Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module B

Meaning of adolescence and its implications for public health

This handout provides information to complement material covered in the module *Meaning of adolescence and its implications for public health*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. Definitions of the term "adolescence" and of the age groups "young people", "adolescents" and "youth"

Adolescence

Adolescence has been described as the period in life when an individual is no longer a child, but not yet an adult. It is a period in which an individual undergoes enormous physical and psychological changes. In addition, the adolescent experiences changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships. The individual's capacity for abstract and critical thought also develops, along with a sense of self-awareness when social expectations require emotional maturity. It is important to keep this in mind for a more complete understanding of the behaviours of adolescents as you read through this handout.

Age groups

WHO defines adolescents as individuals in the 10-19-year age group and "youth" as the 15-24-year age group. These two overlapping age groups are combined in the group "young people", covering the age range 10-24 years (*1*).

WHO clearly recognizes that "adolescence" is a phase rather than a fixed time period in an individual's life. As indicated above, it is an phase of development on many fronts: from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity; the development of mental processes and adult identity; and the transition from total socio-economic and emotional dependence to relative independence.

It is important to note that adolescents are not a homogeneous group. Their needs vary with their sex, stage of development, life circumstances and the socio-economic conditions of their environment.

2. Global demographic and socio-economic information on adolescents

Population

There are more than 1.1 billion adolescents worldwide today – that is, one in every five people on the planet is aged between 10 and 19 years. Approximately 1.5 billion of today's world population are young people between 10 and 24 years old; 85% of them live in developing countries (*2, 3*). Table 1 shows the global and regional distribution of adolescent populations.

TABLE 1

Distribution of the global adolescent population in the year 2000

Region	Total population (' 000)	Adolescent population	Adolescent population (%)
World total	6,055,049	1,153,822	19
More developed regions	1,187,980	159,849	13
Less developed regions	4,867,069	993,973	20
Least developed regions	644,678	152,562	24
Africa	784,445	184,611	24
Latin America and the Caribbean	519,143	105,821	20
North America	309,631	43,751	14
Asia	3,682,550	715,862	19
Europe	728,887	98,866	14
Western Pacific	30,393	4,907	16

Source: Reference (2).

Education

Formal education is of great importance for the development of adolescents. Schools provide an environment for acquiring knowledge, and for building literacy, numeracy, and thinking skills. Education is a vital tool for socio-economic development (through improved economic opportunities available to those who are educated) and also for its positive impact on health. Schools are a major source of education and guidance on specific health issues and, in addition, offer a setting for the provision of health screening and health services. National policies and the available resources determine whether schooling for adolescents is obligatory and accessible. Adolescents in developing countries have fewer opportunities for education than their counterparts in developed countries, and girls have fewer opportunities for schooling than boys. In the least developed countries, only 13% of the girls and 22% of the boys enrol for secondary education (*4*).

Employment

Many adolescents do not complete their secondary school education. A substantial proportion seeks work in the informal sector. Worldwide there are an estimated 73 million adolescents aged between 10 and 14 years who work under conditions that are detrimental to their health (*5*). In addition, throughout the world many millions of adolescents live and work on the streets, putting them at a high risk of sexual abuse and/or substance use (*6*) and injuries.

It has been estimated that between 1970 and 2025 the urban adolescent population in developing countries will grow by 600% (*7*). The projected rapid growth in the number of adolescents living in economically deprived urban areas poses considerable challenges to governments and civil society.

Poverty

Despite many development gains in the last century, both absolute and relative poverty continue to increase in many parts of the world. Although poverty affects all age groups, it brings particular risks to the health and development of adolescents. For instance, the pressure to earn a living at a young age could hinder their ability to stay in school and gain a proper education, and could also expose them to exploitation and abuse by unscrupulous adults.

3. THE NATURE AND SEQUENCE OF CHANGES DURING ADOLESCENCE

Adolescence is characterized by a rapid rate of growth and development. During this period the body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. Social relationships move from being centred on the family base to a wider horizon in which peers and other adults come to play significant roles in the adolescent's life. It is also a time when new skills and knowledge are acquired and new attitudes are formed.

