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British Society for Adolescent Health and Welfare

Incorporating the Newsletter of the International Regional Chapter of the Society for Adolescent Medicine.

Letter from the Editor -

Dear Colleagues,

The European conference is upon us already - it is amazing how fast this year seems to be going by! In this issue we report on the Cuban conference and some of the 1998 proceedings.

May I take this opportunity to remind you all that we welcome contributions to the Journal, to our conferences and we encourage you to join the British Society for Adolescent Health and Welfare - which as you know, is the 'grown up' version of our Forum.

Conference details are on http://www.youthsupport.com
Those who are interested in our assessment and treatment services and particularly our family work will find this detailed at http://www.family centre.com

We have had a number of students and professionals on placement/electives and sabbaticals with us this year, from the USA, Italy and Spain and Russia and hope that this trend will continue. Anyone wishing to spend time at our centres should contact us at Youth Support House. Young people are also welcome to spend their holidays or get work experience at the mini farm, the pet shop, the cyberbridge or generally helping out our charity.

Diana Birch
Director Youth Support

CONTENTS

~ CONFERENCE ROUND UP ~

Personal Views of those attending recent conferences -

Our two conferences at the Royal College of Physicians in October 1996 and 1998 have now both been published as proceedings books which are available - see below.

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Extracts will be printed in the journal.

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Cuba May 1999

The VI[th] Latin American Congress on Paediatric and Adolescent Gynaecology took place in Havana in May 1999. this was a very full event with speakers from the whole of Central and South America, the Caribbean and also some speakers from North America and farther afield.

Bob Blum and Gail Slap participated as did Tomas Silber and several other stalwarts of the Adolescent Medicine community. It is indeed a credit to Jorge Pelaez that he led such a successful team. Doctor Mendoza is an Auxiliary Professor of Obstetrics and Gynaecology at Havana University School of Medicine and he is the President of Juvenile Section of the Society of Obstetrics and Gynaecology in Cuba.

The articles that follow relate to the conference.

Early Pregnancy - Myths, Reality and Long Term Consequences.

Presented at VI[th] Latin American Congress on Paediatric and Adolescent Gynaecology

Dr Diana Birch

Teenage pregnancy and adolescent sexuality as been dogged by numerous myths and false perceptions - some of which have been extremely deep rooted and difficult to eradicate.

Debunking Myths

The surveys and long term studies of young parents which we have conducted in the London area have shed light on these issues and debunked many of the myths.

Myths exert most influence when firmly planted in the belief system of the adolescent and perpetuated by the peer group - but frequently they are given birth and propagated by the media - a powerful force that can quickly spread misconceptions and endow them with a false legitimacy.

Promiscuity

So let us look at some basic myths regarding teenage couples - the girl is promiscuous - Well most of couples had known each other for more than six months, two thirds had been a couple for more than six months and in fact three quarters of them had been friends for more than six months. Most girls became pregnant by their first and only boyfriend. So this debunks two myths - that of the promiscuous schoolgirl and that of the fly-by-night, predatory boyfriends who just get girl pregnant.

Sexual Education

Sexual education is another mine field - tell them about sex and they will go out and do it. This myth hides a deep prejudice against youth and against knowledge. There is no other area of life where we attempt to rationalise the withholding of knowledge from young people. Good decisions are made based on accurate factual knowledge - not prejudices and false beliefs. In our survey over 90% of pregnant schoolgirls had not had any significant sex education - 95% had not spoken to their

parents about it, most had missed sex education at school and the commonest source which was also the least accurate was school friends.

Boyfriends

Myths about boyfriends - Are they just interested in sex and abandon their girlfriends when they get pregnant? Well of course some do - but on average this is not the case. Many of these baby fathers actually want to support their family, their baby, but they're not allowed to being marginalised by the girl's family or her carers; or they may be too young, schoolboys themselves and they don't earn money, don't have jobs. So we are talking about emotional support not financial support and nearly 60% were emotionally supportive of their baby mothers. We do have some cases where the boys were not notified about the pregnancy - although 90% were. Some boys who found out eventually were in quite a lot of stress, suddenly finding out they were fathers and not knowing about it, and also feeling guilty because if they had known, they would have wanted to support their family. An interesting fact which came out of the early part of our study is that 18% of baby fathers were actually present at the delivery. Now we have to remember, that fifteen years ago at the start of the longitudinal study, it wasn't *that* common for fathers to be in on deliveries.

Looking on at the long term figures again debunks the myth of the unsupportive boy. How many stay around for their young families? At two years from first birth about 45% are still involved, but it falls off with time although at fifteen years 20% are still in touch with their kids a fairly high figure really although if you look at the number of fathers that are still in touch, it's also very dependent on the background of the young couples. The girls who had families, were more likely to have their boyfriends be in touch, so they're more likely to be stable relationships. Where the girl had been in care, when their partners had been in care things were very different. And in fact at fifteen years, 20% of the whole population were in touch, but only 2% of those where the girls didn't have a family. Of course one could play devil's advocate and say - well what about the ones that dropped out - 80% are not there at 15 years - but I think that the most important thing is that if 20% are - it shows potential and willing - so what could we have done to keep the 45% who were around at 2 years still available to their children at 15 years?

Looking at the number of boys, this was interesting, because just under half of the girls had multiple boyfriends and were repeating pregnancy. 39% had only one boyfriend, one sexual relationship over the fifteen years, which is quite a surprising fact, so these girls are not promiscuous.

Substitute Fathers

And another interesting little myth to debunk - that of the early substitute father - I am sure we have all seen girls who come to the antenatal clinic and they're pregnant, and their boyfriend has dumped them. And at the next clinic they bring a new boyfriend saying that he

wants to be considered as the father - most clinic staff shake their head and assume he will also be gone in a short time - but not so this 12% of early substitute fathers are boys who it seems have a real need to be a father. He takes on this ready-made family, the girl and the baby because he's the sort of boy who needs to look after people, and is a carer, and interestingly, these were the boys who were much more likely to stay over the period of time. Of these early substitute fathers they were nearly all still there at fifteen years. They were much more likely to stay than the natural fathers, which I think is very interesting and it just shows the need that some boys have to be fathers is very similar to the need that some girls have to be mothers.

