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TODAY'S YOUTH— WHAT ARE THEIR HEALTH NEEDS?



Editorial Note:

As 1985 is proclaimed International Youth Year by the United Nations, our first issue of CONTACT for this year focusses on the health of adolescents and discusses methods of helping solve some of the health problems specific to adolescence.

In exploring this topic we have found that, just as we stated in CONTACT several months ago, "a woman's health is more than a medical issue", so the health of teenagers involves many factors not commonly thought of as related to health. Unemployment, or employment too early in life, early pregnancy and parenthood, drug and alcohol addiction—all these can have adverse effects on the physical and mental health of young people.

As Dr. David Bennett, author of our article concerning health care of adolescents in Australia, points out, until recently adolescent health has not been the study or concern of the medical profession. It was mistakenly assumed that "adolescents are a healthy group". Perhaps also the incipient health problems that young people faced were previously better handled within families and communities. But the breakdown of the family and community life in many developed countries or alternatively, the stresses of poverty, migration, and conflict in the third world, have left many adolescents without traditional support in time of need.

In his article Dr. Bennett describes steps taken by professional and government organizations to begin to answer the health needs of young people in the Australian setting. In addition to his article written for CONTACT, we have also made use of a booklet written by Dr. Bennett for the Australian Medical Association, "Adolescent Health in Australia".

Our second contribution to this issue comes from a concerned physician in Sri Lanka. Dr. N. Kodagoda emphasizes the importance of tradi-

tional culture in the mental health of young people and also thoughtfully considers successes and failures in the broad field of sex education, giving ideas about ways of approaching questions of teenage sexuality. We especially appreciate this contribution from Dr. Kodagoda as it shows some of the conflicts and contradictions which can influence adolescents as traditional cultures undergo rapid change.

Our third source gives extracts of an article by Sally Denshire, also working in adolescent health in Australia. She describes for us a few examples of youth participating in health programmes, and includes recommendations her team has found valuable for involving young people in their own health care.

In naming 1985 "International Youth Year" the United Nations called attention to the large slice of the world's population which is 15 to 24 years old—some 850 million people in 1980. Adolescence *per se* is generally accepted as the period covering the physical transition from childhood to adulthood; it includes a slightly younger segment of the population than the definition of "youth" of the United Nations. In looking to the future, we must recognize the problems and opportunities incorporated in these young people. The future of the world literally depends upon them. If those of us now working in health can help to bring to adulthood a more healthy generation—healthy in mind, body and spirit—the benefits would be inestimable.

As the World Council of Churches says in its statement marking International Youth Year: "God has used young people to bring about renewal within church and society. They keep alive the hope and vision without which nations perish. With their future lying ahead of them, they represent the 'new' that God would do among the peoples."

ADOLESCENT HEALTH CARE IN AUSTRALIA

Early Days and Growing Optimism

By David Bennett*

One of the enduring myths about young people is that they are a fit and healthy group. Gradually it is being acknowledged that this is a misleading view and that there is adequate reason for greater concern. A significant number of all adolescents are chronically ill or disabled and many others feel physically or mentally unwell. A 1977-78 Australian survey showed that 56% of the 12-18 age group reported a recent "significant illness".

Australian Background

Australia is a young country with many natural advantages, and with freedom from famine, war and political turmoil. The total population in 1983 was estimated at 15,225,700 of whom 2,615,145 were in the second decade of life. Although the birthrate is falling and the proportion of elderly is increasing here, we expect that adolescents will continue to make up about one-fifth of the future population.

As we approach the year 2000 it is fitting that we reflect on Australia's early experience and progress in the field of adolescent health care. With a background of increasing interest by Australian governments and various professional organizations in recent years, several initiatives have already been undertaken in the delivery of health services to adolescents. International Youth Year is likely to provide further impetus to health-oriented activities concerning young people.

Threats to Young People

In Australia, as in many other countries, "accidents, poisoning and violence" claim more young lives than any other cause—81 per 100,000 of those aged between 10-19. Most of these fatalities are due to motor vehicle accidents. Around 200 teenagers are rendered paraplegic annually. Between 1960 and 1980, the suicide rate for males aged 15-19 years increased from 5 per million to nearly 12 per million. In addition, many so-called accidental deaths are probably disguised suicides of depressed or troubled young people.