Although the decade of life from 10 to 19 years provides a time-bound definition of adolescence, it is important to realize that the changes occurring during this period may not correspond neatly with precise ages. This is because of variations in the onset and duration of changes between individuals. Moreover, this period of transition is perceived differently by different cultures; its perception is clearly mediated by social, economic and cultural factors. Hence, the experience of adolescence differs among individuals and by sex in any given society, and by varying conditions and circumstances such as disability, illness, socioeconomic status and poverty (*8*).

Peak rates of growth and development during adolescence are exceeded only by those during foetal life and infancy. However as indicated above, in comparison with infancy and early childhood, there is much greater individual variation both in the timing of developmental milestones, and in the degree of changes in rates of growth (*9*).

Adolescence is sometimes divided into early, middle and late periods, which are respectively the 10-14, 15-17 and 18-19-year age groups. These periods roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood (Table 2). While these stages are not universally accepted, and vary as above, they provide a basic framework to understand adolescent development.

TABLE 2

Stages of adolescence

Category of change	EARLY 10-13 to 14-15 years	MIDDLE 14-15 to 17 years	LATE 17-21years (variable)
Growth	Secondary sexual characteristics appear Growth accelerates and reaches a peak	Secondary sexual characteristics advanced Growth slows down, approximately 95% of adult stature attained	Physically mature
Cognition	Concrete thinking Existential orientation Long-range implications of actions not perceived	Thinking is more abstract Capable of long-range thinking Reverts to concrete thinking when stressed	Established abstract thinking Future-oriented Perceives long-range options
Psychosocial	Preoccupied with: Rapid physical growth Body image Disrupted change	Re-establishes body image Preoccupation with fantasy and idealism Sense of all-powerfulness	Intellectual and functional identity established
Family	Defining boundaries of independence/ dependence	Conflicts over control	Transposition of child-parent relationship to adult-adult relationships
Peer group	Seeks affiliation to counter instability	Needs identification to affirm self image Peer group define behavioural code	Peer group recedes in favour of individual friendship
Sexuality	Self exploration and evaluation	Preoccupation with romantic fantasy Testing ability to attract opposite sex	Forms stable relationships Mutuality and reciprocity Plans for future

Source: Reference (10).

4. Global magnitude of selected priority health problems affecting adolescents

Most adolescents are healthy – that is, they show lower levels of mortality and morbidity compared to children and adults. Most adolescents also believe that they are healthy. For instance, a study of almost 16,000 adolescents conducted in nine countries in the Caribbean found that 80% of the adolescents surveyed considered themselves healthy and 88% felt comfortable about their appearance. Two-thirds of them had not had sexual intercourse, and 89% did not use alcohol and other psychoactive substances. The majority liked school (94%) and got along with their teachers (96%), and felt that their parents and family members cared about them (*11*).

There is growing recognition, however, that some adolescents do in fact develop health problems, and in addition many more adopt unhealthy behaviours that lead to health problems in their adult lives. The health problems and problem behaviours affecting young people in developing countries have been classified by WHO (Table 3).

TABLE 3

Classification of diseases and health-related behaviours of young people in developing countries

Diseases which are particular to young people	Diseases and unhealthy behaviours, which affect young people disproportionately	Diseases which manifest themselves primarily in young people but originate in childhood	Diseases and unhealthy behaviours of young people whose major implications are on the young person's future health	Diseases which affect fewer young people than children, but more of them than adults
Diseases: Disorders of secondary sexual development Difficulties with psycho-social development Suboptimal adolescent growth spurt	**Diseases:** Maternal mortality and morbidity STIs (including HIV) Tuberculosis Schistosomiasis Intestinal helminths Mental disorders	**Diseases:** Chagas disease Rheumatic heart disease Polio	**Diseases:** STIs (including HIV) Leprosy Dental disease	**Diseases:** Malnutrition Malaria Gastroenteritis Acute respiratory infections
	Behaviours: Alcohol use Other substance abuse Injuries		**Behaviours:** Tobacco use Alcohol and drug use Poor diet Lack of exercise Unsafe sexual practices	
Young people will contribute a substantial number of cases because they form a large proportion of the population in most developing countries				

Studies suggest that there are significant sex differences in adolescent morbidity and mortality rates. Boys worldwide have higher rates of morbidity and mortality from injuries due to interpersonal violence, accidents and suicide, while adolescent girls have higher rates of morbidity and mortality related to sexual behaviour (*12*).

