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PREFACE

The Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat organized an Expert Group Meeting on "Priorities for Improved Survival: ICPD beyond 2014" at the United Nations Headquarters in New York on 21 and 22 October 2013. The meeting was convened to inform substantive preparations for the forty-seventh session of the Commission on Population and Development in April 2014. In light of the twentieth anniversary of the 1994 International Conference on Population and Development (ICPD), the Commission's theme for 2014 is an "Assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development".

The meeting brought together experts from different scientific disciplines and regions of the world to address key questions about the progress in improving survival at different stages of life since the ICPD, as well as the challenges and opportunities for future mortality reduction. A selection of the papers prepared by experts participating in the meeting is being issued under the Expert Paper Series published on the website of the Population Division (www.unpopulation.org).

This paper examines progress in the areas of women's health and mortality that were at the centre of the ICPD Programme of Action, including reproductive and maternal health and HIV/AIDS. It then turns to other issues in women's health over the life course, including such risks as gender-based violence and indoor pollution. It highlights the increasing burden in developing countries of diseases such as cancers of the reproductive system, cardiovascular diseases, and diabetes. Lastly, it reviews evidence on health and mortality in adolescence and calls for increased attention to this phase of life that influences health and well-being throughout adulthood.

The Expert Paper series aims at providing access to government officials, the research community, non-governmental organizations, international organizations and the general public to overviews by experts on key demographic issues. The papers included in the series will mainly be those presented at Expert Group Meetings organized by the Population Division on the different areas of its competence, including fertility, mortality, migration, urbanization and population distribution, population estimates and projections, population and development, and population policy.

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A. INTRODUCTION

The near closure of the 20 year implementation period of the Programme of Action of the International Conference on Population and Development (ICPD PoA) presents the opportunity to look back on its goals for women's health and assess progress and challenges. It also affords a chance to look forward in time—exploring how trends in women's health and mortality are changing, how those changes demand shifts in global priorities and what can be done to ensure that the post-2015 development agenda effectively responds to women's most pressing health needs over the coming two decades.

Since the ICPD in 1994, the international community has learned much about opportunities and challenges related to global health. Among the most important of these lessons is the value of addressing morbidity and mortality differentially, as they occur across the life course. Addressing child, maternal and reproductive morbidity and mortality remain critical, yet from the perspective of both current health challenges and opportunities to affect future health and mortality, adolescence is a vitally important phase of the life cycle—one that is critical for building the foundation of good health in adulthood. For far too long, however, adolescence has been missing from the global health agenda. Beyond assessing progress and tackling new challenges in women's health and mortality, therefore, this paper also tackles the issue of adolescent health—for both adolescent girls and boys.

A. WOMEN'S HEALTH AND MORTALITY

1. *Looking back: successes and challenges*

The ICPD Programme of Action built on and helped solidify momentous advances that had been taking place in women's reproductive health in the two previous decades. During that time, the world saw significant improvements in women's reproductive health, largely based on a rapid expansion of family planning services that offered improved contraceptive technologies. Voluntary uptake of these services had contributed to large scale fertility declines and associated health improvements across the globe. But the ICPD PoA went further, introducing a new and more comprehensive concept of reproductive health. The new concept included family planning at the core, but also incorporated prevention and treatment of sexually transmitted infections (including HIV), safe motherhood and prevention and response to gender-based violence. Indeed, the PoA hailed what it called "major shifts in attitude among the world's people and their leaders in regard to reproductive health…resulting, inter alia, in the new comprehensive concept of reproductive health, including family planning and sexual health" (UNFPA, 1995). The PoA recognized the need to tackle persistently high maternal mortality rates afflicting women in low- and middle- income countries as part of this comprehensive approach. And while it recognized the still newly-emerging HIV pandemic, it did not go far enough in anticipating the devastating effects it would have on women and girls across the developing world. The PoA's central goal of universal access to reproductive health and its definition of reproductive rights have helped to shift attention globally toward a more comprehensive and rights-based agenda for women's health over the past two decades.

To some extent, the maternal, reproductive and HIV health priorities laid out in the 1994 PoA presaged the ultimate development of the health-related Millennium Development Goals (MDGs) in 2000. MDG 5 calls for a three-quarter reduction in the maternal mortality ratio (MMR). And while it was not originally included in the MDGs, years of advocacy led to the inclusion of a specific target on universal access to reproductive health in 2007 (MDG 5b). MDG 6 calls for a halt to the spread of HIV and universal access to treatment.