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RISK-TAKING BEHAVIOUR

Everybody does dangerous things. There are risks involved in practically everything we do, and without doubt, some accidents are simply accidents. However, the increasing incidence of death and serious health consequences from certain types of behaviour among young people have caused health professionals and researchers to examine the notion of "risk-taking".

Outdoor adventures involving, for example, snow and water skiing, skin diving, hang-gliding or climbing, might be considered part of a healthy lifestyle, in comparison to that of the sedentary individual who over-eats and gets no exercise. Also, for the experienced participant, there may be less risk in such activities than, say, getting behind the wheel of a car and driving "carefully". Driving fast and recklessly, on the other hand, is probably in a different category altogether.

Factors Influencing Risk-taking Behaviour

A number of factors are relevant to risk-taking and its impact upon adolescents in our society. Factors relating to the individual teenager include an increase in aggressiveness and impulsiveness during puberty, which is undoubtedly influenced by hormonal change (especially the surge of testosterone). For young adolescents in whom cognitive development is proceeding, there may be an impaired perception of the risks involved in certain behaviour. This is different from ignorance of risk or a laissez-faire attitude to danger. In the normal process of growing up, adolescents have a tendency to do the opposite thing to family or social expectations in order to gain self-determination. In some circumstances this will expose them to risk. Another relatively "normal" aspect of youthful exuberance is curiosity and experimentation.

For a minority of individuals, dangerous behaviour may be motivated by other psychological factors. For example, "counter-phobic" behaviour involves doing what is actually feared, but with the fear repressed or denied. More importantly, some young people are depressed, and for them dangerous behaviour is a manifestation of underlying suicidal wishes.

Environmental factors with some relevance to risk-taking include tacit or overt acceptance of certain behaviour by the family. The "tough athletes" may reflect exaggerated ideas of parental requirements or wishes. Seeking peer approval or submitting to peer pressure represents for young

people the need to belong, a powerful motivation to behave in certain ways. At the societal level, two factors should be highlighted: the availability of potentially dangerous things such as motor cars, and drugs; media influence ("ill health promotion"). This applies to the advertising of substances and products open to abuse, as well as sexual innuendoes and the general glorification of violence...

Prevention

Acknowledging the contribution of risk-taking behaviour to adolescent development, the challenge is to modify its form to something less dangerous, thereby encouraging young people to care for their bodies and to acquire worthwhile values and attitudes.

Traditional drug education has not only failed to meet its own objectives, but it has been shown to actually contribute to the problem. Adolescents may actually be tempted "to perform activities opposite to those intended". Fear is not the key, especially when dangers lurk somewhere in the future. Tobacco-related deaths, for example, do not occur (yet) in people under 35 years of age, so why should adolescents worry about this possibility now? Likewise, merely giving information about the relevant dangers of different substances does not have much beneficial effect.

On the other hand, the dangers of introducing "forbidden fruits" are all too clear. "Mainstream research indicates that traditional methods of health education are likely to be most unsuitable for drug education, despite their efficacy in other fields."² The key seems to be an approach, oriented to students as individuals responsible for their own actions. It would seem wise for drug educators to withhold moral judgements, and rather to facilitate wide discussion and dialogue on these issues. Teachers need special training in drug education. Ultimately, society needs to move to a position where drug-taking behaviour will become increasingly unfashionable.

From *Adolescent Health in Australia*,
by David L. Bennett

¹ Tennent, F.S., Weaver, S.C. and Lewis, C.E. Outcomes of Drug Education: four case studies. *Pediatrics*, 1973.

² Wallace, S. Has Drug Education a Place in the Secondary School? Paper delivered at 3rd National Conference of the Australian Association for Adolescent Health, Melbourne, 1983.



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• Studies of drug usage by secondary school students reveal that two out of three students admit to use of alcohol. The same proportion admits to use of painkillers, and just under half to the use of tobacco. Other surveys show that illegal drug use is far more prevalent among those who have left school than those still attending.

• Significant psychiatric disorders can be found in 12%-15% of all adolescents. This would amount to perhaps 396,000 individuals in Australia aged 10 to 19, of whom probably not more than 10% undergo any form of assessment. Of those assessed, the most optimistic estimates indicate that only 30% would obtain appropriate treatment.

