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# **PROGRAMMING FOR ADOLESCENT HEALTH AND DEVELOPMENT**

Report of a WHO/UNFPA/UNICEF Study Group  
on Programming for Adolescent Health



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Saillon, Switzerland, 28 November – 4 December 1995

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## 1. Introduction

A WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health met in Saillon, Switzerland from 28 November to 4 December 1995. The Study Group met to bring together the best information available on programming, in order to strengthen systematic action in all regions of the world.

Adolescent<sup>1</sup> health no longer requires justification. More than half the world's population is below 25, with four out of five young people living in developing countries. Changing conditions are bringing about changes in behaviour and countries have recognized that behaviour formed in the second decade of life has lasting implications for individual and public health. The multiplicity of health problems associated with specific types of behaviour include the consequences of unprotected sex, which increases the risks of early and unwanted pregnancy and childbirth, unsafe abortion and sexually transmitted diseases such as infection with the human immunodeficiency virus (HIV); problems associated with the use of tobacco, alcohol and other substances that impair judgement and increase the risk of cancers, cardiovascular and respiratory diseases; accidental and intentional injury; malnutrition and problems related to oral hygiene; as well as endemic diseases. A steadily rising number of countries are allocating resources to adolescent health and development through a variety of sectors.

Admittedly, no institution, private or public, can singlehandedly promote adolescent health and development. There is need for cooperation, to create the environment that will enable all young people to maximize their potential. In this context, WHO, UNFPA and UNICEF have a goal in common: to ensure that adolescents are able to acquire the information, build the skills, obtain the health services and live in the supportive environment they need for their health and development. The cooperation exemplified by the convening of the joint Study Group is vital to the achievement of this goal.

The purpose of the Study Group was to provide the technical rationale and basis for the action required for the health and development of adolescents. The growing interest in meeting adolescent health needs, preventing health problems and providing care and treatment has been manifest in many new projects. What has often been absent, however, is systematically collected and sound information about

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<sup>1</sup> WHO considers "adolescence" as the period between 10 and 19 years. "Youth" is defined by the United Nations as 15–24 years and the term "young people" refers to the composite age group 10–24 years.

effective programming and about the best ways to establish and sustain programmatic approaches. Thus, WHO, UNFPA and UNICEF sought to pave the way for the overall formulation of policy on adolescent health and development, and on a programmatic approach at country level.

Drawing on the experience of WHO, UNFPA and UNICEF, and on that of other United Nations agencies, nongovernmental organizations and the scientific and professional community, the Study Group sought to consolidate knowledge about programming for adolescent health and development, in order to strengthen programming at country level and maximize its coverage and impact.

The Study Group reviewed current experiences, especially in developing countries, as well as the scientific evidence concerning the effectiveness of major interventions for adolescent health. A “framework for country programming” (1) (see Fig. 1) was developed. It highlights the essential elements and strategies needed to establish, implement and sustain programmes for adolescent health and development. The Study Group recommended a common agenda of actions to accelerate and strengthen programming for adolescent health, including the global and regional support needed for country-level programming (see sections 11 and 12).

This report is a synthesis of the material and expert opinions presented to the Study Group and is organized according to the components of the “framework for country programming”. Each component is dealt with more fully in its corresponding section.

## **2. Goals of programming**

### **2.1 Background**

Today, approximately one-fifth of the world's population are adolescents (10–19 years of age), with more than four-fifths in developing countries. When young people strive to fulfil their physical, intellectual, emotional, spiritual, social and artistic potential, they contribute enormously to societal progress. To a large degree future economic development depends upon having increasing proportions of the population that are reasonably well educated, healthy, and economically productive. The kind of adolescence people have has a far-reaching effect on them and their society. The fate of young people depends upon them, their environment and the support and opportunities adults provide them. What, then, should society do to provide greater support for the health and development of its young people?



Figure 1

**Framework for country programming for adolescent health**

Key players: family, friends, religious leaders, teachers, health workers, employers, youth workers, social workers, police, sports figures, musicians, movie and TV stars, journalists, politicians, law makers.

**Challenges**

**Building political commitment**

- \* *"young people are healthy"*
  - but behaviours starting during adolescence are crucial to current and future health
- \* *"the issues are too sensitive"*
  - but the stakes are too high to ignore and there are those able to act
- \* *"young people make economic and political demands"*
  - they are also a great resource for social and economic progress
- \* *"there's no money"*
  - much can be done with better use of existing resources

**Intervention Settings**

- \* home
- \* school
- \* health centre
- \* workplace
- \* street
- \* community organization
- \* residential centre
- \* media/entertainment
- \* political and legislative systems

**Challenges**

**Identifying**

**priorities for action**

- \* collect and analyse data by age and sex
- \* compile data from different sectors
- \* involve young people systematically
- \* determine target groups

Key health problems: *unwanted, unsafe pregnancy; maternal mortality and morbidity; infant mortality, abortion, sexually transmitted diseases, HIV, reproductive tract infections; cancers; homicide; suicide; injuries; disabilities; anaemia; obesity; dental caries; tuberculosis; malaria; schistosomiasis; intestinal helminths.*

**Guiding Concepts**

- \* adolescence — a time of opportunity and risk
- \* not all youth are equally vulnerable
- \* adolescent development underlies prevention of health problems
- \* problems have common roots and are interrelated
- \* social environment influences adolescent behaviour
- \* gender considerations are fundamental

**Programming**

- to promote healthy development to meet needs and build competencies
- to prevent and respond to health problems from
- \* Safety \*Belonging
  - \* Self-esteem
  - \* Caring relationships
  - \* Physical e.g. eating habits
  - \* Psychological e.g. empathy
  - \* Social e.g. communication
  - \* Moral e.g. personal responsibility
  - \* Vocational e.g. entrepreneurial skills
  - \* Early, unprotected unwanted sex
  - \* Use of tobacco and other substances
  - \* Accidents
  - \* Violence
  - \* Poor nutrition
  - \* Epidemic diseases

**Major Interventions**

- \* create safe and supportive environment
- \* provide information
- \* build skills
- \* provide counselling
- \* improve health services

**Keys to Success**

- \* put youth at the centre
- \* address multiple health problems
- \* build on and link existing interventions in various settings
- \* combine interventions
- \* respect cultural diversity
- \* strengthen programme management
- \* encourage positive adult attitudes and behaviours

**Challenges**

**Maintaining implementation**

- \* foster adult-youth partnerships
- \* reorient and sustain existing interventions through training
- \* coordinate activities in multiple settings
- \* continually recruit young people as human resources
- \* achieve large-scale programming

**Challenges**

**Monitoring and evaluation**

- \* establish and use indicators
- \* track quality and coverage in multiple settings
- \* understand the impact of youth participation throughout programming

Human development is a highly complex, little understood process and a subject of much debate. It is clear, however, that human growth and development are profoundly influenced by the environment, particularly during the formative periods of infancy and adolescence. Societal efforts to improve particular aspects of the world in which young people live, learn, work and play will, therefore, greatly benefit individuals and society at large.

The environment encompasses basic prerequisites for health. As presented in the Ottawa Charter for Health Promotion (see Annex 1), they are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. While these conditions exist in varying degrees in different locations, they are far from universal. The Convention on the Rights of the Child (Annex 2) has provided an international framework which outlines the basic conditions, rights, and protection to which *all* adolescents are entitled. This framework is a critical first step which must be followed by sustained national and local action to ensure that basic rights (including the prerequisites for health) are met.

Although governments, the people and organizations concerned with adolescent health should all participate in improving fundamental conditions, this will not be the primary task of programming for adolescent health and development. However, some aspects of the environment fall under the purview of programming. Interventions that address such aspects of the social environment to enhance the health of adolescents are an essential part of national and local programming efforts. These interventions (see section 4.2) will influence individual and societal values and norms.

Improving the conditions which promote adolescent health requires a collective and sustained effort from governments, communities, organizations, and families. Certain aspects of the environment such as economic conditions, war, natural disasters, and violence are beyond the control of individuals and families. But the immediate needs of infants and young children for love, food, shelter, safety, learning to think and act, and moral guidance are usually met first by the family. Their development is enhanced by the support of peers and neighbours; involvement in community activities, education and work; and health care, housing, and social services. During adolescence influences outside the family become increasingly important, and programming must take all this into consideration.

A healthy environment providing both support and opportunities for young people is necessary but not sufficient for their healthy

development. Health-enhancing behaviour is primarily the responsibility of young people themselves, who must increasingly take and effect decisions with major health consequences for the present and future. Young people often have little understanding of their own maturation, are unprepared for new relationships, and are unaware of health services available to them. But information is only half of the equation. Young people must ultimately use the information positively. Young people who have developed personal competence, social maturity, and a sense of identity and self-esteem are much more likely to make decisions which will positively affect their health and development (4). Broadly speaking, the success or failure of programming for the health and development of young people will depend upon two inextricably linked and overarching goals, namely to promote healthy development and to prevent and respond to health problems.

## 2.2 Promoting healthy development

The second decade of life is a period of rapid growth and personal development without which individuals cannot acquire the competence needed to adapt to a diverse and changing world. Generally, competence develops whenever there are opportunities to practise certain skills by understanding and using social conventions. The ability to solve problems and anticipate the outcome of one's choices helps to develop a positive sense of self-efficacy and self-worth.

Some characteristics of adolescence, such as stages of physical growth and development, appear to be universal. Others, such as vulnerability and resilience, depend on the interaction of the adolescent with his or her environment. The social environment can, thus, provide and present hazards to health and obstacles to development. Given the various factors such as the individual, family and community that influence the advancement of adolescent health and development, multifaceted adolescent health programmes stand a good chance of succeeding.

Health policies and legislation can consolidate or limit healthy development. Over the last decade, health policies and legislation have focused on the prevention of problems through a three-tier approach to:

- help the ill or injured;
- modify the beliefs, attitudes, behaviour and environment of those at risk;

- promote a positive approach to the health and development of all young people.

Most of the emphasis has been on the prevention of specific health problems of adolescents such as substance abuse, HIV and the acquired immunodeficiency syndrome (AIDS). While this has merits and has brought legitimacy to the idea of prevention, it is not enough. When policies and services focus on prevention, they are limited to addressing problems, and success is equated with lack of problems like violence, delinquency, drug use, unwanted pregnancy, sexually transmitted diseases (STDs) including HIV/AIDS. There is documented evidence that prevention alone is an inadequate goal. People are not judged in terms of problems (or lack thereof) but of their potential (4). An account of the activities of Service Volunteered for All (SERVOL), an organization based in Trinidad and Tobago, illustrates this.

The Adolescent Development Programme course is based on the Spiritual, Physical, Intellectual, Creative, Emotional and Social (SPICES) curriculum aimed at overall personal development. The activities seek to help adolescents overcome certain characteristics which SERVOL has detected in participants during its years of experience — low self-esteem, lack of self-discipline and self-confidence, and to fulfil their need for love, attention and security. This is achieved through guidance and discipline, in a loving atmosphere. Course participants are expected to observe strict rules which they have helped the staff to set over the years. In a nurturing environment, SERVOL nevertheless insists on punctuality, reliability, cleanliness, and discipline in all aspects of the adolescents' lives (5).

In the light of such holistic approaches, what are the goals for the healthy development of adolescents and how can results be evaluated? Including prevention in the health promotion and development policy requires broadening our definition of desired outcomes and expected competencies. The Carnegie Council on Adolescent Development has defined a generic set of abilities that goes beyond academic or cognitive competencies to include vocational, physical, emotional, civic, social, and cultural competence. While good benchmarks have been developed to measure academic achievement, we have not established developmental measures or defined the steps needed to acquire this fuller list of abilities. Shifting goals from problem prevention to the attainment of an array of skills will require a fairly dramatic shift in strategies.

Human growth and development are continuous processes that young people undergo as they strive to meet their basic need for security,

love and appreciation and to feel valued and useful. The processes, articulated as outcomes of adolescent development (6), can be summarized as follows:

- ***self-worth*** — the ability to contribute and to perceive one's contribution as meaningful; the perception that one is a "good person" and that one is valued by oneself and others;
- ***safety and structure*** — the perception that one is safe both physically and psychologically, in other words, access to adequate food, clothing, shelter, and security, including protection from hurt, injury, or loss. The existence of organized group structures in life can allow young people the freedom to experiment with behaviour and to test their social abilities, while providing limits;
- ***belonging and membership*** — being a participating member of a community; involved in at least one lasting relationship with another person; the perception that one is strongly attached to an institution, organization or community outside of family;
- ***intimate relationship*** — the perception that one is loved by kin, and fully appreciated by friends;
- ***mastery and future*** — the perception that one is accomplished and has abilities valued by oneself and others; awareness of one's progress in life;
- ***responsibility and autonomy*** — the perception that one has some control over daily events; one is a unique person with a past, present and future and roles to play;
- ***spirituality*** — connectedness to principles concerning families, cultural groups, communities and gods; an awareness of one's own personality or individuality.

To achieve these outcomes, young people should attempt to build the skills that will allow them to function within, and contribute to, the communities and societies in which they live. The goals of this process can be categorized as follows:

- ***physical health and development*** — using the knowledge, desire, and ability to develop and maintain a healthy and fulfilling lifestyle; acting in ways that best ensure current and future physical health, for oneself and others;
- ***intellectual development*** — learning in school and other settings to gain basic knowledge, numeracy, literacy; using critical thinking, creative problem-solving and expressive skills and conducting independent study;
- ***vocational health and employability*** — the mastery of skills and attitudes to identify opportunities for economic security, including

management of time and money, and dealing with other people in commercial relationships; understanding career options and the steps necessary to reach goals;

- **civic and social health** — collaborating with others for the greater good; the knowledge, motivation and ability to form and sustain friendships and relationships through communication, cooperation, empathizing, negotiation, patience; and taking initiative and responsibility for one's own conduct;
- **cultural health** — understanding and respecting one's culture;
- **emotional health** — acquiring the knowledge and ability to develop and maintain a personal sense of well-being; and understanding one's own emotions and adapting to changing situations;
- **moral development** — understanding and acting upon the distinctions between right and wrong.

The attainment of such goals is a natural part of adolescence. Verbal and numerical skills, and abstract thinking are expanded in school for those who attend, while most young people acquire new vocational and recreational skills. Of crucial importance for health, however, are the social skills needed for the new kinds of relationships formed during adolescence. Personal communication skills and the ability to assert thoughts, ideas, feelings and beliefs are essential. These are some of the key "life skills" defined by WHO (7) as "abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life".

There are six key aspects of the overall development process (8), namely:

- **ongoing** — it does not end with the termination of programmes and requires continuous input and support;
- **uneven** — it varies enormously both within and between individuals;
- **complex** — individual development is a process of physical, cognitive, social, emotional, and moral maturation; the associated tasks during adolescence are: to reach adult size, and develop comfort with adult functioning; to develop the ability for abstract thinking; the skills and perspectives to function independently of family and peer group; a sense of identity that can guide choices and help to process feelings; and basic values and perspectives that allow the individual to be ethical, just and compassionate;
- **influenced by the environment** — whether this is described in terms of physical attributes (safety or availability of essential facilities, for example) or in terms of the quality, quantity, and congruence of key services, supports and opportunities;

- ***mediated through relationships*** — young people's awareness of, access to, and appreciation of services, support and opportunities are negotiated through others (for example, peers, adults or professionals) who can act as guides and brokers;
- ***triggered and sustained through participation*** — personal growth and development occur when the young person is actively engaged, and thus the tasks and opportunities have to be relevant and appropriately challenging.

Although the recognition that adolescence is a crucial period for acquiring skills and developing positive personal attributes is not new, the acknowledgement of such development as a key predictor of future health is recent. Programmes that focus on skills training, for example, foster the development of young people and are now rapidly gaining ground (see section 4.4). While such concepts in adolescent development allow us to identify fundamental needs, they do not make it any easier to define universal development indicators, primarily because the development of adolescents does not occur independently of the environment in which they live. Social and global upheaval undermines the development of young people and creates new patterns of risk and risk-taking which affect the health status.

### 2.3 Preventing and responding to health problems

Generations of the stable social conditions common in rural societies make for a short adolescence with distinct roles for boys and girls, few choices for them and a predictable future. In such societies young people emulate their elders and benefit from the guidance of adults who grew up in a similar world. However, with rapid social changes, as is generally the case today, uncertainty increases. The contemporary world presents immense opportunities and hazards. One feature of modern society is the rapidity with which people, ideas and images move across cultures, including the rural to urban transition.<sup>1</sup> This can threaten adults' value systems, authority and knowledge. Yet, such increase in communication provides access to information and ideas that can be of value. Meanwhile, the shift of economic control from the public to private sector accentuates a competitive rather than cooperative model of society, and this may also threaten traditional values. Global communication also changes aspirations, and many young people are disadvantaged by the increasing gaps between the rich and the poor of North and South and within countries. This

<sup>1</sup> Between 1970 and 2025 the urban adolescent population in developing countries will grow by 600% (9).

situation is aggravated by rapid population growth in countries least equipped to meet the new challenges.

Such upheaval is accompanied by changing trends in adolescent behaviour and consequently in health status. While new technology and improved standards of living in many societies offer potential for the development of young people, other changes increase the risks to their health, often by influencing their behaviour. Decreasing family influence, earlier puberty and later marriage extend the risks of unprotected sex among unmarried adolescents in some parts of the world. In others a large proportion of first marriages and first births continue to occur among adolescent women. Rapid urbanization, widespread telecommunications, greater access to (and pressure to use) potentially harmful substances, and increased travel, tourism, migration, refugee populations and homelessness are changing society, but their effects on the behaviour of young people remain unpredictable. Inequity between the sexes makes adolescent girls particularly vulnerable to problems arising from these changing conditions.

On the basis of mortality rates alone, adolescence was previously considered one of the healthiest periods in human life. However, there is growing recognition of the wide-ranging health problems faced by adolescents because of a combination of biological, psychological and social factors. Table 1 illustrates the global magnitude of a wide range of health problems that frequently combine to severely limit healthy development. For each broad category, it is possible to identify not only specific behavioural risks (to which the concept of "risk-taking" applies) but also risks which arise simply as a result of the young person being in a particular environment. Risk is therefore not restricted to behaviour. Measures aimed at reducing both types of risk can significantly lower the current high rates of associated mortality and morbidity.

Concerning the nature and scope of these problems, their effects on adolescents and the way to manage them, several points deserve mention:

- Certain health problems are more prevalent in adolescents than in children or adults. These include health problems resulting from early, unprotected and unwanted sexual activity; substance use and abuse; injuries from accidents and violence; health problems associated with overnutrition and undernutrition; and some endemic diseases. Some of these health problems are closely interrelated (such as multiple drug use and depressive states; alcohol use and injuries from traffic accidents; undernutrition and complications in



Table 1

## Challenges to adolescent health and development

### Adolescents in the world today

- In the least developed countries, only 13% of the girls and 22% of the boys enroll for secondary education (10).
- Globally, 5 out of every 10 unemployed are young people; in some developing countries it is 8 out of 10 (11).
- Seventy-three million adolescents between the ages of 10 and 14 are working worldwide. UNICEF and ILO are jointly involved in combating child labour (12).

### Nutrition and noncommunicable diseases

- Undernourishment and overnourishment in young people are increasing problems in both developing and developed countries (13).
- Adolescent girls are often last to be given food, even when pregnancy increases their needs (14).
- Adolescent iron needs, increased by growth, development and menstruation, are being aggravated by malaria, hookworm and schistosomiasis which affect young people disproportionately (15).

### Reproductive health and sexuality

Unprotected sexual relations increase risks of unwanted pregnancy and early childbirth, unsafe abortion and STDs including HIV resulting in AIDS (16).

- Lack of knowledge, skills, and access to contraception; and vulnerability to sexual abuse put adolescents at highest risk of unwanted pregnancy (15).
- In developing countries, maternal mortality in girls under 18 is two to five times higher than in women between 18 and 25 (17, 18).
- Globally, more than 10% of all births are to women 15 to 19 years old (19).
- In sub-Saharan Africa, the majority of first births are to adolescent women (20).
- Adolescent abortions are estimated at between 1 million and 4.4 million per year, and most are unsafe because they are performed illegally and under hazardous circumstances by unskilled practitioners (21).
- Each year more than one out of 20 adolescents contracts a curable STD, excluding viral infections (22).
- Of the estimated 333 million new STDs that occur in the world every year, at least 111 million occur in young people under 25 (23).
- Globally, more than half of all new HIV infections are among 15–24-year-olds (24).

### Substance misuse

- If tobacco use begins at all, it usually begins in adolescence; few people begin after 18 (25).
- Half of regular smokers who start in adolescence and smoke all their lives will eventually be killed by tobacco (26).
- Alcohol is the most common element in substance related deaths of young people (27).
- Illicit drug use is becoming more widespread and is shifting to riskier patterns of use (27).
- Harmful substance use will increase cancers, cardiovascular and respiratory diseases in later life (28).

### Unintentional and intentional injury

- Unintentional injury is the leading cause of death among young people, especially traffic accidents among boys (27).
- Suicide in young people is increasing and is a major cause of death, especially of adolescent males (27).
- Interpersonal violence is increasing among young people, with girls especially victimized (27).

pregnancy and childbirth). This is discussed in greater detail in section 3.3. Table 2 contains a listing of health problems and unhealthy behaviour that significantly affect public health in the short and long terms. One clear indication of the burden of morbidity and mortality is provided by calculating so-called “disability adjusted life years” (DALYs) — a concept illustrated in Box 1.

- Certain risk factors for health problems are peculiar to adolescents, although there are risk factors common to both adolescents and adults. For example, adolescents may engage in sexual activity before they are fully aware of the long-term consequences of their actions, the need for protection against STDs or of the availability of reproductive health services.
- Some health problems may have more serious consequences for adolescents than adults; early childbirth is a case in point. Female adolescents’ pelvic bones continue to grow for several years after growth in height has been completed. If pelvic growth is not completed before childbirth, there is an increased chance of obstructed labour and vesicovaginal fistulae.

Table 2  
**A classification of the health problems and health-related behaviour of young people in developing countries, with illustrative examples (25)**

Diseases particular to young people	Diseases and unhealthy behaviour which affect young people disproportionately	Diseases which manifest themselves primarily in young people, but originate in childhood	Diseases and unhealthy behaviour of young people, whose major implications are on the young person’s future health	Diseases which affect young people less than children, but more than older adults
*Disorders of secondary sexual development *Difficulties with psychosocial development *Suboptimal adolescent growth spurt	*Maternal mortality & morbidity *STDs (including HIV) *Tuberculosis *Schistosomiasis *Intestinal helminths *Mental disorders  <b>Behaviour:</b> *Alcohol abuse *Other substance abuse *Injuries	*Chagas disease *Rheumatic heart disease *Polio	*STDs (including HIV) *Leprosy *Dental disease  <b>Behaviour:</b> *Tobacco use *Poor diet *Lack of exercise *Unsafe sexual practices	*Malnutrition *Malaria *Gastroenteritis *Acute respiratory infections

NB Young people account for a substantial number of cases because they form a large proportion of the population in most developing countries.

**Box 1****Estimates of the burden of disease among young people**

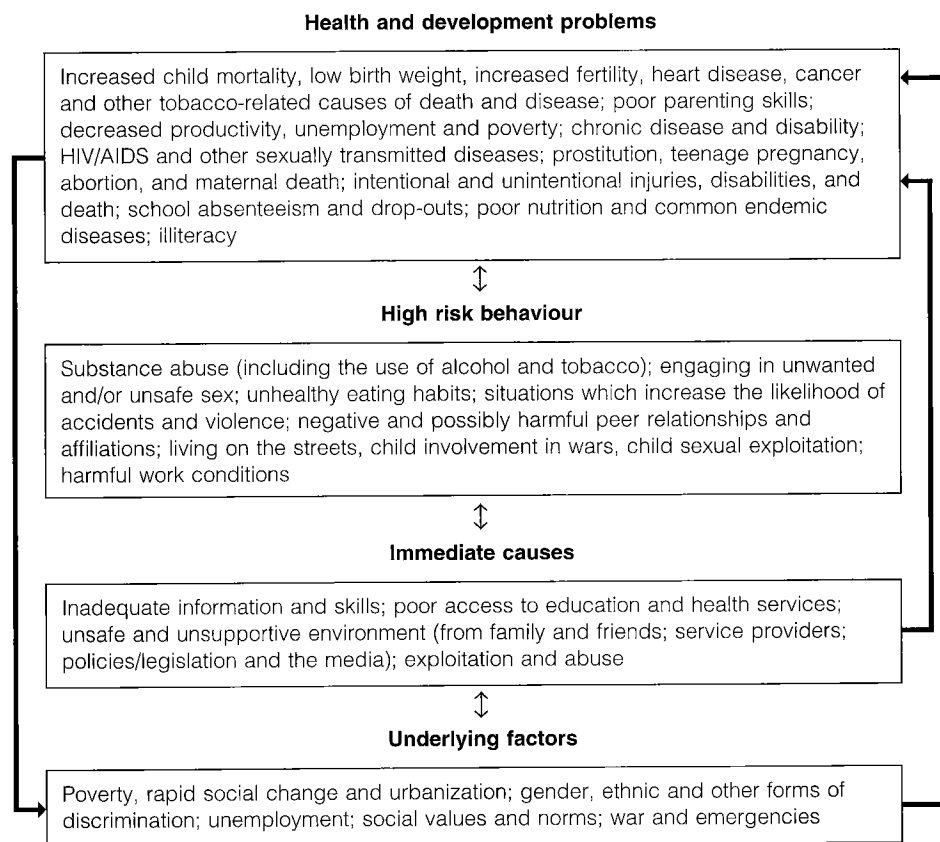
The “Disability Adjusted Life Year” (DALY) is a measure used to quantify burden: it is a time-based measure which captures the impact of premature death (in years) and time (in years) lived with a disability. One DALY is one lost year of healthy life. A recalculation of the *Global Burden of Disease* estimates among adolescents, youth and young people (29) gave the following findings:

- The burden of disease and injury between the ages of 10 and 24 represents 15% of the total burden worldwide.
- Ninety percent of the DALYs are lost in developing countries.
- Forty-two percent of DALYs result from noncommunicable diseases, 29% from injuries and 29% from communicable, maternal, perinatal and nutritional conditions.
- The DALY distribution for adolescents and youths is very different from the pattern observed in children or adults, with STD, HIV and 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 for suicide) tend to be twice as high among males as among females.
- The exception to this are the extreme suicide rates in females in China and India which are higher than those among boys.

- There are health problems which need to be dealt with differently in adolescents than in adults and children — clearly, the traditional approach to preventing and managing the health problems of adults is not always effective in dealing with those of adolescents. The cyclical and complex ways in which the different levels of causation correlate are illustrated in Figure 2 (30). Early education programmes for the prevention of smoking sought to inform about the long-term health problems of smoking. The programmes often used scare tactics, futilely relying on the theory that fear of consequences would deter adolescents from smoking. More successful programmes now focus on the developmental needs of adolescents. They emphasize the short-term physical and social consequences of smoking (such as the disagreeable odour on clothes and on the breath, stains on the fingers and teeth, and reduced exercise and sports performance). In addition, they prepare adolescents to resist social and peer pressure by helping them strengthen their skills.

Adolescents are neither children nor adults, though they share some of the characteristics of both groups. Furthermore, they are not a

Figure 2  
Young people's health and development — levels of causation and impact



homogeneous group; their needs vary with their stages of development and life circumstances. These facts are not just of academic interest; they have tremendous public health implications.

Adolescents tend to view health problems very differently from the adults concerned about their welfare. For instance, although health care providers regard HIV/AIDS as a serious public health problem, adolescents do not always do so (even in parts of the world with high levels of HIV infection and HIV-related illnesses). On the other hand, acne which health care providers may consider trivial is considered a serious problem by adolescents of both sexes (31).

Adolescents with health problems do not always turn to health care providers and to health services for help. Depending on the problem and their perception of it, they seek help from various individuals and organizations around them. Their perception of what assistance they

can get from these individuals and organizations determines their reaction. A study using the narrative research method in 11 African countries shows, on the basis of young people's accounts concerning pregnancy testing, care or termination, that they did not consult health professionals. When presented with various options, the doctor or health services were the least likely option (32). There is need for concerted efforts to prevent the health problems referred to above, and respond to them if and when they arise. When programming for this, it is essential to be cognizant of the perceptions and tendencies of adolescents, and to tailor preventive and curative approaches to their special needs (see section 4).

Concerning the guiding concepts of programming for adolescent health and development, the twin goals set out in this section are interrelated and cannot meaningfully be treated in isolation. To programmatically address the issues of individual development of young people minimizes the emergence of specific health and behavioural problems. Conversely, the existence of specific health problems in the lives of young people will adversely affect their development, and undermine efforts to develop the competencies and skills they need to realize their full potential. Box 2 summarizes the need for programmes for young people to look beyond problem-reduction and towards broader approaches.

### **3. Guiding concepts**

#### **3.1 Background**

There are many facets of human development: the physical, emotional, intellectual, social, moral, spiritual, and aesthetic aspects. Adolescence is a time of very rapid, albeit uneven development. There are differences in the rate and degree to which each aspect of development takes place within the individual, and these differences exist between young people of the same age and sex, of different sexes, and from different sociocultural backgrounds. Development requires an active mind and body, and social interaction. For development to take place, it is essential that opportunities are provided for behaviour that contributes to it. A loving and supportive family and safe environment are more likely than not to foster positive adolescent development.

Adolescent health, like adolescent development, is a positive concept. It comprises physical, mental and social well-being and not merely the absence of disease or infirmity (WHO Constitution) and, like development, it is closely related to adolescent behaviour. However, many

**Box 2****Reducing problems is not enough**

Focusing on problem reduction as a goal leads to an emphasis on short-term, problem-focused services that are offered by institutions that “fix” rather than “interact” with young people and families. Equally important, the focus on problem reduction leads to, and in turn supports, an emphasis on fragmented funding and on accountability measures that fail to capture the full range of impact on adolescent development. Outcome simply becomes a measure of the quantity of services delivered, or of reported changes in the incidence of youth behaviour.

Focusing on problem reduction does not enhance the full potential of an individual. Employers presented with a young person who is not a school drop-out, not a parent, not taking drugs, not illiterate, not in a gang, not a criminal would not hire this individual on the spot. They would, however, interview the young person to assess skills, knowledge, attitudes, commitment. The absence of problems does not imply the presence of competence, commitment and confidence.

Time and again, when asked to list what they would like to see, parents, policy-makers and young people themselves talk about responsibility, self-esteem, ethics, commitment to community, cognitive skills, communication skills and problem-solving skills.

Though the twin goals outlined in this chapter of promoting healthy development while responding to and preventing health problems provide a much more meaningful approach than problem reduction, they are:

- more difficult to define — we lack a language for development that is as specific as the language used to understand problems
- more difficult to quantify — there are no measures to quantify developmental outcomes
- more difficult to justify — investing in development is sometimes seen as taking resources away from the primary concern (problems) or populations (vulnerable youth).

There is a need to expand the list of desirable outcomes of programming (not abandon the present, predominantly problem-focused list) to include outcomes that reflect knowledge, behaviour, skills (competencies/abilities) and those which reflect perceptions and personal assessments (culminating in confidence or a sense of identity). Such a shift in the conceptualization of the whole purpose of programming in adolescent health is a challenge indeed (8).

diseases and injuries are the result of an unsafe environment beyond the control of the adolescent. Health issues related to the young person's own behaviour include: the age at which sexual activity is initiated, and whether protection is used; eating habits; levels of

physical activity; and use of tobacco, alcohol and other psychoactive substances. Evidence shows that the health problems of adolescents are interrelated. That is because the factors which determine their health behaviour are also interrelated. Adolescents who have had the safety, support and opportunity to develop their physical, psychological, social, moral, spiritual, artistic or vocational potential are more likely to have the self-esteem, knowledge and skills to be healthy, and to behave in ways that avert life- or health-threatening problems.

### **3.2 Adolescent development underlies prevention of health problems**

The two overlapping goals of promoting healthy adolescent development and preventing and responding to health problems discussed in the previous section cannot be viewed as separate and distinct, but as inextricably linked to one another. While the public sector could focus more attention on the prevention of problems and not simply their solution, enhancing the overall development of adolescents helps not only to forestall problems but also to improve health and well-being. To encourage healthy behaviour among young people, it is important to provide adequately for their development needs. As stated below, recognition of the importance of overall adolescent development is vital to programming for adolescent health.