As the PoA and MDG implementation periods draw to a near simultaneous close and the world begins to look to the next generation of goals and targets for women's health, now is the time to ask how

well the previous set of goals have been achieved and what unfinished business remains. Unfortunately, progress has been uneven, and in some countries and regions, painfully slow.

The United Nations reports that despite overall reductions in maternal mortality in developing countries—the MMR declined by about half from 440 maternal deaths per 100,000 in 1990 to 240 in 2010—progress is far from its target of a three-quarter reduction (United Nations, 2012). And progress is highly variable. Sub-Saharan Africa had an MMR of 500 in 2010, and less than half of births in that region were attended by a skilled birth attendant. Antenatal care coverage has improved in all regions but still achieves only a small fraction of its potential to save lives. Some 80 per cent of pregnant women in developing countries now have at least one visit with a doctor, nurse or midwife; however, the World Health Organization (WHO) recommends a minimum of four antenatal care visits. Yet nearly half of pregnant women in developing countries do not reach this target. Nearly 50,000 women die each year from unsafe abortion, almost entirely in the developing world, and almost entirely in countries where abortion is not legal or widely accessible (WHO, 2011a). Adolescent childbearing, which carries higher risks for disability and death, has been on the decline since 1990, but progress has slowed and in some regions even been reversed since 2000.

Likewise, the story of contraceptive prevalence and unmet need for contraception is a story of halting progress. From 1990 to 2000, rapid improvements occurred on both measures, but in the past decade, progress has slowed to a near halt. Across the developing world, just over half (54 per cent) of married reproductive-age women were using a modern method of contraception in 2012 (Population Reference Bureau, 2013). In sub-Saharan Africa, just 20 per cent of married women use contraception, while another quarter had an unmet need for contraception.

There is better news to report on progress in HIV prevention and treatment. Between the time of the PoA and 2010, the spread of HIV has slowed dramatically and most high-prevalence countries have seen significant declines in HIV incidence, as well as AIDS-related mortality. Antiretroviral (ARV) treatment has saved an estimated 2.5 million lives and untold suffering, yet treatment is only reaching a portion of those who need it. Women comprise half of those living with HIV globally, but in sub-Saharan Africa and the Caribbean they account for 59 and 53 per cent, respectively. Because HIV testing and treatment have been integrated into antenatal care, pregnant women access treatment in greater numbers than men. Fifty-three per cent of eligible women receive treatment, as opposed to 40 per cent of men across all developing countries (United Nations, 2012). Alarmingly low levels of knowledge about how HIV is transmitted and can be tested for are persistent among young people, particularly girls and young women, in the most highly affected countries in the world. In sub-Saharan Africa, only 26 per cent of young women and 35 per cent among young men aged 15-24 years have comprehensive and correct knowledge about HIV transmission and treatment (ibid). In some countries, girls and young women are infected at rates up to six or eight times higher than boys and young men (UNAIDS, 2009).

2. *Looking forward: emerging trends and imperatives for the future*

The PoA, and the subsequent MDGs, reflect a long-standing focus in international development discourse on maternal and reproductive health. Clearly this is an area of great importance and much work remains to be done in alleviating the burden of morbidity and mortality related to sexual health and childbearing. Reducing maternal mortality must remain a high priority, with efforts focused greatly in countries of sub-Saharan Africa and South Asia where MMR remains persistently high. Likewise, focus must be maintained on reproductive and sexual health services, including family planning and HIV prevention.

However, global patterns of morbidity and mortality are changing fast and the field of women's health must grapple with the implications. A notable example of these changing trends is that deaths from

breast and cervical cancer now outnumber maternal deaths in developing countries (Fourouzanfar et al., 2011). The World Health Organization (WHO) estimates that by 2020, 70 percent of all deaths in the developing world will be caused by non-communicable diseases (NCDs), as compared to less than 50 percent today (WHO, 2013a). Yet few countries are making preparations for these shifts, which will require more creative deployment of existing health system resources and the creation and funding of new services. This will be a heavy burden for many countries, as they are called on to continue making gains in maternal and reproductive health while also improving screening and treatment for non-communicable and chronic diseases, such as cancer, diabetes and cardiovascular and lung disease.