Despite living in a "lucky country", many Australian young people are at risk of physical, emotional and social health problems related to the environment in which they live. Particular vulnerability attaches to those from broken homes or who have experienced other losses; victims of physical, emotional or sexual abuse; members of minority groups (in particular Aboriginal adolescents); or those who are homeless, unemployed and experiencing extreme poverty. In the area of Sydney's notorious Kings Cross, it is estimated there are 2,000-3,000 homeless children and young people. For these adolescents, poor physical health is the norm, and the additional problems of drug and alcohol abuse, prostitution and violence are commonplace.

In addition to these highly visible problems, common teenage concerns related to growth and sexual development, such as delayed puberty, menstrual disorders or acne, are often not taken seriously enough. On the other hand, conditions such as obesity and anorexia nervosa are increasingly recognized but frequently

Other statistics are equally alarming and reflect the general picture of adolescent health in developed countries:

• An estimated 31,196 women aged between 15 and 19 became pregnant in 1982, which amounts to approximately 5% of the total number of women in this age group.



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are difficult to treat. Chronically ill or disabled adolescents, who constitute almost 10% of the age group, pose unique problems which could be better treated if our health professionals were trained to understand teenage problems and if our programmes were better co-ordinated.

Personal Reflections

During my training in the early 1970's, the thing for a physician to do was to "choose an organ system" and specialize. Holistic care was not a fashionable concept at the time, and the inter-disciplinary team approach was viewed by physicians with the utmost scepticism. The health problems associated with adolescence were hardly considered worth studying.

Dr. Murray Williams, a student health doctor, rightly deserves recognition for his early and ongoing efforts to promote improved health care for teenagers in Australia. For over 20 years he has informed the medical profession of developments in the field, and has expressed a simple but important philosophy: *"We must be prepared to examine carefully and considerately, to take time (always difficult in busy professional life), and to listen quietly for the hidden tangential ways in which young people convey their concerns—an attitude of 'being with' them as experienced and open-minded adults,*

prepared to treat them as individuals with valuable opinions and unique experience, offering explanations when they are needed, but refraining from injecting our own philosophies or needs."

To date, a mere handful of Australian doctors have undertaken formal, comprehensive training in adolescent medicine. My own Fellowship at the University of Alabama School of Medicine with Professor William A. Daniel Jr. enlightened and inspired me. Armed with the requisite "attitudes, knowledge and skills", I returned to Australia and was joined in 1977 by a committed paediatric colleague, Dr. Suzanne Robertson. (She had spent 2 years at the Adolescent Unit in Washington D.C. with Dr. Andrew Rigg). Together, we laid the foundation for a co-ordinated, multi-disciplinary health service for adolescents at the Royal Alexandra Hospital for Children in Sydney. This represented the first step towards organized, comprehensive medical care for young people at an Australian hospital.

Trends in Australian Medical-Social Services

Since the Second World War, most new developments in services for adolescents have

occurred in social work and psychiatry. Theoretically, a wide variety of health services is available here to serve young people who need help because of the breakdown of the traditional family and community life. However, in practice, young people stay away from these services, seeing them as unsympathetic or as foreign to their needs.

Despite difficult economic times for the health sector (resulting particularly in funding cut-backs for major urban public hospitals), children's hospitals in particular have begun to grapple with their responsibilities to the adolescent age group. In most capital cities and some country towns specialized adolescent services have been formed in the past few years. "Innovative approaches" to adolescent health care in non-institutional settings, although few and far between, are also gaining support and adding to the pool of early experience in this country.

It is evident that these new services must solve a number of dilemmas: for example, achieving a realistic balance between varying perceptions of needs (such as choosing between needs expressed by health workers and needs seen by young people) and whether priority should be given to specialized or more broad-based services.



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Adolescent health centres have been established in Sydney, Melbourne, Perth and Adelaide, reflecting a diversity of approaches. However, all these services have in common efforts to create surroundings which young people can readily accept as well as reaching out to them in places where they congregate. Adolescent health has been included as a topic in a variety of Australian conferences over the past few years. Everywhere we see inter-disciplinary activity and trends towards increasing the

integration of medical and psycho-social approaches. The practical participation by young people in their own health care is not a reality in most places, but this issue interests people in the field and represents an area for current experiment.

In 1978, the first "Australian Seminar on Health and Medical Care of Adolescents" held in Sydney, resulted in the creation of the Australian Association for Adolescent Health (A.A.A.H.) which has a multi-disciplinary membership. Other national bodies have shown increased interest in adolescent health in the 1980's. The Australian Medical Association published a health education monograph entitled "Adolescent Health in Australia" in May 1983 as a supportive gesture towards International Youth Year.

