CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

December 2000

Volume 9, Issue 4

PRO-TEEN

Inside this issue:

PRO-TEEN

Publisher : CAAH

Editor in Chief
Dr Jean-Yves Frappier

Associate Editors

André Malo
Philippe Nechkov
Julia Sheel
David Blasco

CAAH

Section médecine de l'adolescence
Hôpital Ste-Justine
3175 Côte Ste-Catherine
Montreal QC H3T 1C5

Tel : (514) 345-9959
Fax : (514) 345-4778
E-mail: acsacaah@microtec.net
Web: www.acsa-caah.ca

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Legal Deposit, National Library of Canada ISSN 1201-5474
Canada Post-Convention number 1482351

News from the Association

President's 2000 report

This year is marked by projects and contract for the Canadian Health Network that allowed CAAH development.

Management

For the journal: Philippe Nechkov, a student, is in charge: writing news, scanning or searching articles on web, word processing, page setting. The journal is somewhat different in English and French; Julia Sheel is translating some article. For membership: the information on the members are on a Access Microsoft file. We are able to make list by province, postal code, language, status in the Association, etc. We have a student entering data on members. Communication with members by e-mail is increasing. For the budget: we have improved the accounting procedure. For the promotional mailing list: a student is compiling organizations-professionals. We are constantly improving and expanding the list, especially for the Atlantic provinces this year. For the meetings: the organization of our meetings has been carried out by our staff (except the Moncton meeting where organization was shared), under the coordination of our executive secretary (writing and designing the brochures, arrangements with printers, mailing, entering the registrants on Access Microsoft file, producing the proceedings and all the logistics of the meeting...). This is cost saving.

Members

In 2000, CAAH had 977 members. The state of membership in November 2000 is as follows :

1998 (deleted in December 2000)	201 (21%)
1999	265 (27%)
2000 (registered and paid in 1999)	460 (47%)
2001 (registered and paid since September 2000)	51 (5%)
TOTAL	**977**

This year, 52% of our members have paid their dues. The 201 members of 1998 will not renew and be deleted, but 50% of the members from 1999 will probably renew in 2001 after several reminders.

We are loosing members each year. Many retire or are not working with adolescents anymore. Also, many organizations were taking a membership for many professionals and are renewing for one only.

Members per provinces			
Québec	615 (70%)	Saskatchewan	6 (0.6%)
Ontario	191 (20%)	Manitoba	5 (.5%)
British Columbia	51 (5%)	Newfoundland	2
Nova Scotia	13 (1.3%)	New Brunswick	3
Alberta	20 (2%)	Yukon	1

There are more members in Québec and Ontario because more promotion of CAAH was carried on in those provinces (with more national and regional meetings).

82% of the members are women; 59% of the members want to receive their mail and journal in French, 33% in English, while 8% want both.

38% of the members have a single membership; thus 62% are in a group membership. This includes about 50% of total membership who have an institutional membership (185$ for up to 7 members). It is only 20% of the members who pay themselves their dues, the majority having their dues paid by their institution or organization.

Professions of members	
Nurses	32%
Social Workers	12%
Psychologist	6%
Teachers	1%
Counsellors	3%
Psycho-educator	4%
Community Workers	2%
Sexologist	0.6%
Coordinator	4%
Family Medicine	10%
Doctors : specialists	8%
Dentist	0.3%
Librarian	2%
Dietitian	1%
Others	10%
Not available	4%

Work Place (more than one choice)	
CLSC	30%
Private Office	9%
School	26%
Public Health Department	13%
District Health Services	1%
Hospital	17%
University	6%
Community Organization	7%
Youth Homes	2%
Youth Protection (CPEJ, DPJ)	3%
Custodial Facilities	2%
Government Organization	3%
Others	3%

Type of Work (more than one choice)			
Clinical Intervention	59%	Administration	10%
Teaching	29%	Documentation, library	3%
Prevention / Promotion	54%	Benevolent	2%
Health Education	36%	Media	2%
Coordination	9%	Street Work	1%
Group Animation	24%	Program Development	15%
Community Work	16%	Others	3%
Public Health	17%	Not Available	9%
Research	9%		

Fields of Interest (more than one choice)	
Parents/adolescents Relationships	70%
Adolescent Development	51%
Behavior Problems	60%
Suicide, Suicide Attempt, Depression	62%
Violence	41%
Drugs Use and Abuse	58%
Sexuality, Pregnancy, Contraception	65%
STD and AIDS	53%
Sexual Abuse	58%
Anorexia Nervosa, Bulimia	62%
Nutrition, obesity	45%
General Health: growth, skin, ortho, sport	47%
Psychosomatic Diseases	42%
Handicap, Chronic diseases	46%
Learning Disorders	41%
Rights, Laws	37%
Not Available	9%

Meetings

Annual National Meetings

Annual national meeting, 4-5 May 2000, Montreal
"Adolescent Health: Updates for the Third Millennium" (425 participants)

Regional Meetings

Ontario : Ottawa, October 27th 2000. "Eating Disorders in Adolescents" (145 participants).
Atlantic provinces : Moncton, November17-18th 2000. « Ado-Santé mentale-Action » (165 participants)

For 2001:

Annual National Meeting, Fall 2001, Toronto

Website

We have developed our web site. It is still in an early stage but the main structure is up and running. We are now loading the site with articles that were published in the Journal or from the proceedings of our meetings.

Journal

The journal is very popular. Many of our new members become members to receive the journal. We have to think about the orientation of this publication. Publishing the Journal is time consuming. However, it is encouraging to see that some articles were submitted to the journal by members.

Committees

Advocacy

We have solicited members to be part of the committee. Dr. Leonard chair this Committee. The Committee has no financial or support resources. They are active with gun control laws and smoking in adolescents.

Finances

Over the past years, the CAAH has been experiencing financial difficulties. This is a problem that affects not only the CAAH but also many similar organizations.

Only one third of our spending budget comes from membership fees (approximately $17 000). The rest comes from Conferences that, despite their success and high attendance in general, generate low profits.

It is the time to renew your membership if you have not already done so !