Attempts have been made to quantify the burden of morbidity and mortality among adolescents, using the measure Disability-Adjusted Life Years (DALYs). Box 1 contains a brief explanation of the term and provides estimates of the burden of disease among young people.

BOX 1

Estimates of the burden of disease among young people

The Disability-Adjusted Life Year (DALY) is a measure used to quantify burden: it is a time-based measure, which captures the impact of premature death (in years), and the time (in years) lived with a disability. One DALY is one lost year of healthy life. A recalculation of the global burden of disease estimates among adolescents, youth and young people gave the following findings:

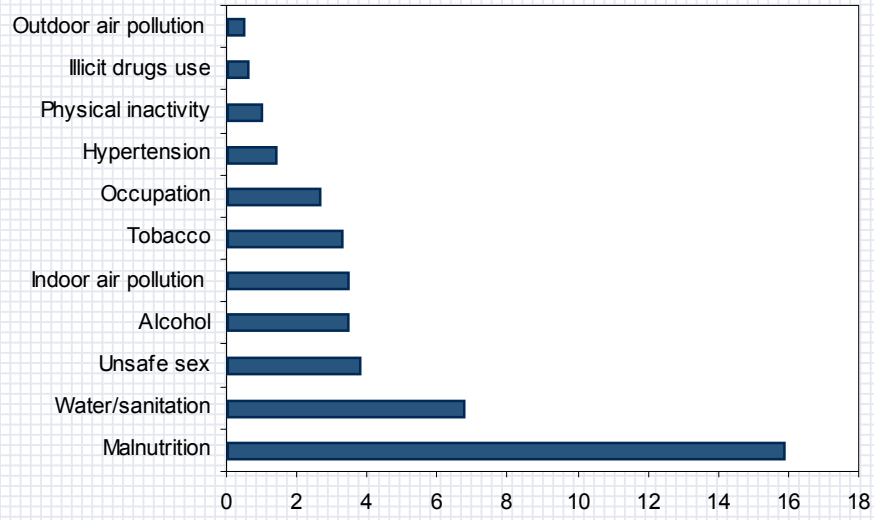
- The burden of disease and injury between the ages of 10 and 24 represents 15% of the total burden worldwide.
- 90% of the DALYs are lost in developing countries.
- 42% of DALYs result from noncommunicable diseases, 29% from injuries, and 29% from communicable, maternal, perinatal and nutritional conditions.
- The DALY distribution for adolescents and youth is very different from the pattern observed in children or adults – with STIs, HIV, maternal conditions, depression, alcohol and drug use, injuries, and road traffic accidents predominating among adolescents.
- Patterns of burden are very distinct between the sexes: DALY rates for injuries (and suicide) in males tend to be twice that in females. Exceptions to this are the suicide rates among females in China and India, which are higher than those among boys.

Source: Reference (13).

Attempts have also been made to estimate the contribution of selected risk factors to the global burden of disease. Figure 1 contains estimates of the contributions made by unsafe sex, use of alcohol, tobacco and other substances, and physical inactivity – all risk behaviours established during adolescence – to diseases, disability and death both during adolescence and beyond.

FIGURE 1

Risk factors for global burden of disease



Source: Reference (14).

Drawing upon data from around the world, a list of "priority" health problems affecting adolescents has been developed (Box 2). Each of the problems on the list meets the following three criteria. Firstly, they cause mortality or morbidity either during the adolescent period, or in later life as a result of behaviours initiated during this period. Secondly, they cause significant levels of mortality and morbidity. Thirdly, many of these health problems and problem behaviours are inter-related. For instance, substance use is associated with depressive states, and alcohol use is associated with road traffic accidents.

BOX 2

Health problems established during adolescence

- Intentional and unintentional injuries
- Sexual and reproductive health problems (including HIV/AIDS)
- Substance use and abuse (tobacco, alcohol and other substances)
- Mental health problems
- Nutritional problems
- Endemic and chronic diseases
- Each of these problems is described briefly below

Intentional and unintentional injuries

Unintentional injuries are the leading cause of death among young people, especially traffic accidents. Of the estimated 195,000 adolescents killed each year in traffic accidents, more than 60% are boys (WHO GPE 2000). Many of these traffic accidents are related to the use of alcohol and other psychoactive substances. For every young person killed in traffic accidents, an estimated 10 more are seriously injured or maimed for life.