International Activities and Aspirations

Within the developing countries of our region, against a background of socio-economic and cultural diversity, issues of particular concern include nutrition, sexuality, and the general effects on young people of modernization and rural-urban shift.

The positive influence that the World Health Organization has played in early developments in this country should be acknowledged. Of particular interest to Australia was the Expert Working Group on "Health Needs of Adolescents in the Western Pacific Region" held in Manila in 1980. It seems to me that the countries who have made first steps in recognizing problems of adolescent health and those with greater resources and expertise should provide support for others which have only begun to be aware of special problems of youth.

Although we in Australia do not have our own house in order, we cannot afford to be too parochial in considering adolescent health. Other cultures already have an impact on our health care system, calling for new insights and knowledge. Well over 10,000 Vietnamese adolescents have arrived in this country over the past six years, for example. The Australian Association for Adolescent Health may be in a position to open a dialogue and share information and resources with neighbouring countries. Recently we have hosted two teachers from the Cook Islands as WHO fellows in "adolescent health counselling". The A.A.A.H., with a

grant from the Australian Development Aid Bureau, will also organize a regional workshop in Sydney in late 1985. In 1987 we will host the 4th International Symposium on Adolescent Health*.

The Future

Recent developments in adolescent health care in Australia have been swift and dramatic. It would be unrealistic at this point, however, to leave the impression that the medical profession is whole-heartedly embracing the idea of

* To be held in Sydney with satellite conferences in Melbourne and Perth. For further information: Convenor, 4th International Symposium on Adolescent Health, The Science Centre Foundation, 35-43 Clarence Street, Sydney.

special adolescent health care; and highlighting hospital-based initiatives should not lead us to ignore the struggles and achievements in other sectors. There are widespread concern and attempts to redress the long-standing neglect of young people.

If I were to present a philosophy, it would be based upon the simple and indisputable premise that the health, well-being and quality of the next generation of adults depend upon the effort we put into the care of today's young people. At this stage of the 1980's, therefore, the primary objective of Australian Governments should be to provide a comprehensive, integrated health service for all adolescents, if not by 1990, at least by the year 2000. I believe it can be done.

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From Sri Lanka

THE UNSERVED AGE BETWEEN

Adolescent Health and Sexuality in a Traditional Culture

By N. Kodagoda*

Many futile hours have been spent in attempts to define age limits of adolescence. So far, little importance has been given to the social factors that affect arbitrary age limits. In Asian societies especially, the influence of the extended family on the maturity of young people is immense.

In our culture, the elderly members of the extended family have a strong influence on the young which may delay their development. The adolescents meet great opposition to the shedding of childhood from well-meaning but condescending old people who obstruct the entry of youth into the adult world. So the growing adolescent is crippled in his psychosocial maturation, although his physical growth marches on, regardless. Given the structures of traditional society, this difficult conflict for the adolescent seems almost inevitable.

In fact, this psychosocially crippling dependence in adolescence may even extend into chronological adulthood. A young adult, although already a husband or wife and parent, may never actually function in either of these roles as long as he or she comes under the wing of the next older generation. In this situation, the unfortunate adolescents and young adults are never free to take decisions, even when such decisions pertain to themselves. We can say that for us the "generation gap" is not just a gap between two generations; it is also the gap (created by the older generation) between what a young person is and what he or she desires to be. This cultural situation deprives the hapless young people of the right to live their own lives, and it also deprives society of the benefits of idealistic enthusiasm and impatience with hypocrisy that are typical of young people who are free to act.

The Right to Know

The drastic nature of the biological and psychological changes of adolescence is well known. The associated social transitions and the morbidity patterns of adolescence are also



Klaus Morgenstern, Berlin, Photo

well recognized. What is not so clear, though, is whether what adults know regarding the changes and problems of adolescence is also understood by adolescents themselves. Experience indicates that there are great blanks in these areas of adolescent education.

It seems that those responsible for development of educational programmes do not consider it appropriate to teach adolescents about themselves, their bodies and psychology. Yet is it not the birthright of an individual in the civilized world to have true insight into one's physical and psychological self?

There are many reasons why the adult world does not think it necessary to impart knowledge about adolescence to the adolescents themselves, not least of which is simple lethargy towards young people's own needs.

