, airbags), seatbelt laws, and enforcement of helmet and speed laws.

In view of our present understanding of juvenile mortality, at least 75% of all deaths in the second decade of life are preventable through implementation of established prevention and intervention strategies. We know that access to contraceptives and family planning services reduces mis-timed and unplanned pregnancies. We know that safe abortion reduces maternal mortality, and education and empowerment of women improve health outcomes in many dimensions and create options for young women. We know that several road safety and driving policies reduce mortality from road-traffic accidents. We know enough about effective interventions to base our services and programmes on what has been empirically shown to work—not what we think should work. And we know that reduction of risk alone is insufficient; we need to build the protective factors that buffer young people from adversity. The challenges are great but so too are the opportunities.

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The deadly toll of *S pneumoniae* and *H influenzae* type b

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Before 2000, the world of global child health was a very different place than it is today. The links between health information from the field in low-income countries and global child-health policies were weak.1 The agenda was driven by panels of experts with decisive influence on donors and policy makers, but there was little consensus among them on key issues.2 Over the years, this reliance on expert opinion has led to snowballing support for some issues over others and striking inequities between investments in research and development across different diseases.3 The legacy of relying on expert opinion rather than a critical review of the evidence...