Interpersonal violence is a form of intentional injury, which is increasing among young people, with girls especially being victimized (*15*). Although boys are far more likely than girls to be perpetrators of violence, research is now showing that boys are also victims of violence.

Data on the incidence of sexual violence and rape are not well-established. A review in 1994 confirmed that rape is not rare. Data from legal statistics and rape crisis centres show that a high proportion of rape victims in many developing countries are under 15 years of age and that most perpetrators are known to their victims (*16*). Sexual abuse of girls and boys is an even more widespread problem, with three times as many girls as boys being affected.

Sexual and reproductive health – consequences of unsafe sex

Adolescence is a time for sexual exploration and expression. For many adolescents sexual relations begin in adolescence, in or outside of marriage. The consequences of unprotected sex in adolescents include too early and unwanted pregnancy, and sexually transmitted infections, including HIV.

When adolescents become pregnant, especially in early adolescence, they are at risk of complications both during pregnancy and during delivery. Moreover, the risk of mortality and morbidity is higher in infants born to adolescent mothers, than for older women.

Lack of knowledge and skills, poor access to contraceptive methods including condoms, as well as vulnerability to coerced sex puts adolescents at high risk of unwanted pregnancies and infections. Further, a range of obstacles to their utilization of health services may make it difficult for them to obtain the advice and health services they need (*17*).

Unwanted pregnancy is often seen only as a problem for adolescent girls, but recent research shows that adolescent fathers face some of the same issues that young mothers face: too-early role transition from adolescent to parent; social isolation; unstable relationships; and social and family opposition to their involvement as fathers.

In developing countries, maternal mortality in girls under 18 years of age is two to five times higher than in women aged 18-25 years (*18, 19*). Worldwide, more than 13% of all births are to women 15-19 years old. There are however considerable variations both between and within countries (*20*). Adolescent mothers in many developing countries face many health and social problems.

Unsafe abortions in adolescents are estimated at 2,5 million a year, representing 14% of all unsafe abortions. A further 4,8 million (or 26%) unsafe abortions take place in young women 20-24 years old (WHO, RHR, 2002).

Every year, more than one out of 20 adolescents will contract a curable sexually transmitted disease (STD), not including viral infections (*22*), and every year a third of the estimated 333 million new STDs occur in young people under 25 years (*23*).

HIV/AIDS

The HIV/AIDS pandemic is one of the most important and urgent public health challenges facing governments and civil societies around the world. Adolescents are at the centre of the pandemic both in terms of its spread, and in terms of the potential for changing the attitudes and behaviours that underlie this disease.

An estimated 30% of the 40 million people living with HIV/AIDS (i.e. 10.3 million) are young people aged 15-24, and half of all new infections – over 7000 daily – occur among young people (*17*). The vast majority of young people who are HIV-positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners.

Young people are vulnerable to HIV because of risky sexual behaviour, substance use, and their lack of access to HIV information and prevention services. Many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV.

Substance use

Harmful substance use (tobacco, alcohol and illicit substances) will increase the risk of cancers, cardiovascular diseases, and respiratory illnesses later in life (*15*).

If tobacco use begins at all, it usually begins in adolescence; few people begin to smoke regularly after the age of 18 (*3*). Alcohol is the most common element in substance-use related deaths of young people. The earlier the age of onset of drinking the greater the chance of developing a clinical alcohol disorder later in life (*24*). More importantly, there is growing evidence of the "clustering" of behaviours risky to health. A recent review of evidence from around the world, carried out by WHO, showed that the use of substances by adolescents, is associated with a greater likelihood of early sexual initiation (*26*).

Mental health

Young people are often vulnerable to the kinds of stresses (including the challenges of growing up and exposure to risky behaviours) that contribute to mental ill health. It is during adolescence that some mental health problems first appear. Mood disorders such as depression, and psychotic disorders such as schizophrenia, are two types of mental illnesses for which early recognition and intervention are critical for a successful and long-lasting recovery (*27*).

Suicide is one of the three leading causes of death for young people. Suicide rates among adolescents are rising faster than among any other age group. There are 90,000 suicides committed by adolescents each year. For every completed attempt of suicide, there are at least 40 unsuccessful attempts (*27*).