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Perhaps a stronger reason is the adults' own ignorance—the ignorance of their own adolescence which persisted unabated into adulthood. Perhaps, too, there is a little selfish feeling of, "Why should they know, if we did not?"

The gaps in knowledge regarding psychosocial as well as physical development of the young are astonishing. There have been until recent times (and perhaps still are) countries that do not know the normal parameters of adolescent development. The processes of the important milestones of human development such as menarche, spermarche, onset of ovulation, symptomatology associated with menstruation, etc., remain unexplored. Ignorance is even deeper when it comes to the onset of sexual activity and sexual practices. If adults and professionals themselves are ignorant about adolescence, it is hardly surprising that the education of adolescents is lacking in this area.

What is Sex Education?

Formerly the greatest controversy regarding education of adolescents centred around the

need for, and suitability of, imparting sex education. Now the need for sex education is rarely questioned in most parts of the world. Even highly conservative cultures no longer seem to believe in a link between sex and obscenity or a causal connection between sex education and sexual permissiveness.

Although we grant these salutary changes of outlook, an inescapable observation about sex education emerges: Sex education programmes aimed at young people are diffuse and out of focus. Most sex education programmes today are presented for acceptance by governments, institutions, schools, etc. under various titles. They are called by names ranging from "family health" to "family life education". Protagonists of this "sugar coating" consider it necessary because a cover-up seems the only way to assure acceptance of sex education courses in highly conservative quarters. Perhaps they are right.

However, because of this camouflage, courses in so-called family life education have come to include wide and scattered areas of learning, ranging from home economics to disaster preparedness. We do not suggest that such

facets of knowledge are unimportant, but we fear that in this diffuseness the focus of sex education may be lost, thereby denying youth the opportunity of satisfying one of their foremost needs and also keeping sex education courses from meeting their stated goals.

More Knowledge—Negative Attitudes?

A survey conducted by us in some schools in Sri Lanka brought to the surface another misconception about sex education. Many people responsible for education of the young are blinded by the delusion that imparting factual biological knowledge is equal to giving successful sex education. This assumption appears to be almost exactly contrary to what actually happens in schools.

What we observed is that with increasing schooling, anatomical and physiological knowledge about sexual systems progressively increases. At least part of this knowledge comes from formal instruction. This measurable increase in knowledge supports the educational system, and if one looks at these results casually, one can feel a false sense of satisfaction.

The disturbing truths emerge when these same students are tested in *functional* knowledge of sexuality and on attitudes that cause fears and anxieties related to sexual function: with higher schooling and increase of

age, the students become more and more negative in these respects! With more factual knowledge, anxieties increase.

So, something seems to be going wrong. Either the course content and educational methodology are inappropriate for dealing with the psycho-social demands of adolescent sexuality; or else, the society to which the adolescent is exposed has an effect that counters the beneficial influences, if any, of formal sex education. Perhaps both factors play a role. In any event, this situation calls for a re-evaluation of the total system of sex education, both in its content and method of teaching.

Fears of Adolescents in Sri Lanka

The fears that adolescents entertain about sexual matters appear to be fundamentally similar in most parts of the world. In our experience, contact with large numbers of young people in Sri Lanka indicates that their main apprehensions centre around: effects said to arise from loss of male sperm; guilt concerning pre-heterosexual stages of sexual gratification; physical appearance; and mythical concepts regarding sexual adequacy.

Many young girls entertain numerous worries about menarche itself, and about the process of menstruation. This is not surprising in view of the secrecy and ritualism connected with these events in many societies in the East. While we try to retain the important values of tradition and culture, the negative effects that emanate from some cultural practices should be recognized and steps taken to eliminate them. Cultural observances at menarche are a rich field for further study. Traditional "rites of passage" would provide opportunities to educate young people about physical changes they are undergoing as well as about psychological and social changes associated with adolescence. Are we not missing valuable rewards by failing to think of ways to use the cultural recognition of adolescence as an occasion for educating young people?

Problems of Teenage Pregnancy

Teenage pregnancy is a matter of great concern. In some countries, as many as 40% of all births occur among teenagers. Even this figure is not a real reflection of teenage fertility, for it does not include the number of teenage pregnancies terminated by abortions. The whole question of teenage pregnancy has to



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Photo Courtesy WHO

be viewed against the background of mortality and morbidity associated with clandestine abortions, or the peri-natal morbidity and mortality of mothers and babies, low birth weight of babies, loss of employment and interruption of education for young mothers, social ostracism of unmarried mothers, etc.