Communities engage in a very different set of activities when their goal is development rather than problem-prevention. Prevention concerns programmes and services while development concerns opportunities and support. Focusing only on prevention singles out high-risk groups, thereby dividing young people and reinforcing stereotypes. The promotion of development involves commitment to young people in general and acknowledges that differences in unmet needs and in family and community risks and assets dictate the use of a variety of strategies. When communities are challenged to focus on development, they develop long-term plans with their own adolescents in mind. When they focus on problem prevention, they develop programmes for other people's adolescents.

In fact, most programmes designed to "prevent" a specific problem do so primarily by promoting competencies that are at the heart of adolescent development. Moreover, many programmes are beginning to employ strategies to modify the social environment of adolescents, recognizing the inherent risk and protective factors in the environment. The process of development involves the changing relations between the adolescent and his or her context. Healthy development requires the meeting of basic needs and also the acquisition of the

competencies necessary to negotiate the social environment and take on adult roles. Resilience, a personal (and hence developmental) attribute that helps avert health and behavioural problems is an example. Research on resilience could help explain why certain children growing up in adverse environments encounter problems while others do not. Characteristics of the resilient child include (8):

- social skills;
- problem-solving skills;
- autonomy (sense of identity);
- sense of purpose and future.

Characteristics of the social environment that are conducive to the development of resilience include:

- warmth and support;
- high expectations;
- opportunities for meaningful involvement.

The development of resilience is linked with prevention. If we know what places an individual or group at risk of a certain negative outcome, and what protects them, then we should be able to enhance resilience and minimize risk. Programming that focuses on helping adolescents meet their basic personal needs and master key competencies for living strengthens their overall development and resilience, and ultimately contributes to the motivation and skills needed to make choices that enhance health. Adolescents with self-esteem, who have mastered essential skills, are better prepared to exploit educational, vocational and social opportunities, or to cope better than others with the lack of such opportunities.

Of course, many young people may, through their own life experiences, situations, and relationships develop resilience. One review suggests (33) that the development of resilience in adolescents has several features some of which contribute to positive outcomes in children exposed to psychosocial adversity. These features are identified in three broad areas as:

- autonomy, self-esteem, and a positive social orientation;
- family cohesion, warmth and harmony;
- external support systems that encourage and reinforce a child's coping efforts.

The challenge is to intensify programming efforts that foster resilience among adolescents.

Young people will seek ways to meet needs and build and use competencies whether or not these are socially acceptable. Given the link



between individual development and prevention of health problems, there is need for programming to assist identified key players (family, school and the community) help adolescents, particularly those deprived of care, support and opportunities.

In an analysis (34) of over 100 programmes in the United States on delinquency, preventing pregnancy, drug use, and dropping out of school, six common themes emerged as vital to successful outcomes, namely:

- skills building (social, communication, decision-making);
- participation (youth-led discussions, peer approaches);
- membership (within a group and through commitment to school, community, organization);
- norms and expectations (establishing new norms for behaviour that are sanctioned by the group);
- adult-youth relationships (reinforcing the relationship between adults and young people through new structures and training for adults);
- accurate information/services (providing problem-specific information and services and access to services).

Further evidence that development underlies the prevention of health problems was provided by one review of adolescent pregnancy prevention programmes (35) which noted that programmes focusing on youth development may markedly reduce adolescent pregnancy rates and seemed more successful than single-focus approaches.

The challenge is clear — programmers must think beyond information and service provision and focus on providing meaningful personal support and opportunity. Whereas services involve the people merely as recipients, support is more interactive and young people become partners. This is even more true of opportunities, which turn the people themselves into key actors.

### **3.3 Problems have common roots and are interrelated**

Research links common underlying causes to a range of behavioural and health problems, an assertion that has major programming implications.

Programming that aims to deal with underlying causes will benefit various aspects of adolescents' health. Because of the correlation between personal development and health status discussed in sections 2 and 3.2 above, such programming must focus upon healthy development by designing and using interventions which help meet young people's basic personal needs and build their competencies and, in addition, offer more focused programming (for example on

information, counselling or health-service provision), to further address specific behaviour and health problems as needed.

A clear example of this would be programming which addresses self-esteem and the mastery of assertiveness skills, in conjunction with an HIV/AIDS information campaign, and concurrently offers the opportunity to practise assertiveness skills through role-playing. The same basic self-esteem and assertiveness skills will also help to address the desire to use drugs, or improve the ability to resist pressure to use them. In parallel, health education programmes on substance use may adopt other interventions to address a particular risk in a given location. In such ways, programming to enhance programmes and more specific interventions can complement and strengthen each other.

Problem behaviour theory identifies several common determinants of diverse behaviour which underlies the health problems that typically concern the public. Hence, interventions should be directed at the common determinants of the set of problem behaviours rather than at the separate manifest behaviour. Interventions that focus only on the specific behaviour, like drug use or sexual activity, are less effective because they do not address the antecedents or determinants of the behaviour (34).

Recognition that specific attention to one problem will also help to reduce problems in another area is a concept that can be used to guide programming. Examples here include some familiar correlations — unprotected sex increases the risk of both unwanted pregnancy and infection with STDs (including HIV/AIDS); intravenous drug use can also spread HIV; alcohol and other drug abuse can lead to increased accidents and violence, including homicides.

The concept that certain problems have common causes has been validated by findings in a recent study in Cape Town, South Africa, showing that risky types of behaviour involving sexuality, smoking, alcohol and drug use, and suicide are strongly related (36). In the juvenile justice sector, work with persistent offenders has identified a “constellation” of personal and social factors which appear to contribute to their criminal behaviour. The factors include breakdown in family relations, high levels of abuse and neglect, learning difficulties and school failure, poor skills development, deterioration in self-esteem, abuse of alcohol and other drugs (37).

#### **3.4 Adolescence is a time of opportunity and risk**

Adolescence is not simply extended childhood. When the child becomes an adolescent, major physical and psychosocial changes occur.

Puberty especially modifies the reproductive system, the sexual response system, and the way young people perceive themselves and are perceived by others. The body changes in size and stamina and in ways which sharpen the differences between the sexes; the capacity for abstract thinking and empathy comes to the fore; and new social relationships develop among young people, and between young people and adults — within and beyond the family. These new developmental capacities give rise to new behaviour, which will vary not only by the sex and level of physical, psychological and social maturity of the individual, but also with the social, cultural, political, physical and economic environment in which the adolescent lives.

As influences outside the family begin to take on greater importance, the decisions that young people take and the relationships they form increasingly determine their physical and psychosocial health and development. What they do at this time will affect them throughout their lives, and will have an impact on their offspring. Adolescence is a time for natural experimentation, abstract thought contemplating the future, empathy and idealism. It is also a time of increasing self-consciousness (and sometimes decreasing self-esteem); a time of self-criticism and the questioning of others. A time of burgeoning sexual feelings and impulses, combined with the beginning of the capacity to reproduce. A time when new skills and knowledge are needed for positive relationships with others, and to begin life in the workplace. A time to enjoy life before the responsibilities of adulthood begin, in ways which do not threaten their health and well-being.

The recognition of adolescence as an essential formative stage of life has implications for programming content and approaches. Young people have to be treated as persons in their own right, and their individual needs considered on a case-to-case basis. The realization that this is a time of significant opportunities and risks highlights the urgency to deal directly with sensitive topics such as sex and drugs, and to deal with the related behaviour openly. Because this is such a crucial stage, young people also need to be encouraged to use their energy and creativity towards positive health choices — again partly because they will encounter risks. To be effective, programming approaches must be attractive to young people and must address their psychosocial needs. Service must be provided by appropriately trained service providers. Underlying all this, however, must be the recognition that adolescence represents a real opportunity to make a difference in life-long patterns, at a key developmental stage when choices and behaviour patterns are being determined.

Unfortunately young people are often considered irresponsible, which reduces their self-esteem, hurts their relationships, and blocks their access to sound information, knowledge, skills, employment and services. Many adolescents encounter serious problems from which they never fully recover. An increasing number of young people are becoming victims of violence, or turning to violence (especially males) either against themselves by attempting suicide or against others. Yet many kinds of action, especially to promote development and prevent health problems, are potentially low cost and high return — a sound investment for which the case must be compellingly made. A better understanding of adolescent needs and their potential, along with the principles of effective intervention, disseminated at all levels of society in each culture, and drawn from each culture, can have a powerful influence in developing positive action and fulfilling the enormous potential that the health and development of young people represents both for themselves and for the future of their societies.

### 3.5 **Social environment influences adolescent health**

Although as we have already stated, there are major environmental factors over which health programmers and others working with young people have little or no influence, this does not mean that there are no aspects of the environment in which young people grow up that cannot be radically improved or usefully harnessed to enhance adolescent health and development. In particular, the “social environment” offers great opportunities for improving the health and well-being of young people.

The key areas in the social environment of young people which need to be considered by programmers can be summarized as follows:

- policies or lack thereof;
- social attitudes and norms (including religious and cultural beliefs);
- relationships with family, friends, and other adults.

An illustration of the types of issues which need to be considered with regard to family and other relationships is provided by an extensive study of American adolescents (38). According to this study, adolescents who have strong emotional attachment to their parents and teachers are far less likely to use drugs and alcohol, attempt suicide, engage in violence or become sexually active at an early age. The study concludes that love, understanding and parental attention help adolescents to avoid high-risk activities, both in one-parent and two-parent households. These factors are more important than the

amount of time parents spend with their children. At school, positive relationships with teachers were found to be more important in protecting adolescents than any other factor, including classroom size or the amount of training a teacher has.

Such findings confirm what other studies have shown — family relationships are critical in supporting healthy adolescent development. As the study has noted: “Many people think of adolescence as a stage where there is so much peer influence that parents become both irrelevant and powerless. It is not so that parents are not important. Parents are just as important to adolescents as they are to smaller children.”

In its examination of schools, the study looked at attendance rates, parent involvement, dropout rates, teacher training, whether schools were public or private and whether teenagers felt close to their teachers and if they perceived other students as prejudiced. But only one of those (whether students felt close to their teachers) made a difference in helping teenagers avoid unhealthy behaviour, confirming the overriding importance of the human interaction. Thus, the development and health of an adolescent is dependent not only upon the individual, but also upon the social environment that informs the decision-making process. The overall aim of adolescent programmes must be to produce well-informed, skilled young people who are motivated to make healthy choices, through an environment that encourages and facilitates these choices, and provides key services, opportunities, and interpersonal support.

### **3.6 Not all young people are equally vulnerable**

While certain characteristics and developmental needs are peculiar to all adolescents, some groups within the adolescent population have specific needs and/or vulnerability. In order to provide equitable opportunities and services to adolescents, there is need to make focused efforts to reach the very vulnerable and disadvantaged to ensure that their problems are understood and their needs met. The differences within adolescent population groups may be due to environmental factors and/or individual characteristics.

The environmental factors that make adolescents vulnerable or place them at special disadvantage are partly attributable to unsuccessful or inequitable development processes, or processes disrupted by war or by major pandemics (such as HIV/AIDS). Some of the underlying causes include the social impact of economic crises and the destabilization of social structures.

For the purposes of assessment and consequent design of appropriate interventions, it may be necessary to categorize the circumstances in

which some adolescents live, even though this can lead to the highly negative labelling of some young people. These circumstances include:

- temporary or permanent loss of family and/or primary caregivers;
- sexual abuse or exploitation;
- disability;
- warfare and other emergencies;
- addiction;
- extreme poverty, especially when this leads to work in hazardous situations.

In terms of operation, programming for adolescent health and development focuses on the needs of all young people by maintaining and strengthening their development, and enhancing prevention. Special efforts, however, may be necessary to reach vulnerable adolescents.

Thus, specific preventive strategies are needed to protect some adolescents from further marginalization, as exemplified by the 35 000 schools run by the BRAC programme in Bangladesh to provide basic education to very poor children who might otherwise be left out of the school system altogether — especially adolescent girls. For adolescents already in very difficult circumstances such as war, compensatory strategies will be needed to help them cope with the damage suffered. However, for adolescents who have suffered other trauma, such as sexual abuse and addiction, rehabilitation will be necessary. It should include appropriate institutional and alternative care arrangements (foster families for children orphaned by warfare and AIDS, community-based rehabilitation for adolescents with disabilities). These adolescents, like their less vulnerable peers, still require support for their basic health and development needs.

However, as one recommendation based on experience with demobilized child soldiers in Mozambique states:

“the special needs of potentially vulnerable groups, including youth, women and the disabled, should be carefully considered. The underlying objective of targeted programmes should be to include these groups in mainstream activities where possible” (39).

In order to deliver programmes which address the needs of all young people, careful assessment is needed to better understand the full range of adolescent needs and situations in their country or local area — a subject dealt with more fully in section 8. The types of intervention, particular settings, and approaches to be used will differ for diverse types of adolescent population.

### 3.7 Gender considerations are fundamental

The marked differences between the sexes which accompany adolescence have profound implications for health and development. In developing countries, girls generally have less opportunity than boys. Early marriage for adolescent girls in some societies often curtails education and economic opportunities. Adolescent females and males develop at different rates, and are generally treated differently by each other and by adults, behave differently and have different relationships, whether culturally or otherwise determined, and are unequally vulnerable to health problems because of both biological and psychosocial factors. Differences between the sexes are, however, often stereotyped, and the perceived pressure to conform can be devastating to the young person who is atypical, or believes himself or herself to be so.

“I have seen that in my society, discrimination begins from the first moment after birth. For instance, I have observed that in the countryside, and in some households in the city, if a boy is born, there is general rejoicing, whereas if a girl is born, gloom descends on the house. It is strange that this sadness is felt not only by the husband, but also by the wife, and that she feels ashamed before the world” (40).

Gender is the social construction of biological sex differences. Gender defines women’s and men’s experiences, roles, and responsibilities as individuals and determines how men and women relate to each other. Like class, race, and ethnicity, gender concerns social stratification and therefore must feature in the design and implementation of programmes that seek to meet the needs of all members of a given population. And like class, race, and ethnicity, gender can greatly affect an individual’s access to essential economic resources and social services.

Because adolescent health programmes seek to reach both boys and girls, they must acknowledge and address gender differences in order to be effective. While the specific differences may vary from one society to another, the concept of differences between the genders is universal and reflected in the division of labour in most societies — namely, the division between productive and reproductive activities. Productive activities generate income while reproductive activities are the usually unpaid work involving child care, food preparation, health care, and the collection of fuel and water. In most societies, women generally bear the responsibility of reproductive activities and conduct productive tasks, while men are primarily engaged in productive activities. More important than the division of labour itself is the

higher value that societies place on paid work as compared to unpaid work, which tips the balance of power between men and women, with men having greater access to vital productive resources and a higher social status.

The gender inequities and differences that characterize social and economic life are reflected in the socialization of adolescents and influence their health and development. Differences in domestic roles ascribed to girls and boys affect their ability to communicate, make decisions, and seek information and services throughout their lives (41). Boys, for example, may be consulted by their parents when important family decisions are made, while the same may not be true for girls. Such discrepancies can translate into greater independence, mobility, spare time, and time spent away from the household for boys, and insecurity among girls.

In reproductive health, for example, these differences in socialization and the power imbalance between the sexes heighten young women's vulnerability to negative health consequences. Data from the International Center for Research on Women's (ICRW) Women and AIDS Research Program, which supported studies on sexuality and susceptibility to HIV in 13 countries throughout the world, showed that lack of economic independence limits young women's ability to leave relationships that they consider risky and predisposes them to exchange sex for economic gain (42). The findings also showed that sociocultural norms that promote virginity in girls underlie girls' ignorance about their bodies, and compromise their adoption of safer sex options and use of reproductive health services for fear of being stigmatized as sexually active. Findings from the programme also showed that sociocultural norms in many societies increase adolescent boys' risk of infection by condoning and even encouraging early sexual activity for boys and multiple sexual partners for men.

The most extreme, and unfortunately common, consequence of the power imbalance between the sexes is women's experience of sexual coercion and violence. Data show that for many adolescent girls the first sexual experience is coercive and that physical abuse and violence are a significant part of young women's sexual lives. One epidemiological survey of adolescent sexual assault (43) showed that in many countries, female adolescents represent a large proportion of those assaulted (Table 3).

While girls generally associate violence with sexual experiences, boys, who are often socialized to be aggressive, independent, and all-powerful, typically associate violence with street crime and fights. In Latin America, North America, and the Caribbean, young men's



Table 3  
**Statistics on sex crimes (43)**

Country	Victims aged 15 or less (%)	Victims aged 10 or less (%)
Chile (Santiago)	58	32
Malaysia	58	18
Mexico (City)	36	23
Panama (City)	40	N.a.
Papua New Guinea	47	13
Peru (Lima)	N.a.	18
United States	62	29

N.a.: Not available.

mortality rates range from two to seven times higher than young women's. The leading causes of mortality for young men in the region are traffic accidents and homicides — both associated with gender socialization (44).

Gender differences also influence the nutritional status of adolescents. In countries, such as those in southern Asia, where preference for the male offspring is the norm, evidence indicates that girls' dietary intake is different from boys' both in quantity and quality — girls are typically fed less and last. The situation, however, can be more complex than it first seems. Recent research on the nutritional status of adolescents noted gender differences in the biological and social indicators of nutritional status. Adolescent boys appeared to have nutritional deficiencies more frequently than girls and in some sites showed higher levels of stunting. Girls, on the other hand, attain lower education levels, which is a key determinant of nutritional status (45).

There is growing recognition of the needs of boys, and of the role their socialization plays in health behaviour. Some researchers have associated boys' inability to meet societal and familial expectations of the role of "real men" with risk-taking and violent behaviour and suggested that young men from low-income backgrounds may resort to violence or drug use to gain prestige and self-esteem (46).

Programmes must be gender-sensitive, so as to ensure that the needs of both girls and boys are addressed in programmes. Because of correlations between school attendance, health status and fertility, efforts should help to promote equality between the sexes with a view to empowering girls. On the other hand, boys should be empowered to reject "machismo" attitudes (and embrace nurturing), while parents and communities must be equipped to give their children a balanced upbringing.

## 4. Major interventions

Young people need places and environments that offer them nurturing, guidance, rules, structures, clear (and high) expectations, consistent limits. They need opportunities to explore, excel, contribute, earn, lead and join. They need high-quality instruction and basic care and services so that they can develop solid skills. Most important, they need people with high expectations who are committed to their well-being (4).

### 4.1 Background

In this section specific interventions currently used to promote healthy adolescent development, and prevent problems, are reviewed to determine their effectiveness. Unfortunately, there are few published research findings from developing countries, and few studies which adequately measure effectiveness. Therefore, findings should be treated with caution. There is obvious need for well-designed research to identify proven approaches and solve some paradoxes. While such research is needed in all countries (especially in the developing world) this should not delay any urgently needed action. Defining interventions that can effectively meet the needs of young people will be easier if the latter are involved in the entire process of designing, implementing and evaluating such interventions, and if interactive approaches are used to help them consolidate what they have gained from such involvement. Interventions play a dual role in promoting healthy development and reducing high-risk behaviour. Designing programmes which involve a combination of interventions suited to the particular needs of the young people served can enhance this dual benefit.

Although adolescents are the primary group to involve in interventions for the promotion of healthy development, prevention of health problems and provision of care, they are a very diverse group, and such diversity needs to be understood and taken into account. Adults who interact with adolescents (for example, parents and other family members, teachers, youth leaders, and religious leaders) are an important secondary group for intervention planners to consider. Interventions may involve adults together with adolescents, or focus solely on enhancing adults' ability to interact with and support adolescents. Another group in the wider circle of people influencing and affecting the health of adolescents are law makers, political leaders, popular entertainers and sports stars, media and industry executives, and other powerful and influential community and national figures.

It is necessary to consider the specific situation of each group of the adolescent population to ensure that interventions address relevant concerns and needs. The type of intervention, activities and approaches used can vary according to gender, age, state of health, marital status, home and social situations. Careful consideration of the needs of particular adolescent population groups is essential to the planning of interventions. The following are the major factors which segment the adolescent population, and an illustration of the role of these divisions in the selection and use of interventions.

### ***Gender considerations***

As the social face of biological sex differences, gender must be considered when programming for adolescent health. Girls tend to suffer more as a consequence of problematic behaviours associated with unprotected sex, overnourishment and undernourishment and substance abuse. Girls often have less access to education than boys, which denies them the opportunity to develop to their full potential. Factors with special risks for the adolescent girl include nutrition, sexuality, pregnancy and childbirth, abortion, STDs (including HIV/AIDS), female genital mutilation, early marriage, substance abuse, and mental illness (47).

Gender is also an important determinant of the utilization of social and health services. Access to services can be greatly constrained for young women by factors such as reduced mobility (making distance an insurmountable barrier) and competing demands on their time because of domestic work and the care of younger siblings. To overcome these gender-based constraints, the particular circumstances of young women need to be considered. For example, services could be provided at times that are convenient for young women; services may be integrated to minimize the time women spend on a variety of services; and whenever possible, community outreach services should be provided to remove the distance barrier to access.

Young men, too, face gender-based constraints to their use of services. Emphasis on the reproductive role of women, to the exclusion of men, means that men often do not have access to reproductive health services. A review of interventions to reduce early and unwanted pregnancies in English-speaking Caribbean countries noted the lack of attention to young men. Interventions excluded males or overlooked their role in adolescent pregnancy (48).

In order to best address adolescent health needs, programmes should acknowledge the gender-based differences highlighted above, to identify the appropriate interventions and approaches to reach boys

and girls, and meet their gender-specific health and development needs. Collection of information on gender roles is an essential part of situation analysis for programming. Service providers must appreciate the gender-based constraints of their clients and the social and economic context that accounts for differences in the roles, responsibilities, and experiences of adolescent girls and boys.

### ***Age considerations***

Documented evidence suggests that early adolescent programming can help prevent lifelong cycles of self-destructive and antisocial behaviour, and mitigate the damage caused by harmful environments.

Various studies have confirmed that the factors related to antisocial behaviour in late adolescence and adulthood are found in childhood and early adolescence — the absence of a competent or caring adult, early educational difficulties and unaddressed learning difficulties, among others — are directly related to unprotected sexual activity, delinquency, drug abuse, and other antisocial and self-destructive behaviour. In addition, evidence from many developing countries suggests that adolescents are dropping out of school as early as age 10. Thus, empirical demographic trends as well as research from developmental psychology suggest that investing in problem prevention for vulnerable adolescents should start at an early age (49).

It is also important to adapt interventions to age and developmental stage. Age-related issues to consider include the type and degree of health-related information to be provided at each age. For example, young adolescents in general benefit from basic information about the changes to expect in puberty, before they are introduced to contraception, pregnancy and disease prevention. It is also important to consider what type of information is needed at each age on health services (such as STD testing, and counselling) available, and on the importance of such services for particular health concerns. Regarding nutrition, drug use, and sex education, it is again useful to determine information content and timing based upon the adolescent's interest in these issues at the different stages of development — stages which are not always consistent with chronological age. There is evidence (50) that introducing basic information on sexuality, emotions, and the new physical sensations experienced at puberty is highly beneficial in early adolescence, before many adolescents become sexually active.

It is important to encourage the development of desired behaviour at crucial stages of adolescence before undesirable behaviour becomes habits. Although it is practical to start with the existing set of

behaviour, adolescence offers a major opportunity to intervene at stages when lifelong behaviour patterns are being established.

Another important age-related issue is to ensure that male and female adolescents are comfortable with discussions. This may involve a comfortable, informal environment and an older peer-trained leader to lead the discussions, be a role model and gain the adolescents' confidence (51). Many studies have found pairing older adolescents to work with younger ones enhances the intervention. It may be necessary, particularly with regard to early adolescence, to separate boys from girls for discussion on sexuality. The two groups can be addressed separately or together based on local culture, and the feelings of parents on the matter.

Although generally the approaches should be adapted to different cultures, certain approaches are universal. Young people in early adolescence respond well to active methods that involve games, the arts, and minimal discussion. With cognitive development comes the appreciation of small group discussions and debates. The adolescents' opinion on content and method is an important contribution to the development and adaptation of the interventions.

The role of parents in planning interventions concerns age, and it is essential to optimize their contribution to the various stages of adolescent development. Cultural expectations of the parents' role in the activities of their adolescent children need to be assessed, and for some activities, parental permission may be required by law up to a certain age.

#### ***Adolescent disability***

Because one in every 10 children is chronically ill or disabled, disabled adolescents represent a group whose particular needs must also be considered in planning intervention strategies. Despite the myriad disabilities and chronic illnesses, interventions which are sensitive to adolescents' obvious needs are both necessary and feasible. Interventions should be functional and not restrictive. In the United States, for example, eligibility for certain services is based on functional limitations, not disease category (52).

Adolescence is a time in which various developmental tasks must be completed. The consolidation of identity, reduced dependence on parents, establishment of intimate relationships outside the immediate family, and selection of a vocation are major tasks of adolescence (53). These tasks may take longer to accomplish in young people who are chronically ill or disabled because of deprivations suffered earlier (53–56). Programmes for adolescents can enhance the

development process in a variety of ways. Factors that influence the growth and development of young people with disabilities or chronic illness include (52):

- family support that is not overprotective;
- a network of friends with and without disabilities;
- having at least one friend of the same age and one adult to talk to;
- domestic and/or community responsibilities;
- having successfully completed a task;
- the belief that despite the physical limitation they can accomplish their goals.

Concerning education about sexuality for physically and mentally disabled adolescents, the information must be appropriate and take into consideration physical limitations. There is also need to explain how one's milieu helps to determine what is appropriate behaviour, especially for those with intellectual limitations, and that the expression of sexuality can go beyond penetrative sex. Emphasis should also be placed on building social skills with the same and opposite sexes (57).

### ***Homelessness***

In 1990, WHO estimated that 30 million children lived or worked on the street (58). According to a report (59) from WHO's Programme on Substance Abuse these young people may be defined by one or more of the following experiences:

- living on the streets and concerning themselves primarily with survival and shelter;
- being detached from families and living in temporary shelters or moving about between friends;
- remaining in contact with family, but because of poverty, overcrowding, sexual abuse or physical abuse within the family, spending most days or some nights on the streets;
- living in an institution or in institutional care, but at risk of returning to their previous street existence.

Continuous exposure to the streets and street life leaves adolescents vulnerable to more difficulties than those typically experienced by other young people. These adolescents must cope with the physical conditions of street life (lack of food, shelter, and sanitation) and the factors responsible for their homeless existence, such as poverty, family breakdown, abuse, or armed conflict. Surviving street life and coping with stress may lead to drug use and dealing, commercial sex work, criminal behaviour, violence, and exploitation by adults.

An additional consideration in intervening to assist such young people is their lack of access to (and mistrust of) services and resources. Adolescents living and working on the street are not a high priority in most countries and are often exploited and viewed as criminals rather than as young people in need of assistance. They may believe that services are merely a ploy by the police or welfare agencies to capture them. Such beliefs foster general mistrust among homeless young people of services. This mistrust of potential resources is compounded by the inaccessibility of services. Underage adolescents may be denied primary health care in the absence of a parent or guardian to provide the necessary documentation. Some nongovernmental organizations (NGOs) address this problem by assigning young people an adult to help them fulfil the necessary formalities to obtain services.

### ***Conflict situations***

In the past decade, an estimated two million children and young people have been killed in armed conflict and three times as many seriously injured or permanently disabled (60). These conservative estimates give no idea of the large number of children whose deaths are concealed or unrecorded. Moreover, many impacts of war and conflict on children and young people are immeasurable. There is no way to measure the emotional and psychological toll on a young person who lives for years with the constant fear of bombings, mutilation, or death. Between 117 and 138 million young people may be indirectly affected by armed conflict by the year 2000. The most affected areas will be South-East Asia, where 50 million children and young people could be at risk, followed by Africa where 20–30 million young people may be vulnerable.

According to global estimates, the proportion of war casualties who are civilians has surged from 5% to over 90% in recent decades. Likewise, a very large number of children and adolescents are victims of human rights violations.

Many of today's conflicts last through an individual's childhood, adolescence and early adulthood. War and conflict disrupt the social networks and primary relationships that support a young person's physical, emotional, moral, cognitive, and social development and consequently have far-reaching physical and psychological implications. The effects of armed conflict on youth development are cumulative and correlated. The well-being of young people is best ensured through family and community-based efforts to address armed conflict and its aftermath. Such efforts are most effective when they are

based upon local cultures and on an understanding of adolescent development. Young people should be seen as survivors and active participants in creating solutions, not just as victims or problems (61).

While thousands of children and young people die every year as a direct result of fighting, many more die from malnutrition and disease associated with armed conflict. The interruption of food and clean water supplies, destruction of food crops and agricultural infrastructure, disintegration of families and communities, displacement of population, destruction of health services, sanitation systems and public health programmes all take a heavy toll on young people. Many of today's armed conflicts take place in the world's poorest countries where there is greater incidence of malnutrition and disease, and the onset of armed conflict can increase the death rate by up to 24 times (61).

Population movements, sexual violence and the breakdown of established social values dramatically increase the spread of STDs, including HIV. Reduced access to reproductive health services increases the vulnerability of adolescents in particular. Transmission is also increased by the breakdown of health services and by blood transfusion services unequipped to screen for HIV.

Landmines and other explosives (bombs, shells, and grenades) pose a tremendous threat to children and young people. Young people in at least 68 countries are exposed to over 110 million landmines that can maim or kill (61). Even without injuring, the presence of landmines causes psychological and emotional distress. If a family member is disabled, the family economy may crumble. Three times more young people are seriously injured or maimed by armed conflict than are killed by it (61). The lack of basic services and the destruction of health facilities mean that disabled children and adolescents get little support. Only 3% of these victims in developing countries receive adequate rehabilitative care (61).

The destruction of educational infrastructure is one of the greatest development setbacks for adolescents and their communities. Years of lost basic education and vocational skills take an equivalent length of time to replace, and the loss further strains society's ability to recover from wars. The conflict in Mozambique led to the destruction of approximately 45% of the primary school networks (61). During the crisis in Rwanda, more than two-thirds of the teachers either fled or were killed. Education is particularly important during times of armed conflict. It provides a sense of stability and connection in a time of chaos. At school, adolescents have the benefit of regular contact



with peers and teachers who help them develop new knowledge and coping skills on such issues as conflict resolution, avoiding landmines, and health education. Appropriate educational activities for adolescents have helped to bolster their psychological well-being and exempt them from military service.

Traditionally, the focus of any response to the needs of adolescent refugees primarily concerned their most obvious material needs. However, the inevitable loss, grieving and fear that adolescents also face in these situations where they may witness extreme brutality deserve serious consideration. The horror and perpetuation of armed conflict curtail crucial adolescent identity development. The feeling of being let down and even betrayed by adults distorts adolescents' perspective and makes them distrustful. Of the 3030 children surveyed by the United Nations Children's Fund (UNICEF) in Rwanda in 1995, almost 80% had lost immediate family members, and among these, more than a third had actually witnessed the family members' murders (61). The adolescents' response to such traumatic events is governed by personal factors (age, sex, personality type, personal and family history and sociocultural background), and the frequency and length of exposure to the traumatic event.

### ***Selecting interventions***

In addition to the particular needs of adolescent populations as illustrated above, selecting, adapting and combining interventions to address a wide range of issues involves several essential steps closely related to the assessment of priorities (see section 8). Therefore, these activities can be viewed as an intrinsic part of the entire programming cycle more comprehensively described in sections 7–10. Ultimately, all adolescent programming is concerned with how interventions affect individual adolescents and the people who interact with them. Programming towards this aim may be accomplished at many different levels: individual, group, community and district, and national levels. An understanding of how the various interventions can work together to promote health will help inform the programming actions needed at the different levels.

Information collected through the assessment process can be used at each level of programming to better understand the needs and concerns of young people and the capacity of the systems that serve them to respond to those needs. Although four levels of programming are recognized, the first two levels (individual and group) are most relevant to the selection, adaptation and incorporation of interventions that directly involve young people. The second two levels (district or community and national) involve assessment on a wider scale

for use in progressively broader programme planning, and are covered in section 8 as part of priority assessment.

Individual assessment involves exploring the needs and circumstances of a particular adolescent to determine how to optimize direct interventions (especially counselling and the delivery of health services), and to adapt and streamline such interventions. With regard to individual assessments, the following should be borne in mind:

- It is vital for assessments to be conducted in a responsible and sensitive manner, limiting the question to information relevant for decision-making on interventions.
- It is important to treat the assessment as the first step in the intervention.
- It is necessary for the young person to be treated with respect.
- They may be staged over a period of time.
- They should be conducted by persons aware of ethical considerations. For example, confidentiality is not always possible and the young person should not be misled concerning the handling of information.
- There is need for them to address the context of the issues, needs and problems presented by the adolescent. Interventions are often needed to focus on the environment in which adolescents live and on their efforts to cope. A homeless young person may need shelter, or some other immediate care, rather than a discussion on the subject of homelessness.