There appear to be clear gender patterns in the way in which young people respond to stressful and traumatic life events (*11*). Various studies have shown that in times of stress or trauma, boys are more likely than girls to respond to stress with aggression (either against others or against themselves), to seek diversion in physical activity, and to deny or ignore stress and problems. On the other hand, adolescent girls more frequently turn to friends and pay attention to health needs resulting from stress. These gender patterns of coping with stress can also be seen in gender differences in suicide.

Nutrition

During adolescence, nutritional problems originating earlier in life can potentially be corrected, in addition to addressing those that begin during adolescence. Malnutrition is estimated to account for 16% of all disability-adjusted life years in the general population and is the largest single factor contributing to ill health. Among adolescents malnutrition is not one of the main causes of ill health as it is for instance in children under the age of 5. However, under- and over-nutrition, anaemia and lack of micronutrients, especially relevant for pregnancy, are increasing problems in both developing and developed countries (*28*). The adolescent's need for iron, increased by growth, development and menstruation, are hampered by malaria, hookworm infestation and schistosomiasis, which affect young people disproportionately (*28*).

Chronic and endemic diseases

Data show that malaria and tuberculosis (TB) are among the 10 major causes of death in adolescents (125,000 deaths each year from malaria and 75,000 due to TB) (*3*). It is important to ensure that adolescents are addressed in programmes to combat these conditions, as well as others such as schistosomiasis and helminth infestations.

Chronic conditions include noncommunicable diseases such as asthma, epilepsy, cystic fibrosis, juvenile diabetes and haemoglobinopathies such as sickle-cell disease. In general, the focus on chronic conditions has been greater in developed countries but there is growing awareness that they need to be addressed in developing countries as well.

Chronic conditions could adversely affect adolescent development. Factors such as growing autonomy and sensitivity to peer pressure, characteristics of an emerging adolescent identity, could hinder compliance to diet and treatment regimens in individuals with chronic conditions. It can hence be a challenge to manage these conditions in adolescents within the context of all the other changes that are taking place. The management of these conditions requires comprehensive care and support addressing both biomedical and psychosocial issues in an ongoing manner, rather than the application of a "diagnose and treat" approach.

Differences in perspectives

The data provided above present information on the major problems facing adolescents as perceived by health planners and policy-makers. However, adolescents themselves often have very different perceptions of their health-related needs and problems. Their concerns often relate to issues such as body size, acne, and relationships with their peers and members of the other sex. Box 3 shows the different priorities given to young people's health by two different stakeholders: health planners and young people themselves.

BOX 3

Priorities in young people's health – two viewpoints

Health planners	Young people
■ STIs/AIDS	■ Relationships
■ Injuries	■ Appearance
■ Psychiatric problems	■ Bullying
■ Too early pregnancies	■ Stress (e.g. due to schooling, exams, lack of employment)
■ Schistosomiasis	■ Access to contraception
	■ Pregnancy

Source: Reference (3).

To be truly meaningful, programmes intended for adolescents must make every effort to understand and address their viewpoints and perspectives. Additionally, adults who interact with adolescents (e.g. parents and other family members, teachers, youth leaders and religious leaders) are important groups to be consulted and involved (*29*). This will make it possible for all the key stakeholders to make their own special contributions to the health and development of adolescents.

5. Why invest in adolescent health and development?

The behaviours and lifestyles learned or adopted during adolescence will influence health both in the present and in the future. Tobacco use is a good example of how a behaviour, almost always adopted during adolescence, leads to disease and death later in life. Further, the benefits of adolescent health and development accrue not only to the adults that emerge from the process, but also to future generations.

The three main reasons for investing in the health and well-being of adolescents are shown in Box 4.

It is estimated that every year about 1.4 million adolescents die – mostly from accidents, violence, pregnancy-related problems and illnesses that are either preventable or treatable. Many more develop behaviours that could destroy their chances for personal fulfilment and their ability to contribute to society (*27*). Investing in adolescent health and development will reduce the morbidity and mortality in this age group. It will maximize their opportunity to develop to their full potential and to contribute the best they can to society.

BOX 4

Three main reasons for investing in adolescent health

Health benefits for the individual adolescent – in terms of his/her current and future health, and in terms of the inter-generational effects.

Economic benefits: improved productivity, return on investments, avert future health cost.

As a human right: adolescents (like other age groups) have a right to achieve the highest attainable level of health.

Source: Reference (13, 30).