Many teenage pregnancies in the East occur with parental and social assent, but they still imply most of the risks mentioned above. The reluctance of adults to face the negative aspects of teenage pregnancies and youthful marriages is, to say the least, irrational. It is of prime importance to assess the magnitude and consequences of the problem in various countries; and having done so, to unhesitatingly institute bold and logical countermeasures. The problem of teenage pregnancy emphasizes the need for well-focussed sex and contraceptive education for adolescents. We must immediately recognize the importance of making contraceptives available to this high risk group.

Teenage Contraception

The delivery of contraceptives to adolescents has always brought strong reactions from society. Different countries adopt policies ranging from total prohibition, to availability of contraceptives with parental consent, to providing free contraceptives to all adolescents. The policy is a matter for people and governments to decide.

It is more important to realize that where delivery of contraceptives to teenagers has been accepted as policy, the programme must be carried out in an acceptable and non-threatening manner, by sympathetic people. Availability of contraceptives alone does not necessarily lead to their acceptance and utiliza-

tion by adolescents. This part of a health service is something very special that needs conscious designing. In planning a contraceptive programme, the most important participant should be the adolescent himself.

A Final Word About Adolescents

Reliable and fair opinions about adolescents can only be formed after prolonged personal contact with them. We have had the good fortune to be in contact with young people over many years, and we have also had the opportunity of conducting studies on them for a considerable length of time. We feel it is fair to close with a plea for understanding of this oft-maligned age group.

After our observations, we have formed certain conclusions about adolescents:

- they have an unquenchable thirst for knowledge, particularly knowledge about themselves
- their search for ideals and examples is intense
- they yearn to pour out their thoughts to empathic listeners, and they build up confidence in those who understand what they are saying.

When adults and society frustrate these basic desires of adolescents for knowledge, ideals and understanding, they build up strong negative reactions in young people.

Teenagers are also often criticized for their lack of cooperation. However, one of our surveys required regular examination of hundreds of young people over a period of two years and also requested that they record certain daily events over the total time. The survey started with 806 respondents and had only 46 drop-outs at the end of two years. (Many of these drop-outs were because of unavoidable migration.) These young people did not cooperate because of material reward. What seems to matter more is the positive psychological bolstering of their personalities. The working motto seems to be: "Give to them, and you will receive from them."

What we have gradually realized in our work is that adolescents are not "little adults", neither are they "over-grown children". Adolescents are individuals and have personalities of their own. They do not need sympathy, but understanding. Above all, if decisions are made affecting them, young people want a voice in deciding. Are we giving them this voice in their health care?

A COMPREHENSIVE RESPONSE TO YOUTH NEEDS

By Sally Denshire *

Adolescence is a period of complex changes in physical growth and maturation and of transition from childhood dependency to adult autonomy. During this phase young people are struggling to establish their personal and sexual identity, a sense of self-esteem and competence. It is also a time to develop satisfactory interpersonal relationships, increasing independence and an ability to cope with both needs and potentials.

A community-developed and community-based youth centre, offering a holistic approach for considering various needs of young people simultaneously rather than treating each need in isolation, assists young people in their development.

Youth participation in planning and service provision is an emerging feature in this comprehensive way of working. The young people who use multi-service centres usually see themselves as members of a club where services are available, rather than as traditional "clinic patients". Easy access, flexible structure, a relaxed friendly atmosphere and the opportunity to be involved in a variety of activities contribute to this perception. A high level of commitment and the ability to take risks are qualities found in workers in these centres. Flexibility in approach is equally necessary: e.g. the Comprehensive Adolescent Program, Los Angeles, only hires staff who can also run at least two creative or recreational classes.

Multi-service centres like this can be developed when a single service such as a youth leadership training facility, S.T.D. clinic, family planning service or medical service is broadened and co-operates with other existing services. Showing commitment to the *value* of youth is what is most important.

* Sally Denshire is an occupational therapist in the Adolescent Medical Unit of the Royal Alexandra Hospital for Children, Camperdown, N.S.W., Australia. This article is condensed from a paper she prepared for the WHO Study Group on "Young People and Health for All by the Year 2000" in June, 1984.