Budget: Auditor Report 1999

Revenues		Expenses	
In bank	1,432	Aministrative support	32,550
Membership fees	15,547	Advertising	558
National meeting (1997-99)	14,402	Secretarial	5,254
Regional meeting Québec	12,597	Data entry	2,464
Regional Meeting Ontario	8,393	Taxes and permits	62
Others	1,521	Journal	11,120
		Office supplies	1,325
TOTAL revenues	52,460	Bank charges	145
		Travel	885
		Representation	545
		Amortization	1,135
		Professional fees	887
		National Meeting	15,210
		Regional Meeting Québec	11,614
		Regional meeting Ontario	5,852
		TOTAL expenses	89,606

In bank, end of year (35,714, deficit)

Budget for 2000 (approximation, not reviewed)
(part of the contracts have not been paid yet, so we still carry a deficit over 30,000$)

Revenues		Expenses	
In bank	(35,714 deficit)	Executive secretary	41,000
Subscription 2000	17,000	General Administration, material	20,000
National Meeting (Montreal)	15,000	Journal	9,000
Regional meeting (Ottawa, Moncton	)3,000	Personnel and projects assistants	53,000
Contracts	114,000	Executive and Board of Directors	2,000
		GST	4,000
TOTAL revenues	149,000		
		TOTAL expenses	129,000

Subscription 2000

Registration fees will stay the same.

Future Actions

The Association has “growing pains” but is alive and can still count on strong partnership. We have to:

- Increase membership
- Solicit new contracts
- Increase the number of Conferences.

The CAAH's survival depends on each member’s efforts. We have to expand in other provinces. Sections must be created and more meetings organized. We need to create a base of collaborators of CAAH. About 100 members throughout Canada will be asked again to collaborate and help with the Journal, and the different activities of CAAH.

Happy and productive year,

Jean-Yves Frappier
President

Scientific Events

7th IAAH Congress

Brasil, May 13-17 2001

Theme: Yes to Life! No to Violence

The 7th Congress of the International Association for Adolescent Health will be held in conjunction with the annual general meeting of the Associaca Brasileira de Adolescencia and the Sociedade Brasileira De Pediatria. An exciting mix of plenary speakers, panel presentations, forums, workshops, poster sessions and displays plus a youth for youth health conference.

Languages: Portuguese and English. All plenaries will be simultaneously translated, some sessions will be unilingual.

Why not join us in lovely, historic Salvador de Bahia. This truly international event will combine an excellent scientific program with the warm hospitality of Bahians. Opportunities for professional networking and lively intergenerational interaction promises to make this a memorable event on the international adolescent health calendar.

There will be a very full program with a variety of medical and non medical topics and formats. Each day there will be 3 main, one hour conferences, and 3 round tables. A total of 56 simultaneously translated presentations spread over the 4 days. For examples: chronic conditions, violence and injury, youth health policy and programs, early intervention in early adolescence, adolescent males, etc.

For the most up to date information visit the IAAH website at www.iaah.org

For more information:

Eventus system, Brasil
eventus@cpunet.com.br

IAAH Secretariat
Box 19. Site 3
Gabriola Island BC V0R 1X0
Email: tonkiaah@islandnet.com

Society for Adolescent Medicine "Changing the Focus: Resiliency and Youth Development"

San Diego March 21-56, 2001

The Society for Adolescent Medicine presents its 33rd annual meeting. This meeting features lectures, institutes, 44 workshops, research presentations, 18 dialogues in adolescent health ,many interest groups. Registration fees for members (add 75$ for non members), before February 23, 2000, include breakfast and lunch at 575$ US for MD and 500$ US for non MD.

Information:

SAM, 1916 NW Copper Oaks Circle, Blue Springs,
Missouri 64015.
Phone: 816-224-8010,
Fax: 816-224-8009.
www.adolescenthealth.org
E-mail : sam@adolescenthealth.org

Shaping the future Helping Clients Achieve Freedom From Eating Disorders

April 26-27, 2001

Loyalist Country Inn, Summerside, Prince Edward Island

This informative, comprehensive two day conference is filled with dynamic, multidisciplinary speakers which include:

- Dr. Joanne Gusella, PhD – Assessing Readiness for Change, Therapeutis Goals and Strategies for each stage
- Dr. David Pilon, PhD – Treatment Techniques for Adults
- April Gates, MSW – Complexities in the Treatment of Eating Disorders: Intervention Strategies
- Dr. Blake Woodside – Emerging Research in Eating Disorders
- Ruth Ann Sutherland, RD – Nutrition Interventions in Eating Disorders
- Dr. Barry Martin – An Overview of Mdeical Consequences of Eating Disorders
- Dr. Suzanne MacDonald – Evaluation and Management of Inpatient Adolescents with Eating Disorders
- Cathy Wagner, MSW – Will discuss the role of the school system
- Clare Lord, B.Sc. – Through Thick and Thin – How to run a support group for adolescents and young adults with Eating Disorders.
- Ellen Coolidge, MSW – Early Phase Work with Families of Adolescents with Eating Disorders

Registration for 2 Days: $ 200.00 (includes dinner and Island entertainment)
Additional conference and registration information will be sent out in February 2001

For additional information: (902) 368-5462 or Email: bareid@ihis.org

North American Society for Pediatric and Adolescent Gynecology Fifteenth Annual Clinical Meeting

Toronto, Canada, Delta Chelsea Hotel, May 18-20, 2001

This will be an excellent program including educational workshops, keynote speeches, research presentations, and Food for Thought luncheons.

The program will address relevant issues for the health care provider in the area of pediatric and adolescent gynecology. We already have commitments for keynote speeches including genetics for the pediatric and adolescent female patient, gender assignment and rearing and the history of contraception. Since it's success in the past, it will continue with clinical case presentations, special interest group meetings, as well as scientific presentations both platform as well as poster exhibits.

For more information :
Frank M. Biro, M.D.
Children's Hospital, Div. Of Adolescent Medicine
3333 Burnet Ave, Pav 2-129
Cincinnati, OH 45229-3039
Phone: (513) 636-8580

Quebec Association for Learning Disabilities 26th Annual Conference

Montreal, The Queen Elizabeth Hotel, March 22-24, 2001

Let's Develop Genuine Learning Communities

The 26th annual LDAQ Conference will be presented in **English and French**. The conference will be mainly on children learning disabilities with a focus on **Attention-Deficit/ Hyperactivity Disorder** this year. Many topics will be discussed in the more than 70 workshops proposed: implementing the new reform, auditory processing deficits, dyslexia, social skills, current research, Internet Lab, differential learning and many others. Many Keynote Speakers and researchers will be present. The official conference program is available.