Investing in adolescent health and development will also reduce the burden of morbidity and mortality in later life because healthy behaviours and practices adopted during adolescence tend to last a lifetime. Today's adolescents are tomorrow's parents, teachers and leaders. What they learn today, they will teach to their own children and to other children tomorrow.

Investing in Adolescent Health and Development (ADH) makes economical sense: better-prepared and healthy adolescents will result in productivity gains when they enter the workforce. Return on investments made in early childhood health and development are being safeguarded by continuing attention to ADH. When adolescents develop suboptimally or die prematurely this means a waste of earlier investments. Investing in prevention and promotion during adolescence also averts future health costs: smoking prevention averts health costs much later in life.

Promoting and safeguarding adolescent health should not only be regarded as an investment, but also as a basic human right. The UN Convention on the Rights of the Child (CRC), which has been ratified by nearly every government in the world, declares that young people have a right to life, development, and (in Article 24) "*The highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*" (*33*). The CRC also gives young people the right to preventive health care and requires specific protection for those living in exceptionally difficult conditions or with disabilities. This means that governments have the responsibility to ensure that health and other basic services essential for good health are provided.

6. Guiding principles and a conceptual framework for promoting and protecting adolescent health and development

Working in conjunction with UNFPA and UNICEF, WHO has developed a framework for country programming for adolescent health (*29*). The framework spells out the twin goals of programming – promoting healthy development in adolescents on the one hand, and preventing and responding to health problems if and when they arise, on the other. It lists the interventions that need to be delivered – as a package – to meet these goals: the creation of a safe and supportive environment, the provision of information, building life skills, and the provision of health and counselling services. It also lists the settings wherein these interventions could be delivered and the players who could deliver them (including both adults and adolescents themselves).

The framework is a truly comprehensive one, and there are many challenges in translating this broad vision into reality. The framework lists key challenges – building political commitment, identifying priorities for action, sustaining the implementation of programmes, and monitoring and evaluating them. Based on experiences around the world, it outlines the guiding concepts (Box 5) that should underpin our work with adolescents as well as keys to success.

BOX 5

Guiding concepts for programming for adolescent health and development

- Adolescence is a time of opportunity and risk
- Not all adolescents are equally vulnerable
- Adolescent development underlies prevention of health problems
- Problems have common roots and are interrelated
- The social environment influences adolescent behaviour
- Gender considerations are fundamental

Source: Reference (29).

Adolescence is a time of opportunity and risk: Generally speaking, adolescence is a healthy period of life. However, some adolescents do lose their lives and many more develop health problems, or problem behaviours, that could lead to disease and premature death in adulthood. In that sense, adolescence is in fact a time of risk; but it is also a time of opportunity for an individual to grow and develop (physically, psychologically and socially) to his/her full potential, in preparation for adulthood.

Not all adolescents are equally vulnerable: Adolescents are not a homogeneous group; their needs for health information and services depend on their age, stage of development and circumstances. Because of their circumstances, some adolescents tend to be more vulnerable than others to health and social problems.

Adolescent development underlies prevention of health problems: The two overlapping goals of promoting healthy adolescent development on the one hand, and preventing and responding to health problems on the other, cannot be viewed as separate and distinct because they are closely linked to one another. The provision of preventive and curative health services for specific health problems is important. However, the prevention of health problems (and problem behaviours) through actions to enhance protective factors (such as positive relationships with parents and teachers and a positive school environment) and reduce the risk factors (such as early initiation of unprotected sex and the use of tobacco, alcohol and other drugs) is even more important.

Problems have common roots and are interrelated: Research shows that the health problems of adolescents are interrelated. This is because the underlying behavioural causes of many of these health problems are the same. For example, studies from around the world – gathered and analyzed by WHO – point to the fact that adolescents who engage in other risk behaviours, such as using alcohol and other substances, are more likely to initiate sexual intercourse early (*26*) (Figure 2).

FIGURE 2

Early sexual initiation

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	?
A positive relationship with teachers	+	+	?	+	Not significant
Friends who are sexually active	-	?	-	-	?
Engaging in other risky behaviours	-	?	-	?	?
Having spiritual beliefs	?	+	+	?	+

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (25).