Clearly, improving women's health and reducing women's mortality in the twenty-first century requires a broad and dynamic vision of women's health needs. Safe and healthy childbearing and increased access to voluntary family planning are essential; however, women's health does not begin and end at reproduction, and increasing numbers of women will have few or no children at all. The "life course" approach provides an alternative paradigm. It focuses on how to optimize health across the lifespan. When applied to women's health, the life course approach helps to break down the silos that have historically segregated maternal and reproductive health from other women's health concerns. This siloing has resulted in a myopic agenda for improving women's health globally—one in which maternal and reproductive health stands as a proxy for all of women's health. Fortunately, some countries have already begun to break down these silos, and models for providing comprehensive women's health care, even in highly resource-constrained settings, are beginning to emerge. But progress is slow. The creation of the post-2015 development agenda presents a valuable opportunity to accelerate those efforts by highlighting a range of neglected, yet profoundly important factors that currently drive women's mortality and morbidity and will likely do so for decades to come.

Gender-based violence continues to be a pervasive global problem affecting millions of women worldwide; yet prevention, screening and treatment services remain exceedingly rare. Violence against women includes a broad range of abuse, such as female genital mutilation, honour killings, child marriage, beatings and rape. A multi-country study by WHO showed that across diverse contexts (urban Tanzania, rural Bangladesh, Samoa and Peru), an average of 30 per cent of ever-partnered women 15 to 49 years of age had experienced either physical or sexual violence by intimate partners in their lifetimes (Garcia-Moreno et al., 2006). Awareness that violence against women contributes substantially to women's ill health has been growing over the past two decades. Unfortunately, global disease surveillance lacks measures that would allow the unique contribution of violence against women to be quantified and thus properly prioritized among other health issues. Various research studies have shown that in addition to the obvious burden of acute injuries women experience from violence, intimate partner violence (IPV) is also linked to chronic pain, gastrointestinal illness, gynecological symptoms, depression and substance abuse (Campbell et al., 2002; Heise, 1994). IPV during pregnancy has also been linked with poor birth outcomes, such as miscarriages, preterm birth and low birth weight (Murphy et al., 2001; Altarac and Strobino, 2001; Rosen et al., 2007; Schei et al., 1991). Women in controlling and abusive relationships also find it difficult to make decisions regarding contraception and family planning (Goodwin et al., 2000; Koenig et al., 2004; Pallitto and O'Campo, 2005; McCleary-Sills, 2011), putting women at increased risk for HIV and other sexually transmitted infections, as well as unintended pregnancy (Campbell et al., 2008, 2009).

Cervical and breast cancer cause more deaths than any other forms of cancer among women in the developing world. Furthermore, mortality from either breast cancer or cervical cancer exceeds maternal mortality in Latin America and in central and East Asia (Tsu et al., 2013). Only in sub-Saharan Africa do maternal deaths still far outweigh deaths from either of these cancers. In South Asia, the mortality from these three causes is roughly equal. If current trends continue, deaths from breast and cervical cancer will very soon overtake maternal mortality everywhere in the world, yet few countries have integrated breast and cervical cancer prevention, screening and treatment into their national health strategies.

Cervical cancer could be reduced by as much as two-thirds in future decades by the widespread vaccination of adolescent girls for human papillomavirus (HPV) today (Hopkins et al., 2013). The vaccine is safe, effective and increasingly affordable for low-income countries. Experience shows that the vaccine can be administered at scale. In 2011, the Rwandan Government embarked on a campaign to vaccinate all girls enrolled in sixth grade of primary school. By 2012, over 227,000 girls had received all three doses of the vaccine, representing over 90 per cent coverage of eligible girls (Bingwaho et al., 2013). But in many countries, resistance to the vaccine by parents and even health care providers – due to unfounded safety concerns or to discomfort with the idea of providing adolescents with sexual health information and services - remains an impediment to its widespread use (Hopkins et al., 2013; Rahman et al., 2013). Until these barriers can be overcome and the long-term benefits of the vaccine start to be seen, diagnosis and early treatment for cancerous lesions can save many lives. Low-cost cervical visual inspection with acetic acid followed by cryotherapy can successfully be integrated into existing health services. In high-HIV prevalence countries, HIV services are the natural target for this type of integration. For example, under the auspices of the Pink Ribbon Red Ribbon Alliance, cervical cancer screening services have begun to be integrated into PEPFAR-supported HIV services in Zambia (Oluwole et al., 2013).This model should be adopted across southern and eastern Africa.