Assessment at the small group level is typically conducted by a youth leader, teacher, social worker or community health worker to help identify interventions to meet the needs of a group of young people. Such groups are often part of larger programming efforts. To help plan interventions at this level assessment involves learning about:

- the basic health needs of the group in relation to the overall situation of group members, and how environmental factors, including opportunities and family support, affect daily life;
- strengths to draw upon among members;
- urgent health risks relevant to group members;
- composition of group and diversity of needs;
- current levels of information on selected health topics, the degree of basic skills amongst group members, and awareness of available resources in the community;
- the concerns of the group members, topics they want to learn more about, and skills they would like to develop.

Assessment should not be considered as an isolated event, but as part of programming on a continuing basis. In addition to aiding in the

selection of initial interventions, assessment can be used to determine their focus. The Street Children Project, initiated by WHO through its Programme on Substance Abuse, recommends, for example, that programmes working with street children aim to run three series of focus groups each year to keep abreast of changing needs. Some tools used by planners for situation analysis can be used at this level. For example, adaptation of the basic focus group methodology has been effectively used in many programmes as a way to assess needs, interests, and behaviour or evaluate information on various health topics. The joint project of the World Organization of the Scout Movement and International Federation of Red Cross and Red Crescent Societies, Action for youth, presents the focus group approach as a method for assessing group needs for programming in Africa, Asia, Europe, and Latin America.

The "Modified social stress model"<sup>1</sup> (63) is one approach which can be used to better understand vulnerability to risky behaviour and situations such as substance use and matters concerning reproductive health. As shown in Fig. 3, the model has six major components, each of which has elements which can either increase vulnerability (risk factors) or decrease it (protective factors). The model helps to identify factors which may explain why adolescents engage in risky behaviour and to identify sources of strength to draw upon. Originally developed for the study of substance use among young people, it is based on the premise that adolescents exposed to many risk factors are likely to begin, intensify, and continue the use of substances, and experience related problems. Conversely, the more protective factors there are in adolescents' lives, the less likely they are to be involved with or harmed by substances. The model is also useful for planning interventions to prevent or treat problems like those related to substance use. Once the risks and protective factors are identified, work can begin on reducing the former and strengthening the latter in all or some of the six major components identified in the model.

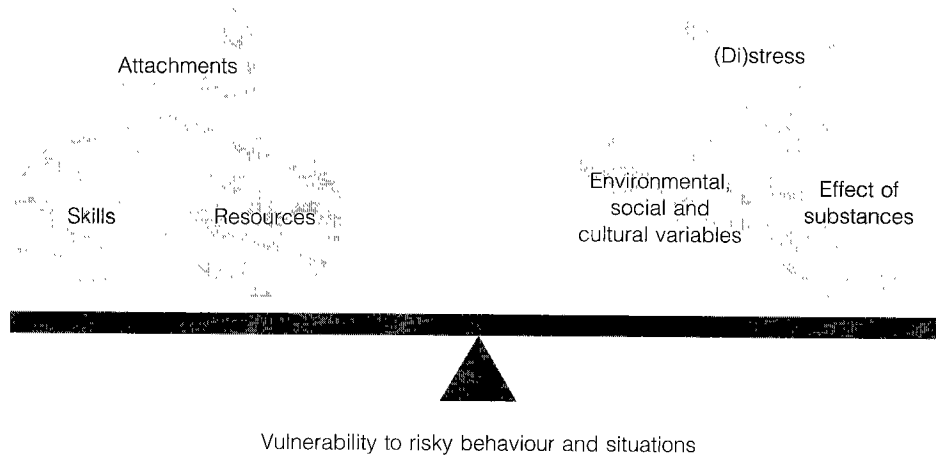
To accomplish the overall goals of programming for adolescent health, the focus of interventions can be seen as two-fold:

- Interventions are required which focus on the individual; interventions, such as providing information and building skills, and counselling may be offered in groups of varying sizes or on an individual basis, but the main focus of each intervention is on influencing the development and behavioural choices of adolescents as individuals.

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<sup>1</sup> This model concerning substance use was developed by WHO and is based on the "Social stress model" (62).

Figure 3  
Modified social stress model



Health services are also identified as an essential intervention concerning the individual, in that the health sector provides services to monitor growth and development, diagnose diseases and injury, and provide care, treatment, and rehabilitation.

- Interventions are also required which address selected external factors in the adolescents' social environment: (a) existing or non-existent policies and legislation, such as laws on smoking and school attendance of pregnant adolescents; (b) the social norms prevailing in a society, such as attitudes towards the general role of adolescents, and towards sexual activity of young people; and (c) the presence of caring and supportive family, friends, and other adults. These factors and the availability of opportunities, such as the opportunity to attend school and to gain livelihood skills, play a significant role in promoting adolescent health.

The interventions presented in this section have been divided into five major categories. These interventions have proved effective in promoting healthy development, and preventing and responding to health problems. The interventions were selected based on research, general consensus on their necessity and benefit, their diverse use in a range of countries and adaptability for use with adolescent males and females, different ages and cultures. The categories are narrowly defined in this text to distinguish the unique contribution of each major intervention, but in practice they often overlap. It is vital to note that single intervention approaches are less likely to be effective in influencing adolescent health than a combination of interventions

appropriate to adolescent needs. The convergence of risk factors across contexts points to the need for multi-intervention, multi-setting programming. The most promising interventions focus on supporting individuals, the influence of close interpersonal relations, and the contexts in which development occurs, since the importance of environmental risk factors compared with individual risk factors may vary with age and by context (64).

#### 4.2 Promoting a safe and supportive environment

A safe and supportive environment is part of what motivates young people to make healthy choices. “Safe” in this context refers to absence of trauma, excessive stress, violence (or fear of violence) or abuse. “Supportive” means an environment that provides a positive, close relationship with family, other adults (including teachers, and youth and religious leaders) and peers. Such relationships can nurture and guide young people, set limits when needed, and challenge certain assumptions and beliefs. Supportive and caring relationships with adults and friends, and positive school experiences are particularly significant aspects of a supportive environment for adolescents. Such relationships provide specific support in making individual behaviour choices, such as when to become sexually active, how to handle anger, what to eat, and when and if to use substances.

Any intervention that focuses only on individual behaviour fails to consider the context that actually motivates and supports the healthy development and constructive behavioural choices of adolescents. Although there may be environmental factors over which adolescent health programmers can have little effect, there are others that can be tackled. A variety of interventions are concerned with helping to create a safe and supportive environment. Several key areas of interventions can positively affect the environment in which adolescents live, and are therefore presented for consideration and assessment of relevance to individual countries or communities. Each area of intervention should be considered in terms of how the action will facilitate growth and development, and encourage adolescents to practise healthy behaviour and receive care and treatment when needed.

Five major aspects of the social environment which impact adolescents in pivotal ways are:

- relationships with families and other people;
- social norms and cultural practices;
- mass media and entertainment;
- availability of vital opportunities and commodities;
- policy and legislation.

Generic approaches which have been useful in influencing these aspects involve mechanisms to:

- Inform, raise awareness, advocate and mobilize — activities, such as community-awareness sessions, group meetings and round-table discussions are used. Creative use of the media, entertainment and the arts is also effective. For example, television, radio, films, flyers, brochures, newspapers, journals, and live theatre and dance all provide great potential to communicate and to mobilize community support for selected adolescent health issues. Programmers can also solicit support from national or local figures to assist in advocacy.
- Provide training — there are extensive applications of the training of adults and adolescents.
- Make room for healthy adolescent development — securing safe places for schools and vocational training, recreation and leisure pursuits (including sports and the arts); and shelters for adolescents in times of crisis are also very important.
- Monitor activities — assessing the progress, success and problems (particularly policy), and monitoring selected activities guide advocacy efforts and use of the media.
- Mediate — those promoting programming have a role to play in finding common ground between differing interests and groups in society, often building on the common desire for adolescent health. Mediation may be necessary in relation to policy issues, cultural practices versus health issues, content for health education curricula, and differing attitudes towards the role of young people in all areas of programming.

It is difficult to assess the actual effectiveness, on individuals, of interventions focused on the social environment, even though benefits can clearly be demonstrated at many levels, such as increases in school attendance and positive school experiences for both boys and girls, or gradual reduction in violent behaviour. The definition of effectiveness can be broadened to include proven effect on social norms, for example, or decline in negative influences. Such measures are useful despite the lack of evidence of a direct link between environmental interventions and behaviour. Concerning policies and media, the need to take the long-term view and appreciate gradual change has been stressed (65), given that efforts have to be sustained over time.

#### ***Relationships with family and other people***

Adolescent health and development are influenced by a myriad of interactions from the immediate (peers, teachers, parents) to the

global (economic and political systems). Because parents usually remain close to adolescents and can exercise some degree of authority over their actions, they are vital to any configuration of social factors shaping adolescent health and development. From time to time, peers and the community may be more or less influential, but parents and family are constant elements in most young people's lives despite fluctuations in their relative importance.

Caring relationships with families and friends play a vital role in fostering healthy development. Studies conducted in the United States note that adolescents who feel close to their parents consistently show more positive psychosocial development, behavioural competence, and psychological well-being (66).

There is need to identify and consolidate the positive influence of parents and families in programming efforts. Some of these influences are indicated below (67).

- Parents provide a positive behavioural role model and transmit values and information — studies confirm the positive regard between parents and adolescents; there may be minor conflicts over appearance or speech but little divergence over more major issues such as morality, religious beliefs, and basic values. The minor disagreements are important for adolescents to mature by testing the boundaries of authority and challenging the beliefs of others in a safe environment. What adults do is often more influential than what they say; so is the day-to-day demonstration of “life skills” — those abilities for dealing with the demands and challenges of everyday life, solving problems and coping with stress.
- Parents provide emotional support — adolescents cope much better when they feel accepted by their parents and able to talk about their problems. Many problems stem from the difficulties parents and adolescents have in communicating their feelings and needs and working out mutually acceptable solutions. The quality of communication in the family dictates the relationship between parents and their adolescent children and ultimately the latter's relationship with peers. Effective communication in the family also provides the adolescent with valuable models of interpersonal skills and training in skills such as self-disclosure and problem-solving.
- Parents promote autonomy and interdependence — adaptability is very important to family functioning. Parents need to continually assess roles and rules in the family to determine their relevance. Roles and rules need to be altered in response to developmental changes in family members. Rules may also need to be changed

with alterations in external circumstances such as new involvement in outside activities. Encouraging young people to express their needs and alter rules can give them a taste of self-reliance, and help them to appreciate the role of interdependence in family decision-making. Adolescents need direction, but above all they need parents who share power and values, and encourage independence, responsibility and discipline.

- Parents are brokers for needed services — they are in a position to identify undesirable adolescent behaviour, explore its possible origins, and help seek support and assistance. In addition, parents hold a considerable position of power which can be used to advocate greater attention to adolescent educational, employment and health needs. However, adults in a position of influence must also loosen their grip on what is perceived to be the right answers and allow young people to explore new and perhaps more positive directions and behaviour.

While these influences seem self-evident, parents and families may need guidance and assistance. Intervention strategies that target parents and families and encourage and support the assumption of such functions are increasingly acknowledged as essential to the promotion of healthy adolescent development.

Interventions to help parents and young people communicate are important (68). Many parents delay talking to their children, especially about sensitive topics, because they feel ill-informed or embarrassed. Parents may fail to acknowledge that uncertainty is normal in learning to make sexual decisions, and may alienate adolescents by demanding rigid obedience. Parents and those in parenting roles may need assistance in positive communication about sexuality, to strengthen the credibility of the information shared with adolescents (68).

Interventions which focus on adults who work with young people can also be useful. Such interventions include using skills-training to share information about adolescent development and strengthen the communication skills of teachers, young people and religious leaders. The training can help improve the implementation of activities and use of methods that involve young people's participation. Training can also reinforce the ability of adults to empathize with, respect, and nurture young people. Examples of relevant successful approaches are presented in Box 3.

Few programmes for the development of a healthy social environment for adolescents have undergone controlled evaluations. However, there are sufficient data to indicate that the approach has promise (71). One programme that was designed to alter the social



### **Box 3**

#### **Supporting parents**

In the area of adolescent mental health, one initiative to help parents be better prepared to understand the potential risk of suicide and how to contribute to an environment conducive to prevention is a booklet published by the Australian Scout Association which addresses youth suicide and its prevention. The 24-page booklet provides information on warning signs and risk factors for suicide, information about what parents can do to help prevent it, and a list of centres which provide child and adolescent psychiatric services. Included in the publication is specific advice for parents about how to improve relations with young people by, for instance, providing a safe physical and emotional home environment, spending quality time with young people, listening to what young people are saying, being supportive and not intrusive, and encouraging appropriate expression of emotions (69).

In the Philippines the Foundation for Adolescent Development produced a video to show parents that their communication with adolescents shapes the way the adolescent communicates with others. In Zimbabwe, the National Family Planning Council has offered a parent education programme to help parents educate their adolescent children about human sexuality and reproductive health (68).

In some countries, manuals have been developed on how to motivate and prepare parents to communicate with their children on issues of sex and sexuality, health, and decision-making. In the United Republic of Tanzania, the Parent Education Organization, working in collaboration with the Margaret Sanger Center of Planned Parenthood of New York City, with the support of UNFPA, developed a manual for trainers to help parents communicate with their children. The overall philosophy of this programme is that the responsibility for family life education lies with parents, schools, religious institutions, and governmental and nongovernmental organizations. In support of this philosophy, training is employed to increase the number of people who can effectively prepare parents at the grassroots level to communicate with young people about sexuality. The manual provides trainers with guidance and suggestions on how to help parents increase their knowledge about sex and sexuality, build communication skills, and enhance the motivation to communicate with their children on potentially sensitive topics. Trainers working with parents use the interventions of information and skills-building, with attention to awareness of health services in the community. This total effort has the potential to enhance an environment that encourages young people to make informed, healthy behavioural choices about sex (70).

SERVOL in Trinidad and Tobago has included programmes for parents in its multiservice adolescent programmes. Parent support services are offered through these programmes as well. SERVOL has a parent outreach programme in which trained parents teach other parents to help with their children's education and to deal with the physical,

**Box 3 (continued)**

emotional, and psychological development of their children. The programme also offers job skills training and organizes parent support groups (45).

The South Auckland Youth Resource Service is an NGO in New Zealand providing services to young people in a "One-stop shop" where a range of interventions and information is available. The interventions are based on the "*Aiga*" model, which means "family" in Samoan. If one of the layers of the "family" (which also includes caregivers from the church, community, village and district) is eroded, this leaves the adolescent vulnerable to ill-health. Each of these layers is rebuilt and fortified in order to reconstruct and strengthen the supportive environment.

environment of schools to reduce problems associated with the transitions to junior and senior high school provides evaluated evidence of this (72, 73). The intervention included two major components: changing the role of teachers to provide a link between students, parents, and the rest of the school, and to give students greater support; and establishing a stable peer-support system by assigning students to all of their academic subjects with the same set of classmates. Programme participants were absent less often, improved their grades compared to the control group's and maintained stable self-esteem, while the control group reported lowered self-esteem over the same period of time.

Another important example of fostering positive development through the creation of more adaptive social environments in schools is the School Development Program (74–76). This programme is designed to facilitate positive interaction between parents and school staff. A "governance and management team" identifies issues ranging from the school's academic and social programmes, to changes in school procedures that seem to engender behaviour problems. Considerable progress has been achieved in elementary schools, and corresponding programmes in junior and senior high schools are now being tried in the United States (71).

Outside the school environment, a youth service bureau in a Puerto Rican community, seeking to reduce youth crime, created an organization to help adults unable to cope with their own lives or children's behaviour gain a sense of control. Full-time paid community workers have been trained to increase public service responsiveness to the basic needs of the community and set up programmes. The workers organize recreational programmes, community outings and meetings,

and act as mediators in general community problems. The activities have contributed to an 85% decrease in the number of young people prosecuted. The quality of the residents' lives has also improved as they have developed confidence and a sense of responsibility towards their community (M. Simon, K. Monahan & G. Slutkin, unpublished data, 1995).

### ***Social norms and cultural practices***

Social norms involve both what people typically do in all areas of life, and people's expectation of others. Understanding how such forces shape the lives of young people is fundamental to programming for adolescent health and development. Intervening with regard to social norms can involve tackling attitudes and practices that are harmful to young people. How roles and access to various services and basic opportunities are viewed by society is an aspect of social norms that affects the health of young people. The attitude that adolescent girls do not need to go to school is one example of a harmful attitude with serious consequences.

Intervening in relation to social norms can mean influencing attitudes to ease the way for adolescent programming. Some areas of adolescent health programming draw more controversy than others. Programming in reproductive health and substance use often involves dealing with conflicting opinions on programme content, objectives and methods. Assessing the social climate surrounding these issues and understanding the concerns and fears will help to determine how best to intervene. Other attitudes and norms that may need to be addressed or challenged concern young people in particular circumstances, early marriage, sexual behaviour among young people, and access to information about sexuality. None of this can be achieved, however, unless the resistance of adults is reduced and the opportunities for young people to have access to sound (and interesting) communication are increased.

An example of activities designed to influence social norms is the Sara Communications Initiative, a multimedia project developed by UNICEF in collaboration with partners (77), focusing on an adolescent heroine, Sara, in periurban Africa. It is an animated film that blends reality and fantasy with serious messages for improving the status and treatment of girls. The film emphasizes the heroine's potential to overcome problems, often in partnership with a male adolescent.

Box 4 illustrates some additional ways in which social norms are addressed as part of programming in various areas of adolescent health.

**Box 4****Addressing social norms and cultural practices**

In the United Republic of Tanzania, learning community attitudes and social norms concerning adolescent sexual activity and family planning, as well as attitudes about young people as counsellors, and taking time to gain support and positively influence acceptance for discussion, amongst young people, on sexuality, family planning, and prevention of pregnancy was identified as a prerequisite to initiating the intended reproductive health peer educator programming. Family life education coordinators, who would be training the peer educators, were trained in how to work with community leaders to increase their awareness, understanding and support of the UMATI adolescent reproductive health programme. The coordinators were asked to identify local community leaders including religious leaders, key influential people, prominent businessmen and farmers, heads of schools, and representatives from various youth groups. It was assumed that these leaders would form a vital link to the project and therefore enhance community support and involvement. All the above leaders were sensitized through a two-day workshop in each of the nine regions in the country on adolescent sexuality and its related consequences, and the rationale for reproductive health interventions. The subsequent community discussions held with the selected community members and leaders to share the aims of the programme and discuss questions and concerns of the community gained the support to go ahead with the peer counsellor training, and initiate counselling of other young people in the communities. The attention to addressing the peer was considered very important for the project's take-off and for the success of youth family planning services through peer projects (N.B. Katunzi, unpublished data, 1995).

To help overcome resistance to the idea of sex education in public schools, the National Programme for Sex Education was formed and Resolution 03353 sanctioning sex education as mandatory was passed. The national programme launched an extensive mass media campaign using radio and television programmes as well as a weekly newspaper supplement on human sexuality. A weekly television serial employed popular actors to address problems of typical middle-class adolescents in an entertaining soap opera format. The media campaign played an important role in changing social norms and increasing public awareness about the need for sex education for adolescents. Although there is still opposition among the most conservative sectors of society, a climate of acceptance of sex education exists within most of the population. Policies were changed, but equally important was the shift in public attitude largely influenced by the media activities allowing the training of teachers and implementation in school to move forward.

Effective health promotion requires enlisting the support of the many institutions and individuals that have contact with or otherwise affect the lives of adolescents. Recent decreases in drunk driving in the United States, for example, resulted from multiple interventions that delivered consistent messages designed to change social norms about drunk drivers, creating a social environment in which it was easier not to drive while drunk, and supporting these messages with new legal sanctions (78).

As programmers recognize and utilize broader spheres of influence, it becomes difficult to evaluate smaller components, such as a particular programme or intervention. On the other hand, expanding responsibility for adolescent health to more than one programme or institution increases opportunities for health promotion. When undertaken in conjunction with greater initiatives, even small efforts serve to reinforce important themes, thus contributing to a larger overall strategy.

Although the National High Blood Pressure Education and Control Program initiated in the United States in the early seventies was not targeted at an adolescent audience, the assertion that this programme considerably influenced social norms through combined interventions (65) is relevant to efforts aimed at influencing social norms which encourage adolescents to make positive health behaviour choices. The programme involved many activities: institutional consensus building, education of health professionals, public education through community organizations, and mass media education. The mass media efforts included distribution of public service announcements for broadcast on radio and television. Results of these activities showed a rapid decline in stroke mortality for the decade following the initiation of the programme (65, 79). The decrease in stroke mortality was most likely due to combined efforts which greatly influenced societal norms.

### ***Mass media***

The media are a very important aspect of the environment, and greatly influence adolescents. The media have been employed to address other aspects of the social environment considered particularly important to adolescent health and development. For example, radio and television can be used to broadcast information designed to influence social norms and attitudes about many health topics. In addition, creative use of the media, entertainment and arts is an important way to modify the environment. The media provide great potential to communicate and mobilize community support on selected adolescent health issues. To this end, there is need to educate

media personnel to increase their sensitivity to issues, and influence their attitudes and opinions. Keeping lines of communication open to give information quickly when a story breaks, and strategically using the various media to provide such information can also help modify social norms and promote healthy behaviour.

One innovative activity has been to print information on products used by a lot of adolescents and adults, encouraging and helping manufacturers to see the benefit of printing health-promoting information on their products. Manufacturers' role in promoting the health of the community can be very successful, especially if the "humanitarian" and economic benefits of their actions are made clear to the commercial sector.

Awards and public commendation can also be used to increase the visibility of issues, and reinforce efforts by media, agencies, and others who support specific aspects of health promotion (30).

In India, *Dehleez*, a radio serial established to inform young people about reproductive health, has also made it easier to discuss sex and health questions, and uses its hero to incorporate model health behaviour in its episodes (G. Giridhar, unpublished data, 1995).

The Jamaica Red Cross peer education project has also used a radio serial drama to promote and reinforce positive attitudes towards STD prevention. The project encourages young people not to be in a hurry to become sexually active, use condoms when they have sex and go for a check-up if they suspect they have an STD. This radio drama has become so popular that the radio station now pays the programmes to provide the scripts for the episodes. The radio serial is designed to enhance the direct health education work accomplished by the peer educators trained in the project to reach other young people and to reinforce the information and skills the participants learn in interactive sessions. The project links the two aspects of the radio programme by having the peer educators contribute to the scripts and participate in a question-and-answer segment at the end of the episodes (Jamaica Red Cross and American Red Cross, unpublished data, 1995).

The media can also help to create a safe and supportive environment by influencing healthy behaviour choice. A film, *A Future for our children*, by a private-sector company was televised to a million viewers in Liberia five times over a six-month period. The film dealt with the effect of population growth on socioeconomic conditions and aimed to generate discussion about family planning and child health. Of the young people who saw the film, 93% reported that they would

change their family planning practices as a result (80). In South Africa, where adolescents are familiar with the use of comic strips and stories accompanied by pictures (*fotonovelas*) as an educational medium, an AIDS education comic, designed to increase youth support for behaviour conducive to the prevention of HIV transmission, was a very successful component of a countrywide, school-based AIDS programme (81).

Assessing the effects of the various types of media campaigns on public health (see section 4.3, Box 10) is difficult because measurement approaches and methods are only able to detect substantial changes (65). As a result, many mass media campaigns are rejected as failures when in fact they may have had a considerable influence on public opinion and even on behaviour in the long term. The Swiss *STOP AIDS* programme, a national multimedia campaign conducted in Switzerland to enhance school programming on sexual and reproductive health, proved effective in increasing the prevalence of contraceptive use among adolescents already sexually active, thereby making safer sex the norm (83). Success appears to have been achieved both by raising awareness and making it easier for girls to discuss the issue of safe sex with their partners. Following formal evaluation, investigators demonstrated the positive effects of the campaign. After five years of the campaign, sexual behaviour changes (especially condom use) were evaluated among adolescents, using self-administered questionnaires. Investigators performed comparative cross-sectional surveys in 1987 and 1990 (using sample sizes of 1359 in 1987 and 817 in 1990) among two similar samples of 16–19-year-old apprentices and concluded that the campaign and local interventions had no real effect on the rate of sexual activity of apprentices, but had a positive effect on the level of contraception and condom use. It has been recommended that this strategy be maintained (83).

#### ***Availability of key opportunities and commodities***

A programme based in the United States has developed an intervention to work with young people with identified risk factors such as aggressive behaviour towards classmates, poor academic performance, and difficult family situations. The intervention provides academic support schemes such as tutoring combined with recreational opportunities. Parent involvement was encouraged and a multi-agency approach was used with the assistance of the police, school district, housing authority, and various partner youth organizations. The juvenile arrest rate decreased by 27.9% over a three-year period (compared to a 17% increase in the rate throughout Florida State),

while the proportion of young people in the programme at risk of educational failure fell by 55% (M. Simon, K. Monahan & G. Slutkin, unpublished data, 1995).

Concerning supplies, programmes which stimulate a demand (for example, on the health system) must ensure that this demand can be met (65). It is, for example, counterproductive to recommend condom use to a target audience if there is no ready supply and easy access. This principle holds true in other areas of health promotion, and in Chile an illustration of this arose when the Ministry of Health sought to gain a perspective on programming needs from diverse youth populations through focus groups. Sports clubs were determined as a useful approach to reach young people living in poor economic conditions; however, to implement this idea it became necessary to equip these facilities with basics such as sports shoes and sportswear as a first step. Two very clear examples of how the supply of commodities can be central to the success of a programme are given in Boxes 5 and 6.

### ***Policies and legislation***

Promoting policies conducive to programming (by supporting development, prevention of health problems, or provision of care) is another important aspect of ensuring young people have the opportunities and services they need to promote and protect their own health. Advocating the amendment of restrictive laws, policies, and regulations, and instituting new ones is, therefore, a legitimate area of endeavour for adolescent health programmers, as is advocating the enactment of policies and legislation to ease adolescent access to important opportunities and services, particularly in relation to formal and informal education; income-generating activities and vocational training; and appropriate health and social services (see sections 4.6 and 5.4). In the area of reproductive health, political leaders can enact and enforce specific laws and policies that (68):

- improve young people's access to reproductive health information and services;
- outlaw the abuse of young people, including sexual abuse and female genital mutilation;
- prohibit child marriage and raise the minimum legal age at marriage;
- emphasize the importance of young adults' reproductive health;
- endorse realistic, compassionate solutions to young people's problems;
- require the news and entertainment media to provide more responsible coverage and treatment of sexual behaviour;
- increase commitment to keeping girls in school.



**Box 5****Nutritional supplementation in Bangladesh**

The safe motherhood project which was implemented by Jatiya Taruh Sanga, an NGO, in collaboration with WHO and the World Assembly of Youth in the early 1990s is an example of a programme which provided an important commodity (nutritional supplements) along with nutrition education to increase the benefits of the programme for young women. Because almost half of all women in Bangladesh are mothers by age 17, the project targeted 3000 women between the ages of 15 and 20 living in all the villages in eight selected unions of two districts (82).

Malnutrition among women, particularly pregnant and lactating women as a result of poor distribution of available food within the family is one sociocultural factor which contributes to the high rate of maternal mortality and morbidity as well as malnutrition among young children. In an effort to decrease maternal mortality and morbidity among women of childbearing age, Jatiya Taruh Sanga launched two four-month health campaigns composed of a nutrition education programme followed by an iron and folic acid supplementation programme. The rationale for implementing both the provision of information intervention and provision of the supplements rested on the assumption that the adolescents would not comply with taking the nutritional supplements as needed if they did not understand why the supplements were important.

In the first stage of the programme, information was provided to help change attitudes about the nutritional needs of women. The campaign was directed toward community leaders and family decision-makers, emphasizing the need for a balanced diet and for young women to consume more food. Specifically, the campaign urged families to make sure the targeted women ate one extra meal each day. The message which the campaign attempted to convey in simple and straightforward terms was that young women need to consume an extra meal a day in order to protect them and their eventual first baby, especially during the first year of marriage. Thirty-two female field workers and eight male supervisors were recruited and trained to implement the project. The women's increase in food consumption was recorded on diet sheets, and after the four-month period, field investigators noted an increase in weight and height after completion of the intervention.

The next four months of the intervention aimed to help the adolescents use their newly acquired nutritional knowledge not only to eat an extra meal every day, but also to take nutritional supplements. Field investigators distributed iron and folic acid supplements provided with World Assembly of Youth funding in four visits to each project area, recording the adolescents' weights in the first and last visits. Each woman was given a daily dose of 60mg iron and folic acid tablets in addition to oral saline, antacid tablets, and water purification tablets. Use of the supplements was positively related to the improvement of the young women's health and weight gain, as the average weight of the young women in the first visit was 42.6kg, whereas in the last visit it was 44.1 kg (82).

**Box 6****Impact of social marketing on use of condoms in Botswana**

The Population Services International (PSI) Botswana social marketing programme monitors and evaluates its effectiveness in several ways. First and foremost, sales are carefully monitored through management information systems. To date, the project has sold over 3.3 million condoms, selling on average 160 000 condoms per month at the annual rate of 1.28 condoms per capita. PSI's annual sales per capita are the highest for any social marketing product in the world. Second, consumer intercept surveys, focus group research, and knowledge attitudes and practice (KAP) studies are conducted to evaluate the impact and performance of the project. Such studies have provided quantitative as well as qualitative information that is used to develop and refine marketing and communications strategies, critical to the project's success.

A 1994 KAP survey performed by a research firm, SIAPAC-Africa, and conducted among adolescents between the ages of 13 and 18, reflected increased levels of awareness about AIDS and condoms. The survey showed that two-thirds of young men report using a condom during their last sexual encounter, as opposed to 28% of the respondents in 1992. Regular use of condoms among adolescents also increased from 1992 to 1994, tripling in one location and doubling in two other locations where the survey was conducted. A cost-benefit evaluation has shown that the Botswana Social Marketing Program has helped prevent 22 000 cases of HIV in the country, thereby saving the government 95 million Pula (or \$35 million in health care costs and loss of productivity). This is the result of the sale of 3.3 million condoms and extensive education activities.

The following are lessons learned concerning access to resources, social marketing of products and services, and involvement of young people in process.

**Lesson 1. Access to necessary resources**

Findings from KAP surveys demonstrated that young Botswanans are willing to help themselves, if they have access to the necessary resources. The adolescent reproductive health project provides these critical resources, and is an important step in learning how to provide health services for young people. The reproductive health services referral network which is part of the project addresses the problems associated with reproductive health and the confusion it can create among adolescents.

The easy access to products such as condoms provides adolescents with the means to take charge of their life. Increased accessibility and affordability depend upon effective distribution that the social marketing channels offer. The affordability of the product makes it attractive and therefore in high demand. Distributors have more of an incentive to sell the product knowing it is in high demand.

**Box 6 (continued)**

Lesson 2. Social marketing works with products and services.

The adolescent reproductive health project referral network for reproductive health services for adolescents showed that it could increase demand for routine and treatment-based health services by encouraging young people to seek advice where they saw the *Tsa Banana* (means "for adolescents" in Setswana) logo, and to follow it up by visiting a clinic. The crucial criteria for success are the necessary link with a tangible product or service and the orientation toward achieving tangible goals.

Lesson 3. Involvement of young people in process

The adolescent reproductive health project experience has shown that the involvement of young people is one of the most important reasons for the project's success. This young adult's programme differs from more generalized health problem prevention activities in that it involves adolescents in the design and implementation of both peer and mass media information and motivational campaigns designed to encourage abstinence or other prudent behaviour. The peer educator promoters, by virtue of their constant exposure to the message and the audience, are knowledgeable about what interventions will succeed or fail with young people, and how to sell to young adults in a direct and measurable way that is acceptable to the rest of society. In the case of Botswana, society at large has been supportive. The messages are even presented to children in school with no ill-effect (P. Hickey, unpublished data, 1995).

The Women's Centre in Jamaica assists pregnant and new young mothers to continue their education. Through its work and links with the Ministry of Labour and Welfare, the centre was instrumental in getting a code changed in 1985 to allow pregnant girls to return to school (84). The World Health Organization, United Nations Population Fund (UNFPA) and UNICEF conducted a survey (85) in 12 countries on three continents to investigate policies and laws governing adolescent access to reproductive health information and services. Policies in most of the countries surveyed appear to ensure confidentiality, which adolescents often cite as a barrier to the use of services. A number of the findings of this survey are presented in Box 7.