The social environment influences adolescent behaviour: A safe (free from danger of disease and injury) and supportive (nurturing) environment is critical for an individual to develop to his/her full potential, and for him/her to be healthy. For example, the synthesis of studies by WHO, referred to above, points to the fact that adolescents who have positive relationships with parents and with other adults in the community are less likely to experience depression (*29*). Unfortunately, many adolescents in today's world are living, studying and working in unsafe and unsupportive environments, with negative effects on their health and development (Figure 3).

FIGURE 3

Depression

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	+
Parents encourage self-expression	+	+	+	+	+
Conflict in the family	-	Not significant	-	-	-
A positive attitude towards school	Not significant	+	+	Not significant	+
Positive relationship with adults in the community	+	+	+	Not significant	Not significant
Having spiritual beliefs	+	+	+	Not significant	Not significant

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (25).

Gender considerations are fundamental: A good understanding of the biological differences in the growth and development of males and females (through the years of adolescence), and of the different ways in which they are affected by health problems is important. Equally important is a good understanding of the different social and cultural influences on males and females, and how this affects the way in which adolescent males and females view themselves and relate with others.

What health care providers need to do when working with and for adolescents

A fundamental principle in working with/serving adolescents is "putting them at the centre", in other words, making their needs and problems, thoughts and feelings, view points and perspectives central to your work with them. Some key issues are listed in the Box 6.

BOX 6

Putting adolescents at the centre

- Regarding the adolescent as an individual, not just as a case of this or that health problem
- Striving to understand the specific needs of each individual adolescent
- Acknowledging – and heeding – the viewpoints and perspectives of the adolescent in line with his/her evolving capacity
- Taking into primary consideration, the best interests of the adolescent, when making decisions – or taking actions – that affect him/her
- Respecting the rights of the adolescent (as laid out in the UN Convention on the Rights of the Child), while at the same time taking into account the rights and responsibilities of parents
- Striving to prevent personal beliefs and attitudes, preferences and biases from influencing one's professional assessments and actions

All these issues will be touched on and developed further in all the Orientation Programme modules. One concrete method which health workers could use to understand the adolescent they are working with is to use the HEADS approach (*31*) (Box 7). This approach consists of a checklist of questions to carry out a rapid assessment to provide information on the psychological and social dimensions of the adolescent's life. It could be used in combination with a medical history to provide information on Box 7.

BOX 7

Areas addressed by the HEADS approach to assess the psychological situation and the social circumstances of adolescent patients

- Home: about the family
- Education: about their interest and performance
- Eating: about their habits
- Exercise: about their habits
- Ambition: about their hopes for the future
- Activities: about their social and recreational activities
- Drug use: whether they smoke and use other psychoactive substances
- Sexuality: their thoughts and feelings about their sexual activity
- Suicide: how they feel and whether they have thought of hurting themselves

Source: Reference (31).

A final point worth noting is that since many of the factors that affect adolescent health and development are interrelated, they cannot be completely addressed by the health sector alone. Health-care providers can, however, work with other sectors including the education and social welfare sectors to address collectively the health issues of adolescents. Health staff can also become more aware of the role and responsibilities of the other sectors and be well informed of what services are available for adolescents outside the health sector. As you will see later in these modules, there are also many things that health care providers can do within the health sector to make the services more adolescent-friendly.

7. References

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

What are important changes that take place in the individual as he/she goes through adolescence?

please provide three answers

SPOT CHECK 2

What are the most important actions to do when working with or for adolescents?

please provide three answers

SPOT CHECK 3

What are the four most important health problems facing adolescents in your area?

please provide four answers

SPOT CHECK 4

We should invest in adolescents because …

please provide four answers

SPOT CHECK 5

Do you agree that adolescents should be primarily involved in the development, planning and evaluation of health programmes that serve them?

please mark your answer with a spot anywhere along the line

agree — possibly — disagree

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Annex 2

Group exercise

Session 3: ACTIVITY 3-2

Events / changes that occur	Early adolescence (10-13)	Middle adolescence (14-16)	Late adolescence (17-19)
Physical			
Psychological: *Cognitive* *Emotive*			
Social			

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Annex 3

Group exercise

Session 4: ACTIVITY 4-2

Characteristics of adolescence	Implications for public health

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Annex 4

Examples of letters

Session 5: ACTIVITY 5-1

These are typical examples of letters written by adolescents to an "Agony Aunt" or to a personal column or health column in a newspaper or magazine, which illustrate the health-related predicaments of adolescents and their need for advice and help. Please select three or four letters reflecting issues which you think adolescents in your country may be experiencing, for discussion during the session.