For more information:
Tel. : (514) 847-1324
Fax. : (514) 281-5187
E-mail : aqeta@sympatico.ca
Site Web : www.aqeta.qc.ca

Articles

Why do Teenagers Smoke?

Editorial: Annals RCPSC, Vol. 33, number 2, March 2000

This is an important public-health question, because if we knew the answer, it might be possible to figure out strategies to prevent adolescents from starting. Getting teenagers not to smoke might not have as big an impact on mortality rates as have immunization, adequate food, and clean drinking water, but it would be an important step.

There is evidence that if one is not addicted to tobacco by age 20, it is less likely that addiction will start later. Thus, teens and pre-teens should be key groups for whom anti-smoking programs should be designed.

But what kinds of programs? Does raising the price of cigarettes work? What about pictures of cancer on the package?

There have been studies assessing whether school-based anti-smoking programs work. They may work for short periods, in some communities, for some children. I suspect that if these interventions had a long-term impact, they would have been implemented by public health officials throughout the developed world. Certainly there is evidence that children whose parents smoke are more likely to become addicted to tobacco. There have been recent studies showing that females who smoke are more genetically predisposed to develop lung cancer than males. Even these studies are unlikely to have much of an impact on girls' smoking habits, and may actually convince boys that smoking is safe.

My own hunch is that teenagers start smoking because it's "cool" to smoke. And it's "cool" to smoke because the idols of many teenagers, movie actors and actresses, smoke on screen.

The *Globe and Mail* of January 11, 2000 had a short article on a study done by the organization Tobacco Control. Actors and actresses surveyed felt that some of the characteristics that cigarettes were seen to portray were sexiness and sophistication, toughness, coolness, and rebelliousness.

It's just a hunch, but I think movies and television may have a significant role to play in this public-health problem. Studies should be done to answer the question as to why teenagers smoke. Before governments implement strategies, they should have evidence from good research that these strategies will work.

William Feldman

Annals RCPSC, Vol.33, number 4, June 2000

To the Editor:

After reading the editorial in the March 2000 *Annals*, I wonder why we do not see the answer to the question "why do teenagers smoke?" Is the smoke blurring our vision?

Nicotine is an addictive substance. It causes tolerance, physiological dependence, and withdrawal symptoms. Addiction is a brain disorder (DSM IV), not a purely behavioural disorder as was previously thought. Nicotine causes self-reinforcing behaviours, and is highly rewarding. In the brain, it produces the neurobiologic hallmark of addictive substances - a surge of dopamine in the nucleus accumbens.

The cigarette is an effective and available delivery system. Thus, tobacco companies are legalized "drug pushers."

Do all teens who smoke become addicted to nicotine? No. But teens may continue smoking because they find it helps them to "cool off"

Frustrations with being unable to cope at school and at home, personal expectations, poor self-esteem, sexual confusion - these are all reasons why teens start and continue to smoke. Particularly vulnerable are those who experience social isolation, and who lack social skills.

For a teen who has an undiagnosed condition such as an anxiety disorder, mood disorder, bipolar disorder, restrictive eating disorder, overeating disorder, or schizophrenia, cigarette-smoking may be the first manifestation of drug-seeking behaviours to self-medicate. These behaviours are recognized coping strategies. Unfortunately, they control the early symptoms and mask the illness.

Other vulnerable teens are dealing with identity issues. Such teens have to cope with chronic illnesses, physical abuse, emotional abuse, or sexual abuse. New Canadians dealing with identity, acceptance, and isolation are at risk for using substances to help them connect.

Teens learn from family members who smoke, older peers, and their primary role models. Most youths, however, can make decisions for themselves. In addition, they can change negative behaviours, when given appropriate support and time.

The Center for Disease Control reports that smoking kills more people each year than does AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires combined. The estimated direct medical costs related to tobacco use is over $50 billion in the U.S. '

Let us not propagate the choice that teens make to smoke by inadvertently being enablers. There are two effective solutions. First, put at least $25 billion into programs for teens so that the vulnerable are managed appropriately. Programs for treating abused youth must be more accessible. Programs for stress management, coping skills, self esteem, and life skills must be provided free at sites that are accessible to all teens.

Second, effective programs must be based on state of the art knowledge, and include pharmacological, behavioural, educational, and supportive interventions.

S.M. Lena MD, FRCPC Adolescent Medicine, Ottawa, Ont.

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The Men Involved in Adolescent Pregnancies

By Meira Stern, McGill University.

In the years 1992-1994 in Canada alone there were 25 000 births to adolescent females aged 15–17 (Millar, Wadhera, 1997). This number does not take into account pregnancies not taken to term. Generally, when thinking about teenage pregnancy, we tend to focus on adolescent mothers. Perhaps this is an attempt to understand these women better in order to determine ways to avoid these pregnancies. In reality, these women are not solely responsible. It seems equally important to look at the fathers as well. The question of who these men are, what their feelings on fatherhood are, and how they measure up as fathers are ones I wanted to examine in depth.

Fatherhood

To begin looking at fatherhood in general, it is useful to consider the complexity of the role. According to traditional western societal values, the father is the provider first and foremost. This feeling is clearly expressed in Marsiglio et al's study (2000) involving young single men ages 16 – 30, looking at their reasons for not being ready to be fathers. The most consistent concern stated was that of being unable financially to provide for their children. It is felt that the ability to provide or lack thereof may play a role in the type of involvement a father will have with his children. For example if a father is forced to work long hours to provide for his family, there may be little time available to be actively involved in the lives of his children. As well, given the importance of this financial role, if a father is unable to provide he may feel he is a failure as a father and may disconnect from his family. As well, he may be seen as a failure and be forced by his wife to stay away (Marsiglio and Cohan 2000). Marsiglio and Cohan refer to Coltrane (2000) who suggested that gender wage inequity has contributed to this role of financial supporter by making women's lower paying jobs more easily dispensable. As such, the mothers will more often sacrifice their seemingly less worthy jobs to take on the role of primary caretaker while the father is providing financially.

It seems that cultural expectations of fathers include a less active role in raising children (Marsiglio and Cohan, 2000). But according to general modern day sensibilities a father should also be a role model. He should be an involved parent providing emotional support and comfort, discipline when needed, working with the mother to instill their values in their children. Marsiglio (2000) also looked at various men's visions of the ideal father in terms of how they themselves would hope to be. These men felt that providing economically is important but not enough. A good father also needs to be "present, approachable, a friend, [and] a dispenser of measured discipline." In other words, he needs to spend time with his children and be involved.