Policies which deal with crime and violence also need to be responsive to the realities of young people's situations, for example by recognizing the need to deal effectively with adults who entice young people into criminal activities such as drug trafficking, or the use of guns. In Costa Rica the Juvenile Justice Penal Code has been revised. There has been a shift in the treatment of adolescent offenders to focus upon

**Box 7****Policies and laws affecting adolescent sexual and reproductive health**

WHO, UNFPA and UNICEF jointly developed and implemented a survey on policies and laws affecting adolescents' access to sexual and reproductive health services and information. The survey was conducted in 12 countries from all regions of the world (convenience sample). Complete information was received on 10 of the 12 countries and the findings have been verified by the countries. The following are some of the findings:

Laws defining the age of consent to sexual relations for girls in two-thirds of the countries ranged between 14 and 18 years of age. Only in a third of the countries is there a law for adolescent boys.

More consistent is the existence of laws defining the minimum age of marriage. The minimum ages range from 14 to 21 years. If the age is different for the two sexes, the legal age for girls tends to be lower than for boys.

Age limit for using services: in one-third of the countries a minimum age for use of services including family planning, STD treatment and information provision was established. The age limits range from 12 to 21 for different types of services. Further research is needed to establish whether the absence of a policy regarding age limits for service use does not in fact hide barriers to access: service providers are not backed up by any policy guidelines.

Marital status: in some countries the provision of information on pregnancy prevention is conditional on being married as is the access to STD treatment and contraceptives.

Parental/partner consent — there is a requirement in some countries for parental or partner consent in the use of certain reproductive health services.

Confidentiality — in most countries, policy exists that guarantees confidentiality for those using services. In many countries, policies exist that exclude pregnant girls, either married or unmarried, from schooling. Some positive examples exist, however, of policies that promote the return to school of adolescent mothers after the breast-feeding period, and which also make special provisions for adolescent fathers.

helping them become responsible citizens within society. In Costa Rica, UNICEF carried out a range of awareness-raising activities on the implementation of the law and its implications, and provided technical assistance for the institutional reform of the sanctions currently applied to adolescent offenders (86).

In general, policies in all areas can:

- set direction for the future as well as reflect the current realities;
- establish goals that serve as standards on which to base programmes and assess their adequacy;
- promote or prohibit specific interventions and actions to be undertaken by various individuals and organizations;
- help gain political and programme commitment to support the promotion of youth health.

There are increasing efforts to create a safe and supportive environment for adolescent health and development, and some lessons have already been learned (87):

- The task of analysing the environment of an adolescent becomes less daunting if the focus is put on the adolescent thereby making it possible to view, from his or her perspective, the relevant factors to consider.
- The process of creating a safe and supportive environment requires the genuine participation of adolescents and their communities, as only they can identify the factors that are supportive, neutral or negative.
- Depending on participatory processes requires a significant investment of resources and time. Working to influence the environment and monitoring effects of this on people is a long-term initiative.
- Many actors and settings are required to work on many fronts in influencing the environment, necessitating the building of alliances and forging consensus on goals.

#### 4.3 Providing information

This intervention can be defined as the provision of appropriate information, by whatever means, with the principal aim of increasing adolescents' knowledge and understanding of a particular health issue, and sometimes with the explicit intention of motivating them to adopt healthy behaviour and to prevent hazards such as unwanted pregnancies, STDs, use and abuse of substances, violent behaviour and nutritional deficiencies.

The term "providing information" is chosen as a simple descriptor of this intervention, even though in reality a broad range of activities are involved, ranging from interpersonal communication to the use of mass media. Nor does the term exclude the educational approaches which are essential in helping young people acquire knowledge.

The types of information needed by young people and the creative education techniques used to enhance the learning process are

discussed in this section to describe this intervention. Provision of information is deliberately chosen in place of the term “information, education, and communication” (IEC) because this term has been used extensively and become confusing. “Education” can mean the full scope of instruction and the process of learning in and out of the school setting. “Communication” is at the heart of counselling interventions, and is also very much part of the process of providing instruction and feedback in skills-building approaches, but these two interventions would not typically be included under the IEC umbrella.

The information young people need and are entitled to is part of a safe and supportive environment for them. Provision of information is the foundation upon which to offer the additional interventions of skills-building, counselling when needed, and access to health services.

- Adolescents require basic information about growth and development and the changes experienced physically, psychologically (both emotionally and cognitively), and socially during maturation.
- Adolescence represents an important opportunity to share and explore information about the needs (both shared and sex-specific) that males and females experience, and about the roles each sex plays in relationships, family life and society. For example, information can be shared about important roles for fathers in raising children, and the need for both girls and boys to be educated (88).
- Adolescents require information about specific areas of health, such as nutritional requirements for males and females at each stage of growth, requirements for good dental care and physical activity, sexual and reproductive health, and ways to express feelings without resorting to aggression towards others.
- Adolescents require information about potential risks to their health from behaviour such as early and unprotected sex, use of tobacco, abuse of alcohol and other drugs, and on how to avert these risks.
- Adolescents also need information about opportunities and available services, related to health, education and vocational and recreational opportunities, to optimize the use of resources available to them.

Because basic information is a foundation upon which young people build knowledge and skills to cope with the world around them (Box 8), it is essential for programmers to take time to learn what information adolescents possess as well as what misinformation may need

**Box 8****Young people voice their need for information**

From a young girl in Ireland who became pregnant:

"I was an immature girl, who because I got pregnant was meant to behave like a woman. Suddenly I came from being a schoolgirl to being a mother. I wasn't wild, I hadn't even lived — I had hardly been allowed out to discos. I felt that my sex education was inadequate. I believed stupid things. I thought it happened to one in every family and because it happened to my sister, it couldn't happen to me" (89).

Workshops on adolescent reproductive health needs conducted with young people and facilitators from local branches of the Boy Scouts and Girl Guide movements, the YWCA, the Red Cross and Red Crescent and the National AIDS Control Programmes in the Philippines, Sri Lanka and Zimbabwe reported (Montsi, unpublished data, 1995) that the main problems common to all three countries, closely related to a local lack of reliable information sources, were as follows:

- While most participants had access to public health and welfare programmes and activities, the subject of adolescent reproductive health was inadequately or not at all addressed in these activities.
- When problems of reproductive health arose, there were no reliable sources of information. Young adolescents were shy, and reluctant to consult health, STD or family planning centres. Such problems were usually discussed with peers, and the answers accepted — right or wrong.
- As a result, there was an urgent need for training of NGO trainers and youth leaders on adolescent reproductive health and for the availability of reliable information to be shared with adolescents.

clarification. Understanding what adolescents want to know more about, as well as what information adults want to provide them is vital.

The actual provision of information can be divided into the following two types:

- interpersonal communication
- mass media.

Activities in both of these broad categories can be assessed on their potential to achieve the desirable features outlined in Box 9. The degree to which information can be shared in the above ways indicates the potential for the approach to positively influence a young person and thus help ensure that the young person acts on it.

### **Box 9**

#### **Features of successful approaches to the provision of information to adolescents**

The information should:

- Be interactive — interactive communication is especially powerful, since it permits the young person to ask questions and explore issues of special individual significance, ensuring that the information has a greater degree of personal relevance (90, 91). Such an approach to sharing information validates the importance of what the young person thinks is useful and significant to talk about, thus potentially motivating interest in the content area. This approach increases the likelihood that information pertinent to the life situation of the young person will be covered or given more attention. Typically the interpersonal ways of providing information have more potential to be interactive; however, some mass media approaches discussed in this section are also interactive.
- Be active in approach — in addition to being interactive, approaches to providing information can also be active physically, giving young people a chance to move around, and if possible (and appropriate to the setting, culture and type of information being shared) to use as many of the five senses as possible to enhance the process of learning. Active approaches help make learning fun. Evaluation of the information sharing components of youth programming consistently confirm that young people respond well to (and prefer) active methods, and interactive approaches (92; YWCA, unpublished data, 1995; Jamaica Red Cross & American Red Cross, unpublished data, 1995; C. Lane, unpublished data, 1995).
- Be offered to a “voluntary” as opposed to a “captive” audience — there is a likelihood that someone who chooses to learn the information offered may be more receptive to it than one on whom the information is imposed. In settings such as a classroom, for example, the use of question-and-answer approaches or other interactive methods become particularly useful to help increase a sense of initiative or control on the part of an audience who have not chosen to be there (93).
- Be tailored to the needs of individual adolescents — activities to share information which addresses known concerns, needs or questions of young people are seen as important in increasing its usefulness, and in ensuring (as far as possible) that the information is shared in a way that helps a person to understand and absorb the information.
- Reach a large number of people — reaching as many young people as possible is also an important aim of sharing information. Assessing the capacity of the approach to reach young people includes careful identification of the population of young people or adults the approach is aimed to inform. For example, some approaches might be very effective in reaching the largest total numbers, but could be ineffective in reaching adequate percentages of selected groups of young people or adults that have been identified to receive the information.



### ***Interpersonal communication***

*Adult to adolescents* — perhaps the most common kind of information provided person-to-person is from family members, teachers and health workers. Parents, especially mothers, are likely to be the primary source of information about health, hygiene, health behaviour and risks for the child and adolescent. However, on sensitive subjects, such as sexuality and use of illegal substances, adults are commonly unable or unwilling to discuss these issues, especially with their own children.

*Adolescents to adolescents* — although typically used in peer education provided by trained young people of a similar age, this method is used more often among friends who are equally uninformed. In countries where cultural or religious barriers obstruct the information of adolescents on sexuality and reproductive health, the young are obliged to obtain their information from their friends. Myths are thus perpetuated, and wrong information can have disastrous results. Peer education, where it does occur, can be distinguished from “peer counselling”, the latter requiring a more sophisticated approach, training, supervision and support (94). Expanding the capacity for proper peer education can help to reduce the misinformation of adolescents.

Peer-to-peer education has also been found to be an effective approach to sharing information. Young people are often willing to listen to and follow advice from their peers. Research indicates that peer-led education is at least as successful as adult-led education in health risk reduction programmes on matters such as drug abuse, prevention of pregnancy and HIV (95). Young people stating support for and modelling important prevention behaviour (such as thinking about personal choices before starting sexual relationships, using a condom, and avoiding abuse of alcohol) have been found to help create and strengthen positive attitudes in groups towards the healthy behaviour. As role models, peers can be very effective in enhancing information sharing as an intervention (51, 96).

The *telephone hotline* — commonly organized by NGOs, the hotline provides a person-to-person service which is popular in many countries. Ensuring confidentiality, the “counsellor” is able to discuss sensitive health problems with young clients, give advice, and arrange referral to health clinics, private physicians or social services as appropriate. In countries such as Indonesia (97) and the Philippines (98), large numbers of telephone hotlines, usually in urban areas, furnish a valuable service by helping to defuse delicate issues and to resolve the problems of individuals. Services can be anonymous while tailoring

help to personal needs. These are two important characteristics, the first making the hotline more likely to be used by young people afraid to approach other sources, and the second providing specific information, and sometimes a degree of counselling. Although the hotline is essentially restricted to urban areas, it can also be made accessible wherever there are public telephones in places frequented by young people, such as factories and youth centres.

*Adolescents to group* — peer education involving small groups features in several successful adolescent health programmes, and is considered very effective for transmitting information on sensitive issues (99). Comprehensive training methods have been developed. Adolescent peer educators often help reach out to parents and communities, as well as provide information, for example on the availability of health and counselling services. Peer approaches have been particularly successful with very vulnerable groups such as street children and commercial sex workers. Peer educators also distribute condoms to sexually active and unmarried out-of-school young people with no access to family planning clinics. One thing often overlooked by peer educators in many countries is practical information about services — what services are available, what they are for, how to use them, what their characteristics are (including whether they are confidential, private, and low cost), and where young people can get them. Such information is likely to make services genuinely accessible to young people.

*Adult to group* — is the most traditional form of instruction, usually provided by teachers in the formal setting of the school, the less formal setting of youth clubs, and sometimes in the health clinic. The school provides the best opportunity, in principle, for a progressive programme of instruction in health and health-promoting behaviour; in life skills and on sexuality and reproductive health, substance abuse, nutrition, and accident prevention, beginning at an early age and continuing through the adolescent period into young adulthood. There are some good model programmes along these lines in the developed world. However, in the majority of developing countries, information on adolescent sexuality and reproductive health and the use of substances does not feature in the school curriculum, and teachers are rarely trained or authorized to deal with these sensitive subjects. Even in countries where communication is unencumbered, information about sexuality and reproductive health or substance use is often given by teachers who are inadequately equipped to deal with the subjects and to communicate with young people in an interactive way, which renders such information irrelevant.

Youth clubs, often run by NGOs, offer many opportunities for youth leaders and invited speakers from the community to inform young people. Youth input and participation in the planning are increasingly common, even when the leader is an adult. Many of these clubs, usually in urban areas (for example, Metro-Manila in the Philippines and Tegucigalpa in Honduras) cater specifically to the needs of adolescents for information, and conduct group sessions to defuse sensitive issues. The sessions give young people the opportunity to air their problems and receive reliable answers. However, youth clubs are also influenced by local cultural and religious barriers, and in some countries the nature of information on sensitive subjects is restricted. Although health clinics, including primary health centres, maternal and child health (MCH), STD and family planning clinics, sometimes conduct health education sessions for groups of young people, this is not usually seen as a primary function. Information activities are, thus, often neglected or ineffective. Questions are rarely encouraged, so that the little information provided is often irrelevant to young people's specific needs. Clinics run by progressive NGOs and catering specifically for young people are the exception.

There are many creative methods that have been tried and found very helpful in sharing information with young people. Useful and engaging basic methods of sharing information used throughout the world include small-group discussion, brainstorming, and traditional folk media such as games, story-telling and proverbs, and the arts (painting, pictures, photographs, music, drama, dance, poetry and so on) (93, 100, 101). An example of a game that has been adapted to share information on health is *Snakes and ladders*, which uses dice to determine players' moves on the game board. Players are required to answer questions on selected health topics to proceed. Played individually or in teams this game has found universal appeal with young people and has been adapted to provide information on issues including growth and development, sexuality, prevention of pregnancy, STDs (including HIV infection), and prevention of substance abuse (101). In Peru a similar board game called the *Road to health* was developed to share information on the prevention of cholera. Young people were also encouraged to take the information they acquired on hygiene and disease prevention home to family members (88). Participatory approaches have been led by both young people and adults and have been successful in peer-education programmes in Botswana, China, Indonesia, Jamaica and the Philippines (Jamaica Red Cross and American Red Cross, unpublished data, 1995; P. Hickey, unpublished data, 1995; YWCA, unpublished data, 1995; 102). In some cultures the technique of using debating teams has been

applied to health, stimulating heated discussions within a context that demands accuracy, a logical approach, and attention to rules of order. Such debates also offer an opportunity for the leaders to hear a range of opinions, perhaps uncovering myths or misinformation held in their groups that may have gone unnoticed.

### ***Mass media***

“Mass media” is a descriptive title referring to the extensive category of information provision interventions which can target and reach a large audience. Radio, television, films, the printed media and the Internet are examples of mass media that have the potential to reach very large numbers of young people. Mass media and entertainment activities which provide information can serve several purposes: increase knowledge, influence attitudes and social norms, and encourage the changing (or continuation) of behaviour.

When the right type of medium is selected for a particular group of young people, and is well designed, such programming approaches have great appeal for young audiences, increasing the chances that the desired information is heard and believed. Concerning radio and television, pilot-testing is necessary to determine if young people intend to listen to (or watch) the information programme and whether they find the presenter believable. When the mass media are used to encourage healthy behaviour, it is important that the actors and presenters are seen as someone young people want to emulate. Role models will naturally vary amongst different groups, and it is necessary to find out the reaction of young people to those featured in programmes before wide distribution is attempted, to increase the likelihood that young people will want to adopt the behaviour demonstrated or suggested.

There is need for young people, adults involved in adolescent health programming, and people in the field of communications to collaborate in the design and implementation of mass media programmes. Such collaboration has been realized in many countries, for example with the development of youth radio and television dramas carrying reproductive health information. Newspapers, radio and television are all examples of one-way mass media sources of information. Nevertheless, carefully assembled information repeated frequently, especially at prime audience times for radio and television, can influence the opinions and even behaviour of young people with respect to nutrition, reproductive health, and the prevention of substance abuse. In most developing countries, the effect of newspapers and television is confined to the cities, due to a lower literacy level and the rarity of receivers in many rural areas. However, this is beginning

to change due to the increasing use of videos, which can carry the visual impact of television into the countryside and villages.

The visual aspect of television greatly enhances its interest and impact. This medium has been successfully used in most countries to inform young people and reinforce efforts to prevent HIV transmission. Television can relay information about adolescent health issues through serial dramas, such as one in the Philippines which dealt with adolescent pregnancy (103). Television has also provided a channel for popular soap operas addressing adolescent health concerns in Latin America. In Mexico, a television mini-series was an important component in a project to promote adolescent sexual responsibility. Colombia's National Programme for Sex Education helped to overcome people's resistance to sex education in public schools with a weekly television serial which employed popular actors to address the problems of typical middle class adolescents in an entertaining soap-opera format (84). As with radio, a single presentation can expect little result, and repetition over an extended period is essential to achieving a lasting effect on young people. The idea of a multimedia campaign has been tried and successfully tested in many countries.

Radio is universally available, and programmes in local languages reach schools and young people as well as adult communities. An example of the use of radio to share information and increase awareness on reproductive health topics, drug use, and other topics is the *Dehleez* radio drama in India (G. Giridhar, unpublished data, 1995), broadcast in 52 episodes each year. The drama is targeted at adolescents, and is reinforced by extensive mail feedback from its listeners, estimated at 800 000. As with all successful mass media programmes, it was preceded by a careful study of listener attitudes and opinions, and the essential information on sexual and reproductive health was integrated into the series and repeated frequently. The popular Radio Botswana programme *Teen Chat*, which is part of the Botswana Peer Approach to Counselling by Teens Programme (YWCA, unpublished data, 1995) is designed and implemented by young people themselves. Similarly the serial radio drama activities run by the Jamaica Red Cross island-wide youth HIV/STD prevention project has been equally successful in augmenting peer education efforts (Jamaica Red Cross and American Red Cross, unpublished data, 1995).

Popular rock stars, singers and actors give credibility as well as publicity to songs, serial dramas and soap operas which contain themes on sexuality, reproductive health, drug and alcohol dependence and violence (104). Such figures play an important role in creating awareness

among young people, and, where the star is a role model for the young, even in changing behaviour. The efforts of a popular singer in the Democratic Republic of the Congo were considered to be the country's most effective public-health intervention in activities to prevent HIV transmission (103). In Burkina Faso, Mali and Senegal, 12000 young people participated in a writing competition on short scenarios for a video on HIV/AIDS. The archive with the 150 selected scenarios provides insight into young people's language, perspectives, concerns and possible solutions, and provides a basis for formulating more effective communication strategies. Thirty of the best scenarios will be aired in Burkina Faso (105).

Songs were found to be an important part of health education programmes in 11 countries (including Bolivia, Mexico, and Peru) by bringing home the message that "It's alright to say no" as part of an adolescent pregnancy prevention programme targeting 13–18-year-olds. Focus groups with adolescents were used to determine the messages used, and the boy and girl singers were carefully chosen. One song reached the top of the hit parade in Mexico after 6 weeks and was heard by millions of young people as a result (100). Entertainment, almost by definition, is popular, especially with young people, being mostly about interpersonal relationships. An example of what can be done to highlight relationships is a series of successful drama-writing contests by young people during the 1980s, initiated by the Centro de Orientacion para Adolescentes in Mexico. Winners often come from the most economically deprived sections of society, and their plays are performed in public with considerable impact on audiences. Similar experiences are reported from many African countries, an example being in Ethiopia where a youth touring drama group reached 65000 young people (106).

Radio, television and the performing arts can, therefore, all present important information in entertaining and credible ways. In Bolivia, the Health and Education Ministries have successfully used radio to broadcast information to school classrooms on disease prevention (starting with diarrhoea prevention and oral rehydration, and expanding to include cholera, personal and dental hygiene, acute respiratory infections, immunization, infectious diseases, and accident prevention). The radio programme emphasizes actions that young people can do for themselves, or for younger children (107).

Newspapers, magazines and other printed material also have an important role in sharing information on health topics. In some cases, unresearched stories and sensational accounts lead to misinformation. Because many young people gain information through such

printed material, it is vital for programmers to be aware of the factual content of articles, as well as of opinions expressed in print media.

Newspapers continue to be an important source of information. In Zimbabwe, 50% of secondary school students cited the newspapers as their first source of information on adolescent sexuality and reproductive health (108), followed by television, radio and magazines. Health care providers were only cited by 20% as a primary source, as were classmates. A similar result was obtained in Nigeria, where 42% of teenagers stated that their first source of such information came from television and newspapers. The media were urged to provide accurate information in order to correct various misconceptions, and promote healthy preventive practices. A survey of young people, conducted in the Russian Federation, revealed that their preferred sources of information were mass media (109).

Other kinds of printed material are also important media for providing information. A booklet was developed and widely distributed in Kenya for children entering adolescence, with content addressing issues such as sexual development, emotional health, menstruation and pregnancy, health risks of teenage pregnancy, child-spacing, and nutrition. The booklet aims to help young people understand birth as well as human growth and development, and appears to have helped young people to develop healthy attitudes towards sex (110).

Another example of the innovative use of printed material to inform adolescents on health is a romantic novel developed by a Chiang Mai research team in Thailand. The novel, about a young working woman who becomes infected with HIV, seeks to increase young women's awareness of their risk of contracting HIV. After reading the novel, the target group of young female factory workers showed increased awareness of their own vulnerability to HIV/AIDS (111).

Although mass media are often considered as one-way communication, there are many ways in which some form of interactivity can be achieved. These include: telephone talk-ins to radio programmes; questions and answers in magazines and newspapers; discussion with or by young people in debate on television or radio; plays written or performed by young people in the mass media. Another innovation — the computer kiosk — simulates the interaction between young people and bartenders, and has been used for information and research on substance abuse. In one example, an interactive individual computer programme was used by young people at a scout jamboree (attended by 20000 young people), and at various urban sites. In many developing countries, more traditional forms of communication

can be used effectively in rural and urban settings, and can help consolidate existing expertise in many societies.

In 1992, China's Radio Shanghai launched a talk show called *Whisper* which accepts listeners' written questions on sexual and reproductive health. Covering topics such as misconceptions and myths, abortion, STDs (including HIV/AIDS), the 20-minute show is aired twice daily in the late evening and is claimed to reach nearly half of China. Answers are given on-air and, if the questions need further clarification or a listener needs information about where to get medical attention, replies are mailed. In order to provide comprehensive coverage, the *Whisper* staff have also produced cassettes and books about the topics covered on the programme, and a counselling centre has been established (112).

Other projects include the development and production of leaflets and brochures, bulletins and newsletters, as support learning materials targeted at both young people and the community, or as a promotional tool to inform young people of the availability of services (N.B. Katunzi, unpublished data, 1995; Jamaica Red Cross and American Red Cross, unpublished data, 1995; 92). The best effects are obtained when adolescents participate actively in the design of materials, or even assume full responsibility for their production and dissemination. The value of such materials rests in the provision of accurate information on different aspects of adolescent health and development. They help to dispel myths prevalent in countries where free discussion of sexuality and other sensitive issues is forbidden.

The *fotonovela* and comic magazine are very widely used throughout the developing world as a means of transmitting health information in an entertaining form. In many countries, comics are the main reading material of adolescents, and NGOs and adolescent health programmes have designed comics and serial magazines which contain information on adolescent sexuality and reproductive health, and on the use of substances integrated into the storyline. For example, comic-style newspapers and magazines are very credible and popular in Nigeria, and have proved very effective in educating adolescents about reproductive health, sexuality, and STDs including HIV/AIDS (113).

The provision of information through interactive methods is vital to programming to influence attitudes and behaviour choices in sexual and reproductive health. One meta-analysis of the effectiveness of United States school-based programmes to reduce sexual risk behaviour (96) identified the provision of information through interactive learning methods as one of the six distinguishing characteristics



of programmes which can reduce rates of unwanted pregnancy and STDs (including HIV). The analysis notes that effective programmes provided basic, accurate information about the risks of unprotected intercourse and methods of avoiding it through experiential activities designed to personalize this information, rather than through didactic instruction. Interactive methods included various games and small-group discussion. Although increasing knowledge was not the primary goal of these programmes, all provided basic information that students needed to assess risks and avoid unprotected sex, emphasizing the basic facts needed to make behaviourally relevant decisions.

A review of the effectiveness of measures to reduce risk behaviour among young people in selected health areas (114) presents findings on the usefulness of providing information as an effort to prevent substance abuse. According to the review, one assessment of adolescent programmes on tobacco, alcohol and drug abuse found that programmes focusing on knowledge and attitudes alone had limited effect (115). The conclusion was that such programmes often fail to address the psychosocial factors promoting substance use, particularly peer and community influences.

Programming that specifically addresses the influence of the media on young people's choices concerning smoking, alcohol, drugs, and sex is an essential component of initiatives aimed at modifying behaviour (34, 51). Such programming includes adolescents' analysis of the media's portrayal of drugs and different forms of drug use, or of sex and relations. The programming incorporates the consolidation of skills to help young people learn to respond to pressure from the media. Nevertheless, activities that focus on exploring and increasing knowledge about what is in the media are the first step. Data on effectiveness relates to interpersonal communication because it takes interpersonal communication to discuss and clarify these issues fully. Box 10 illustrates a number of evaluated examples of programmes which demonstrate the effectiveness of mass media and entertainment in providing information and positively influencing adolescent behaviour.

#### ***Effective provision of information: lessons learnt***

Although many questions remain about what works best in effective provision of information, it is clear that efforts should be made to exploit the various ways of reaching young people, especially by involving them directly. Using large-scale media approaches to disseminate important health information that can be imparted through

#### Box 10

##### Information provision — evidence from the field

Mexico — an example of the effectiveness of the media in reaching young people with information through songs and videos is the multimedia campaign in Mexico urging young people to postpone sex. The popular duo, Tatiana and Johnny, recorded songs and a music video which encouraged abstinence.

Survey results: a survey of 2296 young people indicated that 98% remembered the song when the title was mentioned, and 51% of the respondents talked to friends about the songs (116, 117).

In the Democratic Republic of the Congo a campaign to increase the use of condoms was launched by the AIDS Mass Media Project to promote safer sex practices among young people ages 12–19 and prospective parents between 20 and 30. The entertainment component of the project included television and radio spots, music videos, dramas, and comic strip calendars. Investigators evaluated the programme using periodic knowledge, attitude and practice studies followed by a post-test survey after the broadcasts.

Results: a 15% increase in condom use and an increase in condom sales from 900 000 to 18.3 million were reported over three years of the campaign (118).

The Young People's Project in the Philippines promoted sexual responsibility by releasing two songs in 1988 called "*That situation*" and "*I still believe*" which were supported by a telephone counselling hotline called "Dial-a-friend." Evaluation of the project was conducted both by monitoring the hotline and with three-part pre-broadcast, mid-broadcast, and post-broadcast surveys.

Results: the songs reached 92% of the target population in the Metro Manila area, and 44% of those surveyed said they talked to their parents or friends about the songs. One-fourth of those who called the hotline said they had sought information about contraception (119).

The Soul City Project in South Africa is an example of a mass media programme which used multiple media channels to communicate information about maternal and child health to encourage healthy behaviour. The multimedia campaign targeted young women in lower income groups, concentrating on topics such as breast-feeding, safe motherhood, infant nutrition, immunization, diarrhoea, respiratory illness, child abuse and accidents. The campaign included a dramatic television show aired during prime time called "Soul City," a radio drama called "Healing hearts," newspaper inserts, and a glossy booklet covering the maternal and child health topics mentioned above. The Institute of Urban Primary Health Care refers to the material as "edutainment," that is, education combined with entertainment. The dramas presented various health dilemmas and showed, in an entertaining manner, how the characters solved them.

**Box 10 (continued)**

Results: the IUPHC campaign was evaluated by investigators who interviewed a national sample of 800 black South African adults over age 16. Exposure to IUPHC programmes and health knowledge learned were evaluated in individual interviews. The evaluation results indicate that the campaign reached approximately 8.1 million people and 46.8% of black South Africans over age 15. The material proved highly successful in reaching the primary target audiences of young adult women in lower income groups and was especially well-regarded in rural areas. The combination of educational and dramatic material was clearly more attractive than either component alone. Close to one million black South African adults report that they have changed their behaviour as a result of the IUPHA media programme and 87% of respondents said they would use the information when the need arises. Examples of behaviour changes reported included treating injuries, breast-feeding, discussing child abuse, giving children fluids to control diarrhoea, using condoms, and visiting clinics (120).

interpersonal means is important in maximizing the chances of reaching young people (65).

It is important to present information to young people in a non-judgemental manner as this makes it possible to provide them relevant information and encourages healthy choices without condemning the options individual adolescents may take. People with field experience in working with young people report that this approach encourages young people's participation and responsibility for individual actions (Young Women's Christian Association, unpublished data, 1995).

Providing information to individuals and groups is enhanced by discussion and questions. Conditions which foster a supportive climate include acceptance of all questions, the facilitator's willingness and ability to offer the information or identify other information sources, and mutual respect between participants and the facilitator. Such conditions are important for communication about all health topics, and are vital in sharing and discussing sexual health, substance abuse, violence, and other potentially sensitive topics.

People are more likely to respond to information that they hear frequently. Health programmes that intend to influence behaviour often rely upon unpaid public service announcements that are broadcast rarely and at off-peak hours. These are not likely to encourage behaviour change. In the early stages of the HIV/AIDS pandemic, all

public and private means of communication were harnessed, with a predictably high influence on behaviour. However, with gradual decline in allocations to mass media campaigns, the influence on the public waned (65).

In developing Soul City — a media intervention evaluated as being successful in enhancing knowledge and encouraging healthy behaviour choices regarding maternal and child health — the Institute of Urban Primary Health Care in South Africa identified the following three factors as necessary for success (120):

- Popularity — each medium should be used in its most popular form, which presupposes access to prime time and use of the most popular and accessible genre.
- Multimedia — more than one type of medium should be used in order to maximize the audience of the various media campaigns.
- Formative research — continuing consultations with the target audience and experts in the field, in addition to pretesting and modifying materials, are necessary.

Interpersonal and mass media efforts to provide information must determine the type of information young people need to make behavioural choices that foster development and sustainment of health, and ensure that programming not only describes health problems but also offers information on how to prevent them. Information on the prevention of substance abuse should relate to the effects of substances on judgement, for example, rather than to the catalogue of drugs people abuse (J. Howard, unpublished data, 1995). Regarding reproductive health, functional information should cover facts about contraception, STDs, and the correlation between the treatment of STDs and the prevention of HIV infection. Practical information on the prevention of HIV infection covers basic facts like how the virus is spread, not spread, how a person can prevent the spread of HIV, and where to get testing and counselling services (96). Concerning prevention of violence, there is need for information on the various unaggressive ways of expressing anger. It is also vital to share information about services such as counselling services, STD treatment, and hotlines that are available for young people.

Although the overall programming objective may be to inform young people on selected health issues, it may be necessary to delay this to give them the opportunity to discuss other questions or health topics of immediate interest to them. Responding to their priorities will have several benefits. These include capturing adolescents' interest, demonstrating flexibility, allowing their input in setting the agenda, and

assuring them that their needs will be considered. With regard to entertainment, UNICEF has identified the factors which heighten the scope, appeal and influence of popular entertainment for the benefit of health, as follows:

- The focus on health should be clear, concise in scope and an integral part of the entertainment.
- Partnerships between the entertainment media and health experts are necessary.
- Entertainment media capacity should be assessed.
- Evaluation studies should have clear indicators of the impact of entertainment programmes.
- Entertainment programmes should encourage interpersonal communication.

There are major limitations to what the provision of information alone can achieve. Some drug prevention education programmes developed and implemented in the 1970s and 1980s in Australia, the United Kingdom and the United States, which focused on providing information, assumed telling young people about the dangers of drugs would be a deterrent to their use. Evaluation of the programmes, however, indicates no change or an increase in drug use (121–123). Providing clear, accurate information about health topics of interest to young people is essential to programming, but knowledge alone is inadequate to help young people develop and sustain healthy behaviour concerning nutrition, sex, alcohol and drug use. As noted in the introduction to this chapter, information skills, services, and a supportive environment are all needed to promote adolescent health and development.