LETTER 1

Dear Dr (please insert local name),

I am a 19-year old girl, still in school, and have a steady boyfriend who is also 19. Our love is very strong, but we never get involved in sexual acts. Recently, he proposed to have sex with me. I refused because it is against my religion to have sex before marriage. He tells me that since we will get married anyway, it would be okay to have sex. I love him very much and do not want to lose him.

What must I do to keep my boyfriend, but without having sex with him?

LETTER 2

Dear Dr (please insert a local name),

I'm an 18-year old girl who is dating a much older man. He is about 37 or 39 and is very nice to me. He always helps me with buying books, clothes and other things I need for school. We have had sex once but I am worried that I could be pregnant. I'm afraid that he might leave me because he already has a wife.

How can I know for sure that I am pregnant? Do I tell him? What if he leaves me? What should I do?

LETTER 3

Dear Dr (please insert a local name),

I am 17 years old and have sex very often with my boyfriend. I recently read that failure to use a condom could lead to STIs or AIDS. I talked to him about using a condom. He threatened to leave me and go back to his old girlfriend if I open this subject again. I do not want to lose him by insisting that he should use a condom. My friend told me that if I washed immediately after having sex, I would not get an STI or AIDS. This is what I am doing now.

Is this the right thing to do? Can this help?

LETTER 4

Dear Dr (please insert a local name),

I am a 16-year old boy and feel very happy that I have met a friend whom I like very much. We play football and go to the cinema together. Some days ago I discovered that he is using a drug called Ecstasy. I am terrified about this finding because I have heard that this drug could have serious consequences on health. I am not easily led to do things I don't approve of. I certainly know that I would never use any drugs. My worry is that if my parents find out about what my friend is involved in, they will not permit me to be friends with him any more.

What can I do to ensure that nobody knows what my friend is doing and how can I help him stop using the drug? I really do not want to lose him as a friend.

LETTER 5

Dear Dr (please insert a local name),

I am a very unhappy 18-year old girl. I had an affair with a boy of my age a year ago. We were so much in love that we even had sex on several occasions. After discovering that I was pregnant, my boyfriend deserted me. I went ahead and terminated the pregnancy with the help of a girlfriend. Apart from my ex-boyfriend and my girlfriend, nobody knows what I did.

However, I feel very guilty about what I have done. I do not seem able to forget it. This is affecting the way I deal with people. I do not want to be with people as I feel that they can see through me.

What must I do to get on with my life without carrying this heavy burden?

LETTER 6

Dear Dr (please insert a local name),

We are two brothers who need your help about a terrible family problem. Our father is an alcoholic and drinks daily. Each time he comes home drunk he picks a fight with mother and beats her up badly. This has been going on for a long time. We can no longer bear to see our mother suffering like this. We are also afraid that he could kill her.

We have thought about leaving them but are anxious that something could happen to us as we do not know of a place to go to and find some peace. Our parents would kill us if they found out that we are writing to you about our problems.

Where can we go to without our parents knowing our whereabouts?

LETTER 7

Dear Dr (please insert local name),

I am in tears as I write this letter. My father decided that I should quit school and be married to his 40-year old rich cousin who already has two wives and children older than me. I am used to calling him uncle, so how can I marry him? My father says he is rich and will take good care of me.

I love school and am doing really well, my teacher says. I want to go to university and become a teacher. No one at home, not even my mother would listen to my begging and crying. I am still young; I don't want to get married now. Maybe the best thing to do is to kill myself.

Can you help me?

LETTER 8

Dear Dr (please insert a local name),

I'm so very scared that I am writing to ask for your help. Our neighbour offered to give me a ride home from school a week ago. You know how far it is as it was your school as well. I thanked him and got into the car. He was very nice to me, gave me sweets and told me that I had turned into a beautiful young woman. He then took the back roads because they were nicer, he said. He then drove into the forest and started kissing me and ripped off my clothes. I begged him to stop and tried to get away, but he was very strong. He hurt me and raped me. He told me that he would kill me and hurt my little brother if I told anyone. He demands that we get together again. Last month in school we had a talk about AIDS and I think I may have got the disease. My poor mother works so hard and I'm afraid to tell her. I feel so guilty and I am in pain.

I don't know what to do. Can you help me?