In the case of breast cancer, improved prevention efforts in all countries and the expansion of screening and treatment services in developing countries will be absolutely critical in the coming two decades. Globally, breast cancer is the most common type of cancer among women and is the leading cause of cancer death among women age 20-59 (WHO, 2013a). Increasing incidence of breast cancer has been observed in many countries over the past three decades, in part attributable to the advent of improved detection and diagnosis using mammography (Bray et al., 2004). More than half of all breast cancer cases reported globally occur in industrialized countries where the technology for detecting breast cancer is most available. In developing countries, data on the incidence of breast cancer are sparse due to the absence of screening technologies and lack of population-based cancer registries. However, estimated fatality rates for incident cases of breast cancer are higher in developing countries, due to lack of access to screening and treatment, such that more than half of all deaths from breast cancer occur in developing regions. (Tsu et al., 2013). Furthermore, breast cancer's ranking as a cause of death is rising relative to other health threats for women in developing countries even as it is falling for women in industrialized countries. According to the 2010 Global Burden of Disease Report (Institute for Health Metrics and Evaluation, 2013), breast cancer's ranking rose precipitously between 1990 and 2010 as a cause of death in almost all developing regions of the world. Latin America and Southeast Asia saw the most striking increases. In Southeast Asia, breast cancer moved from the twenty-sixth most common cause of death to the eleventh over this time period. In the absence of expanded access to breast cancer screening and treatment, this disproportionate burden of mortality between high-income and low-income countries will very likely widen in coming decades. The situation is particularly worrying because the known risk factors for developing breast cancer are becoming more prevalent in the developing world. Trends toward having fewer children, breast feeding for less time, earlier menarche, later menopause, increasing alcohol use and obesity all point to potential increases in breast cancer incidence in coming decades for developing countries. This trend has already been well documented among migrants who move from countries with lower rates of breast cancer to countries with higher rates and begin to manifest higher rates in very short periods of time (Kliewer and Smith, 1995).

As rates of tobacco consumption continue to increase among women and girls, rates of lung cancer and other respiratory and cardiovascular diseases will increase among women as well. Women and girls currently comprise nearly 20 percent of the world's tobacco smokers, but this proportion is projected to rise in developing countries, as girls and women increasingly access economic resources, as advertising campaigns continue to target women and girls, and as appropriate tobacco control policies are weak (Hitchman and Fong, 2011).

Women's mortality from cardiovascular disease and diabetes has long been underrepresented in the global discourse on women's health. Globally, ischemic heart disease and stroke were the leading causes of death among women in 2010 (Institute for Health Metrics and Evaluation, 2013). The burden of disease gap that at one time divided high-income and lower-income countries related to cardiovascular disease and diabetes is shrinking quickly and these trends are likely to become even more pronounced over coming decades. By 2010, ischemic heart disease and/or stroke were the leading causes of mortality among women in developed countries but also in Latin America and the Caribbean, Southeast Asia, South Asia and East Asia. Southern Africa will likely not be far behind—mortality from stroke and diabetes are currently ranked second and fourth, respectively. HIV is still the leading cause of death among women in Southern Africa but as treatment reaches more and more of those in need, HIV-related deaths are expected to drop precipitously.

Meanwhile, the changes in lifestyle that have produced the epidemic of cardiovascular disease and diabetes in high-income countries in recent years are being replicated around the world with great speed. More than half the world's population now lives in urban areas, and from 2000 to 2030, almost all of the world's projected population growth will be in cities and towns of low and middle income countries. Accompanying changes in diet and exercise are laying the foundation for explosive growth in cardiovascular disease and diabetes. Unfortunately, experience demonstrates that in both developed and developing countries, women's heart disease is more likely than men's to go undiagnosed (Azad and Nishtar, 2005). This is due both to its more subtle manifestations and to the fact that healthcare systems for women are primarily designed around reproductive health, not the chronic diseases that are more common in older women.

More than three billion people, nearly all of them women and girls, cook over stoves fueled by wood, dung and other sources that produce toxic emissions that damage not only the atmosphere but also the health of those who sit for hours over them daily. According to the WHO, wood-fired cook stoves can produce pollutants at levels up to a hundred times higher than recommended limits, leading to pneumonia, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease, which affects girls and women at significantly higher rates than men and boys (Global Alliance for Clean Cookstoves, 2013). Indoor air pollution is ranked as the fourth largest health risk globally and COPD ranks as the fourth largest killer of women. It has remained so since 1990 (WHO, 2011b). Without more concerted efforts to introduce cleaner cooking stoves and fuels, an estimated four million premature deaths will continue to occur each year, most of them among women and children. Global attention toward the health impacts of indoor air pollution has been growing over the past few years, as evidenced by the creation of the Global Alliance for Clean Cookstoves, a public-private partnership led by the United Nations Foundation; however, the scale of the response remains incommensurate with the severity of the problem.