It must be noted that peer-focused interventions can have unintended negative effects on participants if they require increased contact with peers with undesirable attitudes and behaviour (64). This statement applies to the delivery of any of the major interventions, but is noted here in association with the provision of information, as many programmes rely on sharing information in groups of adolescents in similar circumstances.

There are untested but promising methods of information provision such as computer technology. While this may seem far off in many economically disadvantaged countries, changes are taking place much more rapidly than expected. Young people take naturally to the use of computers. These hold the promise of being a rapid, entertaining, personalized and interactive method for promoting the health and development of young people in the future.

#### 4.4 Building skills

While the recognition of adolescence as a crucial period for developing skills is not new, the idea that they are needed for health, that having them can predict health, and that training can enhance them, has been given considerable attention in the last few years.

The intervention of building skills is the process of teaching competencies to influence behaviour through a set of structured activities. Teaching of skills is practical and intended to equip the young person with new or improved abilities in selected areas. The practical nature of this intervention is reflected in the methods used, which are experiential rather than didactic (124). Young people need to develop competencies and particular skills in physical, psychological, social, moral, and vocational areas, to promote healthy development and help prevent particular health problems (Table 4). Skills are needed for performing various specific tasks in everyday life and include:

- practical self-care skills such as how to plan and prepare healthy meals, or ensure good personal hygiene and appearance;
- livelihood skills, such as how to obtain and keep work;
- skills for dealing with specific risky situations, such as the ability to say “no” while under peer pressure to use drugs.

Skills are part of a cluster of key “life skills” defined by WHO (7) as “abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life.”

Life skills also refer to those skills which enhance psychosocial development. These include skills for decision-making and problem solving; creative and critical thinking; communication and interpersonal relations; self-awareness, and coping with emotions and causes of stress. They help young people deal with many life situations and can be applied to specific risky situations related to sexual behaviour, use of substances, or violence for example.

Research (64) links aggressive behaviour to the lack of certain skills. It has been noted that normative beliefs supporting the acceptability of aggression are important predictors of subsequent aggressive behaviour on the part of adolescents; also low skills for pro-social (constructive interaction with other human beings — sharing, taking turns, cooperating) involvement appear predictive of aggressivity leading to delinquent activities.

Skills developed in conflict resolution, namely: clear communication and effective listening; the ability to recognize bias, misconceptions,

Table 4  
**Skills for a spectrum of adolescent health and development concerns (7)**

Skills	Level 1	Level 2	Level 3
Self-awareness	Learning about "me as a special person"	Self control	My rights and responsibilities
Empathy	Understanding how people are alike and how they differ, and learning how to appreciate differences between people	Avoiding prejudice and discrimination against people who differ	Caring for people with AIDS
Interpersonal relationship skills	Learning to value relationships with friends and families	Forming new relationships and surviving loss of friendships	Seeking support and advice from others in a time of need
Communication	Basic verbal and nonverbal communication skills	Assertive communication in the face of peer pressure	Using assertiveness to resist pressure to engage in potentially health damaging activities (e.g. unprotected sex)
Critical thinking	Learning the basic processes in critical thinking	Making objective judgements about choices and risk	Resisting media influence on attitude towards smoking and alcohol
Creative thinking	Developing capacity to think in creative ways	Generating new ideas about things that are taken for granted	Adapting to changing social circumstances
Decision-making	Learning the basic steps for decision-making	Making difficult decisions	Decision-making about important life plans
Problem-solving	Learning the basic steps for problem-solving	Generating solutions to difficult problems or dilemmas	Conflict resolution
Coping with stress	Identifying sources of stress	Methods for coping in stressful situations	Coping in situations of adversity
Coping with emotions	Recognition of the expression of different emotions	Understanding how emotions affect the way we behave	Coping with emotional distress

and stereotyped thinking can help to reduce the use of violence as a means of handling problems. There is substantial literature that associates lack of effective skills in peer relations and social problem-solving in peer situations with behavioural problems and psychopathology (64).

Based on the assessment of the specific needs of young people in different situations, programming will need to put the focus on help-

ing individuals to develop specific skills. For example, programming aiming to promote health may need to address physical skills, such as learning particular sports to enhance the ability to use recreational alternatives to substance use. Programming may need to teach vocational skills, such as a craft or trade to help provide means of immediate basic survival or teach adolescents about protection against STD infection through correct use of condoms. Many young people have inadequate basic literacy, verbal and numerical skills, and this may need to be addressed at the individual and community levels. Interventions to create opportunities for both formal and informal education ultimately aim to help young people learn the skills they need to function well, establish satisfying relations, and to avoid specific health risks.

In addition to basic psychosocial skills, well-developed physical and performance skills are crucial for the survival of many young people who live or work on the street. The capacity to fight, to run, to react quickly and to weather physical harm will determine whether they may survive in such an environment. Practical performance skills such as juggling, singing, bartering, making crafts and vending provide the means for an income (59).

Adolescent mothers and fathers need to know basic child care, such as oral rehydration, to maintain the health of their children, and how to cope with the stress of parenting. A residential programme for young mothers and their babies in Guatemala City responds to this need by providing training in child care in addition to vocational training (63).

In some cases, specific programming efforts are required to increase adolescent access to basic services available in the community. In India, a programme offered by an NGO called Prerana launched an innovative project in January 1991 to help adolescent girls of 12 to 20 years improve their lot in life. The project seeks to empower the girls by providing them information to enhance their basic life skills and teaching them how to gain access to various services, including banks, post offices, local transport systems, hospitals and primary health centres. It also discusses women's legal rights and explores social problems, such as dowry, alcohol dependence and drug abuse; environmental issues, including fuel conservation, reforestation, soil degradation, pollution and garbage disposal; and personal skill development through goal-setting, decision-making, communication and leadership (G. Giridhar, unpublished data, 1995c).

Some important skills are acquired through ordinary experiences, situations, and relations. However, specific programming efforts can



strengthen skills. The Scout movement, along with other groups, promotes a process of learning through practice.

Efforts to build skills are either “generic” or concerned with specific problems. Generic programmes centre on the development of attitudes and behaviour that foster a positive self-image, healthy relations with others, and skills to solve everyday problems. The programmes focus on self-efficacy; self-control; the ability to act assertively in changing one’s environment in response to a problem; the ability to consider alternative solutions to a problem; the capacity to pursue goal-directed behaviour; the capacity to resist pressure from others and, concomitantly, to experience a sense of autonomy and personal control over one’s behaviour; and the capacity to evaluate the effectiveness of one’s actions and pursue alternative solutions if necessary. Programmes concerned with skills that help prevent specific health problems usually include similar concepts. However, making a distinction between the two types of programmes is helpful in exploring what has been learned, although experience shows that generic programmes easily overlap those dealing with specific problems (see Box 11).

The activities used to build skills include working in small groups and pairs, brainstorming, rehearsal, role-playing, games and debates. To teach a new skill, it is useful to introduce the behaviour or skill and provide information on its use, demonstrate the skill, give participants an opportunity to try it out, ask for self-assessment of performance (and of ways to improve it), provide feedback, and then provide the opportunity to try out the skill again. It has been found most effective to give the feedback in a constructive, supportive manner. This in itself is an important skill that adolescents and adults can learn. If the technique of role-playing is used, for example to learn skills for avoiding risky situations, it is often useful to introduce progressively complex situations to which the young person must respond, thereby practising the selected skills.

Adolescents can help define specific activities for building skills by making contributions regarding their particular circumstances and needs. Curricula are also useful in giving examples of training methodology to help standardize practice among youth workers, teachers and others and inspire the preparation of activities aimed at building skills that can be integrated into other syllabuses (125).

Evaluation studies have shown that programmes focusing on building skills of adolescents have the potential to promote various aspects of

**Box 11****Developing generic skills — some examples**

Programmes focusing on the development of generic skills have been implemented in some schools in the United States. Seventy-eight runaways at one residential shelter provided with up to 30 HIV/AIDS education sessions aimed at increasing general knowledge, coping skills, access to health care, and reviewing individual barriers to safer sex were compared with 67 runaways at a nonintervention shelter. A before and after assessment, at three and six months, showed more consistent condom use and less high-risk sexual behaviour among the 78 runaways.

The authors noted that other evidence suggests that sexual health education may increase young people's knowledge but not change their behaviour. Many studies do not even examine behavioural outcomes. Of the seven methodologically sound studies which provided evidence of effectiveness, only two showed short-term effects on young people's reported sexual behaviour. They suggest that while there is no evidence that providing practical information and contraception leads to sexual risk-taking behaviour, there is some evidence that aggressively promoting chastity may encourage sexual experimentation.

Programming that aims to increase the basic life skills of particular population groups needs to carefully assess what skills are needed for adolescents to gain access to the range of services available in the community. In India, for example, a programme offered by an NGO called Prerana launched an innovative programme in January 1991 to reach young women and girls of 12–20 years of age, to enable them to avail themselves of better opportunities in life. The effort is to empower the adolescent girls with relevant knowledge, enhance their basic life skills and access to various services, teaching participants how to gain access to public services, including banks, post offices, local transport systems, hospitals and primary health centres. It also discusses women's legal rights and explores social problems, such as dowry, alcohol dependence and drug abuse, and environmental issues, including fuel conservation, reforestation, soil degradation, pollution and garbage disposal, as well as personal skill development in goal-setting, decision-making, communication and leadership (G. Giridhar, unpublished data, 1995c).

positive mental health and prevent emotional behavioural problems (71).

A review of some research on life-skills programming (126) noted:

- positive changes in self-reporting of health behaviour (for example, substance abuse and smoking) following the programmes;
- those based upon skill learning worked better than traditional approaches based upon information provision;

- improvements in mental health status, in particular in self-esteem and self-confidence;
- improved relations, and more open communication with parents;
- evidence of teacher satisfaction, improved teacher–pupil relations and classroom behaviour, following training and implementation of a programme on skills.

One review (35) of the effectiveness of programmes to reduce high-risk sexual behaviour identified experiential methods of building skills as one of the nine characteristics of programmes that have helped reduce high-risk sexual behaviour. The characteristics cited are similar to those found effective in reducing substance abuse. The effective methods included role-playing; rehearsal; written rehearsal; verbal feedback and coaching; locating contraceptives in local drug stores; visiting or telephoning family planning clinics; and interviewing parents. In addition to these experiential activities, several curricula used peer educators or videos with characters resembling adolescents and with whom the adolescents could identify. By providing instruction on social influences and pressure, reinforcing individual values and group norms against unprotected sex, and increasing skills and confidence in those skills, these activities helped the adolescents personalize the information.

The findings of a recent meta-analysis indicate that the largest impact on smoking behaviour can be expected from interventions focusing on the ability to recognize social pressure and related skills-training, as compared to interventions merely providing factual knowledge, addressing self-esteem and general decision-making skills, or stressing alternative behaviour. The AIDS curriculum that managed to reduce adolescent sexual risk behaviour was based on a similar theoretical framework (127).

The findings further indicate that programmes using a social influence approach, addressing social norms and reinforcement to discourage smoking among adolescents hold more promise for older students, and have helped curb drug abuse and high-risk sexual behaviour. However, it is also noted that the only programme which produced long-term behavioural effects was part of an approach involving the community as a whole. This supports the mounting evidence of the benefits of programmes that combine various types of interventions in a range of settings.

A review (J. Howard, unpublished data, 1995) of the effectiveness of interventions to reduce substance abuse identified training in skills, along with cognitive-behavioural and residential treatments, as having positive outcomes in the few controlled trials available. Training

in skills has also been cited as important in reducing alcohol consumption among adolescents in both the short and long terms (128). When psychotherapy and general counselling approaches are compared with structured approaches based on cognitive behaviour and/or skills, the latter consistently yield better results.

A review of the effectiveness of tobacco, alcohol and drug abuse programmes for young people (114) noted the importance of teaching young people skills to help them resist identified pressure in the media, and correcting misconceptions of social norms governing drug use. Also highlighted was the importance of teaching adolescents general skills to prevent drug use. These typically include two or more of the following types of training in skills: problem solving and decision-making, cognitive skills for resisting negative social influences, skills for increasing self-control and self-esteem, coping strategies for relieving stress and anxiety, interpersonal and assertiveness skills. Such approaches have reportedly shown some success in relation to both alcohol and marijuana use.

Documenting the relation between possessing skills commonly promoted through youth organizations, and the impact on health outcomes will determine the value of the skills. An example is a study investigating efforts to reduce adolescent pregnancy by involving girls in sports. The rationale for this approach is that learning to play a sport involves the development of certain basic skills; there is the mastery of various general and fine motor skills, skills in making decisions, communicating, and taking assertive actions.

The relationship between girls' participation in sports and their physiological, social, and psychological development has received little attention, especially in developing countries. According to a Population Council (129) hypothesis, participation in sports helps girls not only experience the physical power of their body, but also formulate a sense of bodily integrity.

In addition to designing interventions for building skills in schools, efforts are increasingly focusing on adolescents who do not regularly attend school. Initiatives in this area include programmes with several components, such as SERVOL in Trinidad and Tobago, Girl's Town and the YWCA in Jamaica, and the Human Resources Centre in Antigua — all working to develop adolescents' self-confidence and self-esteem. These projects also offer vocational training as an alternative to formal education. Adolescents report that they are drawn to these centres primarily for such training. Even though programmes with several components do not always directly associate life and vocational skills with adolescents' reproductive health, the correla-

tion may be critical to improving young people's reproductive health (48).

In a collaborative outreach initiative of the Ghana Red Cross and Ghana Scout Association, *Action For Youth: Reaching Working Youth with HIV/AIDS Prevention*, peer educators have incorporated training on skills for negotiating safer sex, saying "no" to sex, and assertiveness (130) into their HIV prevention programming. The Federation of Red Cross and Red Crescent Societies is helping to focus on the global expansion of HIV programming through skills-building interventions to other areas of health. Such work has been actively undertaken by the nine-country Asian Task Force on AIDS. The nine countries are developing their own curricula, adding basic skill development components and tailoring content to multiple health issues endemic to their national situations.

There is considerable consensus on conditions which contribute to the effectiveness of efforts to strengthen the skills of adolescents in both school and out-of-school settings:

- Initial assessment is required to identify the most common risky situations involving young people, parents and community leaders.
- Interactive, participatory approaches which fully involve the adolescents are recommended for building skills, instilling information, and building the confidence and motivation to exercise skills.
- Teaching of skills should not be undertaken in isolation, but rather as part of a programme which also covers the context of risk and information and provides an opportunity to clarify and reinforce positive values.
- Training adults to conduct activities and use participatory methods with young people is necessary as it reinforces the adults' ability to empathize with, respect, and nurture young people.
- Young people should be given the opportunity to practise the skills over time and ultimately apply them. Supportive environments are needed to reinforce and sustain the use of skills over time (96; J. Howard, unpublished data, 1995).

Because adolescents can learn skills and still not apply them, motivating them is a challenging aim which must not be disregarded. Programming which addresses gradual personal development can help motivate adolescents but there are also environmental factors (such as caring relations and opportunities) that determine whether the skills learned are applied. Providing adolescents greater opportunity to learn skills would improve the quality of more traditional health education efforts. The skills highlighted in this section can empower

adolescents to translate knowledge, attitudes and values into actual abilities — what to do and how to do it.

#### 4.5 **Counselling**

Counselling is a process of interpersonal communication within a supportive professional relation through which the counsellor helps the counselled person (or client) to deal more effectively with problems by enabling them to understand their situation better and make sound decisions. It is meant primarily for relatively stable individuals with difficulties rather than those with deeper underlying psychological problems for whom psychotherapy or other forms of treatment may be more appropriate. Emphasis is placed on personal interaction which helps the client understand the crucial emotional and rational aspects of decision-making and behaviour. As counselling is an interactive process it will also reflect culture through the counsellor as well as the client (C.A. Wastell, unpublished data, 1995). Counselling may be provided for couples, families, small groups and individuals.

Within this broad definition, the term “counselling” is used in a variety of ways and can carry very different meanings. One of the most important distinctions in counselling is between directive and nondirective approaches. In the former, advice is provided by the counsellor primarily on the basis of the counsellor’s expertise and knowledge of the situation. In the nondirective approach much of this work is done by the clients, based on their own enhanced understanding of themselves and their situation. The nondirective approach has much to recommend it since the issues typically require decisions and action by the client. This influences the training of counsellors, and the choice of skills needed, since a nondirective approach is more difficult and, in many cultures, unusual. This approach also distinguishes counselling from the guidance and advice typically provided by many other people including religious figures, teachers, and of course family members, who all tend to be more directive in their approach. The basic elements of counselling are described in Box 12.

In many developed countries, a profession of counselling has therefore evolved for which special training and qualifications are required, including those for guidance and vocational counselling. In some situations counselling is provided by other professionals such as psychologists, social workers or health workers. Counselling is provided in a wide range of settings including schools and universities, clinics and hospitals, youth centres run by community and nongovernmental organizations, multipurpose centres, and religious institutions, among others (M.R. Montsi, unpublished data, 1995; A. Monroy, unpublished data, 1995; D. Samarasinghe, unpublished data, 1995). The

**Box 12****The basic elements of counselling**

Assessment helps determine how help can best be provided through the adolescents' articulation of their concerns: the reason they have come (or have been sent), the context in which the difficulty has arisen, how they feel about being there, and what they hope to achieve. It is especially important to enable the adolescent to articulate feelings since this is often the most important and most neglected component motivating behaviour.

Listening and asking open questions will help the young person understand and reflect upon what has led to the current situation. A better understanding of the origins of the problems may help stimulate action which will have a more durable and wider ranging effect.

Information provision is required to explore options related to identified needs. There is often a need to counter misinformation.

Support for decision-making is essential and includes consideration of the implications of decisions on the adolescent, family and friends.

Referral should be possible in those instances when additional assistance is needed, for example a medical examination, psychological testing, or a social service if such services are available elsewhere. Obtaining the agreement of the adolescent is important and special care is needed so that the adolescent does not feel personally rejected.

street is another setting where counselling sometimes takes place, often as part of programmes designed to reach out to young people living and working there (63). Counselling is therefore used in many places, often informally, by teachers, youth leaders, health workers, religious leaders, traditional healers, and others.

Young people themselves have also been trained to carry out basic counselling with their peers. "Peer counselling" should be distinguished from "peer education" because counselling requires more intensive training, supervision and support. Peer counselling has been used in efforts to prevent pregnancy, STDs, smoking, and alcohol and drug abuse. Information provision and sometimes skill building have been incorporated into some counselling (94). Table 5 shows a typology of peer approaches, noting objectives, coverage, intensity, and examples.

Counselling for adolescents has an important added dimension since it takes place during a phase of rapid development when young people experience physical, psychological, and social changes which are often uneven and a source of anxiety. Young people are also more

Table 5  
Typology of peer approaches (94)

	Peer communication	Peer education	Peer counselling
Objectives	Information building, some attitude change	Information and skills building, attitude change. May also include social support	Information and skills building, attitude change; problem solving and social support
Coverage	High coverage	Medium coverage	Low coverage
Intensity	Low intensity	Medium/high	High intensity
Focus	Community, large groups	Community, small groups	Individuals
Examples	Drama, leaflet distribution, condom distribution	Peer-led group education activities	School, health facility, or community-based peer counsellors
Role of peers	Communicators recruited continuously on voluntary and motivation basis. They have limited roles. Their commitment is usually for brief or sporadic periods	Educators are selected based on specific criteria. 20 to 30 educators are usually recruited at a time. They have specific tasks to perform. They are committed for short periods (6–8 months)	Counsellors are carefully selected. In many cases they are paid. They perform a highly skilled task. They are highly committed over a long period of time
Training	Short briefings or motivational sessions are sufficient	Short intensive training workshops and refresher courses	Long duration and intensive training

volatile, receptive and vulnerable than adults, so care must be taken to ensure that the effects are both benevolent and lasting. Many experiences occur for the first time in adolescence, and new behaviour and relations sometimes engender health risks. However, the causes for the adolescent's anxiety may be different from those which trouble the adolescent's family, or other concerned adults. This discrepancy between adult and adolescent viewpoints has been highlighted in a review (D. Samarasinghe, unpublished data, 1995) of Asian Services, which noted "that where evidence is presented to support the assertion that sexual matters cause concern to young people, it usually takes the form of reference to increasing rates of STDs or abortions or similar problems. But these are more probably reasons for being concerned about young people, than being concerns of young people."

Since adolescent health problems have common roots and are interrelated (see section 3.3), it is becoming increasingly apparent that an approach which deals with the whole individual (rather than with a specific problem exclusively) is to be recommended. This implies that while specific issues might be the entry point for counselling (for



example, a problem related to pregnancy or substance dependence), the intervention should deal with the issue in such a way as to strengthen the adolescent's overall capacity for self-understanding and build the confidence needed for positive and effective action to help prevent future problems. The counselling process should be used to achieve a mutual understanding of the client's needs, reach agreement on the goals of the counselling process, help the client reach those goals, and ultimately achieve a mutually agreeable end to counselling (131).

Counselling is very commonly provided for reproductive health issues as summarized in Box 13. Issues covered include STDs, HIV/AIDS,

#### **Box 13**

##### **Counselling for sexual and reproductive health**

Counselling for family planning conducted by a trained family planning service provider is especially helpful in personalizing information to ensure relevance to the adolescent's special needs, and help young people go through a decision-making process which will protect them from health problems and possibly promote positive and responsible relationships. It has also been found useful to extend the assessment of the young person's needs beyond an initial narrow focus on family planning needs. Young persons may not be clear what their needs are, and they may benefit from the opportunity to explore the reasons for seeking or being sent to obtain family planning services. A complete discussion during the first interview can help the counsellor to better understand the needs of the young person, and to consider if other referrals or services are appropriate. The application of the nondirective approach, which allows the young person to lead the direction of the discussion, can be especially helpful to aid the counsellor in getting a fuller picture of the needs and concerns of the young person, before moving to the next step and discussing contraceptive methods in detail.

An issue particularly relevant for adolescents is that at this stage of development they may not be sure they want to be sexually active. The family planning counsellor may be in a key position to help the young person with basic decision-making about sexual activities. Many adolescents may have little experience in making independent decisions, and deciding whether to become sexually active may be the first major decision they will have made on their own. In many cultures adolescents receive little guidance in making decisions about sex. Adolescents often become sexually active without consciously deciding to do so (132). The advantages and disadvantages of being sexually active can be discussed and counsellors can reinforce the personal authority of young persons to determine and assert their choices about sexual activity, despite any general peer pressure or particular pressure from one

**Box 13 (continued)**

person. It is useful to tell clients about available family planning methods, whether the adolescent is sexually active or plans to be sexually active soon, or for future use.

In a study of 122 American adolescent family planning clients, it was found (132) that those who were counselled about family planning at least once, were more likely to continue using contraceptives for one year than those who were not counselled. In the study, 78% of the female adolescents who were counselled were still using their methods after one year, and only 5% had become pregnant, while of those not counselled, only 30% were effectively using contraception one year later while another 30% had become pregnant (133).

There is a need in many places to increase awareness that family planning services exist and that they are beneficial for young people. For example, a one-year report at a youth counselling project in Addis Ababa, Ethiopia, found that of the 557 young people who came for counselling and reproductive health services, 39% were there because of unwanted pregnancy, and only 8.4% had come for family planning counselling and services, thus highlighting the need for family planning counselling early on to help prevent pregnancy (134).

Counselling using a traditional approach to prevent STD/HIV infection is applied in Uganda by the AIDS Support Organization, a national NGO. Since 1987, it has been providing counselling and clinical care to people of all ages affected by HIV, in major towns in seven districts of the country. The NGO has extended its activities to provide information in some communities about care for people suffering from AIDS and also to prevent infection with HIV. In 1993, to help young women in rural communities avoid the risk of contracting HIV from infected partners not using condoms, the NGO began a counselling programme built on the cultural tradition of young girls talking to "aunties" — trusted older women in or outside the family — about sex and reproductive health. The "Aunts project" selects and trains women to be counsellors, as well as to work as HIV prevention educators in the villages. It aims to prevent HIV infection by helping girls explore this risk through counselling on a broader range of issues which affect them personally, including relationships, personal goals, and other concerns. Counsellors are trained to help clients make decisions about life situations, including preventing HIV. Girls, who are referred by their mothers, or come of their own will, have been receiving help from the "aunties" about such issues as whether to begin sexual activity, how to seek a marriage partner, concern about having an STD, being pregnant, or contraception. The aunties are known in the villages as "counsellors", rather than "AIDS counsellors", not only to avoid stigmatizing those seeking help but because this more accurately reflects their role. Evaluation data are not yet available, but the initial response is positive with counsellors reporting that young women are seeking them out and that parents and other adults in the community are supportive (135).

contraception and family planning, pregnancy, abortion, and childbirth (M.R. Montsi, unpublished data, 1995; A. Monroy & L. Valesco, unpublished data, 1995; D. Samarasinghe, unpublished data, 1995; C.A. Wastell, unpublished data, 1995). Counselling can play a crucial role in helping the young person appreciate the positive aspects of sexuality, and can reduce anxiety about feelings which arise naturally in adolescence, while helping the adolescent to make decisions about behaviour and achieve fulfilling and responsible relations. There is evidence to support the benefits of counselling for family planning, as this results in increased client satisfaction with the chosen method of contraception and more consistent and sustained use of contraception (132).

Treatment for problems of substance abuse usually incorporates counselling in community activities of adolescents or hospital programmes which include extended after-care.

Suicide is one of the most difficult subjects for counsellors, since it sometimes engenders a feeling of panic or helplessness in the counsellor, which is counterproductive. The counsellor may want more specialized help, when none is available (C.A. Wastell, unpublished data, 1995). Suicide attempts are often triggered by a feeling helplessness and worthlessness, which counselling can counteract by helping young persons to value themselves, and take positive measures to restore self-efficacy. Training for counsellors needs to address the best ways of handling adolescents with suicidal tendencies who seek help. Depression in adolescents is common, and does not always lead to suicide attempts, but it often initiates a cycle of self-destructive and nonproductive behaviour which aggravates the depression. Counselling can reduce depression by helping the young person to take positive action.

Violence appears to be increasing rapidly among adolescent males. Young females are often the victims of violence perpetrated by men. While much of the problem of violence stems from wider social factors, counselling can help by offering a different way of dealing with the impulses that lead to violence. This is done by helping adolescents learn to respond differently to their environment. It helps adolescents to develop insight into the destructive consequences of violent behaviour, and helps them choose options that are ultimately more positive. But it is probably the close and supportive relationship with another person, inherent in counselling, that will be the most powerful means of intervening, especially with the young adolescent who has turned to violence as an expression of low self-esteem (C.A. Wastell, unpublished data, 1995).

Counselling is combined with skill building, information and health services and sometimes with policy to reduce aggressive or violent behaviour. A case in point is Norway where a project was initiated to deal with bullying, which had been identified as a causal factor in the suicide of three young males (136). A national strategy was developed and implemented to reduce bullying among schoolboys aged 8–16. Information, brochures and a special school conference day were used to increase awareness of the problem; clearly defined rules of unacceptable behaviour and related noncorporal sanctions were established; skill building and cooperative learning projects were introduced; and joint meetings were held with parents and participants. Counselling was provided for bullies, victims, and parents. The programme was evaluated in 42 schools and showed a 50% decrease in bullying over a two-year period. Theft and vandalism decreased and more positive attitudes towards school were reported by the students.

Counselling is of particular importance to help young people in times of crisis. The crisis may arise from sexual abuse or other forms of violence. It may be endemic in a situation of war or natural disaster which displaces individuals and often breaks up families. For young people, the experience of trauma can cause lasting damage if no appropriate support is at hand. Although counselling can clearly play a vital role in helping young people deal with many different health and development problems, the scarcity of counselling resources in many situations means that more commonly available forms of help (such as information and health care) must be used first.

Because of the harm that can come to adolescents from injury of whatever origin, it is important that emergency care providers have some understanding of adolescent needs and can react appropriately. Injury which may result in permanent impairment or disfigurement will be particularly frightening to an adolescent. The ability to reassure and support adolescents without misleading them is vital. It is important to provide some emotional support. Adolescents may need more specialized help to cope with the aftermath of injury, and to adjust to any changes in their circumstances. How young persons are treated will affect their attitudes towards the health system as a whole (see sections 4.6 and 5.7). Minimal training in counselling adolescents is necessary for those likely to come into first contact with adolescents in situations of trauma. The contact in an emergency may be the only one the young person has had with the health system and it offers an opportunity to offer other services, if needed.

Counselling is another intervention used to help adolescents living and working on the streets. In the Republic of Maldives, CHILDHOPE ASIA, an NGO, was requested by UNICEF to provide training to child-welfare workers in basic psychosocial interventions, including specific counselling, to respond more effectively to the needs of street children. This approach focuses on the steps taken by the counsellor and the young person in identifying target problems, developing solutions and formulating tasks, decision-making and agreeing on and implementing a course of action.

In the Philippines, counselling is also part of the care and rehabilitation programme for female child prostitutes. Basic counselling is offered, along with training in skills, food, clean water, and a place to rest in the drop-in centre. Counselling is part of the structured three-phased rehabilitation and social reintegration project components for girls who have decided to leave the streets. The second phase is residential and provides a safe therapeutic environment, education and preparation for job placement, in addition to the intervention of counselling. This programme includes the training of paraprofessional counsellors to assist the young girls (137).

The diversity of counselling, and the gender differences in its use, have been highlighted by a review (A. Monroy, unpublished data, 1995) of counselling services for adolescents in 10 Latin American and Caribbean countries which reported that female adolescents sought counselling for relationships, when to become sexually active, information on contraceptive methods, pregnancy, affective disorders, and medical problems such as gynaecological and nutritional problems. The same study reported that males sought counselling for help with issues such as sexual performance, sexual identity, when to become sexually active, information about STDs, relationships, affective disorders, and dermatological, hormonal, dental and nutritional problems.

It is difficult to evaluate the effectiveness of counselling as an intervention for promoting adolescent development and health since some difficulties gradually disappear without counselling. Another constraint lies in the fact that several factors influence behaviour and it can be difficult to determine the contribution of counselling.

A review of the effectiveness of counselling (C.A. Wastell, unpublished data, 1995) noted the general consensus on the great effectiveness of counselling interventions for young people. The contribution of such interventions was considered well beyond the normal reduction in problems associated with the transition through adolescence. According to the review, findings from two major studies indicate that

between 75% and 85% of young people treated were better adjusted in areas such as social adjustment, fear and anxiety, and achievement in school, than those who did not receive treatment. The treatment being referred to was psychotherapy broadly defined, encompassing counselling as an intervention (138, 139).

Despite the limitations in research to evaluate counselling concerning the prevention of substance use, one review (140) of residential and outpatient individual and group therapeutic counselling, family therapy, and treatment involving skills training for adolescent substance abusers, has concluded that:

- some treatment is usually better than none;
- few comparisons of treatment methods have consistently demonstrated the superiority of one method over another;
- achieving at least brief periods of abstinence is easy but maintaining abstinence is difficult;
- post-treatment relapse rates are high (35% to 85%);
- reduction in the use of some substances is achievable but fewer positive outcomes are realized for alcohol, tobacco and cannabis;
- for the few controlled trials, positive outcomes were found for cognitive behavioural, skills-training and residential treatments;
- for residential treatment, three months appears to be the maximum optimal period.

An evaluation of health sector interventions to reduce the use of tobacco, alcohol and other psychoactive substances (J. Howard, unpublished data, 1995) indicates that counselling which focuses on structured, cognitive behavioural approaches and/or skills achieves better results than psychotherapy or general counselling. Approaches which address educational, vocational, family and partners' needs have also proved successful. There is need for more systematic research on the extent to which adult models of treatment such as therapeutic community programmes, Alcoholics Anonymous or Narcotics Anonymous, and various kinds of psychotherapy are appropriate for young people.

A type of counselling which uses intensive family therapy called "multi-system therapy" has also proved effective against the antisocial behaviour of adolescents in a programme in the United States. Multi-system therapy views the client as part of an interconnected system comprising individuals, the family, peers, the school, and other factors in the environment. One such programme provided an intervention to adolescent offenders at imminent risk of incarceration (and to their families) over a period of 13 weeks. Services were directed towards the psychological, social, educational, and material

needs of the families which were monitored for more than 59 weeks subsequent to therapy. An evaluation compared this intervention with that being offered by the Department of Youth Services and showed 58% of young participants in the family therapy were not re-arrested, as opposed to 38% in the control group, and 80% of those in family therapy were not incarcerated versus 32% in the conventional services. The four-year recidivism rate was 22% (a 70% reduction) versus 72% for the usual treatment (141).

