Rapid declines in fertility, increasing survival through infancy and childhood and greater longevity mean that this generation of adolescents will be the largest in human history. In low-income countries, the ‘youth bulge’ has the potential to bring great economic prosperity. In contrast, many high-income countries face a ‘demographic cliff’, where a smaller pool of young people poses major economic and social challenges. In both contexts, the health and well-being of this generation of adolescents will determine future national development.

Shifts in adolescent development have major implications for health. Falls in the age of puberty together with a rising age of marriage have, for example, given rise to more sexually active unmarried adolescents. In settings where healthcare needs are well met, the benefits are clear in terms of lower pregnancy rates, lower maternal mortality and lower rates of HIV and other sexually transmitted infections. Conversely, where this shift occurs in settings with poor adolescent health care, where sexual activity in young unmarried women is stigmatized and where poverty forces young women into early marriage or selling sex, both health and life outcomes can be catastrophic. In this context, poor and socially marginalized adolescents, particularly those out of school, without stable accommodation or family, or in juvenile detention, have the worst health profiles.

The opportunities for gain or loss are great across all aspects of health in adolescence. It is during these years that the risks for injury and mental disorders are highest, and when risks for later-life noncommunicable diseases (cancer, cardiovascular and respiratory disease) such as tobacco use, obesity and inactivity are established. The great majority of adult mental disorders begin in adolescents. So too injuries rise sharply with high rates of suicide, motor vehicle injury and violence, including sexual violence in these years. All will affect the future health, social adjustment and economic prospects of today’s adolescents. It will in turn affect their capacities as parents and a healthy start to life for their children.
There is great variation between countries, even within the same region, in patterns of adolescent health. For low-income countries, key indicators at national and district levels should include rates of maternal mortality, HIV and sexually transmitted infections, age of onset of sexual activity, early childbirth, availability of contraception and age of marriage. Countries should also have data on adolescent nutrition including anemia, patterns of injury including sexual violence and coercion, mental health and disorder, and substance abuse. At a local level, data on family functioning (e.g. violence, conflict), educational engagement, peer behavior and community attitudes (e.g. to providing contraception to sexually active unmarried adolescents) are also needed to effectively guide programming and health service delivery.

The evidence base for prevention in adolescence is stronger than ever before. Public health approaches that use multiple coordinated actions at national and local levels show great promise. These typically involve steps of using best available data to evaluate local needs, identifying priority targets for intervention, implementing evidence-based programs and policies followed by monitoring, commonly using the same indicators that framed need.