Indoor air pollution is only one among several environmental factors that in total comprise nearly one-quarter of the overall global disease burden (Ginty, 2013). With increasing industrialization across the developing world, more and more countries are facing threats introduced by new synthetic substances, like pesticides used in agriculture, persistent organic pollutants found in auto exhaust and other toxins closely regulated in most industrialized nations, which are seeping into the natural environment in developing countries. These pollutants are reaching the bloodstreams of girls and women in low- and middle-income countries through soil, air and water, increasing health risks for them and their children (ibid).

Finally, as the world grapples with the many challenges presented by climate change, it will have to account for the significant impacts that a changing climate will have on human health. With the continuing expansion of cities and urban slums, as well as with changes occurring due to climate change, communities around the world are seeing increasing outbreaks of water-borne and vector-borne diseases.

Malaria and dengue continue to plague many countries, and have only recently begun appearing in locations that have never before faced these serious health challenges, such as the highlands of East Africa (Githeko et al., 2000). As droughts and deforestation continue, women and girls across the developing world will have to travel further each day to fetch water and firewood, placing them at risk of violence, including sexual violence. Women represent some 60 to 80 per cent of agricultural workers in many developing countries. Their work to produce sufficient amounts of healthy and nutritious food will become more challenging in the face of droughts, floods, crop shortfalls and other consequences of climate change. Further, due largely to gender discrimination and their low socioeconomic status in many low- and middle- income, women are more likely to die than men during natural disasters, which are anticipated to become more frequent in the future (Neumayer and Pluemper, 2007).

C. ADOLESCENT HEALTH

1. *Looking back: an under-examined phase of life*

Increasing attention by donors, policymakers and researchers has enabled the international community to learn significantly more about women's health over time, allowing for a greater understanding of the challenges to be encountered in the coming decades. Increasingly, albeit slowly, the same holds true for the health of adolescents and young people.

One quarter of the world's population—some 1.8 billion between the ages of 10 and 24, the vast majority living in low and middle income countries—is comprised of young people. Despite these large numbers, however, adolescence as a distinct phase of life has rarely been taken into account by those conceptualizing and addressing global health needs and mortality trends. Indeed, adolescence has traditionally been viewed as a rather healthy period of the life cycle, requiring less attention than other age periods. New evidence, however, proves that it is not.

While childhood mortality rates have continued their historic and rapid decline since 1994, mortality among adolescents and youth have improved only marginally, and in some cases, not at all (Sawyer et al., 2012). In one often noted example, more boys aged 15-19 years die from violence in Brazil than do children under age 5 from infectious diseases (UNICEF, 2011). In 2004 alone, some 2.6 million 10- to 24-year-olds died, with mortality rates for adolescents and youth in low- and middle-income countries up to four times higher than those in industrialized countries (Sawyer et al., 2012).

Since the ICPD, researchers have made particular strides in understanding basic facts about adolescent health and mortality, as well as about the broader needs and assets of adolescents across the world. Research on brain development, combined with a better understanding of changes in physical, cognitive, mental and social development over the course of the life cycle, have begun to demonstrate adolescence as a profound and complex period that can influence health outcomes, as well as consolidate attitudes and behaviours for the rest of one's life (Sawyer et al., 2012).

Taking into account a life-course perspective requires an understanding of the deep relationships between early childhood health and development on adolescence, the importance of biological changes and social norms associated with puberty, and social determinants that influence whether and how adolescents take up health-related behaviours. It also requires a deliberate association between adolescent behaviours and the burden of disease in adulthood (Viner et al., 2012; Sawyer et al., 2012). In thinking about adolescent health, therefore, one must consider meeting the immediate health needs and concerns of girls and boys both before and during puberty and adolescence, while at the same time recognizing that what they do now may affect their health across their life cycle.