Housing

Let us look at another myth - that of the girl who gets pregnant to obtain a council flat, better living conditions, welfare money. One glance at any of our cases shows that to be the lie that it is - but whole papers can and have been written on the 'culture of poverty' that teenage pregnancy is. In the International conference on adolescent gynaecology in Cuba 1999 we heard over and over about the poverty of girls in Uruguay, Brazil, Chile and it is not a phenomenon limited to Latin America by any means - London is another example . Housing can be squalid, squats or families can remain homeless for many years. Poverty and dietary deficiencies perpetuate from one generation to the next as is evidenced in the poor dietary record of pregnant girls - thirty four percent had very poor diets and no employed adult in the home - coupled with low birth weight and prematurity in their children. This factors also associated with high perinatal mortality.

Adoption

So, people say, why leave children with young mothers? Would they not be better off adopted or placed with good families and would the girls not do better if unburdened by these children? This myth must be eradicated once and for all in order to make any positive change in the lives of young parents and their offspring. Repeatedly it has been show that children placed in care fare worse than those raised by their parents

Care System

Girls in the care system had more pregnancies, more boyfriends who stayed around for shorter periods, they had more of their children removed into care and fared worse on every parameter researched. Their children had more problems at five, ten and fifteen years. A perpetuating negative spiral of deprivation and misery.

Father Figures

Another misconception here is that the influence of a father figure on the young mother has been emphasised without considering the effect on the boy. It is accepted that girls may be predisposed to getting pregnant because they come from single parent families, they don't have a father and so they need to go out and find a boy because they don't know how to relate to men, they've got an absence of a father figure in their lives. What the fifteen year study showed was how important it was, especially to the first born male children, this absence of father. For example in

children of teenage mothers at fifteen years - behaviour problems in the girls - 20%, in the boys - 70%. More boys bullied than girls, more boys having minor crime than girls. The relationship with the mother, worse for the boys than for the girls, as you might expect. Smoking is about the same, alcohol more in boys, drugs more in boys, sex education - the girls are more likely to talk to mum so sex education is better. Sexual activities - the boys had more girlfriends, the boys had more sex.

Finally let us consider some of the psychological myths … which could and do take up a whole thesis of their own. Firstly linking with the commonly held misconception that contraception is the answer. Yes, we need better contraceptive services for youth , but these are worse than useless if the young people themselves do not see the need or wish to use them. Inability to see the consequences of their actions, concrete thinking, and lack of a future time perspective all impact here.

Denial

I have described 'magical thinking'. To explain briefly, young people have a set of belief systems governed by their society, family, peer group and we can confront these beliefs and educate by working on the level of the internal parent (beliefs and prejudices) or the internal adult (factual knowledge) confronting myths such as 'you can't get pregnant the first time' with 20% of girls got pregnant the first time they had sex - or 'you don't get pregnant if you do it standing up' confronted with sperm can swim up hill. But underneath these considerations and beliefs is the 'magical' level of hinking - governed by te nner child, priitive fundamental ad based on emotion and not on logic. The denial , the it can't happen to me, the belief in the 'autonomous womb' that gets pregnant all by itself - a complete manifestation of the external locus of control.

Self Esteem

And then there is the myth of 'the only thing I can do right is have a baby' - a false solution and a condemnation of youth. Our self esteem study showed that in response to deprivation and particularly sexual traumata -young mother's self esteem fell - but pregnant teens were protected by their pregnancy from the true impact of these assaults - they believed in themselves while pregnant and this gave them a better sense of self during the early months of the child's life - but it did not last - hence repeat pregnancies. What we need to do is to give these young people something else to value in themselves - to value themselves as women or as young men and not only as mothers and fathers.

Poor Use of Contraception

The following article was Jorge Pelaez presentation to the International Conference in London October 1998

Sexual Practices in Adolescent Sexual Initiation

Jorge Pelaez

We listened previously to speaker talking about some problems that are very common during adolescence, abortion, sexual exploitation and STD. Now I am going to talk about the first step in sexual behaviours during adolescence, it is sexual initiation. Risky behaviour in adolescence is very common. We recognise under this a precocious first intercourse, poor recognition of the risks with regard to relations, health concerns, in inappropriate circumstances and places, frequent change of couples, ignorance about sexuality, birth control is not considered, Lack of essential knowledge and use of contraception and insufficient knowledge about STDs and their prevention. Today adolescents are affected by disproportionately high prevalence of unplanned pregnancies, sex transmitted diseases including AIDS and other STDs that affected their reproductive health. Risky sexual behaviour is considered responsible for almost all of these problems.

Sexual Initiation

We are going to talk now about sexual initiation and we define that as the first coitus. An intimate experience of communication of the signs of affection existing between two human beings which could take part voluntarily. And precocious sexual initiation we define that sexual relationship that begins before the adolescent's arrival to consolidation stage between age 17 to 19 years (Bloch and Erickson classification) To remind you this classification covers four stages. First stage is between 12 and 13 years, second stage between 14 and 15 years - motivation manifestation, third stage around 16 to 17 and the fourth stage is over 18 years. We consider that any relationship that begins before this stage is precocious.

Masters and Johnson said in 1989 that commitment in a couple does not imply only preoccupation about sexual pleasure but includes direct reciprocal responsibility on birth control as a result of such union, in other words pregnancy. That is not common in a couple of adolescents that are below 18 years. That is another reason why we recognise that the relationship that begin before 18 years is precocious.

This is the consequence, the popular consequence of precocious sexual initiation: frustrating experience, favouring sexual dysfunction, continuous change is couples resulting in risky sexual behaviour, increased rate of STD, genital infection and their consequences - cervical changes neoplastic and PID, higher risk of abortion, unplanned

pregnancy and their consequence and higher risk of PID and in the medium and long-term consequence, we are talking about infertility and ectopic pregnancy.

Objectives

The main objective of our study is to know the frequency of adolescents attending secondary school that have initiated intercourse, to determine the course that led them to have a precocious intercourse and to study the adolescent environment, establish risks and protective factors for precocious intercourse and to know the characteristic and motivation for the first intercourse.