When we look at women and childbearing, the term "biological clock" is familiar. With women there is a sense, right or wrong, that it is their role to bear children and they must fulfill it before they are unable, before their "biological clock" runs out. For men, a sense of readiness to have children is felt to be related to whether they feel they fit the mold of how a father should be. This is often affected by their own relationship with their fathers and an awareness of how their fathers were positive and/or negative role models (Marsiglio 2000). Guidelines used for fatherhood readiness include whether they are financially ready, whether they have achieved all their goals for themselves as single people such as completing college and whether or not they feel ready to settle down into a steadier lifestyle. Personal experiences with children and pregnancy also can be a strong influence. Threats of unwanted pregnancies and dealing with unwanted pregnancies may show them that they are definitely not yet ready or may make them realize that this is what they want. On the other hand, personal experiences with the children of friends and relatives, babysitting and playing, may show to some that they are not prepared for that responsibility or, on the other hand, may show them that this is something they want (Marsiglio 2000).

Age

If men really are choosing to wait to achieve certain goals in order to be ready to have a child, then this begs the question of who is fathering the babies of adolescent mothers. In other words are these men adults who feel they are ready for fatherhood or boys who are not. Lindberg et al (1997) did a study in which they looked at age differences between adolescent mothers and their partners. Despite the acknowledged norm in society of women being with slightly older partners, there is a societal concern about older men and younger women when the women are minors. This concern is particularly strong when it comes to adult men fathering the babies of these minors. This study showed that among mothers between the ages of 15 – 17, 27% had a partner 5 or more years older than them. Many of these women were married to their partners leaving 21% as unmarried minors having babies with men at least 5 years older than themselves. This number is reinforced by Taylor et al (1999) in their look at fathers of babies born to young adolescents up to 15 years of age. According to their results, 26.7% of these fathers are on average 8.8 years older than the mothers. While this number can not be considered insignificant, it is perhaps not as large as some fear. In a look at Canadian statistics (Millar, Wadhera, 1997), it is seen that 77% of males involved in teenage pregnancies are older than the mother, 37% of these men are within 2 years of the mother, 39% are 3 – 5 years older. The overall rate in Canada of paternal age being 6 or more years older than that of the mother is 24% with Quebec and British Columbia having somewhat higher numbers. This is similar to the above-mentioned rate in the US (Lindberg et al 1997). So if adult men are fathering approximately one quarter of these babies, this leaves adolescents as the fathers of as many as 75%.

It has been found by Lindberg et al (1997) that for many of these adolescent women with adult men as the fathers of their babies, the relationships are close and considerably long lasting. This is significantly different from when the fathers are minors as well. Also, it has been found that women with older partners are more likely to report that their pregnancy is wanted. These findings may be related to the fact that older fathers are more likely to have jobs and be able to support a family to some extent, at least more competently than an adolescent father (Lindberg et al, 1997). From this angle adolescent mothers with older partners appear to be better off. But, it would seem important not to lose sight of the fact that these women are still children themselves. Even if well provided for it is unlikely that they are any more ready to be having children of their own than any other adolescent. Lindberg et al point out that an older man may make a better partner in the sense that he would have a greater immediate earning potential than an adolescent father. However, an adult male involved in a sexual relationship and bearing children with a minor may "possess developmental or psychosocial deficits (Lindberg et al 1997)" that would make him a less desirable partner. In fact, these may be men who are considered by adult women to *not* be good partners. Over time they may prove to have less earning potential then other adult males. Finally, Lindberg et al (1997) suggest that if disadvantaged men had more access to economic opportunities they may be less likely to become involved with adolescent women as they would be more desirable to women their own age.

Four major risk factors for adult paternity with adolescent mothers are defined by Taylor et al (1999). First is if the father's educational achievement is at least three years below what would be age appropriate. Second is if the mother's education is 1-2 years below the average for her age. Third is if the mother's birthplace is not the United States and finally, the fourth is if the father is either Hispanic or African-American. All of these variables are associated with adult paternity with young adolescent mothers. The first two may suggest that teenagers who are not prepared for a successful future are more at risk. The other two factors bring into attention how different cultural values may play into young adolescents choosing older partners and vice versa.

While it is suggested that statutory rape laws may reduce adult paternity (Taylor et al, 1999; Lindberg et al, 1999) it would seem that these are difficult to enforce. In fact, at times the relationship may only become known once there is a pregnancy. While the man may still be punishable by law, the end result is still an adolescent woman with a baby. Whether

prosecution and punishment of this offense should be more severe is a different question that will not be discussed here. Important to mention, however, is that even if these relationships could somehow be stopped entirely, this would still only put a minor dent in adolescent pregnancies. Particularly in view of the fact that a small but considerable proportion of these relationships, 23%, are marriages thus lending them legality (Lindberg et al, 1997). So, even if somehow effectively prohibited, only a small decrease in numbers would actually be achieved.

Risk factors

When considering adolescent fathers an interesting thought is, what if anything is the difference between adolescents who become fathers and those who do not. Is it simply a question of bad luck or are their certain factors in an adolescent male's personality and behaviour that make him more likely to impregnate his partner. Marsiglio et al (2000) discuss that when young men contemplate fatherhood what often comes out is that they are not ready for children. One major factor is that they do not want to interrupt their own immediate goals of finishing school and enjoying a social life. Are these young men who become fathers less intent on their own goals for the future or are they simply more ignorant of the consequences of their actions?

Spingarn and DuRant (1996) looked at male adolescent fathers and whether specific problem behaviours and/or health risks can be associated with becoming a young father. By looking at randomly selected 9th through 12th graders in 51 schools, they concluded that being involved in a number of risky behaviours seems to coincide with being involved with a pregnancy. As such, when risky behaviours are encountered among these boys, special attention should be given to impressing upon them methods and importance of birth control. Specific behaviours noted include smoking cigarettes, use of cocaine, earlier sexual intercourse, greater incidence of times being injured in a fight in the past year, drinking and driving, and multiple sexual partners. If engaging in unprotected sex is looked at as simply another risk-taking behaviour than it would not be surprising that these actions coincide in the same individual and that these patterns are seen. These ideas are reinforced in an article by Nesmith et al (1997) who look at incarcerated adolescent males and their experiences with paternity. Of all adolescent males in a specific long-term facility over one quarter reported being involved with a pregnancy. Of these, almost half reported more than one pregnancy. These results fit with an increase in risk taking behaviour, particularly risky sexual behaviour. Fagot et al (1998) showed how a difference in boys who would become young fathers and those who would not could be seen as early as sixth grade in terms of those felt to be on a pathway to antisocial behaviour. Poor parental discipline, a deviant group of friends, academic failure and antisocial behaviour were all predictive of fatherhood before the age of twenty. In this study early sexual experience was not predictive of early fatherhood but poor performance in school and low income were. Jones Harris (1998) reinforces this point in his study of adolescent attitudes towards multiple issues, showing that the majority of fathers were already having difficulties in school before the pregnancy occurred. Having a child and new responsibilities was not responsible for trouble at school, these problems already existed.