YOUTH PARTICIPATION IN ACTION:

The Adolescent Orientation Centres (C.O.R.A.), Mexico

This Latin-American multi-service approach to family planning started in 1978. In 1982, C.O.R.A. had 4 service centres in Mexico City, one in the State of Tamaulipas as well as trained workers in Guatemala, Panama, Nicaragua, Costa Rica, Honduras and Mexico. These preventive pilot programmes offer promotional, educational, medical, psychological, cultural and recreational activities to normal adolescents 11-19 years. Family planning services, sexuality information and counselling and gynaecology services are also available. The face of family planning is used to offer other services in an attractive, "social club" atmosphere that is fun and healthy, rather than that of a traditional clinic.

Young people themselves are employed to motivate their peers and disseminate information. These groups of young people are coordinated by a social worker and offer recreational, cultural and artistic events as well as working individually and in mutual support groups with adolescents attending the centre. They co-ordinate with their counterparts in other centres and promote family planning in the community. C.O.R.A. also invites adolescents and some parents to participate actively in the development of preventive programmes.

A few years ago, a local television station approached C.O.R.A. when researching a soap opera about adolescence. C.O.R.A. in turn asked the television station for technical dramatic assistance and now there is an annual theatre contest where young people research adolescents' needs and then write scripts and perform a play. These plays started out as tragedies with lots of swearing but now more often contain solutions. First prize is the opportunity to perform for a season at an established theatre; other prizes include travel to different parts of Mexico.

The Door—A Centre of Alternatives, U.S.A.

“The Door—A Centre of Alternatives”, was established in 1972 with recognition of a group of young professionals that the life needs of urban youth could only be met by a new approach to youth services. “The Door” was created as a model to demonstrate the effectiveness of providing comprehensive, integrated services and of developing networks of linkages among existing service systems. Today, more than 400 young people from throughout the New York metropolitan area come to “The Door” daily. Upon entering, they have available to them the following services:

- a comprehensive health programme staffed by physicians, nurses and other medical staff
- family planning and sex counselling services
- a prenatal, young parents and child care programme
- nutrition counselling, food services and a cafeteria
- social services, crisis intervention and run-away counselling
- a mental health counselling and therapy programme
- drug and alcohol abuse counselling and treatment
- an education programme with counselling, tutoring, remediation, language training and treatment of learning disabilities
- career counselling, vocational training and job placement



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- legal advice, counselling and advocacy
- arts, crafts, music, theatre and dance programmes and workshops
- recreation and martial arts programmes and facilities.

Services and programmes at “The Door” are easily accessible. The entire range of services and programmes take place under one roof in a setting architecturally designed to permit appropriate privacy in an open, friendly atmosphere attractive to young people.

To thousands of disadvantaged adolescents, “The Door” has become a viable alternative to what are often selfdestructive life styles, providing a meaningful response for young people who are unable or unlikely to seek help from traditional agencies and institutions.

“Out there on the streets, scared and alone, man, I was doing crazy things. When I came to The Door, my whole life changed. This is a place where anybody can walk in and be offered an opportunity with no strings attached.”

“There’s a chance at The Door to deal with the basic causes of problems rather than just putting band-aids on the symptoms and seeing the same young people return with the same problems year after year. You feel as if something is happening and it’s actually possible to see young people getting better.”

Level of involvement

To what extent a teenager participates in health also needs consideration. A teenager may be involved actively on a personal level, looking after his/her own diabetes. Or as a service provider, (s)he may support and educate a newly diagnosed peer. Involvement in problem solving strategies to plan, design, implement and evaluate services, require a further level of commitment and responsibility. Young people concerned with problems and issues relevant to youth, who are seeking opportunities to be of service to others, and who are ready to assume leadership roles among their peers are equipped to tackle this work. A peer health assistant has a more clearcut role than an adolescent user of health services who may be attributed the role of “patient”, while also wanting to be of service to peers.



Klaus Morgenstern, Berlin, Photo

Roles for young people in their own health services can include reception, accompanying others, acting as a host or guide, advocacy, devising resources and teaching creative skills, health education, advising, planning and evaluation. Youth in this role provide a "barometer" for a service.