As you can see we develop a history that include a junior high, technical and high school institutions from Havana city where they were randomly selected. A self-responding questionnaire was supplied to all the students who went to classes on the day established by the study. A total number of 2713 filled the questionnaire, 73 were excluded because of incompleteness or mistakes totalling a sample of 2640 students. This is 1425 females and 1215 males. Informed consent was obtained from each individual and institution.

Results

Here are some of the results. The majority of the students included in this study were in the second stage of Bloch and Erickson, between 14 and 15 years. There is significant difference between the no-initiation and initiation and it represents that the males have a higher proportion of initiation during adolescence, they also start earlier than women. The higher group is 14 years in males and the higher in female is between 15 and 16 years.

Partner in the first intercourse - There is not big difference between male and female, it was the boy or girlfriend the majority of the partner of the partners in the first intercourse. The only difference was in the when the partner was a friend more common in females and if the partner was a relative there was no difference between female and male.

In males the paramount motivation behind first intercourse was group pressure and family pressure. In women we had the peer and the partner pressure. And the difference was significant.

Where happened the first intercourse? As you can see the majority in both sexes were always in park. I had a lot of problems in finding a correct word because we found in the dictionary alleys I don't know if it is correct, it is small street, dark street, you know something like this, and parks. But you can see that there is a lot of places, all of them are not good to have a sexual relationship. You can see motel/hotel is very small, beaches, camping, party, even a school.

And here the enjoyment by gender concerning the first intercourse. When we asked them, How did you feel in your first intercourse? And

we found also a big difference between male and female. Very pleasant - male always. Female – almost nothing. Pleasant – the same, too much male, few female. Fair stresses – more female, indifference – more female, unpleasant, almost every female.

Contraception

The use of contraception in the first intercourse was also a thing that we want to know. And we found that only 14% of the students use contraception in their first intercourse. Why they didn't use contraception? First – unplanned relationship, that's very common during adolescence. They were surprised by the relations, they don't plan it, they didn't know that they are going to have the first intercourse. Ignorance about contraception, ignorance about the risks of unprotected relations. But you can find some other reasons, but for example, here is very important, I call out-drop effects. So of the first intercourse in the adolescence were all these high risk sexual behaviour.

Sexual Knowledge

Sexuality information errors. Is it important to prevent and to delay the sexual initiation? – I think so. You see that when there is a very good level of sexual knowledge the percentage who don't initiate is bigger. When the knowledge level is very bad or bad the majority have been initiated. The sexual information level is protection factor against the proportion sexual initiation.

Peer Group

Here is the influence of the peer group in the sexual initiation. We have 2 groups of peers. We divide the adolescents into the peer groups where the majority are initiated, had sexual intercourse and a peer group in which the prevalence is not initiated. When the peer group is initiated the majority of the students included in this study will start the sexual relations. When they are not initiated there is a big difference and the majority have not initiated. And when they ignore peer opinion also the majority have not initiated. And we can conclude in this case when they adolescents ignore if the peer group have or not sexual relations they are free of pressure, of group pressure to start the sexual relation because it is clear that it is not a topic for conversation. Here is the incidence of abortion in the peer group. When the peer group had a high incidence of abortion almost all the students had been initiated. When there is not intention of abortion this thing changed. And when they ignore even big the difference.

Family

What about the family? We recognise a very importance to the characteristics in the sexual practice during adolescence. And as you see when the relationship define very good or good you see that the big percentage of the sample have not initiated. When they said that the relations in the family is very bad or bad almost the majority of adolescents have been initiated even when they say that is regular. The closeness with the parent is also a very important topic. When the adolescent lives with both parents the majority has not been initiated the sexual relations. Even when they live with the grandparents or others the

difference is very high and almost always has been initiated the sexual relations.

Finally I would like to show you the life projects and the importance of this in have a preventing protection factor for sexual initiation. In this study we find that 39% of the sample have a clear and defined life project, 30% - absent and 32% is confused, they are sure about the future. When we connected the life project and the sexual initiation we found that when they have a clear and defined life project they majority of the students have been initiated the sexual relations. That is one of most important protection factors. When there is absent almost all had been initiated, even when they said that they had a confused life project.

We arrived to these conclusions that there is high percentage of adolescents that initiate precociously their sexual relationship more frequently males. The majority of adolescents start their first intercourse voluntarily, also through a high degree of pressure from their counterpart and group. The patterns to a group in which the majority have begun sexual relations as well as to belong to a dysfunctional family behaved as a risk factor of precocious sexual initiation. A big majority of adolescents had their first intercourse in inappropriate places and circumstances, did not use contraceptive methods. A high percentage of female referred to a non-pleasant experience during their first intercourse and living with both parents as well as a clear definition of their life plan behaved as a protective factor of the precocious sexual initiation. As recommendation we can say that an intensive work should be developed aimed to elimination, modification of control of reproductive risk factors of relations with special attention to the precocious sexual initiation. The following aspects to be considered: gender perspective, education in sexual health, project for development of youth, psychological and social pressure.

- International Chapter News -

News of the **International Regional Chapter (IRC)** of SAM
(Society for Adolescent Medicine)

Co Chairs -	Diana Birch	Gustavo Girard	Treasurer	Aric Schichor
	London	Buenos Aires		Connecticut
	England	Argentina		USA

Our 1999 Chapter workshop **"When is a family dysfunctional? - A cross cultural view." Will be printed in the next issue of the Journal.**

Israel 15th – 18th November 1999

International Seminar on Violence and Adolescence

A series of workshops run by international experts will examine the factors that determine the presence of violence , preventive measures to reduce its incidence and the provision of mental health care for the victims of violence. Among the speakers will be

*D Birch UK * E Chigier Israel * M Christensen, Sweden * J Cohn Norway * S Gordon USA Israel * * Y Harel Israel * J Kienhorst Netherlands * H Tolmas USA * L Verhofstadt Switzerland.*

Details from – ISAS - PO Box 574 , Jerusalem 91004, Israel -
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SAM 2000 - IRC Workshop
Washington March 2000

PLEASE PREPARE IDEAS AND SEND IN CONTRIBUTIONS
SUBJECT

Proposal for SAM meeting March 2000
'Institute' - International Regional Chapter (IRC) SAM

'Youth in a Violent Age – The Challenge of the new millennium?'