Interestingly Cox and Bithoney (1995) in their look at fathers of babies of adolescent mothers determined that whether they are adults or adolescents themselves, they are similar in many significant ways.

Employment status, interaction with partner and child, criminal history and use of illegal drugs were found to be similar in both groups. In terms of education, however, adolescent fathers are more likely to have dropped out of high school either because of fatherhood or because of other associated risk factors.

Looking at risk factors for early fatherhood among high school students, Pierre et al (1998) looked at 4159 students in grades 9 through 12 in Massachusetts in 59 high schools. Of these, 824 males reported being sexually active. 12% of these reported being involved with a pregnancy with the proportion increasing with age. Interestingly, 8.1% of the total sample reported having had sexual contact against their will. Of these, 36.4% reported being involved in a pregnancy versus 9.4% of the rest. So, for a male, having forced sexual contact appears to

be associated with early paternity. Considering the males involved in pregnancies they found a number of risk factors similar to those mentioned above. Carrying a weapon to school, number of cigarettes per day, number of sexual partners in the last three months and not having used a condom the last time they had intercourse were all considered factors that make an adolescent male more likely to be involved in a pregnancy. To this list they add the experience of forced sexual contact. It is left unclear as to why boys involved in less desirable behaviours are more likely to have this experience. However, as above, they conclude that risky behaviours are associated and that someone willing to take more risks will be more likely to end up involved in an unplanned pregnancy.

Attitudes on parenting

How do these young fathers actually feel about fatherhood? Again looking at Nesmith at al's (1997) look at incarcerated adolescent fathers it is seen that the majority look at fatherhood as something desirable. They feel that they could be capable and responsible fathers. Twenty percent of the adolescent males in this jail felt that fatherhood would make them feel like "real men." No racial or cultural differences were seen in this result. In Marsiglio's (1993) look at a population not incarcerated, only 5% felt that fatherhood would make them "real men." Interestingly 40% of Nesmith's incarcerated group felt that their families would be happy if they were to become fathers. 62% felt that their friends would be happy. In comparison, in a group of rural American high school students (Robinson et al 1998), 93% felt that their parents would not think it was alright for them to become teenage parents. 81% felt they would definitely use birth control if having sex but only 11% of the study group had actually had intercourse. Even though these teenagers in comparison to those in the above study seem to have greater awareness that pregnancy is something to be avoided at this time they do not seem to have a clearer understanding of the reasons. When asked whether being a teen parent would keep them from being a successful adult 35% felt it would while 32% felt it would not. While it is possible for teen parents to go on to be successful adults it is not easy and requires support. Even in this group their seems to be a lack of understanding of how becoming a parent before you are emotionally and financially ready can make life difficult. Fagot et al (1998) show that adolescents with less money and fewer options may be more likely to become fathers. This may have to do with a lack of plans that would be interrupted by becoming a parent. As well, they may feel that becoming a father is the only thing that would give them a positive role as fully functional adults. Sadly, it is pointed out that 40% of the fathers did not have contact with their children and so in the end failed in this role as well.

Marsiglio (1993) in his article *Adolescent Males' Orientation Toward Paternity and Contraception* looked at a sample of 1880 men between the ages of 15 and 19. Specifically he looked at their *procreative consciousness* and *procreative responsibility*. In other words, their personal experiences of reproductive issues and their sense of obligation regarding procreative issues such as birth control, pregnancy resolution and care of children. He found that a number of factors such as economic status, parental education, ethnicity and attitudes about gender roles all play into feelings about contraception and the threat of unplanned fatherhood. Among his results is the fact that young men in poorer areas were more likely to feel that pregnancy was a good idea and that it would make them feel more masculine. These feelings in both poor and more upscale neighborhoods were stronger among blacks than whites. Blacks were also more likely to have used effective contraception the last time they had intercourse. Marsiglio suggests that to some young men possession and use of a condom may actually be associated with feelings of masculinity and sexual prowess. Adolescent boys who knew they had already caused a pregnancy were found to be less likely than average to have used effective contraception and were also more likely to feel that becoming a father would be a positive thing and would increase their masculinity.

Looking at urban African American adolescent parents it is interesting to hear some of their views on sex, love, intimacy, pregnancy and parenting (Jones Harris, 1998). The majority of both mothers and fathers interviewed for Jones Harris' study claim to have been in love with their partners when the pregnancy occurred. The majority of the mothers said that

they were still in relationships with their partners while most fathers said they were no longer in a relationship with the mothers of their children. This apparent inconsistency was not explained. For the mothers it was seen that most considered sex to be part of an intimate relationship while for the men this was not the case for any. For the fathers sex was not part of the definition of love and intimacy. In other words, for these young men sex and love were not necessarily connected while the women seem to feel that they should be. All the men admitted that the pregnancies were not intended to happen yet only one had actually used protection. This shows a lack of responsibility together with a feeling of invincibility, that nothing bad could possibly happen to them. Finally, all the fathers felt that life was more difficult since the pregnancy due to less freedom and more responsibilities.

Adolescents as fathers

Dallas and Chen (1999) spoke with five mothers of adolescent fathers to hear their perspectives on their sons as fathers. They began with the suspicion that these women had a strong influence on their sons' parenting behaviours. In their discussion, seven major themes were identified. To begin with, they discussed barriers to fatherhood. These included the fact that they saw their sons as children who still need parenting themselves and that this dependence is normal for their age group both emotionally and financially. They discussed the value of fatherhood and from their own experiences felt that in general fathers are more peripheral than mothers, mothers are able to take on both roles. Interestingly, they did not seem to blame fathers for leaving. They all seemed to feel that men had to undergo a transition to fatherhood, which their own sons had not yet achieved. To make this transition they would have to finish school, be employed, get married and set up their own households, a point that none of their sons had reached. These women seemed to expect fathers in general to provide financial support and guidance to their children however their own sons were still expected to act like children. For the most part these women did not want their sons to marry the mothers of their children believing that the relationships would not last. However they did expect their sons to remain in contact and involved with their children. They felt that it was up to the adolescent mother to provide support and cooperation so that they and their sons could maintain contact with the children. Overall, these women did not feel their sons were ready for fatherhood nor did they expect them to be. However, they did believe that they should be involved with their own children. The mothers are putting their fingers on the paradox here. Their sons are not ready to be fathers and nor should they be yet their babies have been born and so they must fulfill their responsibilities.