Moises Perez Martinez and Linda Loffredo of the Institute for the Development of Youth Programs, New York, describe the following levels of youth involvement at "The Door" in New York City. Service users may start as assistants, helping out in the library or in creative workshops, with homework or outreach work in schools. They can progress to becoming service providers, offering peer support, which provides the opportunity to be able to give back within a milieu setting. Young people at this level of development can be tour guides, tutors, nursery workers, health advocates who can check blood pressure, for example. With increasing responsibility young people may assume a responsible adult role within their service. Their work may include liaising between youth and staff, project co-ordinator, peer counsellor, carrying out a psychosocial interview including presentation to the supervision team.

A youth advisory board comprised of young people is a way that youth can contribute to policy formulation. Resource staff are needed to co-ordinate training experiences, develop roles and job descriptions for youth, facilitate groups to reflect on experiences. Young people in these roles also need space of their own within the centre.

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Youth Participation in Health Settings

Commenting recently on youth participation, the Australian Association for Adolescent Health emphasised the following principles:

1. **Effective communication between young person and adult, where both are listening to each other, is a necessary pre-requisite for actual youth participation and training.**
2. **The support of a multi-disciplinary team is essential for youth participation to become an integrated part of a health service. When this process begins, teenagers and adults learn from each other and advice-giving gives way to mutual exchange.**
3. **The format of adolescent systems, which are often informal and non-confronting initially, is necessary. So are opportunities for young people to express themselves in creative ways.**
4. **A well planned training programme providing the opportunity for personal development as well as knowledge and skills about how community systems work needs to be offered.**
5. **Use of peer groups for learning and to support one another is valuable.**
6. **To take an active role in health care, teenagers need easy access to many kinds of accurate, clear health information. "Healthy Lifestyle" information on diet or skin care for example, is more available to young people than complex medical information on a chronic illness or information on sexual issues, which may be considered controversial.**
7. **Youth participation seems more feasible in primary health care settings than in more specialised settings. Often the more dependent or sick a young person is, the lower their health status is and the harder it is for them to find out about their body, their feelings and the work around them, although they want achieve some measure of independence and control.**
8. **The approach where a teenager receives support from friends who are/have been disabled, awaiting surgery or pregnant for example, complements the often theoretical input of adults. The role of "informed friend" or "peer advocate" also builds self-esteem for the young person who is offering the support. After training, this can be a paid position.**



Photo Methodist Missions, T. Fujihira

CMC NOTES

The MEDEX Group at the John A. Burns School of Medicine, University of Hawaii, will be offering a course in "Strengthening Primary Health Care at the Health Center and Community Level". Subtitled "A Practical Course in Primary Health Care Manpower Training & Operations Management," the programme is designed for personnel from Ministries of Health, international organizations and non-governmental organizations.

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Graduate School of Public Health
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NEW PUBLICATIONS

District Health Care, R. Amonoo-Lartson, G.J. Ebrahim, H.J. Lovel, J.P. Ranken. Macmillan Press, London, 1984. 208 pages.

Subtitled "Challenges for planning, organisation and evaluation in developing countries", this comprehensive handbook gives practical advice and support to District Medical Officers and District Health Teams throughout the world. The authors have brought together their diverse experience in the development of primary health care and teaching practical mother/child health in a wide range of countries including Ghana, Tanzania, India, Thailand and Lesotho as well as the United Kingdom. A valuable aid for all those involved in the planning, establishment and running of district health services.

Price: £ 3.50 paperback or £ 10.00 hard cover.

Available from:

Macmillan Distribution Ltd.
Houndmills, Basingstoke
Hants. RG21 2XS, U.K.

Test-Tube Babies: Morals, Science and the Law, Very Rev. Prof. Thomas F. Torrance. Scottish Academic Press, 1984. 12 pages.

This short pamphlet discusses the ethical and moral questions raised by genetic engineering,

test-tube babies and surrogate motherhood. Professor Torrance particularly discusses the question in terms of the recently published Warnock report presented to the British Parliament. The author is a former professor of Christian Dogmatics at the University of Edinburgh.

Price: 50 pence.

Available from:

Scottish Academic Press Ltd.
33 Montgomery St.
Edinburgh EH7 5JX U.K.

Adolescent Fertility, Report of an International Consultation. International Planned Parenthood Federation, 1984. 59 pages.

This report of the Bellagio Consultation on Adolescent Fertility considers the needs of adolescents in the fields of sex education, contraception, family life education, early marriage and early pregnancy. It devotes 15 pages to an action plan recommended by participants in the consultation.

Price: £ 3.75 (£ 2.50 U.K. only)

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