While the need for adolescent counselling is gaining recognition, it is only sporadically available to the majority of young people living in developing countries (M.R. Montsi, unpublished data, 1995; A. Monroy, unpublished data, 1995; D. Samarasinghe, unpublished data, 1995). Throughout the world counselling tends to be more accessible in the towns and it is often difficult for girls to avail themselves of the services, especially in the rural areas. Montsi (M.R. Montsi, unpublished data, 1995) reports in a review of counselling in adolescent sexuality and reproductive health in 17 African countries that the needs of young adolescents (10–14 years) are frequently overlooked. In addition, surveys and focus groups in many countries indicate that young people are often unaware of locally available counselling and advisory services (M.R. Montsi, unpublished data, 1995; 68).

Relatively few counselling services have been adequately evaluated and it is difficult to identify the components of counselling that determine its effectiveness. Nevertheless, those who have worked with young people or provided counselling generally agree on principles, practices, skills and training that make counselling effective. The WHO counselling skills-training guide for adolescent sexuality and reproductive health (131), which has been used widely with participants from developing countries, has elaborated on this. Some of the key factors in delivering counselling services to adolescents are:

- *The relationship between the counsellor and adolescent* should be characterized by honesty and empathy. The counsellor should give priority to the well-being of the adolescent, believe that the young person is worthy of help, and show him or her respect regardless of the present problem.
- *The services should be accessible* in terms of cost, location, hours of operation, and conditions of service use (for example, appointment or referral required).
- *Confidentiality* is essential as counselling often involves sensitive subjects. Adolescents are reluctant to share their problems when confidentiality is in doubt. This may arouse controversy, say in the area of family planning, where offering adolescents services, such

as counselling without their parents' knowledge or consent, is considered unethical by some people (142).

Counselling for adolescents faces a number of constraints. Young people may seek help on issues for which the counsellor is not trained; they may seek outcomes that the counsellor does not consider desirable; or they may be sent for counselling against their wishes. Counselling services are likely to be underutilized by adolescents if they are unaware of them, see them negatively or are uncertain whether and how to gain access to them. Assessment of these constraints will help to overcome them.

Counselling is usually conducted on an individual basis, and requires some special training. This may limit the degree to which counselling can be incorporated in adolescent health programmes on a large scale. However, counselling is not needed by most adolescents, but is crucial for some. It is useful to see counselling as a complement to the other major interventions. It can be combined with adolescent health programming at the local level, and be offered on a self-referral basis, at school, in health service clinics, in religious settings, and other community activities, as well as through referral by a peer leader, teacher, health worker, family member or other concerned adult.

Despite its constraints, counselling can be a valuable and necessary intervention for adolescents. Short but effective counselling, especially before small hidden problems become large permanent ones, is a crucial part of programming for adolescent health.

#### 4.6 Health services

Various people and organizations play important and complementary roles in programming for adolescent health and development. Increasingly, those in the health sector are striving to attend to adolescents, recognizing that they have been underserved in the past. Health workers can make valuable contributions both within and outside health facilities by helping to:

- *Promote healthy development* — for example, by advocating supportive policies and solid programmes, supporting other sectors' contribution to programming, and through direct delivery of intervention outside health facilities (for instance information provision, skill building and the creation of a safe and supportive environment).
- *Prevent health problems* — for example, by monitoring growth and development, and checking on the health status of the adolescent; providing health products (such as vaccines, nutritional supplements, contraceptives and condoms); providing information and



advice to adolescents and an opportunity for them to ask questions and to clarify any doubts they might have; being alert to the possibility of health problems or problem behaviour; and by collaborating with organizations that can provide appropriate non-health services (such as legal and social services).

- *Respond to health problems as they arise* — for example, by detecting them and/or unhealthy practices promptly; and managing them; referring adolescents to the next level of health service delivery and/or to organizations which provide non-health services.

In such ways, health services can contribute to the health and well-being of adolescents. When adolescents have limited access to such services, this represents countless missed opportunities for the prevention of health problems (143). However, a central function of the health sector is the provision of health services, which should at least comprise the management of emergencies, routine treatment of commonly occurring diseases, and ensuring the regular supply of health products (30).

In most developing countries, government bodies and (non-profit-making) NGOs offer adolescents health services and products, for example, through:

- *School health services* — where they exist, these services are provided by local government bodies, in conjunction with school authorities. The nature of services provided varies greatly from place to place, and may include periodical monitoring of growth and development, routine checks for the detection of problems (such as visual or auditory disorders), administration of vaccines, and the diagnosis and treatment of common illnesses, and arrangements to refer to health and social services elsewhere. In schools, health services in sensitive areas such as sexual and reproductive health are often limited (as in Tunisia) (144) or severely constrained by shortages of personnel and facilities and poor links outside of the school (as in Côte d'Ivoire, Ghana and Togo) (145).
- *General health services* — in most places, both emergency and non-emergency health services are provided by government health systems. Generally, the only health services available are intended for adults and children. A few places have clinics for adolescents within government health systems. They generally operate for a certain duration in a particular location on certain days and rarely on a full-time basis (48, 84, 97, 98).
- *Special health services* — in the large urban centres of various countries, special community-based centres are being established by indigenous and international NGOs, to provide health and other

services to adolescents or marginalized groups, such as those working and living on the street. These special health or “multi-service” centres often form part of a wider strategy on the prevention of public health problems like adolescent pregnancy, sexually transmitted diseases or substance use/abuse. Often, a network of peer educators and/or youth workers advertises the services offered by the centre and provides information on health issues (68, 84, 146).

- Social marketing — some countries have started launching initiatives to give adolescents greater access to health products like quality condoms and other contraceptives. The initiatives go beyond conventional social marketing approaches by involving young people in the design and implementation of activities and seeking to increase demand for routine health services for adolescents (P. Hickey, unpublished data, 1995).

However, in most countries the formal private sector (private hospitals, clinics and pharmacies) and informal private providers (untrained medical practitioners and street vendors) are taking on an increasingly important role in the provision of health services and products (147). Furthermore, in many parts of the world, adolescents rely on traditional healers for help. These healers operate within both the public and private sectors.

Even when health services are available, adolescents are often unable or unwilling to use them (42, 68). Various barriers hinder the adolescents’ access to and utilization of health services (see Box 14).

The value of easing adolescents’ access to appropriate health services cannot be overstressed. When the necessary health services are unavailable or deficient, adolescents tend to contract preventable illnesses.

Moreover, there is compelling evidence of the value of health services in the prevention of recognized public health problems among adolescents. Although most studies reported below have been carried out in developed countries (especially the United States), there are increasing efforts to measure the impact of health service provision in resource-constrained countries as well (148). The provision of health services to adolescents has demonstrated:

- Reductions in intestinal helminth infections, thereby promoting growth and development — the availability of effective drugs (for the treatment of intestinal helminths, schistosome and other fluke infections) that are safe and easy to administer (for instance in single oral dose regimens) has made mass treatment acceptable and affordable. Studies have shown that programmes to reduce

**Box 14****Barriers to the utilization of health services to adolescents**

Adolescents may fail to seek help because:

- They do not recognize their illnesses or are not aware of the serious consequences of their illnesses.
- They do not know that they could get help to prevent these illnesses, and to have them treated if they do arise.
- They do not know where, and under what conditions, health services are provided.
- They do not want to call attention to themselves or to their actions (for example, their sexual activity or use of substances).

Organization and delivery of the services

- Services are located a long distance away from where adolescents live/study/work, or in places that are not easily accessible.
- Services are provided at times of the day when adolescents cannot get away from their study/work.
- Services are provided in a place where they could be seen by people who know them, which would compromise discretion.
- Health-care workers cannot provide young people the services they need without the consent of parents or guardians.
- Health workers cannot maintain confidentiality.
- Health workers may ask them difficult and embarrassing questions, and put them through unpleasant and painful procedures.
- Adolescents cannot afford to pay for the services they need.

helminth infestation in schools can have a significant impact on health and learning. Outcomes of de-worming interventions among children and adolescents in schools show remarkable spurts in their growth and development. In addition, evidence suggests that cognition improves concomitantly although careful long-term studies of the nature and magnitude of this effect are needed. Thus, mass treatment can reduce existing infections, and periodic use of antihelminth treatments can prevent the development of symptomatic disease, and improve growth, nutritional and possibly cognitive status (149, 150).

- Reductions in the incidence of early and unwanted pregnancies — according to studies conducted in the United States, the provision of reproductive health services by health centres operating within schools or collaborating with them, together with information provision and skill building have proved effective in reducing early and unwanted pregnancies (151, 152). Another study conducted in the

United States showed that health services delivered as part of a wide range of activities in schools and surrounding communities significantly reduced early and unwanted pregnancies (153).

- Reductions in complications during pregnancy and childbirth — a meta-analysis of studies from different parts of the world, but primarily from developed countries, showed that comprehensive prenatal care programmes for pregnant adolescents helped diminish complications of pregnancy, namely induced hypertension, premature birth and delivery by caesarean section (154). A study in Nigeria showed that iron supplements and antimalarial prophylaxis administered to pregnant adolescents in the second trimester increased their height and reduced the incidence of cephalopelvic distortion (155).
- Improved fetal outcomes — a study in the United States showed that a comprehensive programme for pregnant women under the age of 18 (from deprived socioeconomic backgrounds) significantly lowered the incidence of low-birth-weight babies (156).
- Increased breast-feeding and use of postpartum contraception — a study in Mexico showed that a group of adolescent mothers who attended postpartum sessions had a higher rate of contraceptive use, and breast-fed for a longer duration, than a control group of adolescent mothers who did not participate in the sessions (157).
- Reductions in the sexual transmission of HIV through improved treatment of other STDs — a study in the United Republic of Tanzania showed that improved STD management services provided to all the members of a given community, including adolescents, helped lower HIV infection (158). Another study in the United States showed that STD management services offered as part of a programme targeting a group of incarcerated, vulnerable young people reduced infection in the group (159).
- Decreased use (or abuse) of tobacco, alcohol and other psychoactive substances — studies suggest that health care providers play a significant role in preventing tobacco use by reinforcing information that adolescents receive from other sources. In addition, they can help identify and assist adolescents who are abusing alcohol or are dependent on it. Advice and guidance that health care providers offer can engender behavioural change because they are often seen as credible sources of information (160).

Although it is difficult to draw definitive conclusions about the conditions required for effective provision of health services to adolescents, there is consensus on several strategies.

It is important to work with community members (including parents) in order to present them with accurate and up-to-date information about the health problems faced by adolescents in the area, and to create an understanding of what health care providers/services can and should do about these problems. Community members are more likely to support health services when they fully understand their value in promoting and safeguarding health, and the consequences of not making them available to adolescents.

Human contact is all important in the provision of health services to adolescents. To improve health service delivery, it is vital for health workers to view adolescents as people, rather than problems, and be able to tailor their practices to individual adolescents. To do this, health workers need to be technically competent, have the right temperament (interested and concerned, understanding and considerate, easy to relate to and trustworthy), and certain qualities (including communication skills, and a team spirit). Unfortunately, in most developed and developing countries, doctors, nurses and other health professionals are not adequately trained to meet the needs of adolescents effectively and sensitively, and only a few of these professionals develop these qualities and abilities in the course of their clinical work (161, 162). The World Health Organization is working with UNICEF and the Commonwealth Medical Association to develop an orientation programme on adolescent health for health care providers to meet this pressing need. Taking account of local preferences and sensitivities regarding the age and sex of health care providers can also make a difference, for example by directing training efforts in adolescent health to the younger health care providers.

The use of precise guidelines and protocols has been shown to improve the quality and consistency of the clinical management of adolescent patients by health care providers. It can also lay the basis for the specification and assessment of acceptable standards of the quality of clinical management. In several industrialized countries, efforts are under way to develop such guidelines for health care providers who work with adolescents. The guidelines for the provision of adolescent preventive services, developed and advocated by the American Medical Association (160) and which cover a wide range of health problems, are a case in point. However, the presence of guidelines and protocols does not guarantee their use by health care providers, even those trained to use them.

The provision of an array of health services (and other services including counselling) "under one roof" has been effective in meeting the various needs of adolescents. Where this is not possible, close

collaboration with providers of other services and user-friendly transfer/referral mechanisms may be crucial to ensuring that adolescents do not fall through the cracks in the system.

Adolescents are more likely to utilize available health services if they perceive them as user-friendly (see section 5.6).

Involvement of adolescents in planning and implementing these initiatives will help adapt health services to adolescents' special needs. In addition, it would be useful to establish a mechanism for health service users to provide feedback, so that problems can be identified and dealt with promptly, and changing needs met.

Adolescents need to know about the types of health services being provided and the way in which they are delivered. The news that good quality services are available and that adolescent patients are welcomed and treated well will probably be passed on by satisfied users to their peers. However, relying entirely on "the-word-of-mouth" to disseminate the information may not be enough. It is important for adolescents to know where they can get help, if and when they need it. An innovative way of doing this is a collaborative initiative in Switzerland involving the health, education and social welfare government departments and the Catholic church's youth programme in distributing booklets with information on local organizations which offer health and social services to adolescents (163).

The burden of providing services to other sections of the population, especially mothers and children, in resource-constrained countries, lack of recognition of adolescents' need for health services and the controversy often involved in addressing such needs have inhibited health authorities in many countries from taking the bold steps required to make youth-friendly health services available even at municipal or district levels (let alone the national level). Not surprisingly, the only youth-friendly health services that exist in these countries are stand-alone units run by NGOs. In addition to meeting the needs of adolescents in their respective "catchment areas", these stand-alone units demonstrate the feasibility and value of making health services accessible to adolescents. However, it must be noted that their very nature often limits the number of adolescents whose needs they meet. Replicating such initiatives could be part of an overall strategy to extend user-friendly health services to adolescents. However, the main thrust of such a strategy should be to improve the responsiveness of district or municipal public systems for the delivery of health care to adolescents.

There are several noteworthy ventures at the district level, such as the one in Zambia. The Youth-Friendly Health Services Project is being implemented in Lusaka urban district by a consortium of NGOs working in conjunction with the health department of the district council. UNICEF has been closely involved in the initiative, and continues to provide technical and financial support. The project was conceived through a local consultative process, involving many different organizations, and the approach used was developed with the help of health care providers and young people. Activities are under way in three townships. They consist of sensitizing and training health care providers, and involving young people in the work of health centres. Young people's participation involves the secondment of youth workers from NGOs participating in the project to health centres to bridge the gap between young people in the community and health care providers. In addition, these young workers provide health information to adolescents in the community and advertise health services. A simple and useful monitoring system and mechanisms to facilitate information sharing and problem solving have been put in place. An internal review undertaken after a year of field activities identified both success (such as the development of a good rapport between the young workers and the health care providers and a greater recognition of what young people need from health centres) and weaknesses (like the inadequate supervision of and support to youth workers in the field). It also confirmed that the number of young people using health services (for the treatment of reproductive health problems) had risen steadily. Building on the lessons learned in the first year of implementation, the project is to be extended to other townships in the district. The Zambian initiative underscores the point that through a series of simple (but strategically chosen) actions, even complex health systems struggling to cope with heavy patient loads can be made more responsive to the needs of adolescents; and even more importantly, this increased responsiveness leads to tangible public health benefits (164).

Similar initiatives are under way in several Latin American countries. To support the work of district and municipal level government bodies, the Pan American Health Organization (PAHO) has developed some guidelines for the evaluation of outpatient health services for adolescents (165) and other guidelines for the evaluation of lost opportunities in the provision of integrated care to adolescents (166). In addition, working with an academic institution in Uruguay, PAHO has developed guidelines and accompanying computer software for health facilities to maintain and access records of their adolescent patients, thereby helping to improve the treatment of such patients

(167). The Pan American Health Organization is helping these countries improve access to health services, while striving to enhance service quality (168).

The pressure to identify initiatives which can help improve access to health services and the quality of such services and to expand application of the initiatives may lead us on a well-intentioned but misguided search for a single model to apply nationally or even globally. This would be a recipe for disaster. Whereas the consortium of young people serving NGOs is clearly a valuable resource in Zambia, a similar consortium does not necessarily exist elsewhere. Even within a particular setting, more than one approach may be necessary to reach different groups of adolescents. A study in Mexico revealed that three different approaches used to deliver health information and contraceptives in a particular urban setting reached three very different groups of adolescents (169).

Providing health services relevant for the transition from childhood through adolescence to adulthood is now firmly established as an essential part of programming for adolescent health and development. It is necessary to redouble efforts to review approaches that have succeeded elsewhere, draw inspiration from them and adapt them to the needs of local adolescents, using local resources and opportunities to transform the pilot projects of today into nationwide programmes of tomorrow.

## 5. **Intervention settings**

### 5.1 **Background**

There are a number of important overall considerations in selecting particular settings for programming if the benefits of programming in each are to be maximized. In general, programming is needed in various settings to reach different sections of the adolescent population and to provide different interventions. Each setting can be assessed in terms of its advantages and constraints. Settings can be assessed on their capacity to offer programming coverage (number of adolescents reached) and provide interventions which involve interpersonal communication, which is important in the development of health-promoting behaviour, and discouraging harmful behaviour. Capacity for coverage and opportunity for interpersonal communication can be assessed as high, medium, or low (94). See Table 5, section 4.5.

It is also useful to consider which interventions are easily introduced into different settings and sustained, and assess how different settings



influence the effectiveness of different interventions. Some interventions, and approaches such as peer education, have a natural affinity with particular settings. Young people may be more receptive to particular interventions in different settings, thereby enhancing effectiveness.

Interventions in different settings not only reach different kinds of young people, but also affect different spheres of an individual's life. For most young people there is also a chronological shift as the influences of the home give way to those at school and then the workplace. Health centres are frequently the first resort of the ill or injured, though often barriers prevent many young people from using the centres. For many of the disadvantaged, the street is the only place they can be reached, while community organizations and residential centres provide settings often with a special focus on certain populations, or with a particular emphasis (religion or sport). The following is a brief account of the features of each of the settings which relate to the development of intervention strategies:

## 5.2 Home

The home is the centre of family life, and family structures are still very strong around the world. The family can play a major role in the lives of adolescents. The meeting of the WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health identified the following important health promoting functions performed by the family. The family:

- provides support, love and a caring environment for the adolescent;
- promotes moral development and a sense of responsibility (as family members, young people are often expected to obey certain rules and assume certain responsibilities to guarantee approval and spare the family embarrassment);
- provides role models and education on the culture;
- sets expectations;
- negotiates for services and opportunities;
- filters out or counteracts harmful or inconsistent influences from the environment.

The home setting offers an entry point for early intervention, particularly with mothers, and in some cases fathers, and with young children, as it might be the only place to reach them. There is also the opportunity to reach more than one age group simultaneously if there are young people of different ages in the home. The home is a good contact point for an assessment of the psychosocial situation and

needs of adolescents in the family context and there is an opportunity for contact with the extended family. Home contacts with the families of adolescents living in high-risk situations offer a way to reach parents that some studies have shown to be infrequent participants in parents' activities in schools or other places in the community (170).

The home should be considered as a place for intervening with adolescents with antisocial behaviour exacerbated by frequent social contact with other adolescents with similar behaviour, such as substance abuse. The home can offer an opportunity to reach such young people through counselling without the immediate negative influence of the peer group (34).

Many forms of mass media reach the home unintrusively. Such forms of communication provide a vital opportunity to share information with adolescents and their families, as well as influence social norms and attitudes about health issues that are important to adolescents.

In some communities, the home can be an informal place to engage small groups of adolescents in discussion on health or a creative alternative to the school or community settings for organizations involved in services for adolescents to provide training on peer education. Input from the young people concerned is essential to determining whether the home is available and appropriate for selected interventions involving small groups of adolescents.

Adolescents may or may not want to participate in activities in the home, and their preferences should be respected. Some adolescents and their families may resist the idea of health workers entering their homes to realize interventions, considering this as invasion of privacy. However, certain people in the community may be seen as natural workers in the home setting. These include people from the religious sector, village elders or community health workers. They could play an important role in interventions designed to enhance adolescent development and health.

Some promising results show that outreach to the homes of high-risk families has helped adolescents as well as preschool and other children by improving nutrition, reducing smoking, and enhancing school performance. In one evaluated preschool programme, the long-term outcomes were reduced rates of pregnancy and arrests among adolescents (Annex 3). The programmes that used home teams in the United States considered the parents as partners in the programme; outreach workers provided information and counselling and consolidated mothers' skills to help them reinforce the interactive skills-building activities being offered to their children at school (34).

As the home is a central place where families interact, interventions to improve relationships between parents, other adults in caretaking roles, other family members and adolescents are vital examples of efforts to create a safe and supportive environment. Interventions that help teach and enhance parenting skills are reported to be well received in countries such as Mexico, the Philippines, the United States and Zimbabwe (68). Research is needed to determine the effect of interventions concerning the quantity and quality of communication between parents and adolescents, sensitive subjects such as sexual relations and the prevention of substance abuse.

In economically developed societies, young people often indicate their desire for a loving family with a positive atmosphere. "Reinventing" such family life is not always possible; other settings in which interventions can be provided must be used to help make up for what is missing. Environments which provide services and the support, love, warmth as well as the responsibilities that adolescents need should be created. They seek opportunities to make decisions, and to express themselves. They also need privacy. It is important that supportive environments exist to harness their energies in a positive direction, to build their moral values as well as their negotiating skills. Regardless of their circumstances, adolescents want to belong to their families, peer groups, and societies.

### 5.3 School

The school has the potential to provide an excellent base for large-scale programming and high coverage of adolescents in countries with secondary school enrolment rates for both male and female adolescents (171). There is a need to strengthen the school as a setting for health interventions because of the potential for high coverage in many countries. In countries where school enrolment is low or uneven, and where particular sections of the adolescent population (such as young people living and working on the streets and on farms or girls who become pregnant) are not in school, the setting is still important but does not offer the access and opportunity for programming to reach many adolescents. Nevertheless, the school as an important institution in the community can play a role in addressing issues in the social environment beyond its perimeters, such as looking at the environmental factors which drive young people out of school. The school can be part of a larger community group concerned with adolescent health programming and can be a catalyst in starting such groups if none exists.

There are many opportunities for adolescent participation in schools, from planning and advisory committees to peer education as a school approach to the prevention of substance use and to reproductive health (YWCA, unpublished data, 1995; Jamaica Red Cross & American Red Cross, unpublished data, 1995; 94). Some schools offer opportunities such as family life education clubs (134).

Schools can provide many services to young people in addition to formal education. These include:

- healthy and safe environments — often combining good nutrition with clean water and sanitation;
- health education (including skill training);
- monitoring growth, health and development, and offering health services (including primary health care and counselling) or referral to other services;
- sports and recreational skills and facilities.

The school also helps health care providers forge links with the families of adolescent students and strengthen the capabilities of families to help young people. Building a common consensus at the community level among parents, teachers and health workers will also reduce obstacles to sex education, reproductive health services, programming on use and abuse of substances, and programming to reduce violence.

Schools are faced with inadequate staff, space, materials and time for training, and adapting prototype curricula to local needs, and for fully implementing programming plans. A review of sex education in primary and secondary schools and teacher training colleges in Nigeria revealed that although the school curriculum offered information about drug abuse and HIV/AIDS, the programming was not as comprehensive in reality as it was in theory and the curricula were actually American and Canadian programmes unadapted to the local situation. In addition, the programming was condensed into a year instead of being spread out over the whole school career (171).

The formal education system in Africa has for the most part not accepted the task of providing family life and sex education. Where information is given, it is predominantly biological in character (110). However, the *Let's Talk* programme in Zimbabwe is an exception. Sponsored by the Ministry of Education in collaboration with UNICEF, the programme uses grade-specific activity booklets and does not focus on the biomedical aspects of health risks. Rather, it aims to help students "focus on feelings, examine alternatives, think through situations and make decisions . . . scenarios and stories focus

on growing up, friendship and love, dating, career choices, self-esteem and gender roles" (172).

Interventions to reduce the use of tobacco, alcohol and other psychoactive substances have been used in programmes implemented in schools, where students may receive specific input on drugs and their effects, ongoing drug education as part of a life skills/personal development curriculum, or short programmes delivered by persons external to the school education system, such as mental health professionals or police officers (J. Howard, unpublished data, 1995). Programmes implemented in schools can, however, be limited in only being able to address a small range of the complex factors associated with the onset, escalation, and maintenance of substance use. Schools do not exist within a social vacuum, but issues of poverty, criminal gangs in communities, the individual and family need for income generation and various elements of family dysfunction are often beyond the control of schools. As a result, their focus is often more on the individual and on resistance to negative peer influence. An additional concern is that many young people who most need an effective intervention are not at school when it is delivered; they are truanting, have been suspended, or are needed by their parents to generate income or provide child/house minding tasks. This is particularly so in some developing countries where only a small percentage of young people enter and remain in secondary school (J. Howard, unpublished data, 1995).

Overall, the desired outcomes of many programmes realized in schools can be difficult to sustain, particularly in the case of the use of substances (other than tobacco). It is imperative to give greater attention to the real life contexts within which such programmes operate. As J. Kay notes, "we have largely ineffective drug education programmes being taught for a few hours a year in the turbulent lives of teenagers who live in a drug-using world, surrounded by contradictory messages about those drugs. The youths most needing the messages are those least likely to be receptive to them and they may not even be there when the messages are delivered" (173).

Three studies in Côte d'Ivoire, Ghana, and Togo (145) present a picture typical of most of tropical Africa. School health services do not function effectively mainly because:

- The lack of national policy with a clear definition of the roles and responsibilities at all levels has led to confusion. In Ghana, four different ministries, Health, Education, Youth and Sport, and Employment and Social Welfare have a hand in school health.

- There is no coordination between the various service providers (especially in the rural areas) and the schools.
- Since school health is not seen as a speciality, the service staff are not trained in the role.
- Operational facilities, premises, transport, funds, supportive learning materials are unavailable.
- The absence of any organized system of documentation and records on pupils' health status makes follow-up almost impossible.

What is encouraging, however, is that all three countries are now developing serious plans for an effective school health service which should be operational in the next few years. The biggest impediment will be lack of funds to implement it. Close working relations with the health sector would strengthen these capacities at less cost.

Sometimes, the school health service meets the needs of children, but for adolescents in school in many countries even this service is totally inadequate. In Togo, which in common with many countries has a problem of unwanted pregnancies (some occurring among those under 15), family life education teams are part of the social services, but they were able to visit only 19% of primary schools in 1994. As in many other societies, sex and reproductive health education is not offered in rural areas, and school teachers are not trained to provide it (145).

Changing norms in schools may be crucial for reducing aggression or forestalling it in younger children starting school (64). Skills-building too is an intervention which has the potential to work well in the school setting. The school offers the potential to provide sequential programming in areas such as life skills that can be tailored to the developmental needs of young people at each age. The school is an appropriate setting for the introduction of life-skills education because (7):

- it offers access to children and adolescents on a large scale;
- it is economically efficient (uses existing infrastructure);
- experienced teachers are readily available;
- it has credibility with parents and community members;
- there are possibilities for short-term and long-term evaluation.

One example of working to provide information in a school-based programme is government-funded, school-based summer clubs in Egypt. Students between the ages of 10 and 12 visited the clubs three times a week for three hours over a six-week summer session. Topics covered included personal, domestic and environmental hygiene. In-

interviews with teachers, children and parents indicated that the programme effectively provided students with important health information (174).

Provision of information and certain commodities was carried out in Switzerland, where topical fluoride applications, fluoridated toothpaste, and oral hygiene instructions were given to students as part of a dental health programme between 1962 and 1988. In 1967, most 15-year-old students had cavities; by 1988, only 34% had them (172).

Although interventions concerning life skills are valuable in the school settings, there are practical problems. The new health education curriculum being piloted in 30 selected schools in Ghana, and which contains important components on reproductive health, STDs (including HIV/AIDS) and life skills, has had little effect because its implementation is limited. Resource books for teachers and students have been developed, but circulation has been limited by a lack of funds (145).

There is need for community programming in out-of-school settings to reach young people who do not attend school, and to provide this type of programming when schools are unable to offer skills-building interventions. Schools in many places do not offer such programmes for a range of reasons. Overall, programming can work to strengthen schools' capacity to cover various types of interventions. To build skills, however, other settings need to be considered and promoted.

The World Health Organization through its Expert Committee on Comprehensive School Health Education and Promotion (172) reviewed the current global status of world health and identified the principles and priorities for action listed in Box 15. It also pointed out five broad concerns and challenges for global school health:

- The theories and frameworks for a coordinated and integrated approach to school health are relatively sophisticated; their application and adaptability to different nations and cultures, as well as their evaluation, are far less developed.
- Policies on school health, intersectoral collaboration, and frameworks for successful programme implementation are essential but rarely developed. Administrative as well as financial support is critical, but lacking in many countries.
- Although successful interventions have been devised to address specific health problems, the measures are typically unrelated to the rest of the school programme or merely related through a single component.

**Box 15****Recommendations of the WHO Expert Committee on Comprehensive School Health Education and Promotion (172)**

- 1 Investment in schooling should be improved and expanded.
- 2 The full educational participation of girls should be expanded.
- 3 Every school should provide a safe learning environment for students and a safe workplace for staff.
- 4 Every school should enable children and adolescents at all levels to learn critical health and life skills.
- 5 Every school should more effectively serve as an entry point for health promotion and a location for health interventions.
- 6 Policies, legislation, and guidelines should be developed to ensure the identification, allocation, mobilization, and coordination of resources at the local, national, and international levels to support school health programmes.
- 7 Teachers and school staff should be valued and provided with the necessary support to enable them to promote health.
- 8 The community and the school should work together to support health and education.
- 9 School health programmes should be well designed, monitored, and evaluated to ensure their successful implementation and desired outcomes.
- 10 International support should be further developed to enhance the ability of Member States, local communities, and schools to promote health and education.

- While some of the components of school health programmes have proved effective, overall there is no practical guidance on their implementation.
- Little information exists on a truly comprehensive approach to school health programmes. While the concept of the health promoting school is generally accepted, continued development, implementation, and especially evaluation of such programmes is vital to the advancement of the health and education of children (172).

Schools are places of learning. Investments in education are expected to yield benefits to individuals, communities, and nations. Schools are in a position to contribute to social and economic development, increased productivity, and a better quality of life for all. In many parts of the world, some schools are making significant progress. But even more could be achieved if all schools could promote the healthy development of young people as actively as they promote learning (175).



#### 5.4 Health centres

The term “health centre” is used broadly to cover any recognized institution that provides health services. It includes small clinics providing a limited range of (primary level) health services, at one end of the spectrum, and large hospital complexes providing a wide range of (tertiary level) health and social services at the other end. Health centres may be operated by the public, private and charitable sectors. The centres may exist as independent entities or part of institutions such as schools, correctional institutions and youth hostels, which offer other services to adolescents. They may also be established on a temporary basis in sites where large numbers of people are forced to live in camp-like conditions, for example in the aftermath of a natural disaster, civil strife or war.

Clinicians and public health workers are increasingly acknowledging the urgent need to remove barriers to the delivery of health services to adolescents and to the use of such services. Also acknowledged is the need to change the image of health centres as forbidding places that are best avoided, to one of a welcoming and user-friendly institution. The term “youth-friendly” health centre has been coined to do just this. It is important to understand the concerns and needs of young people and address them systematically. Box 16 compares the findings of two studies aimed at identifying the characteristics of the ideal centre from the viewpoint of young people.

It is evident from Box 16 that adolescents from very different backgrounds share similar viewpoints and expectations. Other studies indicate that adolescents elsewhere share some of these perceptions too. Efforts to make existing health centres in a particular place more youth-friendly or establish new ones must begin with a careful assessment of the needs of the intended users, adolescents, and their perceptions of how these needs could best be addressed. This can be done with little effort and inexpensively, using rapid assessment tools such as the user-system interaction method (13). Both developed and developing countries have growing experience and expertise in making health centres youth-friendly, to make health services widely available to young people.