Fagot et al (1998) look at how adolescents do as parents. They show that their children appear to have somewhat greater health risks. They suggest that the same factors such as low maturity and engagement in risky behaviours that lead to fatherhood also predict failure in fatherhood. These adolescents do not possess appropriate monitoring skills. Nor have they developed skills necessary to control and to guide their children. Rather than teaching and guiding their children they seem to use more negative controls. The use of more negative and coercive parenting strategies has been associated with the development of antisocial behaviour. It can be seen how this creates a pattern. If these children develop antisocial behaviours they will then be more likely to become adolescent parents themselves.

The question of financial support is a large one. If this is considered such an integral part of fatherhood as suggested earlier, do adolescent fathers even stand a chance of success? Rhein et al. (1997), in looking at fathers of babies of adolescents found that financial contributions were more sporadic from teen fathers than older fathers. It would seem that for adolescent fathers to earn sufficient money to support their child, an immediate future in school is less likely. Without an education, these men have less earning potential. Despite this Rangarajan and Gleason (1998) found that younger fathers were actually more likely to provide support than older fathers. This was explained by the idea that perhaps older fathers are more likely to have other children with other women and would therefore be less likely to support all their children. Looking further at the sample of young fathers in this study, one third were found to have no high school degree or equivalent and more than a third did not have jobs. In the end only one in ten was able to financially support their chil-

dren. In terms of non-monetary support such as food and clothing, more than fifty percent had never provided any. This study found that often the amount of support given depended on the father's relationship with the mother and the child. For instance if another man is involved they will be less likely to provide support. As the relationship weakens, financial support may also lessen. In turn, if the father has no contact with his child he will be less likely to provide any support.

In terms of the question of how involved adolescent fathers are, it appears that they are more present than would be assumed. Of the six fathers interviewed in Jones Harris' study (1998) discussed above, only one was not in contact with his child. Perhaps adolescent fathers are more willing to take responsibility than is commonly believed. There are multiple factors influencing their involvement. While Rangarajan and Gleason (1998) found that unwed adolescent fathers are less likely than single adult fathers to have regular contact with their children, they are still involved. In their sample almost one half of the fathers had had no contact with their children in a specific three month period. However, the rest did maintain some degree of contact. Some fathers are felt to substitute emotional support and contact for economic support that they are unable to provide while others feel that if they cannot provide one that they should not be providing the other. The encouragement or discouragement of mothers is also an important factor in their involvement. If a father is unable to help financially the mother may not want him involved at all.

In general, fathers who see their children regularly are more likely to provide financial support, showing that they are acknowledging the responsibilities of fatherhood along with its rights. Cox and Bithoney (1995) make a connection between the amount of active participation on the part of the father in the prenatal and neonatal periods to later, continued contact with their children. They hypothesized that father involvement in prenatal and perinatal care, and those who are older with more education and in stable relationships with the mother would be more likely to be involved with their child in the long run. Their results showed that prenatal involvement, contact with the baby by two weeks of age and support of the mother's family were found to be the most important indicators of involvement at the two year mark. Age of the father, education and relationship with the mom were found to be less important. Finally it is suggested that father involvement in the prenatal process may "enhance role satisfaction, self–esteem, and parenting effectiveness (Cox and Bithoney, 1995)" and so should be encouraged as it would likely encourage future involvement. From these results it would seem beneficial for fathers to be encouraged to be involved early on in the pregnancy.

Of 173 teen fathers in a study done by Rhein et al (1997), the majority were involved in the lives of their children. Going back to the traditional view of father as provider it was found that a main reason for a seeming disinterest among fathers was inability to provide financially. As well, lack of knowledge concerning childcare was found to lead to less interest in their children. Fewer fathers than mothers claimed to have wanted the pregnancy however, fewer fathers admitted to considering an abortion. They showed that while most fathers expected to be involved with their children this expectation was more likely to include playing with and dressing their children rather than taking responsibility for feeding their children or taking them for doctor's visits. In other words, they do not seem as eager to take on the more difficult roles of parenting as they do for the lighter ones.

Pregnancy Decisions

In regards to decisions about whether or not to go through with a pregnancy it is generally acknowledged that in the end it is the mother's body and therefore, her decision. Yet this decision also has a large impact on the father as it is his partner and his child involved. A study from Sweden (Holmberg, Wahlberg 1999) concerns teenage boys involved in the process of an abortion decision. Thirty-five adolescent boys were interviewed in the waiting room of clinics. Common concerns mentioned were a need to be taken care of, a struggle to reach maturity and responsibility and thoughts about their autonomy and ability to be care providers. The staff in these clinics were asked for their impressions of the adolescent fathers. They found it was common for the fathers to be concerned about the process of the abortion

and potential complications, to be feeling powerless concerning a lack of influence over the decision. As well, many expressed concerns about their own maturity. The most common feeling noted among the young men (90%) was relief. Other feelings noted were grief, depression, disappointment and irritation. Only 25% of males actually went with their partners to appointments. However most wanted to be included in the decision of whether or not to have an abortion. Twelve percent of responses from clinic staff stated that the male partner was frequently allowed to take part in the decision, 62% said rather frequently while 26% said that it was a rare occurrence. 61% of adolescent males felt that if the father objects to the abortion than it would be wrong for the women to have one. In general, teenage fathers have been found to have more liberal attitudes towards abortion than those who are not fathers.