Evidence is providing a greater understanding of the critical importance of this phase of life in influencing health and well-being for decades to come. Indeed, not only is adolescent mortality a concern, but so too is the outsized influence of behaviours, norms and practices that begin in adolescence on impacts throughout adulthood. Values and norms, including those related to gender, tend to be formed and consolidated early in adolescence, and can have impacts for decades to come. Further, some 70 to 80 per cent of the burden of NCDs stems from behaviours that start or are reinforced in adolescence, such as the use of tobacco and other substances, physical inactivity, unsafe sex and nutritional intake (Patton et al., 2012, UNICEF, 2011). As the scope of the expanding NCD burden is increasingly coming to light, the importance of targeting behaviours and knowledge in adolescence will be critical to the prevention of NCDs worldwide. More broadly, recognizing that adolescents themselves can act as positive agents of change in regard to their health and well-being, as well as that of their communities, can help the international community not only support that agency, but also make adolescent health visible in a different light (Sawyer et al., 2012).

Finally, understanding adolescent health requires understanding the vast diversity of adolescents, as well as the diverse ways in which to address their various needs and support their empowerment. Even within a relatively short age interval (for adolescence, 10-19 years and for young people, 10-24), there is tremendous diversity. The health needs, opportunities and challenges facing a 12-year-old girl forced into marriage in a rural village of a low income country vary considerably from those of a 19-year-old gay urban migrant male living in a middle income country. Age, gender, marital, migration, educational, family, sexual orientation, HIV status, physical or cognitive disability, socioeconomic and geographic status are just some of the many factors that must be taken into account when considering adolescent health.

2. *Looking forward: emerging trends*

It is important to acknowledge that, while the adolescent health evidence base is growing, tremendous gaps exist. As with women's health, health interventions for adolescents have traditionally focused on sexual and reproductive health. For this reason, the collection and reporting of data regarding early pregnancy, sexually transmitted infections, maternal health and associated sexual and reproductive health outcomes is relatively strong (Blum et al., 2012). Even here, however, scant data exist for 10-14 year olds, and because of poor records, social norms and other barriers, much of the data that do exist likely do not capture the true scope and scale of sexual and reproductive health issues and challenges.

Just as this lack of data poses challenges to health practitioners, planners and policymakers, so too does a lack of information serve as a major barrier for adolescent health, particularly for adolescent girls. Inadequate access to sexuality education and family planning, combined with a dearth of information about their own bodies and sexuality more generally, contributes to girls lacking power in their relationships, and puts them at increased risk of unwanted and high-risk sexual encounters. These factors, combined with coercive sex and pressure to marry early and have children, contribute to continued high rates of early pregnancy, which continues to be the leading cause of death among girls aged 15-19 years (UNFPA, 2012; WHO, 2011c).

Some 16 per cent of all births that take place each year are to adolescent mothers. Importantly, more than 90 per cent of those girls are married, highlighting the persistent and interrelated challenges of child marriage, early pregnancy and related sequelae. In spite of the fact that child marriage is a violation of international human rights standards as well as national law in most countries, it continues to be a pervasive practice throughout the developing world. Defined as a legal or customary union between two people, at least one of whom is below the age of 18, child marriage disproportionately affects girls, who are typically married to older boys and men (Warner et al., 2013). Roughly one-third of women aged 20-24 years in the developing world were married before the age of 18. Twelve per cent of those women

were married before they turned 15. This translates into 14.2 million girls married each year, or 39,000 girls each day.

Beyond sexual and reproductive health, more attention is now being paid to other issues that influence health and mortality during adolescence, as well as issues that influence healthy adolescent transitions to adulthood. As with adult women, rates and causes of morbidity and mortality among adolescents differ substantially by age, region and socioeconomic status, among other factors (Sawyer et al., 2012). According to the latest data and analyses, the leading causes of death among adolescents worldwide were injuries, maternal causes, communicable, nutritional deficiencies and perinatal conditions, and non-communicable diseases. Boys are more likely to die of injuries, including those caused by road traffic accidents, homicide, suicide and violence, while girls, particularly those in the least developed countries, are most susceptible to maternal mortality. Accidents and injuries account for 40 per cent of deaths among young people, four times higher than among those aged 25 years and older.

Beyond reproductive and maternal health, girls' health is disadvantaged in many ways. For example, girls, especially those living in poverty, bear a disproportionate burden of household work. They often walk long distances to gather fuel wood and water, spend hours doing physical labor, and often cook food for their families using polluting cookstoves that can damage their physical health. Additionally, adolescent girls in poor countries face a high risk of anemia and malnutrition, which can have long-term consequences for their health and that of their children (Biradar et al., 2012). In many cases, girls bear the brunt of food shortages, eating what little food remains after the male members of the family have eaten, which can also result in under nutrition and ill health (Food and Agriculture Organization, n.d.).