Experiments conducted in the United States in the 1970s yielded the integrated, comprehensive approach to providing adolescents with health and social services. In this model, the complaint for which an adolescent seeks a health service is seen as an opportunity to introduce the adolescent to other services provided by professionals drawn from different disciplines. This “one-stop shopping” approach means that the various needs of adolescents can be met under one roof by a

**Box 16****Adolescents' views on youth-friendly health services**

In one study involving six English-speaking Caribbean countries (48), young people said that their perception of an ideal centre was one which would:

- offer many services (including social and sporting activities, self-esteem and self-confidence building activities, coaching and job training, and comprehensive health services);
- not look like a clinic;
- be open to both boys and girls;
- be open after school hours;
- have empathetic and knowledgeable counsellors who could be trusted;
- provide a hotline service;
- encourage parents to participate in activities.

In another assessment of opinions and expectations, young people in Vancouver, Canada, identified some of the same characteristics as important (176). In their opinion, the characteristics of an ideal community based youth health service were that it:

- is discrete, and looks like a house on the street;
- has a straightforward name (e.g. "the youth health centre");
- is colourfully decorated, not drab;
- has comfortable seating and magazines for adolescents.

The young people further noted the ideal community youth health centre is one that is staffed by people who:

- are casually dressed and can be addressed on first name terms;
- listen and try to understand rather than talk down to their patients;
- have enthusiasm for youth health;
- can be contacted on subsequent visits (not a different doctor every time).

The policies:

- should provide for unbiased, nonjudgemental advice;
- should guarantee complete confidentiality, and secure permission of patients before passing on information to anybody (including parents and other care providers);
- should provide for the presentation of test results as soon as possible, to reduce the anxiety of waiting.

team of professionals who understand such needs and are trained to address them effectively (161, 177). The integrated comprehensive model has inspired the development of similar models in other developed countries and some developing countries (notably in Latin America). Experiments conducted in Sweden led to the creation of youth clinics. These clinics provide information and advice, counsel-

ling and clinical services relating to reproductive health. Their informal and friendly atmosphere appears to be very popular with young people. Over the years, youth clinics have been set up all over the country and a national network of these clinics is in place (178). The Swedish model has been widely emulated in other parts of the world. However, there is need to carefully assess the sustainability of widespread use of this model in resource-limited countries.

Considerable efforts have been launched in many developing countries as well, and there are many useful lessons drawn from these initiatives. Detailed descriptions of these initiatives are available (49, 179–182). The following is an attempt to describe the various models in place:

- A health centre specializing in adolescent health and linked to a medical school: this centre provides clinical services to adolescents, serves as a referral centre to other (general) health facilities, and conducts training programmes for professionals from different disciplines who provide services to young people.
- A community-based health facility: this facility strives to provide user-friendly clinical services to adolescents, within the context of health service provision to all segments of the population. This model includes two distinct categories:
  - (a) stand-alone units, almost always operated by NGOs, such as Marie Stopes International, in Uganda and elsewhere, and the African Medical and Research Foundation in the United Republic of Tanzania;
  - (b) district or municipal health systems, almost always run by the government, which are working to reorient the delivery of its services to meet the needs of adolescents more effectively.
- A community-based centre (which is not a health facility): this centre is dedicated to providing adolescents with some or all of the services they need. There are two categories of this model:
  - (a) centres which provide health information, counselling and clinical services only, such as the youth counselling centres run by the Family Planning Association of Kenya in Nairobi and Mombasa, and the Naguru Teenage Information and Health Centre in Kampala, Uganda;
  - (b) centres which provide a wider array of services (of which health information, counselling and clinical services are only a small part) or organizations which focus on the non-health needs of special groups of young people (such as pregnant adolescents and adolescent parents).

In addition to providing some health services themselves, these organizations often collaborate with health facilities nearby. Such centres tend to be operated by NGOs (sometimes with government funding). In addition to the services described above, some of these organizations set up temporary stations and provide basic health services in schools, stadia and other places where adolescents gather.

- Organizations that improve adolescents' access to health services in their community: these organizations (mainly NGOs) seek to prevent one or more specific public health problems of adolescents in general or of especially vulnerable subgroups of adolescents. Their main emphasis is on outreach work to provide information and educate their target group. Many of these organizations offer the most rudimentary clinical services (if at all) but closely collaborate with health facilities in their areas of operation.

In addition to the critical function of providing a setting for the delivery of health (and counselling) services to adolescents, and for conducting other activities such as information and skill building, the health centre could serve other valuable functions, as indicated below:

- In a needs assessment exercise, patient records in health centres provide very useful information on the nature and scope of health problems affecting adolescents in an area.
- In a community-based health programme, health centres can provide a useful venue to invite community leaders and others for discussions and negotiations.
- In community-based health programmes, health centres can be a base for the operations of field workers involved in outreach activities.

The health centre offers an opportunity to inform adolescents and adults about health, behaviour and development; and to provide counselling on healthy development, gender equity, healthy sexuality, and relationships. It is often the primary point of contact in delivering medical interventions. Some health centres with innovative programming have also incorporated skills building into their activities (48). Unfortunately, in many countries, health centres (especially clinics in periurban and rural areas) are not as active as they could be. In the worst cases, the buildings that house these centres are dilapidated and the equipment rudimentary and often out of order. Drugs and other commodities are often in short supply and the staff poorly paid and demoralized. Health sector reform seeks to involve the people more closely in setting priorities and making decisions, and this should help

revitalize and tap this underutilized resource, the health centre, to contribute to the health and development of adolescents and other segments of the population.

### 5.5 Workplace

In many countries large numbers of young people work in factories, free trade zones, and tourist areas. They are often at high risk of substance abuse and dangerous sexual behaviour as well as injury associated with unsafe working conditions and lack of experience. Providing health information, arranging visits by health services, and installing telephone hotlines accessible from work premises are all examples of initiatives which can benefit both workers and management by ensuring a healthier workforce. The commercial sector can contribute variously to adolescent health by direct intervention for the benefit of their employees, collaborating with (and sometimes funding) projects motivated by health-conscious employers, or by raising public awareness.

Workplaces for adolescents include those which are informal and mobile and the more traditional ones like factories. For adolescents workplaces include markets, where young people sell food, crafts, and other goods, or offer services such as shining shoes and washing cars. Young people often engage in menial work but there are those who learn trades and may get small wages in apprenticeship programmes in mechanics, rug-making, baking, carpentry, shoe-making, and farming. The military is another important work setting where young people can be reached, especially young males, although the participation of young women is increasing in some countries. It is vital to recognize the full range of workplaces where young people spend time. Both formal and informal workplaces are important settings to consider as sites for programming because each offers opportunities to reach young people. Informal workplaces are particularly important to consider because they may be the only point of contact with out-of-school and/or homeless young people who are otherwise difficult to reach.

The positive and negative aspects of adolescents' work experiences need to be explored. Some work experiences can contribute to healthy development by helping adolescents learn new skills, enhance self-esteem and earn a living. However, some work situations present high risks of physical injury, financial or sexual exploitation. Young male and female sex workers may be at particular risk of contracting STDs including HIV, falling prey to substance use, and exploitation by adults. One benefit of implementing interventions in some workplaces is that the interventions can deal with risky behaviour as it arises.

There is need to assess conditions in the formal and informal workplaces to determine whether policy interventions are needed to help improve working conditions. Programming can also be developed to offer young people a chance to develop skills to gain less hazardous employment. Workplaces offer an entry point to provide vital health information or services.

The workplace also presents a prime opportunity to reach adults with information about adolescent development and adolescent health needs for information, skills-building, counselling and health services. The workplace can offer training for adults to enhance parenting skills and can extend services to the families of workers, which can include interventions for adolescents. Businesses do benefit when they take responsibility for programming for family health, including programming of specific activities for adolescents, as has been demonstrated in some countries. This is a promising area of support to programming for the health of adolescents.

One such programme was carried out by the Tata Steel and Iron Company in India (D. Dey, unpublished data, 1995). The Parents of Tomorrow Programme provides training that covers information and communication on sexual and reproductive health and services offered by more than 25 clinics and mobile services in urban and suburban areas. The programme's emphasis in the 1990s has been on health problems related to behaviour, and has covered drug abuse, alcohol dependence, single motherhood, unwanted pregnancies and STDs, including HIV/AIDS. The programme seeks to identify high-risk areas and to meet the reproductive and sexual health needs of the young. The programme focuses on boys and girls aged 14–18. The target groups are adolescent school and college students, apprentices, police and military recruits. Parents and teachers are also invited to the training sessions to help motivate the larger community to the usefulness of such training programmes.

It is a challenge to fully understand the positive and negative aspects of adolescent work situations and define appropriate interventions. There is need to protect the rights of young people in relation to work, as defined in the Conventions on the Rights of the Child, to prevent their exploitation. Policy and other interventions which limit adolescents' employment opportunities as part of initiatives to create a safe and supportive environment could inadvertently harm adolescents.

Some workplaces may be more or less willing to offer health information or services to employees particularly if they have engaged

underaged people. It is, therefore, necessary to forge relations between the health sector and the private sector. To gain access through the workplace, the needs of management must be considered and compelling reasons presented to support the argument that improving the health of young employees is useful to business. This can help to reach young people directly or adults in the workplace with the aim of improving family health, adult awareness of adolescent needs and health information.

Some innovative programming to reduce substance abuse by offering alternatives to young people living and working on the streets has also been effected in informal workplaces. A case in point is a programme in Paraguay which engages young males in a shoeshine project using bus stations as the workplace. This programme is structured to train the participants to cooperate with other workers, cultivate a positive work culture and to manage money. To enhance learning about teamwork, the participants are required to work in shifts to give everyone equal access to peak earning periods; and to learn responsibility, participants pay a percentage of earnings for their materials. The programme recognizes the benefits of opportunities provided in other settings and encourages participants to remain in school, for example, while still earning money. By involving street youth, the programme hopes to contribute to a decrease in the use of harmful substances (183).

Interventions to reduce the rates of HIV and STD infections have been successfully implemented in places where sex workers operate. An intensive campaign to promote condom use among commercial sex workers in Thailand helped reduce the rate of HIV and STD infection among young male clients of the sex workers. The programme used information interventions with owners and sex workers and intervened in two areas of the social environment by making condoms easily available, and by working with the police to enforce compliance (184). Young people also work in sex-work establishments, and this places them at particularly high risk not only of STDs (including HIV/AIDS) but also of other health problems such as violence and substance abuse. Effective interventions like the one in Thailand highlight the need to design interventions that focus on young people in controversial high-risk workplaces and in the more traditional or socially accepted ones.

## 5.6 Street

The street setting lends itself to many creative activities and innovative approaches to the implementation of interventions. Markets and

streetlife form the centre of everyday living in many places around the world, both in rural and urban communities. In poor areas, the communal water source is the daily meeting point for communication, bathing, food preparation and child care. In cities, street vendors and markets also bring people together daily. Adolescents participate in activities in the street throughout the world. Interventions designed to take place in the street usually reach people, including adolescents, in a more informal manner than in other settings. Drama troupes providing information on health issues through creative street theatre are a case in point.

In many developing countries, a very small proportion of adolescents attend school, and girls are especially disadvantaged. In some cities, the numbers of street children are growing, some without families, and most at risk of multiple health and development problems. It is estimated that 30 million children live or work on the street (58). The street setting may be the only way to reach these young people.

Programming in the street setting offers a particular opportunity to involve young people who live and work on the streets in intervention planning. Adolescent participation has proved essential to successful programming in this setting. Participation in decision-making concerning programmes is a valuable part of the intervention. Such involvement helps to develop basic socialization and communication skills, and offers a chance to develop a sense of self-esteem through meaningful activity and contribution.

Young people living on the street need to make money to survive. There is need for programming interventions that do not compromise their ability to do this, yet defining such interventions is difficult and challenging if the adolescents' work is likely to increase the risk of health problems. Programming can aim to engage adolescents in activities which will help them move away from such work to less risky ways of earning a living, but such programming needs to recognize the realities of street life and not further alienate young people by stigmatizing them (92). Active assessment of interventions and the participation of young people in their definition have led to the formulation of approaches to maintain relations with young people on the streets, thereby increasing the opportunities for providing information, and health services, while also promoting skills-building.

There are many innovative projects which reach the adolescents who live and work on the street. Such programming provides information, builds skills, offers counselling, and improves health services for boys and girls living on the streets in many countries. Linking such activities with existing support systems can be of benefit, at low cost.



Skills-building has been found by programmers to be especially important among young people living in street settings. Assessment of the type of skills needed is essential if programming is to relate to the actual needs of those reached. In the area of programming to prevent HIV infection among street children in the United Republic of Tanzania, it has been noted that preventing HIV infection and other STDs requires life skills — the power to turn information into reality in your life (92). Life skills needed on the street include making decisions and taking responsibility for oneself, dealing with peer pressure, being assertive, and seeking necessary information. The *Kuleana* programme, which is a small NGO concerned with the human rights and sexual health of young people, has found role playing, puppets, and forum theatre helpful for building skills, recognizing that skills are developed over time and that street adolescents need support and encouragement.

The street setting also offers opportunities to intervene to create a safe and supportive environment. For example, in the area of social norms, attitudes towards young people who work on the street can be changed, as demonstrated by successful programming in the Philippines which changed attitudes away from perceiving street workers as offenders and more towards recognizing them as young people responding to their survival needs in an environment of poverty and unequal distribution of wealth (T.L. Silva, personal communication, 1995). The street setting offers a chance for interventions to be effected at the site of risky situations, to create a safe and supportive environment, for instance by decreasing drinking and related violence in bars, and working with bartenders to enforce laws. Interventions can directly take place in the street setting to decrease violence as has been demonstrated by a successful programme in Julakari, Australia (M. Simon, K. Monahan & G. Slutkin, unpublished data, 1995). In this programme, volunteer community elders work with local police to staff night patrols, to offer intoxicated individuals on the streets transport to a “sobering-up” centre and ensure they are not involved in violence or arrested.

#### 5.7 Community organization

Throughout the world, organizations committed to serving young people (often nongovernmental) provide support and opportunities for them to engage in constructive and rewarding tasks which promote their development and contribute to the community. Such organizations can also provide peer education, peer counselling (if support and training are provided) and practical information about other resources in the community, including health and social

services. Many have become sustainable and some operate at national level.

These organizations can provide young people with social support and guidance, skills training, positive and constructive alternatives to hazards and create opportunities for them to contribute meaningfully to the community. They can also meet many developmental needs — sense of structure, safety, status, and belonging. The overall aim of some of the organizations is to help young people develop their full potential (185).

Many older adolescents credit groups such as the Scout movement with instilling in them the values, attitudes (including openness to others, a sense of responsibility towards others developed through group activities) and confidence in their resourcefulness that have enabled them to develop and prepare for adult life. The activities undertaken in such groups are driven by the challenge and the enjoyment young people derive from taking part. The activities constitute the framework within which skills are learned and the relationships are nurtured which will create opportunities for personal development. For many young people, the unit is a unique structure whose group dynamics and activities teach them to take responsibility for themselves and to assume a role within the group. Young people who have been in the Scout movement for a long time accept and sometimes emphasize the need to take responsibility, help young members develop skills they have acquired and for each person to contribute to the group's welfare. The majority of young people believe in the importance of this experience in preparing for adult life. Parents and leaders share these views (185).

There is an interdependence between learning skills and assuming responsibility. By developing certain technical and practical know-how, young people can take on greater responsibility, and through accepting certain responsibilities they are able to develop their capacities. There is also an interdependence between the level of responsibility assumed and the level to which they feel integrated in the group and an essential part of the whole, recognize the contribution they have to make, and see that it is acknowledged by the group.

International service organizations such as the International Lions Clubs and the Rotary Clubs have established special initiatives to support programming for young people in many countries. The Lions Clubs in Switzerland, for instance, work in partnership with local school districts in Lausanne to provide funding and programming assistance in the development of innovative school programmes to help reduce substance use among adolescents.

Religious organizations too play an important role in providing structured programming specifically for young people in addition to offering them the opportunity to participate in the organizations' primary activities. Such participation offers the young person spiritual guidance and a chance to feel part of the community, thus contributing to their moral and spiritual development. The organizations often provide opportunities for important supportive relations with adults outside the family. Various religious organizations are also very active in reaching out to young people and their families both within and outside their faith, and by so doing they reach particularly vulnerable people in the community.

It is vital for community organizations to seek meaningful roles for young people. In an assessment of certain opportunities to serve the wider community, one survey involving young people (185) concluded that the young are often asked to undertake boring or tedious activities which seem unrewarding and offer no chance for them to develop contact with those they are supposed to be helping; this can make young people feel they are being taken for granted. Opportunities to discover a new environment and develop relationships with new people are important to them.

In addition, it is often challenging for NGOs to coordinate their youth activities with other NGOs and governmental programmes. Time and limited resources make it difficult to meet centrally to plan and assess activities. Conflicting mandates and priorities may also at times make collaboration with other groups difficult. There is also the reality of competing for the same money from the government and donor organizations outside the area or country of operation, which too has sometimes made it difficult to coordinate efforts.

Interventions to build skills in various community settings, in a number of organizations that provide services to young people — the Scouts, Girl Guides, Young Men's Christian Associations (YMCAs) and YWCAs, Boys Police Clubs — have achieved some success. These organizations are often able to effectively use the peer education to provide information to other young people. Counselling too can be offered through religious organizations in some places, because the role of the religious leader as counsellor is naturally accepted by the family. The religious setting also offers an important point of contact for referral to health services in the community.

The Boy Scouts in Alexandria, Egypt, together with the local government, supported by UNICEF Egypt, have organized recreational and other skill development opportunities for working adolescents. These activities, offered at the Boy Scouts recreational centre, include

swimming, health services, literacy classes and vocational training for carpentry and other handicrafts. The recreational opportunities are therapeutic for these adolescents who typically work 12–14 hours a day under less than ideal conditions. Noticeable changes among the adolescents include improved abilities for communication, better manners and morale, which have earned their families' support for these efforts. Interestingly enough, the employers of these adolescents, who initially resisted the idea of their employees' involvement with this recreation centre, eventually appreciated its effect: it raised employee productivity and lowered the incidence of problems attributed to these adolescents (186).

#### 5.8 Residential centre

The term “residential centre” covers a broad range of places where young people stay for short-term, medium-term, or long-term periods. Some places are designed for particular sections of the adolescent population; others offer particular programmes. The following are examples of residential centres:

- Shelters typically offer food and a place to sleep. Some are specifically designed for adolescents, others for all ages. Many shelters are offered by NGOs, and often religious groups. Adolescents may reside overnight, several days or even longer. Shelters are used by young people in difficult circumstances, as well as by those living away from home, perhaps doing seasonal farm work, or working in factories for very low pay.
- Drop-in centres are often designed to meet needs of particular sections of the adolescent population, such as young males working on the streets or young girls working in the market or as commercial sex workers. They are included here only because for some of these adolescents, such centres are the only places that offer some of the advantages of a positive home environment, including safety, food, and caring adults. Some drop-in centres also act as contact points with young people over a long period of time, while others offer mid-term programmes which may help specific sections of the adolescent population to find a longer-term residential programme. For young people living and working on the street, drop-in centres may offer respite from situational and episodic difficulties on the street such as a police crackdown, or represent a place to receive help if ill.
- Vocational training centres provide opportunities to learn trades.
- Residential living for therapeutic purposes may be part of substance abuse or mental health treatment, for example.

- Orphanages usually admit children at an early age to live on a long-term basis. They are set up privately and through public programming.
- Juvenile placement or detention centres offer shelter on a voluntary as well as compulsory basis. They are often called “open” or “semi-open” centres (or “closed centres” if compulsory). Many such centres house young people who have committed no crimes other than vagrancy along with those who are incarcerated for petty crimes. The juvenile justice system may in fact be the first official contact point (and therefore a possible intervention point) for young people engaging in a series of harmful, illegal or antisocial activities like substance use, violence, and stealing. D.S. Elliot suggests that: “An effective intervention at this point should have a significant impact on the full set of problem behaviours, and should reduce the likelihood of escalation to more advanced stages of the deviant lifestyle. Perhaps a greater allocation of resources ought to be made at this point while many youth are still at early stages of lifestyle development” (187).

Residential settings are especially important in adolescent health programming because each may be the only place to reach particular groups of young people, such as those separated from their families through death or conflict situations at home, or those living away from their families due to special needs or problems. Many of the young people in residential settings are particularly vulnerable to health problems. They may have no other source to provide for the basic needs and opportunities often offered through the home setting. These settings offer unique opportunities to help adolescents experience positive relations with adults, continue some basic education or develop livelihood skills and regain access to basic services. Each of the settings offers an important entry point for the delivery of health services, as well as programming opportunities for other major interventions. Residential settings also offer the chance to intervene with young people at particularly high risk of substance abuse or early, unprotected, and unwanted sex. Through these settings adolescents may be offered better nutrition, family planning and STD services including early detection of pregnancy, and access to maternal care.

Due to the live-in nature of residential settings, the unique opportunity exists to engage young people in programme planning, implementation, and evaluation through focus groups, young people’s councils, peer education, and monitoring of programming. Some residential settings facilitate longer-term relations between young people and adults, as well as among young people themselves.

In some residential centres, particularly juvenile detention centres which place adolescents with different profiles and needs in the same programme, intervention is hampered by the influence of the more antisocial adolescents (such as aggressive ones) on the others. Furthermore, the staff-to-youth ratio is typically low, and the low pay fails to attract the most qualified adult workers. The training of staff is an opportunity as well as a challenge. Another challenge is the lack of resources for supplies — some residential settings have the machinery for vocational training activities such as woodwork, but are unable to use it due to lack of basic raw materials. Some residential income-generating schemes lack technical expertise in buying and marketing products likely to succeed in the local market. Many of the young people served through residential centres lack money, and the design of interventions must take this into account. Some programmes have successfully developed short-term money-making schemes along with the teaching of longer-term livelihood skills. There are many opportunities to incorporate interventions in the areas of:

- Social environment — a chance to offer and enhance positive relations with adults; provide for basic needs, such as nutrition, and formal and informal education; as well as to help young people regain access to such opportunities through increased awareness.
- Providing information — a prime opportunity to offer basic health information on the prevention of substance abuse and STDs including HIV and on contraception, as well as to provide information on education, vocational opportunities, and health services. A youth advisory model has been developed in Egypt. It involves monthly meetings of youth representatives from a range of residential programmes, with particular focus on vocational skill development. In addition to helping young people who participate in the advisory meetings to strengthen their planning and organizational skills, the programme has the added benefit of increasing the flow of information about other opportunities and services amongst the groups directly to the adolescent representatives and then through them to others throughout the programme.
- Skills-building — seems naturally suited to the residential setting. Programmes have found young people interested and motivated to develop their skills, particularly when this involves opportunities to make money. Residential settings which combine social and vocational skills-building and activities to develop positive attitudes towards oneself, others and work (like the SERVOL programme in Trinidad and Tobago) have demonstrated that with help young

people do gain the skills needed to obtain employment, and can refrain from self-destructive behaviour when jobs are not available (188).

- Health services — the residential setting is an important access point for providing basic nutrition and delivering services for the prevention and treatment of disease to young people who may be excluded by other settings and traditional health clinics. Along with skills-training and behavioural counselling, residential treatment for substance abuse was found to be one of the most effective approaches among adolescents — three months appeared to be the optimal period (140).

## 5.9 Media/entertainment

In previous sections, the settings described could be identified as places where interventions are provided to adolescents. In every case, the settings which offer the greatest opportunities to promote healthy development and prevent problems among adolescents are served by the people.

Media have become a pervasive feature of the human experience. For adolescents, in particular, the media hold particular attraction due to their ability to entertain, educate and inform. Often considered as conveyors of values detrimental to development, their positive role has now been confirmed.

The growth of television, the video industry, and the rapid spread of interactive computer technology, along with the more traditional forms of mass media and entertainment such as radio, newspapers, magazines, comic books and live drama, offer tremendous opportunities for reaching young people and for promoting their health on a large scale, by:

- communicating health information — great potential exists for the use of the mass media to inform adolescents (and adults) about adolescent health and development;
- influencing attitudes and contributing to positive societal norms regarding adolescent health issues, often by creating an awareness of health issues and providing an important forum for public dialogue;
- providing positive role models in the entertainment they offer, and reducing the number of negative ones;
- influencing the attitudes and health behaviour of young people — the mass media can also be used to influence the attitudes and behaviour of adults towards young people.

For examples of how the media provide a setting for the provision of health information and help create a supportive environment for healthy development, see sections 4.2 and 4.3.

The media offer the advantage of reaching those excluded from the more formal settings. In some places they may be the only way to reach young people who do not attend school. One example of targeting out-of-school adolescents is *Karate Kids*, a comic book and a video on HIV prevention, for street children, produced by Street Kids International (189). Mass communication also has increasing potential to reach settings in remote areas. In the developing world there is one radio for every five people, and there are one billion television sets worldwide, with ownership increasing by 10% per year (190).

The people in the world of media and entertainment are partners to engage in the promotion of health for adolescents. They can help to highlight the conditions that affect the health and development of adolescents and stimulate public debate that can pave the way for programming efforts in other settings (32).

#### 5.10 **Political/legislative systems**

The environment in which policy-making takes place differs from country to country depending on the country's form of government and the particular policy content under consideration. For adolescent health and development, several policy domains are usually involved in facilitating the delivery of interventions. For instance, individuals and institutions in the education and health sectors are obvious actors to engage in debate on current policies and practices that promote or impede health and development. There are others whose interests need to be considered to address particular groups, like the very vulnerable, or health issues, like the sale of harmful substances. For examples of how political and legislative systems have played a role in programming for adolescent health and development, see Box 17.

### 6. **Keys to success**

#### 6.1 **Background**

What makes adolescent health and development programming successful and how is success measured? Most adolescent health programming has been assessed against the absence or presence of problems such as drug abuse, adolescent pregnancy, HIV/AIDs, violence and so forth. However, there is increasing evidence that successful programming must also focus on the acquisition of positive skills and attributes such as self-esteem, a sense of belonging, self-worth,



**Box 17****Supportive policies and legislation**

The role of adolescents, particularly working and street youth, in advocating the passage of a law (R.A. 7610) against child and youth exploitation has been realized in the Philippines. The adolescents on the streets were assisted to hold regional and national congresses in which legislators were invited to listen to the adolescents who met with them in the Senate and House of Representatives. NGO coalitions with support from the Department of Social Welfare conducted advocacy sessions and meetings with members of the legislature. The law was passed and its implementation is now to be monitored by an interdepartmental (ministry) committee recently established by the president with support of an NGO advisory group (T.L. Silva, personal communication, 1997).

**Changing working conditions — New Delhi, India**

"Butterflies" began in 1987 with a small group of "street educators" committed to helping boys and girls living and working in the streets and marketplaces in New Delhi. The NGO gradually built relations with the children and their families. More than 80% of the children had never been to school, and the programme's priorities were education, employment and health. The core of the activities is the *Bal Sabha*, or children's council, formed from representatives from each contact point in the city. It meets monthly and helps to create and monitor policy, and provides a forum for the children to have a say about their future. Activities include alternative education, savings schemes, health care and health education, counselling, and nutrition through a Butterflies restaurant which is managed by the children themselves (8).

Although small, this NGO's influence and outreach have grown through advocacy, networking with other NGOs and government departments, and the provision of information and training. Butterflies played a major role in advocating legislation to give Indian children the right to form associations. Consequently, in 1993, the Child Workers Union was established and recognized by parliament. The NGO has also supported self-help projects run by the children through the creation of a credit union and cooperative. This model has been applied by other Indian NGOs working with children. In addition, Butterflies has been active in advocating the rights and needs of street children in the international forum.

**Fiscal policy as a tool to reduce tobacco consumption by young people**

From 1981 to 1991, Canada reduced tobacco consumption using fiscal policy. A campaign carried out by health organizations brought about increases in tobacco taxes, which in turn resulted in a 43% drop in per capita tobacco sales. As the real price of cigarettes rose more than 150% in 10 years, the percentage of 15–19-year-olds who smoke cigarettes daily dropped from 42% in 1979 to 16% in 1991 (191).

and knowledge to make healthy life decisions. Despite the recognized need to focus on a holistic vision of positive adolescent development, no new methods of gauging success have been developed and problem-oriented indicators remain in trend.

During the past decade, efforts have been made to identify “keys to successful youth programming.” Among the efforts were: a joint effort of WHO and the International Youth Foundation on measures of success; the International Youth Foundation’s development of “17 criteria” for effective youth programming; the WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health; and a joint initiative of representatives from 16 countries to develop more appropriate indicators to measure the “state of the child”.

Despite lack of research, the experience of adolescent health programmes and projects throughout the world has demonstrated the value of certain essential characteristics in ensuring that programmes make a difference to the lives of adolescents. The characteristics which are gaining recognition from a variety of quarters — global and national agencies and organizations involved in planning and implementing of programmes, sociobehavioural research, and young people themselves — are interrelated and build upon each other.

## **6.2 Putting young people at the centre of programming**

The active involvement of young people is one of the most important principles of successful programming. This is because their involvement in planning, implementing and evaluation ensures relevance of programme activities to the real needs of young people, commitment to the programme objectives, and significantly contributes to the development of those young people who are actively involved. Contributing in such ways to the “social good” and being recognized for it reinforces self-esteem — altruism being associated with emotional stability and positive social relations (192). Such involvement goes far beyond token efforts to merely seek the opinions of adolescents on the problems they face. It requires commitment and expertise on the part of organizations serving young people.

Young people have tended to be treated as the object of research and to be excluded from the research process itself, or the planning of interventions. Studies conducted in Brazil and Nigeria by the International Center for Research on Women found that enlisting the participation of young people enhanced research and programming outcomes (42).

In a review (J. Howard, unpublished data, 1995) of the effectiveness of various methods to reduce alcohol and substance use, it was noted

that young people must be involved for any intervention programme to benefit from their perception of the issues. In addition, interviews with young people, host agency personnel, and recipients of community action programming at three sites (and pre-project and post-project surveys) showed that the greater the role of young people in actually developing and managing the projects, the greater the benefits and successes were (193). Examples of young people's involvement in programming are presented in Box 18.

### 6.3 Addressing multiple health problems simultaneously

As discussed in section 3.3, many health problems have common roots and are interrelated. Interventions that focus only on specific problem behaviour, like substance use or precocious, unsafe sexual activity, are less effective because they do not address the antecedents or determinants of the behaviour (34). It has been noted that the overlap between good practice in the prevention of substance abuse and of other risk-taking behaviour among adolescents far outweighs the distinctions (195). Additionally, findings of the ICRW's Women and AIDS Research Program recommended that programming should broaden HIV/AIDS education to include a discussion of physical and sexual development, relationships and gender roles for young men and young women (42).

Many current interventions on behalf of young adolescents are targeted to one problem behaviour — drug abuse or pregnancy. While targeted approaches can be useful, they do not take adequate account of two important findings from research: firstly, serious problem behaviours tend to cluster in the same individual and reinforce one another (positive or health-promoting behaviours also tend to cluster) and secondly, such behaviours often have common antecedents in childhood experience and educational failure.

It is important to “focus on approaches that deal with factors that predispose adolescents to engage in high-risk or problem behaviours. These are generic in nature; concentrating on the positive possibilities inherent in the adolescent transition — possibilities for educating and motivating young persons in the pursuit of healthy lifestyles, for fostering interpersonal and decision-making skills to help them choose alternatives to very risky behaviour and for providing them with reasons and tools to build constructive lives” (6).

Generic approaches address underlying factors that predispose adolescents to high risk or problem behaviour. The factors include low self-esteem, underdeveloped interpersonal and decision-making skills, lack of interest in education, inadequate information on health,

### **Box 18**

#### **Young people participate**

The Project Alternatives in Honduras provides education and social services to working children in the informal sector and their families, and to abandoned street children. Young people participate in the planning and implementation of all aspects of the project and in all educational, welfare and recreational activities. A youth advisory council has been recently introduced in order to formalize planning and decision-making by young people in the project interventions, which include a peer education component (D.C. Kaminsky, unpublished data, 1995).

In Poland (M. Holzer, unpublished data, 1995) a "community club" provides assistance to "problem children" between the ages of 7 and 17 in one of the poorest districts in Warsaw. Relations between trainers and young people are based on partnership. Young members of the community club cooperate with trainers in laying down the club rules, and in preparing "contracts" which are binding on everyone. They also choose a youth council and propose programme modifications. In addition, the young people are directly involved in planning and organizing the different community events.

Based on the assumption that a didactic top-down approach from adult service providers is likely to have a negative impact on young people, a number of African initiatives (YWCA, unpublished data, 1995; C. Lane, unpublished data, 1995) have tried to encourage programmes to look at young people not as problems to be tackled, or as recipients of direction from adults, but as partners in doing what is necessary to positively affect their health. This involves young people in programme planning, implementation and evaluation through the training of peer educators and the establishment of youth-involvement mechanisms such as youth advisory committees. All projects are strongly encouraged to solicit youth involvement in project planning, implementation and evaluation. There is preliminary evidence that the services provided by peer educators in this initiative (including counselling, contraceptive distribution and referral) are being well received by the intended beneficiaries.