Possibilities

Danielson et al (1990) arranged a reproductive health intervention for young men. In it they examined the question of whether adolescent use of contraception would be affected by receiving intense sexual and reproductive counseling. This included a very explicit audiovisual presentation as well as one-on-one consultation. There was some evidence that this led to more effective use of contraception, however this was only significant among participants who were reached before becoming sexually active. They felt that this intervention could promote better communication within couples by giving practice discussing sexual matters and by improving male understanding of female anatomy, sexuality and health concerns. It was felt that "sexual impatience" was a main contributor to unprotected sex and that this intervention helped to reduce sexual impatience, in other words this intervention promoted sexual restraint. In general there was a small increase in use of protection. The control group versus the group with the intervention showed that 39% versus only 32% were having unprotected sex. This may however, partially reflect an increase in
awareness of what method his partner may be using as a result of improved communication about sexuality.

There is no question that adolescent pregnancy is generally undesirable; yet, adolescents continue to have babies. The question remains what can be done to help reduce the numbers. One thing that is clear is that much work must be done to target young men as well as women. To begin with the aim of prevention, it would seem that a large effort to educate is required. The studies examined here suggest that education is an appropriate first step. This education should begin with contraception and safe sex. If communication regarding birth control among couples could be improved, this alone would be a positive step. However, this education needs to go further by focusing as well on the realities of parenthood. Marsiglio (2000) suggests that it can be useful to encourage adolescents to really think about whether or not they are ready for fatherhood, whether or not they can fit the role that they envision a father should have. Also it may make a difference if young men are encouraged to examine their own experiences with children, or even if they are provided with experiences in childcare. This would force them to think about whether babies are something they are ready to handle. Together these will help increase awareness of the consequences of not using birth control in terms of the reality of having a young baby to raise before they are ready. As well, as demonstrated by Taylor et al (1999) cultural values can play a role in teenage pregnancy and so, in creating programs for prevention it is important to look at different cultural beliefs in order to have a better understanding of motivation for young parenthood. Finally, for situations where prevention is no longer possible there is clearly a need to teach young unprepared parents how to be more effective. Not only will their children experience immediate benefits but in the long run they may be less likely to become adolescent parents themselves thereby breaking the cycle seen earlier in the discussion of Fagot et al's (1998) study, of children having children.

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This educational program is multi-disciplinary in nature and is designed with community practitioners in mind. It uses a regional ‘‘Train the Trainers’’ approach (TTW) and is intended to raise the level of adolescent health knowledge and skills among medical and non-medical primary care practitioners across Canada.

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Key elements of NTIAH are:

- a learner-centered curriculum adaptable to a variety of disciplines and timeframes
- a train-the-trainer network
- an Internet-based Educational Resource Centre to act as an information clearinghouse.

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YOUTH and DEVELOPMENT

S. M. Lena MBBS, FRCP(C), MRCP, DCH. (Lond.)

Division of Community Pediatrics, Children's Hospital of Eastern Ontario, Ottawa, Ontario;

Introduction

Adolescents and youth make up over 50% of the world's population. Despite this fact, they have received very low priority for service delivery and programs in the past, by both government and non-government organizations. Due to their overall health and lack of political clout, the needs of youth are often overlooked during the allotment of resources. The needs of youth need to be carefully addressed, as they are not only the next generation, but also, as they are the most vulnerable age group after early infancy and prior to the very old age.

Youth are a nation's immediate future. In the last several years, due to the increase in the identification of problem behaviors associated morbidities and mortality statistics of adolescents, there has been many initiatives from various quarters to assess, evaluate and establish systematic programs for adolescents. The involvement of young people in the planning and implementation of programs and services has begun to take place over the last ten years.

Policy makers and planners, together with funding agencies must seek more and more to incorporate the views and experiences of people in the front line when making decisions and planning for youth programs. Youth leaders, social workers, teachers, nurses, psychologists, physicians are a rich source of expertise and information on which to base effective policies and develop programs.

Terminology

The terms "youth, adolescence, adolescent, teen" are utilized in the context of this transition period of human growth. Each term refers to a particular age group. The term 'YOUTH' is generally used to designate the 15 to 24 age group, particularly used by the UN, WHO, and PAHO. This term is most useful in policy making, legislation, and funding projects. The term **'TEEN'** is very clear in itself, and includes persons between the ages of 13 to19 years. 'ADOLESCENCE' is a term used to indicate the process of psychosocial development of the adolescent. The term **'ADOLESCENT'** is often used in medical practice to include the 11 to 19 age group. It is a practical range used to include the pre adolescent (11-13), mid-adolescent (14-16) and the late adolescent periods (17-19). **'PUBERTY'** denotes the steroid mediated phase of growth and development. It is noteworthy, that there is an overlap in the utilization of the terms puberty and adolescence.

In legal matters, **'MINOR/ EMANCIPATED MINOR'** refers to a youth who is under 16 years. These are terms used when dealing with rights, freedoms, consent, confidentiality and powers of attorney. Emancipated minor is used to denote the following people: married minors, minors serving in the armed forces, those living independently, and minors who are pregnant or are parents. A mature minor is a young adolescent who can make health care decisions.

Developmental Process of Youth

In considering youth and development it is paramount that the developmental process from childhood to adolescence, and then to adulthood must be given due thought and consideration. Planning programs for youth in order to potentiate their growth into healthy, responsible caring adults must take the stages of maturation of youth in account.

The developmental process of youth includes both physical growth and hormonal changes that occur with puberty, in addition to the psychosocial and sexual development of youth. Adolescence is marked by a period of rapid and extensive physical and pubertal growth, whose dramatic changes are surpassed only by intrauterine growth. Every organ and system of the body grows and matures. Previously dormant systems such as the hypothalamic pitui-

tary genital axis become active and reach their peak activity during late adolescence.

Psychological developmental milestones are achieved during adolescence. Social skills that are necessary for adult life are learned and established. Sexual orientation and identity development are major tasks of adolescent development.

In view of the above it is generally accepted that health problems in adolescents and youth are characterized by infrequent somatic disorders but they have a high level of psychosocial, sexual, behavioral disorders. However, it is important to note this data may not be representative as the data gathering systems using existing indicators for mortality and morbidity in adolescence are not accurate.

In the process of development of adolescents, there is a wide range of normality. There are many deviations, aberrations and abnormalities from the normal. "Normal" is used here in the medical sense, when certain established milestones, such as normal patterns and values are not reached. In these cases, medical concerns arise and have to be investigated to identify and monitor morbidity. This does not happen in many parts of the world, as there are no established adolescent specific norms. Instead, extrapolations from childhood and interpolations from adult values are utilized. As a result, developmental problems may not be identified and could put the adolescent at risk for difficulties in later life. Research is needed to establish adolescent specific norms for nations, cultures and ethnic backgrounds. From a health perspective, this is an area that needs much development and support.