Increasing attention is being paid to mental health issues among adolescents, which is now recognized as the greatest contributor to the non-fatal burden of disease in young people (Sawyer et al., 2012). Mental health is critical to healthy transitions to adulthood, with implications for overall well-being, growth and development, self-esteem, school attendance, social cohesion, and resilience in the face of future health and life changes (UNICEF, 2012).

Even newer drivers of ill health in adolescence are emerging, including the globalization of tobacco and alcohol marketing specifically to adolescents and youth, as well as obesity and malnutrition fuelled by unhealthy foods and a lack of physical activity as daily patterns of life change to more sedentary lifestyles. Increasing exposure to both mass media and social media across the world present many opportunities to promote good health, but can also "be viewed as a vector that carries attitudes and products to an increasing number of hosts, resulting in outbreaks of previously uncommon behaviors (Sawyer et al., 2012).

3. *Imperatives for the future*[1]

The growing knowledge base on adolescent health, both in its own right and for the health of individuals and societies in the future, demands action. Recognizing the diverse and rapidly changing contexts in which adolescents live and engage, it is imperative to prioritize equity in access to health, taking into account the differential influences of gender, age, race, ethnicity, socio-economic status, disability, sexual orientation and other factors on adolescent health and well-being. Further, while the global community has some data on adolescent health, much more is missing. Acting strategically, effectively and accountably to improve the health of adolescents requires collecting, monitoring and making visible data and evidence related to adolescent health, from the local to the national and ultimately, global levels. This requires collecting data beyond sexual and reproductive health, expanding

[1]The Lancet Commission on Adolescent Health and Well-Being, launched in October 2013, will tackle this agenda over the coming two years.

data collection and outreach efforts for very young adolescents (i.e., 10-14 years), and ensuring that adolescents and young people themselves are involved in collecting and analyzing data (Blum et al., 2012; United Nations Population Fund, 2013).

The systems in which adolescents and young people are growing up can have critical influences on how healthy they are—now and in the future. Families, schools, peer groups, communities, media, the employment sector and a range of other systems can be critical enablers, helping adolescents and young people develop to their full potential and attain good health as they move into adulthood (Viner et al., 2012). But they can also have negative impacts on health. These systems, including the health sector and other platforms for health information and service provision, should be analysed to ensure that interventions have the most positive effects on adolescent health possible.

Finally, none of these efforts can be effective without the genuine involvement, engagement and leadership of adolescents and young people themselves. Adolescents are the ultimate stakeholders. They have a wealth of knowledge and assets that must be brought to the table in identifying what matters to them, how they and their peers can best contribute to and benefit from the health sector, and what policies and practices will help ensure their positive health now, and for decades to come.

D. CONCLUDING THOUGHTS

The ICPD Programme of Action highlighted the tremendous need to increase access globally to a comprehensive package of reproductive health services, so as to address, among other things, the high rates of maternal morbidity and mortality, increasing rates of HIV infection and tremendous unmet need for family planning that existed in 1994. While some regions of the world have made progress in some of these areas over the past two decades, progress has been uneven, with the poorest and most vulnerable yet to benefit from these positive epidemiological transitions. Focusing on achieving truly universal access to sexual and reproductive health and rights must therefore remain a critical global development goal moving forward.

At the same time, the global community must think more holistically about women's health. This demands a comprehensive, life course approach that recognizes that women's health goes beyond sexual and reproductive health and that also considers the diverse contexts of women's lives that impact on health, including social norms that drive gender-based violence, exposure to environmental pollutants and marketing of unhealthy products, and the effects of climate change, among other critical areas. It also requires attention to, and prevention of, the diseases and conditions that are most likely to spread globally in the coming years, including a range of non-communicable diseases.

Finally, the international community must recognize that adolescence is not the healthy phase of life that it has long been treated as, particularly across the less developed world. The majority of deaths in adolescence are preventable. Ensuring the right to health requires investing in this critical second decade of life. As UNICEF noted in 2011, investing in adolescent health is not only the right thing to do, it also protects the tremendous investments and achievements that have been made in childhood health; it accelerates the achievement of equity, poverty alleviation and discrimination; and it helps to equip young people to face current and emerging challenges that will affect their health and welfare for decades to come (UNICEF, 2011).

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