As we enter a new millennium, part of Europe is at war; nail bombs have exploded in London; there is news of school massacres and the number of dispossessed children and young people rises. Are we moving forward to a healthier future or to a disordered era of escalating violence?

Our modern age has brought continents and cultures closer together, air travel, the media and now the internet has bridged the gap between social groups disseminating not only knowledge and information but also spreading cultural challenges and 'unhealthy' behavioural patterns. Youth learn to mimic gangs, gun carrying school boys, and violent cultures – the peer group has become worldwide. The International community can no longer regard certain patterns of disorder as relating to 'other cultures' – we are fast becoming uniform in the problems we deal with and hence need to find common solutions.

In this institute we will examine some key areas of universal international interest focussing on issues of Youth and violence.

Just for fun ...

Written as a message home to my kids ...

Our Mum in Havana

The nervously dressed official holds up a placard with my name, scanning the arrivals like a bird searching for a worm. Beamingly deferential she ushers me to a VIP suite whilst a worried looking boy attempts to find my luggage. No good trying to help or do it myself - would cause too much loss of face. Eventually, two coffees later he triumphantly appears and we whisk through immigration and customs at record speed - quite a change from the almost painful, long slow perusal of self and documents which is the norm - using mirrors to make sure nothing is concealed behind you and attempting to reconcile faces with a stranger's image in a passport photo - can't help looking shifty trying hard to be relaxed.

Then the taxi. I reach behind me for the seat belt only to be reassured - no don't worry, you don't need to do that. I politely agree not to be inconvenienced by safety precautions and the cab ploughs it's way towards Havana dodging smoking Russian trucks and time expired American cars. Juke box style 50s chevys and resurrected junk heap bodies limp along with dented fenders and skewed chassis - a miracle any are still on the road. Time warp indeed.

Major junction - no road signs as usual - turn left at the thirteenth bridge! The Police man sternly waves down the car in front - what now? He jumps in for a lift back to the city! Anti imperialist slogans almost obscure the level crossing - the car screeches to a almost stop peering right and left to look for trains - at least they are slower than the cars. At least a semblance of slowing for the traffic - more than can be said for the red lights - which we just shot straight through.

Funny how you forget about the decay, the rubbish in the street, the dust and fumes, somehow it is all too much to take in. Depressing tall blocks of flats, ragged washing hanging on balconies. Imperialist once palace like constructions covered in stucco ornamentation now crumbling beyond repair. Buildings defying logic in staying up - hollow empty shells, missing ceilings, floors, windows, roofs and yet there are families living in every inconceivable ledge.

And not just families - businesses also dicing with perilous conditions. The restaurant on the fourth floor reached by groping up decayed marble staircases through derelict floors populated only by large bats - a security man pretending to challenge at the door in case the visitor should be 'official'. Families are allowed to have a restaurant and serve meals in their homes as long as no more than twelve people sit around the table. We ate an illegal meal squashed into a room which had been used as set for a famous Cuban film - hence the popularity - at least the food matched

the reputation. Unusually for Cuba where the exotic sounding menu is not usually paid justice by mediocre and sometimes unpalatable food.

At the hotel they were trying hard but the smell of paint could not quite mask out the musty mildew odour of drains and the cockroaches seemed quite at home in the bathroom. Memories of the Rossia in Moscow - but that's another story. The TV carrying CNN and RAI as well as an American movie channel and cartoons in Spanish mysteriously went blank when Castro gave a speech - his was the only channel visible. Technological idiosyncrasies hit other electrical devices as the power supply varied, cut on and off and differentially cut one side of the room or the other reminiscent of a Bob Hope horror film - the hero creeps around the haunted house avoiding zombies etc.

So many incongruities - looking up from the swimming pool, with the peacock strutting on the grass beside, my vision carried through cracked dirty glass to naked children perched on the edge of a tottering balcony of their overcrowded tenement. The historical room with photos of long dead film stars who graced the place in bygone decades, mixed with revolutionary texts and memorabilia. Old Hollywood style elevators with bronze dials indicating the floors - you could just imagine Fred Astaire dancing out of one - except that he would not know what floor he was on - the indicators had a life all of their own.

On route to the hospital, it's been three days since I could get through to home on the phone, the car radio played a plaintive 'don't cry for me Argentina' echoing my mood which was not lifted by block after block after block after crumbling block. I wonder if you get used to it after a while - do they notice?

Feeling I'm travelling through the set of 'Twelve Monkeys' the Bruce Willis 'destruction of a civilisation' film with echoes of Planet of the Apes - the scene where Charlton Heston turns a corner on the beach and sees the statue of Liberty jutting out of the sand. Weird - it's as if everything has been destroyed but somehow the people are left behind - teeming masses of people peeping out through every crevice. Everyone in a fifty year time warp - time to move on - away from the US embargo - away from the rusted remains of the American dream, rusted drunken lamp-posts, corroded cars, mummified Hemmingway remnants.

At the Floridita you can eat Hemmingway - drink his daiquiris - sample his prawn cocktail - eat fish the way he liked it. My bottle of water sat incongruously in a champagne style ice bucket tended by three waiters. Who cares about Hemmingway in the slum streets where children wait to get their water out of a truck in plastic buckets.

It doesn't feel quite safe walking the streets alone - maybe because of the poverty making us feel guilty for what we have - but it's more than that.

Setting aside the unnerving 'sexual undertones' in many of the ogling men's eyes in old Havana - undressing you and more with their eyes; there remains a sort of desperation, a feeling of being almost at the end of civilisation ... maybe because people are apparently living passively oblivious of the decay around them. You walk avoiding gaping chasms in the street, dodging piles of dust and rubble, picking your way through roads that can one moment be a main highway and suddenly peter off into a slum alley.