In India (G. Giridhar, unpublished data, 1995a,b), a radio soap opera, with 52 20-minute episodes, was broadcast twice weekly for one year from October 1993. The serial incorporated feedback from listeners (mostly adolescents) in successive episodes, based primarily upon an analysis of nearly 500 letters received every month.

The basis of the Scout movement is individual development through self-education. Youth members are each offered possibilities to set personal objectives, make voluntary choices, monitor these through observations they can make in their daily lives and publicly acknowledge the progress made by each of their peers to assist in motivation and self-esteem (194). These guidelines also explicitly indicate the need to involve both adult leaders and young people at the local level in the review of existing programmes.

low perception of opportunities, the absence of dependable and close human relationships, and meagre incentives for delaying short-term gratification.

Generic approaches seek to meet the fundamental developmental needs of adolescents and promote a cluster of healthy behaviour that is likely to emerge when these needs are met. Such approaches are especially useful for young people at risk of negative outcomes and who therefore can easily “go either way”: toward problem behaviour or toward healthy adolescent development.

There is a complementary relation between generic approaches and targeted approaches that deal with specific problems. A generic approach can help an insecure adolescent earn self-respect or find a place in a valued and constructive group — both of which enhance the individual’s ability, for instance, to resist pressure to use drugs or to engage in early sexual activity. At the same time, it is important for all adolescents to acquire accurate information about each of these risks and develop specific skills in avoiding them. In sum, the aim of addressing multiple health problems is to enhance the development and continuation of healthy behaviour and to create an environment conducive to health. Box 19 discusses a number of initiatives launched to simultaneously address a range of health issues.

#### **6.4 Combining interventions**

Young people have diverse health and development needs which change over time and may differ according to their sex and circumstances. At various times they will need information, acquisition of skills, counselling, and health services. Programming that encompasses a variety of interventions, like promoting a safe and supportive environment, providing information, building skills, providing counselling and health services for a range of adolescent health needs, is likely to have a positive impact on adolescent health. Youth input in the selection of intervention combinations will enhance the interventions’ response to adolescents’ needs. It is worth noting that young people may not be experienced in expressing their needs, and innovative priority assessment approaches such as those described in section 8 can be helpful in overcoming this problem.

This is in line with the report of the Office of Substance Abuse Prevention of the United States Department of Health and Human Services (196) which stresses that comprehensive programmes hold the most promise for substance abuse prevention efforts. Programmes that address more than one level of influence — and thus take into consideration the complexity and interrelatedness of the

**Box 19****Addressing multiple health and development needs**

The Project Alternatives cited in Box 18 works with street and working children and provides community-based health care, targeted food supplementation, basic and health education (including adolescent sexuality and reproductive health and substance abuse) and psychosocial counselling.

Butterflies (8) targets street and working young people, providing health care, nutrition and meals, health education, counselling, and in addition, job placement and savings schemes.

The Centre for Population and Development, Philippines (WPRO, unpublished data, 1995) — three urban youth centres provide personalized counselling and education on sexuality and reproductive health, referral to health centres and distribution of condoms. They also use multiple media channels such as television (including a serial television drama with positive health messages on responsible adolescent behaviour), radio and a heavily utilized telephone hotline service.

The Vietnamese Youth Union (C. Serrano, unpublished data, 1995) focuses its activities on unemployed young adolescent married couples and young singles. They receive education in income-generating activities and information on reproductive health. The project provides financial assistance and loans to help them to establish themselves.

many causes affecting use — are likely to be successful. Components cited as important are:

- accurate and appropriate information;
- social and life skills training;
- family education and support (programmes which help parents articulate clear expectations for behaviour, monitor and supervise their children, consistently support prosocial behaviour, create opportunities for family involvement and greater family cohesion, and promote the development of their children's academic, social and refusal skills);
- peer involvement in modelling and delivering interventions;
- positive alternatives (such as parties without drugs).

Much is being learned about what motivates and sustains healthy behavioural choices. The most effective health promotion interventions are those which consider three types of factors that influence adolescent health-related behaviour: predisposing, reinforcing, and enabling factors. Predisposing factors motivate a behaviour before it occurs and include knowledge, values, beliefs and attitudes. Enabling

factors facilitate the performance of an action and are generally conditions of the adolescents's environment. Reinforcing factors reward the behaviour after it occurs and increase the chance that it will continue (197).

Combining interventions involves understanding the needs of a group of young people in a particular setting and applying the right mix of interventions to meet these needs, using the most appropriate approaches for that setting. An example is the creative use of interventions in the social environment — laws and policies, attitudes and norms, combined with activities aimed at providing the needed information and building the needed skills — to prevent the initiation of smoking among adolescents in the United States. Laws have been passed to prohibit the sale of tobacco products to young people, policies restricting smoking in public places have been formulated, mass media programmes have worked to influence the opinion of communities at large on smoking, and well-conceived school-based interventions are in place. In discussing adolescent smoking, the report of the United States Surgeon General (198) states that “the most effective preventive programs are community wide ones that combine education and public policy approaches.”

In a recently published report on lessons learned in preventing adolescent pregnancy (35), it was stressed that sustained and intensive multicomponent programmes (consisting of classroom instruction, school-wide activities, supply of contraceptives and media campaigns) had proved effective, but that simply having multiple components did not ensure success. Experience from youth development programmes that focus on improving levels of education, employment potential and life options suggests that the programmes markedly reduce the rates of unwanted and precocious pregnancy.

#### 6.5 **Building on and linking existing interventions in various settings**

Various sectors can substantially contribute to promoting and safeguarding the health and development of adolescents. Each sector typically has distinctive competencies and perspectives which, if employed within a common framework, are more likely to deal with the multifaceted nature of adolescent issues through greater consistency of goals and approaches. Moreover, although the fundamental character of the interventions the sectors deliver are similar, their activities usually take place in different settings and, therefore, have the potential to reach young people in differing circumstances. The promotion of adolescent health and development is faced with issues that are often controversial and enlisting the support of various sectors can

be invaluable. The reluctance of young people to seek assistance and use services can be minimized by improving the collaboration among programme activities in various sectors, thereby providing the former with a safety net.

Interventions which can serve adolescents are often focused upon a single issue and need to be linked together to provide a more holistic approach. A case in point is the way in which health service delivery is organized in most places. The services are often inadequately linked with each other so that an adolescent who, for example, is vulnerable to STDs and substance abuse may have to overcome the hurdle of going to several individuals and departments. Furthermore, health services are rarely linked to information activities, yet a cooperative effort could be much more effective. The situation can be rectified (in the absence of formal structures) through an informal network of people interested in adolescent health from different services within the health sector, as well as among different sectors. Such groups can exchange information about their activities, and discuss trends in adolescent issues, in referral practice, and in the observed needs and opportunities.

It has hence been stressed that more effective solutions can be found if those responsible for nurturing adolescents build a supportive and caring infrastructure composed of several pivotal institutions working in concert to meet fundamental requirements for healthy adolescent development. The institutions include the family, schools and community organizations. No one institution can ensure that today's adolescents will grow into responsible, decent, thoughtful and competent adults. Rather, it is the mutual influence of these institutions that will be critical. Together, they have the potential to address the underlying factors that increase the likelihood of millions of young people becoming involved in behaviour that seriously compromises health (6).

Because of the constraint on resources for health in most countries, programming for adolescent health is most likely to succeed if it builds upon available resources and existing structures. In all countries there are many different organizations and institutions that do (or should) contribute to the health and development needs of adolescents. Clearly no institution, private or public, governmental or non-governmental, can singlehandedly seek to meet the goals of adolescent health and development. Many groups can make contributions, which may be small but significant. Alliances and cooperation are, therefore, needed to create environments that will maximize the potential of all young people.



Partnership for complementary action between government and non-governmental bodies, including those in the commercial sector, are vital and can be mutually beneficial. Partnerships are needed across sectors, especially health, education, youth, social welfare, justice and labour, to provide the safety net for adolescents in need. And partnerships are needed between those who provide information to young people and those who provide health and related services, to make optimal use of existing resources and improve upon them. The formation and maintenance of fruitful partnerships between the different sectors involved in programme implementation and/or support could in future help broaden the policy formulation base by drawing input from different sectors. This is particularly true in relation to the involvement of the commercial sector. In essence, through its involvement, the sector shares responsibility with the government and NGOs for carrying out and/or supporting programmes. In addition, by its experience in corporate survival — namely dynamic and innovative adaptation to changes in the environment through organizational renewal — the commercial sector could help increase the sustainability of programmes.

An important challenge is to find ways to help decision-makers counterbalance the tendency to generate new programmes and policies as a primary strategy to demonstrate action. Recommendations for planning such new approaches should only be made after:

- an explicit and thorough review and assessment of existing assumptions and available resources;
- ensuring that specific strategies reflect input from stakeholders not only about what they want and think but also about what they are willing to do and be accountable for.

Box 20 illustrates the range of approaches which can be adopted in this area.

#### 6.6 Respecting cultural diversity

There is an important relationship between cultural identity and adolescent development. Understanding one's culture is an important part of exploring personal identity; this in turn is part of the overall developmental process. Adolescents' understanding of who they are and where they fit in their surroundings and social environment, compounded by an awareness of culture, can greatly enhance a sense of belonging, which is one of the basic needs of adolescents that programming aims to achieve.

Adolescence is a critical time to introduce and reinforce tolerance for differences amongst people. Adolescence is a stage of receptivity to

**Box 20****Combining interventions — some examples**

YWCA/PACT, a YWCA project in Botswana began as an extracurricular peer education activity in secondary schools in Gaborone, and extended to out-of-school young people, families, communities; it ran a popular local weekly interactive radio programme called *Teen chat*; its peer educators work closely with the Adolescent Reproductive Health Project which is a part of the Botswana Social Marketing Programme. It assists other youth organizations to mount training of trainers programmes; and it works with the Department of Vocational Training to develop peer education activities with targeted unemployed teenagers. The programme has used information sharing and skills-building among the young people. Through use of the media and building community support, the programme has also helped create a more supportive environment. This programme works with partners from various government agencies, and the commercial sector.

The project Youth Front against Drug and Alcohol Abuse in the Gambia tackles health issues and problems exacerbated by poverty, lack of education, and unemployment by offering positive alternatives (primary health care, educational support, recreational and cultural activities, psychological counselling, career-training and job placement). It also targets school drop-outs with remedial education, and conducts a nationwide literacy programme. Organizations involved are drawn from the health, education employment and communication sectors.

*Je mange bien à l'école*, a health and education project in Belgium (C. Vandoorne, A. Poumay & M.L. Nieuwenhuyse, unpublished data, 1995) targeting the improvement in nutritional status of school children in 35 schools in Liège, also helped to successfully influence private food stores to restrict their beverage and snack sales to approved healthy products for the children. The same applied to caterers employed to provide school lunches in the schools.

In the Philippines, UNICEF supports multiple projects targeting urban poor children, especially those living on the streets. Strategies include the promotion of education and protection from harm; access to health services; capacity-building of service providers, families and communities; school-based interventions on nutrition, health education and HIV/STD; and policy development, by assisting the National Youth Commission in reviewing and updating legislation.

The involvement of the commercial sector further supports the multisectoral approach to programming. In essence, through its participation, the business community shares responsibility with the government and NGOs for carrying out and/or supporting programmes. If systematic, the formation and maintenance of fruitful partnerships between the various sectors involved in programme implementation and/or support could help broaden the policy formulation base by allowing input from all the sectors involved. By generating ideas based on its

**Box 20 (continued)**

practical experience with corporate survival — namely dynamic and innovative adaptation to changes in the environment through organizational renewal — such participation by the commercial sector could increase the sustainability of programmes.

Adolescent Reproductive Health Project (*Tsa Banana*) (P. Hickey, unpublished data, 1995) is a part of the Botswana Social Marketing Programme and provides one example of a multisectoral initiative that involves the commercial sector. The programme is implemented by a local NGO, PSI Botswana. The project works in medium-sized towns and targets 13–18-year-olds through a three-pronged approach. This consists of a media campaign about reproductive health protection (abstinence, condom use, female-controlled contraception, double protection, use of clinic facilities for screening for hormonal contraception, etc); condom sales through commercial sector and clinics, targeting young customers through promotion by adolescent peer educators and promoters; and a referral network consisting of selected retailers, clinic workers, young people, teachers, and parents to increase adolescent use of clinical services.

Through its Centre for Family Initiatives, the Tata Iron and Steel Company, a large commercial enterprise in Jamshedpur, India (D. Dey, unpublished data, 1995), targets adolescents (14 to 18 years old) of both sexes, single and newly married, living in the residential, peripheral and slum areas around the company, as well as those whose parents work in the company. The centre seeks to establish a model of corporate action to create awareness and understanding, among young people, of sexual and reproductive health through the use of IEC (including the media) and through health services, in a cultural environment which does not favour frank discussion. It is a pioneering effort which has been operating for more than 10 years with the long-term aim of preventing/minimizing child marriage, premarital sex, pregnancies among unmarried young people and adolescent maternal mortality. The company generates income for the centre through performances of the latter's drama troupe of unemployed young people. In addition, it assists the launching of awareness programmes by other organizations by providing support in cash and/or kind. Its success in meeting the needs of young people is evidenced by the centre's expansion to other target groups, such as college students, youth clubs and police and military recruits.

Another example of an innovative project organized by a corporation is the newspaper-in-education programme of the *Times of India* (J. Kaur, unpublished data, 1995). This reaches students aged 11–18 in three major cities, through educational workshops on numerous topics, including HIV prevention, nutrition and interpersonal relations, and through use of the newspaper as a learning tool.

ideas, and young people tend to be open to weighing the inherent value of the beliefs and norms in the culture around them. It is typical for adolescents to challenge injustice and question the world around them. But the process of developing increased tolerance of differences requires guidance and modelling from others in society. If tolerance is not demonstrated, explored and valued in programming during this stage by adult and peer role models, and conversely intolerance is allowed unchallenged, it can become fixed in the young person. Adolescents' gaining of tolerance for cultural differences is critical to society's hope for more tolerance in the next generation.

An atmosphere of respect in programming also helps to create a feeling of safety among adolescents, and this is vital to their healthy development. Whenever young people live in an environment lacking in tolerance for cultural differences, the importance of programming in this area is heightened. Many adolescents, especially those belonging to ethnic minorities are obliged to live in two cultures — the culture of their family and that of the mainstream society. Encouraging these young people to identify their own values and learn to respect other cultures will help them to respect their own background, while adapting to the extent necessary to function well in the societies they live in.

Basic respect for and sensitivity to the cultural and individual diversity of young people and adults are features of successful programming approaches (34). Programming which demonstrates respect for cultural diversity validates the personal worth of all participants and acknowledges the role that a sense of cultural identity plays in adolescent development. Programming which respects the inherent value of different cultures and the adolescent's basic need to explore the cultural aspect of identity contributes to the development of a sense of belonging, another critical aspect of adolescent development. Such a social environment contributes to the potential of programming to promote development.

In every culture, the programming process needs to explore and understand how different cultural traditions affect adolescents because, although many cultural practices are positive and need to be reinforced, some have harmful health outcomes.

When cultural diversity is respected the potential for interventions to be effective with adolescents is enhanced because:

- When people feel their traditional cultural values are regarded as important, parents and others in the community are more likely to

be responsive and supportive of new approaches, such as participatory methods or discussion of reproductive health topics, to achieve goals.

- Adolescents who feel that their subjective experience of culture is being listened to, and respected, are more likely to contribute to the programming process not only as recipients of programming, but as planners and leaders as well.
- Understanding why young people are at risk of certain behaviour improves the ability of programming to design effective interventions. Assessment of risky behaviour and related health problems is more complete when the cultural factors that influence behaviour (such as substance use) are considered (59).

Programming can demonstrate respect for cultural diversity in a wide range of ways, some of which are summed up in Box 21.

#### **Box 21**

##### **Programming and respect for cultural diversity**

Programming can show respect for cultural diversity by:

- Acknowledging the different meanings 'culture' may have for young people — an adolescent's sense of cultural identity is defined by many things, including race, ethnicity, language, and nationality. It is also defined by the groups of people with whom the adolescent shares values, norms, traditions, and customs (200). Adolescents may feel part of the culture of their parents, but also may feel part of a youth culture or several youth cultures, represented by the groups with whom they share common interests, beliefs, and activities.
- Ensuring that each phase of the programming process includes cultural diversity as an important factor — for example, data on the interests and needs of young people in diverse cultures should be collected. The influence of practices of different cultures on adolescents should be documented in the assessment phase. The needs and issues of young people in all cultural groups should be assessed during the priority identification stage. Representatives of different cultures that young people belong to should be involved in the planning stage and sit on youth advisory teams. Various expressions of cultural diversity such as dress, language, stories and proverbs, important festivals and holidays, can be sought and included in the approaches and interventions used in the implementation stage. Evaluation may be rendered sensitive to the different ways that various cultures respond to written and verbal monitoring and assessment tools. Finally, people considered appropriate to ask certain questions or hold discussions with particular groups should be involved. Indicators that monitor how respect for cultural diversity is demonstrated in programming can be developed and used (199).

**Box 21 (continued)**

- Placing value on the heritage and social practices of people based on their culture throughout the programming process is part of demonstrating respect for cultural diversity. Cultural traditions, beliefs and related practices in each country and within local communities play an important part in shaping the social environment which the adolescent experiences.

When there is need to change cultural practices which are harmful to adolescents, an approach which respects cultural diversity begins with an attempt to understand the practice in the context of the culture. Reflecting on the purpose of the activity has proved more successful when this process is approached with respect for the culture. When there is need for change in cultural practices, it is essential that the perceptions of what needs to change, and how the change should be effected, are generated from within (200).

It is important to consider alternative activities which can accomplish the same purpose or symbolism without being harmful. A process which respects the culture also works with the community to encourage local ideas and solutions for activities to express the intended symbolism. The support of many people in communities — leaders, adolescents and adults — is needed to help bring about change. How males and females are viewed in the culture interrelates with the cultural significance of rites of passage, for example, and understanding how attitudes toward gender influence the continuation of practices such as female genital mutilation should be part of the process of understanding the best ways within the culture to bring about change (200).

- Respecting cultural diversity — this means taking time in programming to explore the influences of culture on adolescents and their perception of how culture influences specific health behaviour.

Perhaps the most neglected of all issues relevant to fostering adolescent health are differences in culture-based values, especially when these values are implicit, rather than explicit. Because the promotion of adolescent health is relatively new, it may be seen as alien to the culture and imposed from outside, in which case antagonism to interventions for adolescents will arise and persist. This fuels the myth that young people, especially those exposed to ideas from other cultures, are opposed to the basic values of their elders. The most effective way to deal with this is to elicit the views of concerned people (including the young) about what they want young people to become, and work towards consensus. Evidence strongly suggests that young people actually share the basic values of adults in their own cultures, despite some ephemeral differences. Other essential differences across cultures are the extent to which adolescent autonomy is seen as desir-

able; the value placed upon a cooperative rather than a competitive system of human interaction; and the importance of the family as the most significant source of authority.

Programmes have successfully changed harmful practices, such as female genital mutilation (201), by working with the culture, respecting the positive aspects of rites of passage, without the fear of challenging traditions which harm adolescents. Such programmes have demonstrated respect for the culture by helping the community make changes from within to find other ways to address rites of passage to replace those that harm adolescents.

The Family Planning Association of Tanzania (UMATI), is an example of programming that demonstrated respect for local cultural attitudes and feelings of parents about sex education for young people, and worked successfully to build parental and wider community support for the peer-to-peer reproductive health activities (through providing information and counselling). Community awareness sessions were held prior to the implementation of activities, which included peer education, distribution of contraceptives and referral to health services.

#### 6.7 Strengthening programme management

Ensuring that programming fully addresses the characteristics discussed above involves some special challenges. These challenges involve: dealing with controversies that often arise about sensitive topics dealt with in the programmes; engaging, collaborating with, and often coordinating activities in multiple sectors; ensuring that the differences in developmental perspectives between young people and adults are attended to when the former are part of the planning and delivery of programme activities; identifying the aptitudes, skills and training of human resources needed to carry out a combination of interventions, and recruiting people with these qualities; as well as coordinating the whole operation.

There are compelling reasons for adolescent health and development programmes to manage their activities deliberately and to strengthen this largely underestimated function:

- Programmes for adolescent health and development are possibly more complex and certainly more difficult to implement than many other kinds of health and welfare programmes. Their complexity lies in the fact that they are multidimensional: at best, they address multiple health problems, and consolidate and link existing interventions in various settings. Their complexity means that there are many variables to manage, all of which are needed for the

programmes to succeed in accomplishing their objectives. This in turn requires more effort and time for management and coordination.

- Many programmes operate with limited and unreliable financial resources, which means that funds have to be stretched and used with caution. This can only be done through deliberate management focused on effectiveness, efficiency and transparent financial reporting.
- Although essential, it is often difficult to obtain and build financial and political commitment for programming for young people because of its controversial nature. Sexual and reproductive health, substance use and violence, among other issues of concern to programming, are emotionally charged. Parents and others, whose support is required, are often reluctant to support programmes if their views differ from the position advocated by the programme. In this instance, management assumes a crucial role since programme survival and self-sufficiency hinge on formulating a meticulous strategy for establishing solid relations with the external environment. Some programmes have not only earned the community's tacit support, but have actually incorporated community participation into programme design.
- There are several reasons why systematic monitoring and evaluation of programme performance is critical. Given the controversial nature of programmes for young people, monitoring and evaluation will provide data to document programme success that can in turn be used as evidence of effectiveness. Documentation of effectiveness is a powerful vehicle for fund-raising and building a more stable financial and political base. In addition, these two management functions will provide feedback which can facilitate efforts to:
  - improve technical programme performance and increase impact;
  - improve financial programme performance by, for example, identifying the costs per adolescent reached which can then be reduced to an acceptable level;
  - attain technical and financial self-sufficiency;
  - expand to scale.

Management may be hesitant about tracking and evaluating the quality and coverage of the programme, in part because of the challenges posed by its complexity. However, to control present operations and future growth, it is imperative for management to convince staff that monitoring and evaluation are priority activities



and, at the same time, to develop systems that will permit the routine implementation of these two functions.

- When programmes emphasize a participatory approach and use young people as staff and volunteers, special attention needs to be paid to the human resource management function. This is because young people are a less experienced workforce and also because of the relatively high attrition rate associated with turnover of those young people who leave the programme as they get older. Management should, therefore, establish innovative and effective systems for continuous recruitment, orientation and training, and motivation which can handle substantial numbers of people. Such systems must offer competitive and internally equitable staff compensation and volunteer incentives. In addition to other staff, efforts should be made to identify, screen, hire and reward young staff and volunteers, and possibly to boost the morale of staff who stay, as they have to establish new working relations on a continuous basis. The training unit may be more active here than in non-participatory programmes working with other population groups. Management's attention to this web of human resource requirements in the programme is the basis for sound operations.

Below are two examples of adolescent health and development programmes recognized in the field for their accomplishments. Their particular focus on management issues has been the key to their sustained effectiveness, expansion to the national scale and move toward sustainability.

SERVOL, a national NGO in Trinidad and Tobago founded in 1972, was "born out of the specific developmental and educational needs of large numbers of children living in disadvantaged areas" (202). It runs, among a host of other community development programmes, the successful Adolescent Development Programme for "unmotivated, discouraged and battered adolescents," with the objective of providing them with self-understanding, positive attitudes and marketable skills which will help them obtain employment. Since its beginnings, SERVOL's philosophy has been to help disadvantaged young people help themselves and become productive adults who will contribute to their communities. SERVOL's clear focus on management has considerably contributed to the NGO's accomplishment of its mission. It has identified the management issues that are organizational and programme priorities, developed and implemented appropriate strategies and systems to make the priorities operational. These include:

- Financial sustainability — SERVOL has invested management expertise and time to develop and implement a realistic strategy for achieving financial independence from donors within a specific timeframe, and is making systematic progress toward this milestone. Transparent financial management and reporting are part of this.
- Community support through networking and participation — the NGO has applied the principle according to which effectiveness depends on the ability to work with governments and other groups and to share power and responsibility with them. For example, to expand early child care and education centres and adolescent development centres to communities throughout the country, the delicate sharing of power has been effected through two mechanisms, both of which reinforce community ownership of the centres:
  - initially, through “attentive listening” to key needs, demands and problems of the target population, parents and the community during community meetings organized by SERVOL to analyse the situation (this laid the groundwork for the design of respectful interventions);
  - by facilitating the establishment of a structure, the village board of education, for each centre. The board houses the centre, helps monitor the performance of the centre’s teaching staff, and attends to administration and fund-raising (202).

SERVOL’s continuous training of staff of the boards has increased their technical expertise, thereby strengthening their capacity to run the centres.

- Monitoring and evaluation — the NGO has made concerted and systematic efforts to monitor and evaluate programme performance at various programme levels. For example, its training courses are evaluated by external evaluators as well as by the participants themselves in order to improve the courses and to raise the instructors’ level of training. In terms of impact, for example, of the Parent Education Programme, the “growth” of very young parents and their children has been “rapid and gratifying” (203). At the operational level, the ultimate evaluation of the quality of the Adolescent Development Programme is the demand by the business community for SERVOL-trained employees. According to an evaluation done in 1985, businesses preferred SERVOL graduates despite their limited academic backgrounds over unemployed but “academically superior job hunters”. It was concluded that their self-confidence and work discipline were generally higher than in employees from comparable educational and social backgrounds,

and in many cases higher than in employees with more academic credentials. The evidence of success has had a ripple effect, permitting the organization to start paving the way for financial sustainability, by attracting attention nationally and internationally. This in turn has facilitated financial in-flow and generated further demand for SERVOL programmes.

- The human resource management system — SERVOL's human resource management system is based on the positive premise that people's potential to move up the career ladder to assume leadership positions can and should be developed through a continuous built-in training programme and opportunities for professional growth within the organization. To illustrate this, more than 80% of SERVOL's senior positions are filled internally. Management is committed to promoting staff and moving them "out of their comfort zones" (188). This is a clearly powerful incentive for employees to give their best to the organization and to reduce staff turnover.

The Adolescent Health Programme of the Ministry of Health in Chile is another example of the vital role of management in making programmes work, survive and thrive. In the case of Chile, management systems have been critical, in particular for:

- sharing its organizational philosophy and objectives with its staff regardless of the structural level at which they operate;
- permitting proactive, two-way communication and coordination between the regional level and the local level through an efficient decentralized system as well as between the different sectors involved.

This has been a challenge specifically because the programme addresses many different kinds of health problems, operates at multiple levels throughout the country, and is also multisectoral with different ministries having youth-focused projects or components and with an active NGO community.

In addition, the programme's success can in large part be credited to the concrete decision to make managers responsible for the survival of their own programmes regardless of the level at which they are working. This has led to programme ownership linked to the application of innovative entrepreneurial strategies to mobilize financial and human resources.

## **6.8 Encouraging positive adult attitudes and behaviour**

Adults play a vital role in the healthy development of young people, and can contribute to a supportive climate for positive behavioural

choices through relationships that express love and concern and through communication on important health and development topics. Adults play a major role in the lives of young people in many ways through: their fundamental role as parents and care-givers from the base of the family; their involvement with young people as teachers, health workers, social workers, and leaders in the religious setting and in other community groups and organizations; roles as supervisors in the workplace, or through relations within the legal system, as police or judges, for example.

The relationships between young people and the adults in each of these roles will influence the lives of young people and be a part of the social environment that surrounds them. Positive attitudes on the part of adults towards young people and adult behaviour that demonstrates concern for their well-being and healthy development will enhance development of self-esteem, sense of belonging, and the capacity for caring relationships. It has long been known that a positive response is a more powerful motivator than a negative one. Adults who are able to identify the good things about a young person or a young person's behaviour will be more effective in sustaining constructive behaviour, establishing positive relationships, and reducing or eliminating negative ones.

While research has shown that peers can help fill gaps in adolescents' knowledge about HIV/AIDS and support for behaviour change, several studies from the International Center for Research on Women research programme conducted in Brazil, Mexico, Thailand and Zimbabwe highlight the fact that young people need and desire communication with trusted adults. Adults have traditionally played a wide range of roles in the sexual education and orientation of young people. The research results indicate, however, that various factors have acted to diminish the involvement of adults in providing sexual guidance to young people. "The challenge is how to assist families and communities establish new roles for adults that fit the changing physical and emotional needs of young men and women in light of the HIV/AIDS epidemic" (42).

Programmers must be concerned about the quality of relationships between adults and young people to help create a climate conducive to adolescent development and to foster and permit positive behaviour choices on the part of young people. Programmers must also be concerned about how to intervene where adults fail to provide for the basic needs of young people or violate their basic rights.

The behaviour of adults will influence that of young people. In addition to being very interested in and influenced by the ideas, attitudes

and behaviour of their peers, adolescents' choices are still influenced by those of their parents as regards behaviour such as smoking, using alcohol and getting regular exercise. Adults need to be encouraged to be positive role models for responsible behaviour.

The attitudes of parents towards programming in which their children may participate influences participation level. When parental attitudes are positive, they can support full adolescent participation and reinforce the ideas and behaviour promoted by the programming. To achieve youth participation in programming, it is essential to help adults understand the benefits of such participation, and to aid adults in gaining the attitudes and skills required to cooperate with young people in planning roles and implementing programmes.

A youth participation philosophy does not negate the vital role that adults play in the lives of young people or the key role of adults in programming for the health of adolescents. It does, however, promote an equal "place at the table" for young people and adults, and an appropriate distribution of labour and responsibility based on aptitude, training and experience necessary for various programming tasks. Youth participation does not mean that adults give up their share of responsibility for programming, but that they accept the challenges of adult-youth collaboration, contribute lessons of experience and accept that their viewpoints may be questioned.

Youth participation in each programming stage can benefit from the guidance, training, supervision and encouragement offered by adults.

This is clearly illustrated by an evaluation of the activities of the Ghana Red Cross Society and the Ghana Scouts Association, which identified that for the peer educators engaged by these organizations, adult support from the project team, including constant visits, sharing of views and ideas, were important factors in their continued motivation in the project. In addition, the training, supervision and support of the peer educators was important in assisting them to develop their skills, and maintain their motivation (130).

To sum up, as an increasing number of countries are identifying adolescent health as an important area for action, a need for a strategic framework for programming has emerged. As we have seen in this and preceding sections, knowledge about the principles and practice of effective interventions is building rapidly, but there is less experience with programming at national level, especially in implementing effective, relatively low-cost, sustainable action on a scale large enough to meet the needs of young people nationally. Such

programming requires a climate in which the urgency and value of action is recognized. The case for adolescent health is a powerful one, but it needs to be made clearly and in ways which respond to the concerns of decision-makers in different sectors.

In addition, the objectives and strategies of programming need to be clear and feasible, and its effectiveness measured through appropriate indicators. It must also be flexible, not only to take into account the different needs in different social contexts, but to respond to change and apply lessons learnt from experience in this relatively new field of action. If all of this were easy, then the universal implementation of adolescent health and development programmes would already have been achieved. In reality, the challenges which face those working to improve the lives of young people are considerable but not insurmountable. What follows is an account of the major challenges which must be addressed and overcome if health sector agencies and their partners are to bring about any significant improvements in the experience of growing up for millions of the world's young people.

## **7. Building political commitment**

### **7.1 Background**

Considerable progress in recognizing the importance of adolescent health has been made in many parts of the world, and this is just beginning to result in policy formulation and programming at the national level. International support for adolescent health has been proclaimed in a number of high-level fora, most recently at the 1994 International Conference on Population and Development in Cairo, and at the 4th International Conference on Women held in Beijing in 1995.

Agencies of the United Nations which have formulated policy or are focusing attention on adolescent health needs include FAO, ILO, UNESCO, UNFPA, UNICEF, WHO and the World Bank. Major bilateral donors and foundations that have committed support to promoting adolescent health in developing countries (as well as their own) include the governments of Italy, Sweden, Switzerland, the United Kingdom, and the United States. Foundations such as Rockefeller, Kellogg, MacArthur, Carnegie, Johann Jacobs and the International Youth Foundation are among the major participants in this field. In addition, international youth-serving NGOs with national affiliates that are highly active in this area include the World Organization of the Scout Movement, the International Federation of Red Cross and Red Crescent Societies, the World Young Women's