I go into survival mode - dress down, blend in, memorise the map in my head and don't look at it, keep walking purposefully and confidently - I'm sure it's when you're nervous that you give off vibes that attract street crime. It's afternoon, my shadow's in front of me, so I must be walking east (not so easy on a cloudy day!). Four miles on I get to the Cathedral square for a much needed drink. The little group of street players is already in full swing and suddenly a little frail old lady jumps up and starts to Salsa with a younger man who could be her son. Her painfully thin form can hardly move but she sways to the rhythm and soon others join her. I suppose you have to lose yourself in music here - restores some humanity. Yes, there is a certain energy to the place although why is so much of that energy dedicated to looking back - the revolution was so many years ago - Che has been dead a long time - surely there must be new, younger heroes?.

What of the new generation - what hope for the future is there for youth? My mission in Cuba was to lecture on adolescent health and to attend a conference on youth - a vibrant, well attended affair with delegates from all over South America - is this where a new direction , a new initiative for young people will be born?

The US embargo has had drastic results but a generation have been raised looking backwards. Rural scenes resemble the old wild west with horses and rum laden 'cow boys' riding the range. Urban decay goes unrepaired. On my journey home to Jamaica I rode in the oldest plane I've ever seen - a Russian craft reminiscent of one I travelled in to Kiev in the late sixties - and it looked old then! So much for time warps .... My thoughts as we circled appearing to miss Kingston runway on the first attempt and dump into the sea to join Captain Morgan's bones at Port Royal - were - 'Beam me up Scotty, I've had enough !'

The following article was presented by Gail Slap at the International conference in London 1998 – Gail also was present in Havana and spoke on a related theme.

Adolescent Reproductive Health
Lessons Learned and New Directions

Gail Slap

What I want to do today is talk about adolescent reproductive health and I'd like to do it in a variety of ways. We'll talk some about clinical service, but really what I'd like to do is consider with you where we've gone in terms of our research efforts in adolescent reproductive health and where I think we need to be heading as we move into the next century. Well, first I think it's fair to a ask a question why adolescent. Firstly, and I think you all know this, 20% of the world population is 10 to 19 years old, there are 1.5 billion teenagers between the ages of 10 and 24, 50% of the world's population is under 25 and this is climbing, 86% of youth now live in developing countries and further more if we look at youth around the world living in urban environments, a youth is three times as likely to live in a city in a developing country as in a city in a developed country. These youths face the highest risk, they face the least support. And even more than that group is the 70% of the world's urban migrants who are youths.

Beginning Sexual Experience

So why adolescent reproductive health. Well, whether you're married or you are unmarried, people are most likely to begin their sexual experiences during the adolescent years. 50% of African women and 30% of Latin America women are married in adolescence, and yet if we look at what's happening to the average age of marriage around the world it's actually increasing. So the time between puberty onset and growth considering even somewhat later the beginning of menstruation, menarche, and the time of marriage we are seeing an increased length of time. What that means is that we're likely to see increased sexual behaviour during unmarried years. Now in North America we know that over 75% of teenagers are sexually active. If we look at births we know that about 20% in the United States and over half of African first births are to adolescent mothers and around the world the number is 10%. Whether you think that's right or wrong and I think I've heard people argue both ways one thing's for sure, and that is morbidity and mortality faced by mothers and by their infants is greater during the adolescent years. Maternal mortality for adolescents is twice that of adults, the risk of low birth weight is about 1 and a half fold, the risk of death during the first year of life infancy is about twofold, the risk of neuro developmental delay is about threefold. And finally 1 in twenty teenagers around the world is affected by a sexually transmitted disease.

Individuals

But adolescent reproductive health means more than the risks, it means more than the pregnancies, it means more than the sexually transmitted

Development

disease. It also means looking at individuals - take some examples - three girls, all aged 12, best friends, birthdays within one month of each other, and helping them cope with the differences in their pubertal development, but also trying to understand what controls these difference in development. If you consider the first 12-year old, she is 10-0-4, she is 50th percentile for height and weight, note that she is not smiling. Why is she not smiling? She is wearing braces. Look at this teenager on the left. She is also 12 years old. What was the first thing she did when I asked to take her picture. She kicked off her shoes. Why did she kick off her shoes? She is worried about being too tall . She is barely 10-0-2. And this 12 year old, 10-0-2 notice what she is doing, when I asked to take the picture. She is standing on her toes because she is fearful of being too short. So they all have their own difficulties and differences to deal with and yet they are all entirely normal.

Now let's look at this 14 year old. This too is adolescent reproductive health. She has delayed puberty, markedly delayed puberty. She is in the hospital constantly for her sickle-cell disease. And let's look at this 16 year old father who's hospitalised after a gun-shot wound out on the street. This young man has 2 children. We cope not just with the violence of the inner city, not just with the medical complications of his gun-shot wound, but we cope with the difficulties that this young family faces.

Risk Behaviours

Now what we do know about risk behaviours is that they increase dramatically during adolescence and yet I think there is a tendency to say all risks at all times. Data from the United States shows that the risks at age 11 to 12 are going to be different than the risks at age 18 to 19. Certainly in the prevalence if nothing else. What's going to increase most dramatically, as you would expect is sexual activity - alcohol is the earliest behaviour likely to start, it quickly increases and consider what's likely to happen is the sexual activity is increasing, the same time this experience with alcohol and other drugs is increasing. The chance that the sexual activity is going to happen in a risk way is very very high. Well the World Health Organisation responded to many of these issues in early 1990s with a call for action and we've seen several publications over the 90s from WHO and also from UNICEF, most recently the 1997 report which I am sure many of you have seen. What in the earliest work that went on in the 90s what the WHO asked that we do is to document the health status of adolescents, looking at morbidity, mortality and the prevalence of problem behaviour around the world.

Positive Indicators

But the WHO asked us to do something else and that was to identify the positive indicators for adolescent health what I would consider the good adolescents, as well as the bad adolescents. I think we've done a good job and are working hard on this. I don't think we've done as much here. Yes, we've identified the negative indicators, we're getting much better in identifying which adolescents are at risk. But we don't really understand is what makes a teenager resilient. They ask that we explore the

perceptions of teenagers regarding their health needs and problems and again I do think we've made headway here. Now our job is to truly explore the perceptions of teenagers rather than giving teenagers instruments that are developed by adults that force them to respond to what our preconceived notions of their perceptions are. And finally we were asked to evaluate the effect of interventions and programmes and again I think we are moving steadily in this direction.

Critical Research Issues

When I thought about what are the critical research issues in adolescent reproductive health this is what me list would look like:

- what is the access around the world to reproductive health care;
- how do we modify risk behaviours for HIV and other sexually transmitted diseases;
- how should we screen for STDs and how shall we treat for STDs; not just in terms of what is the best treatment, but also what is the most realistic treatment, given the environment.
- Contraceptive counselling and compliance;
- pre-natal care, content, quality and utilisation;
- gender roles and responsibilities, which I don't think we've done enough with; and
- physical and sexual abuse, and I'd like to point out here I am talking not just about girls but also about boys.

Access to Services

Now, I won't have time to go through all of these, but what I'd like to do is walk with you through at least two of them. Let's take a look at what's happening to access, how teenagers present and who they present to at least in the United States to start. And then let's take a look at what's going on with STD screening. And finally what I'd like to do is go through a type of case example for HIV treatment.

First utilisation. Data from the United States comes from a very large data centre, it's called the National Hospital Ambulatory Medical Care Survey. Now at the time that we did this analysis I think this was the best data centre we had to look at utilisation patterns in any age group. I think now in the United States we have something new that I think is going to really improve our ability to look at utilisation. It's called the Medical Expenditure and Provider Survey, but for now let me share with you what this survey showed. The three components of this survey: one is on emergency department utilisation, one is on physician offices and one is on in-patient hospital stays. The data I am going to be showing you is on the physician offices. What we did in this study was took the adolescent years and rather than looking on block, sort of 11 to 21 year old approach, we decided to ask the question, does utilisation across adolescence change, and does that utilisation change in a way that makes our current guidelines, the gaps, break future guidelines for adolescent preventive services makes sense, or either some dis-synchronies here. What we found is when we looked at visits compared to census population proportion

what you can see that across adolescence there is under-representation in visits compared to the percent of population. Now I am hesitant to say there is under-utilisation because for example it would make logical sense that the geriatric population would use more services than the adolescent population. The trouble I have with that, is when we look at emergency services what we see that adolescents are over-utilising emergency services. And they are over-utilising because of crises be they injury, STDs, pregnancy.

Now let's look closer what happens to visit numbers by age and sex. What you see is that during childhood and into the early adolescence years girls and boys are seeking physician offices about equally. We begin to see some change in the mid-adolescent years and look at what happens by late adolescence 18 to 21, girls are over twice as likely to seek care in offices as are boys.

Now let's keep going. Well you might say how does all this relate to non-insurance. And I think we begin to see something very telling. When we look at the non-insurance rate, What you see is that males are far more likely by late adolescence 18 to 21 to be uninsured as females, well why is this, And here we begin to get some indicator of what's going on . Look at what happens to public insurance at age 18 to 21 for girls, look at what happens with boys, remains absolutely stable . So what's going on here? Why are the girls suddenly receiving so much public health insurance while the boys are remaining quite low and flat. And the answer is adolescent reproductive health problems as you might expect.

Looking at the percent visits to various specialist by age. What you can see at age 11 to 14 is that about 40% of the office care is to paediatricians and that about 25% is to family practitioners. A very small number are to obstetricians /gynaecologists. Now let's look at what happens at 18 to 21. Adolescents are as likely to see an obstetrician /gynaecologist as they are to see a family practitioner. And this is not 25% of female visits, this is 25% of all visits. What's happening is that males by and large in the late adolescent years simply are not seeking care at the rate that females are and females are seeking care primarily for reproductive health issues.

Diagnoses

Now let's take a look at what the leading diagnoses are. By 18 to 21 nearly a third are coming in for prenatal reasons. At 11 to 14 adolescents come in for routine care, pre-school, pre-camp kinds of check-ups. How many 18 to 21 year olds do you think are coming in for, check my ears and listen to my heart, no. What they are coming in for is pre-natal care.

Age at Onset

Let's move on now to talk about sexually transmitted diseases. In 1997 the Institute of Medicine in the United States issued an important report than was called "The Hidden Epidemic". And what the Institute said in this report was that public awareness about sexually transmitted diseases was dangerously low. And the theory was that it's low for three reasons:

one is obvious, and this is the stigma regarding sexually transmitted diseases which inhibits both discussion and education. A second reason though is many infections are asymptomatic and undetected. And the third reason is that the sequelae of the infections are often delayed. If you can consider for example cervical cancer and human papiloma virus or if you consider infertility following pelvic inflammatory disease. Secondly the impact on women is not widely recognised. A large survey which was done about five years ago in women ages 11 to 60 showed marked underestimation of the effect of STDs on female anatomy. Thirdly pathogens are still being identified. Consider since 1980 we have identified 8 new pathogens for sexually transmitted diseases. Next, clinical spectrums are still being described. Consider here, the newly reported relationship between bacterial vaginosis and pre-term delivery. Consider the many new clinical manifestations of AIDs that previously were unrecognised.

Prevention

And finally prevention in the United States is unfocused and it's controversial. And that's despite good evidence that various interventions work. Let's take a look at the school-based interventions. Education about sexually transmitted diseases is under-funded, it's restrictive, it's inconsistent and it's delayed. This was a report from the Centres for Disease Control in 1996. Programmes that teach contraception have not been shown to hasten sexual initiation, there have been many reports on this, one of the best summaries came again from the Institute of Medicine in 1995 and yet despite this we continue to see teaching programmes in schools that are really not talking about contraception what they are talking about is abstinence. It's not that its' wrong to talk about abstinence but we must do more than just talk about abstinence. School condom availability programmes have been showing to decrease sexually transmitted diseases. But are few and still relatively new, in the United States it's estimated that only 2 per cent of schools distribute condoms. And finally students in schools with condom availability do not have intercourse earlier or more often and again this is not new work, this is going back 4 years, and yet we really have not seen a change.

We've seen other successful interventions. But once again the implementation has been markedly delayed. So whether we look at individual counselling or couples counselling or programmes for high risk groups or peer leader education, or mass media campaigns they have been shown to work, and yet have they been implemented broadly, for the most part - no. One of the things that these studies have done is look not just at the ability of interventions to improve knowledge but also the ability of the intervention to change behaviour. I think our next step is to look, yes, at knowledge, yes, at behaviour, but also to look at health outcome.

When we think about STD surveillance strategy most surveillance strategies, no matter what country you look at, use passive reporting rather than active case finding. What that means, is that no matter how bad the

numbers sound they probably still an under-estimation. Secondly the surveillance data are difficult to interpret when we consider that 8 new pathogens have appeared in the last 18 years, that we have new syndromes, and we have new tests, such as LCR. Periodic behavioural health surveys are very important, they've been underdeveloped and they've under utilised and they've often been blocked in many countries, including at times in the United States.

Provider performance measures. And I think this is very important. Increasingly certainly in the United States we have seen measures of the doctors doing what they should be doing, what are called performance strategies or screening strategies typically these have not included STD screening, they've included things like our mammograms being done at the appropriate rate in some cases our PAP smears being done at the appropriate rate. Several of larger managed care organisations are now beginning to include chlamydia screening as a performance measure and I think it is a very important step in improving care.

Well, if we think about what the current focus for adolescent risk research has been certainly over the 80s and much of the 90s we've tended to look at selected problem behaviours, at youths in difficult circumstances, we've looked at the deficits, the problems, the risks of individual adolescents and we've looked at family and peer characteristics. What are the limitations to this kind of approach? I think the biggest problem is rights of the youth, it imposes a deficit model. What that means it will not help us identify the predictors of success. Why is it that in adolescent who's impoverished, who's on the streets, who has minimal support may still do well. And there are adolescents who despite very adverse circumstances do do well.

Neighbourhoods

I think the second thing it does it de-emphasises the study of neighbourhood influence in youth development, yes, we've looked at the individual, yes, we've looked at the family and the immediate peers. But we really have not used the kind of sophisticated and often qualitative research methodologies that are needed to look at neighbourhood. And I am not talking here just about the neighbourhood where the adolescent lives, think about the adolescent's day: they may wake up in one neighbourhood, go to school in another neighbourhood, play basketball in a third neighbourhood, go to movies in a fourth neighbourhood, they are very very mobile, and all of those neighbourhoods can have influence and impact on the adolescent's development.

And finally I think this approach encourages fragmented services that really are aimed at the crisis, at treating rather than preventing the sequelae of problem behaviours.

Now what I'd like to do is take you through a case example of why I think this approach is a problem. Consider here two 18 year old men, both have HIV. Both are good candidates for triple chemo therapy. Both live in

urban slums. Both are uneducated, unemployed and poor. Both rely on local hospital clinics for their health care. Both have families that want them to take medicine yet neither has done so. Why? Two situations sound very similar.

One man lives in Punei?, India. The annual cost of the three drugs is US $10,000 which equals the combined annual salaries of 30 workers. The drugs are neither available nor they are affordable. The medical doctor has little to offer and the man decides to see a local healer.

Now consider the second man. He lives in Philadelphia, United States. The annual cost of the three drugs is the same and fully paid by the Government. The medical doctor has the medication and urges the man to take them. The man refuses and decides to see a local healer. The diseases the same, the outcome is the same, the individual characteristics seems the same, the reasons behind the outcome are different. But are the reasons really different? I would challenge they may not be so different as they initially appear. How does the neighbourhood influence in Punei? Really compare to that in Philadelphia? Do these two men perhaps share sentiments of uncertainty or distrust or disbelief in health care system that are more similar than they are different? Are the reasons for not using the medication therefore are more similar than they really are different? So within example like that what I would suggest is it's time to shift our prospective, it's time to explore the effect of environment, the economic opportunity and the subsocial network on youth behaviour, it's time to move beyond easily measured demographic and economic factors to the more complex study of social interactions, both the density of the interaction and the quality of the interaction. What this means is that we need new methodologies, we need to be working with social science and scientists, we need to combine quantitative and qualitative methods. And finally it's long overtime to translate our research into services that promote positive outcomes for all youths rather than services that try to curtail negative outcomes for some youths.

The new direction then in reproductive behavioural health research that I would see are to define what are the societal realities and expectations regarding reproductive behaviour and health care, to identify the neighbourhood norms and expectations for sexual behaviour, to begin to remove neighbourhood barriers to help the behaviour and to try to define programme effectiveness as more than improve knowledge, more than better behaviour

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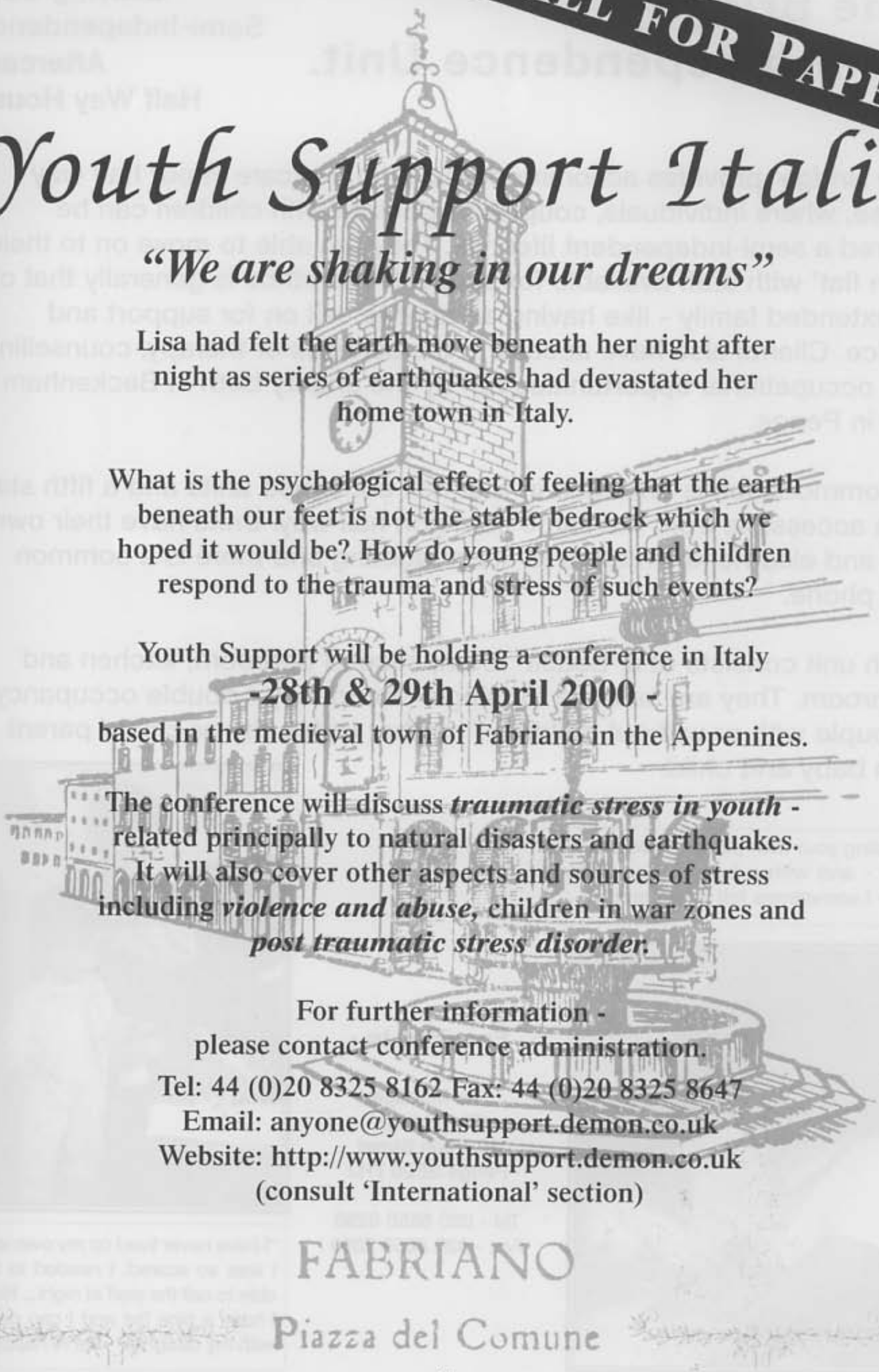

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Forum Comes of Age!!

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First in the Field

The forum was the first national body to draw together professionals in the field of Adolescent Health and Welfare and now with thirteen annual meetings and two major International conferences to our credit - the Forum can well and truly be described as highly important if not the leading force in this difficult area. We have achieved our goal - that of putting Adolescent Health and Adolescent needs on the map!

Conference Success

The feedback from our last conference has been overwhelming in it's praise and encouragement and many delegates expressed the wish for -

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In response to delegates suggestions the 'Forum' has been renamed -

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If you would like to be involved in:-

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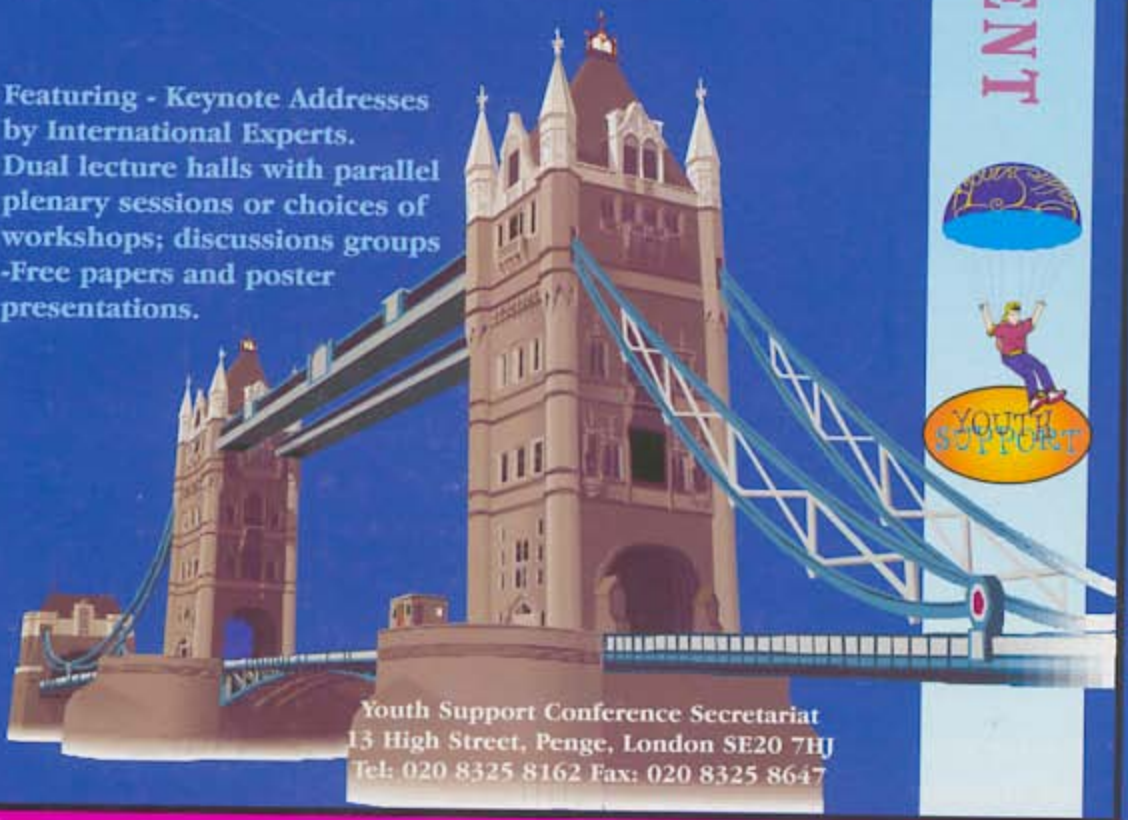

Youth Support Conference Secretariat
13 High Street, Penge, London SE20 7HJ
Tel: 020 8325 8162 Fax: 020 8325 8647

Youth Support
Publications Department

13 High Street
Penge, London
SE20 7HJ
Tel: 020 8325 8162
Fax: 020 8325 8647

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