Pubertal Development

Puberty has a recognized age of onset and age of completion. Menarche should occur around 12.5 years in girls and andrarche in boys at 14 years. Onset of puberty at 8 years in girls or boys is a serious indication for medical investigation for precocious puberty. Similarly, delayed onset, with few changes by the age of 16 years, warrants investigation for delayed puberty.

There is much variability in the timing of the onset of puberty. Some children develop earlier than the norm and others have their development delayed. As a consequence, these children are at risk for emotional and psychosocial difficulties, acceptance of self and adjustment to peers. Apart from the timing of the onset and the completion of the physical development in adolescents, the many stages of growth may progress out of step or non-sequentially. Other factors can influence the growth process, such as onset of a chronic illness, malignancy, malnutrition from famine or anorexia nervosa, and can cause an arrest in growth. Pre-existing chronic illnesses such as diabetes, Crohn's disease or cystic fibrosis, may have profound effects on the process of adolescent development. Treatments associated with illnesses may also have serious consequences for growth and development.

Psychological Development of Youth

Many developmental psychologists have proposed theories of growth and maturation, often describing the phases and stages of human development. Erik Erikson described the eight stages of development through the life span, namely: infancy, pre-school, school age, adolescence, young adult, adulthood and senescence. In particular, he described the psychosocial tasks of adolescence. They are the development of self-identity, achieving adult autonomy, committing to a lasting sexual relationship, establishing a work or career path to economic independence.

In 1904 G. Stanley Hall, in his treatise on adolescence established the belief that adolescence is a period of storm and stress. Behaviors during adolescence were explained by an inner turmoil. It was assumed that it was necessary to work out these personal conflicts in order to achieve autonomy. Other psychoanalysts, Anna Freud, Pauline Kestenberg and Peter Blos have perpetuated this concept. Surprisingly, these early beliefs still strongly influence parents, teachers and care givers to the point that these theories have at times even inhibited and seriously interfered with the proper investigation and diagnosis of psychiatric morbidities. This interference can come with severe consequences, as many psychiatric illnesses have their onset during adolescence.

The reality is that the majority of teenagers do not show evidence of unusual conflict or stress during adolescent growth, if they are physi-

cally, emotionally, and mentally stable. Normal psychological development does not require adolescents to be rebellious or defiant, as long as they are physically, emotionally, and mentally stable with wholesome nurturing parents or adults in their lives.

Vandalism, juvenile delinquency, indiscriminate use of mind-altering substances, sexual promiscuity, are pathological behaviors. Teenagers have the tendency to over-value activities that relax them, challenge them, and improve their skills. They are happiest when they are engaging in sports, hobbies, music, art, dancing, intimate friendships and creative activities of various sorts. These activities give them a sense of fulfillment that increases their competence and consequently improves their self-esteem. Teenagers do not derive pleasure from indulging in destructive behaviors unless they are ill, dysfunctional or disturbed or struggling with internal or external conflicts. Another common myth is that boredom leads teens to find destructive behaviors to execute. On the contrary, teens who are functional and well adjusted find creative activities to do when they are bored.

These findings have been supported by a number of studies. Offer's longitudinal study of normal adolescent boys, confirmed that the majority of adolescents do not experience turmoil related to adolescent development. Offer and his colleagues identified three main developmental routes for adolescents. The first was continuous growth, which was found in 25% of the group. These adolescents followed a path characterized by smooth well adjusted, functioning through adolescence even in the face of stressful circumstances or adverse life events. The second classification was surgent growth, which comprised 34% of the group. In this path, well-adjusted adolescents showed good adaptation to the minor vicissitudes of ordinary life but with unanticipated stressful events they experienced noticeable difficulty and distress for a short time. In his study, only 21% of the adolescents showed a tumultuous growth. Adolescents in this group had mood swings, troublesome feelings, of anxiety, depression, guilt and shame. The researchers found this group was characterized by economic disadvantage, family and marital conflicts, and a high rate of family mental illness.

In Rutter's landmark study of British adolescents on the isle of Wight, it was found on a self-report questionnaire that 50% of teens were sad or miserable. However, on closer investigation, it was found that only 12.5 % of boys and 24.8 % of girls were depressed in an in - depth interview. Rutter estimated that 10% of teens were actually suffering from a diagnosable low level depression in this group. These findings are comparable to the tumultuous group described by Offer. These two studies are further confirmation that intense turmoil is not a part of normative adolescent development.

True turmoil represents psychopathology and will simply not be outgrown. Two longitudinal studies by J. F. Masterson and I B Weiner have shown that a majority of severely disturbed adolescents continue to be severely disturbed adults. Most of these adolescents also had disturbances during childhood. These disturbances were neither normative nor situational. These disturbances need serious clinical attention. Normative fluctuations are transient, lasting hours or days. On the other hand, unremitting, long-standing mood and behavior changes are serious and must be given serious clinical attention.

More recent researchers such as J. Brooks Gunn, Carol Gilligan have enlightened us on the psychology of women's development and the sociology of female development from a feminine perspective. Minority youth and disabled youth have specific characteristics and additional tasks to fulfill such as acceptance and integration of their disability into their sense of self which influences their transition into adulthood.

Sexuality Development

Teenage sexuality is often looked at from the perspective of parents and care giving adults. They view it negatively, from the teen pregnancy, teen parenting, loss of education, job prospects, career prospects, and as a means of contracting sexually transmitted diseases, such as AIDS. Sexuality is often associated with other undesirable behaviors such as smoking, drinking alcohol, drug use and victimization by sexual abuse and prostitution.

However, it is important to consider that sexu-

ality development in humans includes many enriching features such as the development of bonds, relationships, and its affective capacity. These are important behaviors for adolescents to become familiar with. Sexuality development is unique in its ability to give and receive pleasurable sensations, its transcendental communicative powers, its creative and procreative capacity with shared moral and ethical responsibility for a new human being.

Sexual behaviors of adolescents are very diverse. Whether the sexual orientation is heterosexual, homosexual, bisexual or otherwise, there are inherent medical problems and outcomes of sexual behaviors. Some of the sexual orientations can lead to more serious medical problems. Similarly some sexual behaviors are more risky than others are. Sex without commitment, intimacy and responsibility is neither satisfying nor liberating for the mature, functional adolescent. Physical sexuality expression, or expression of a biological need is at one end of the spectrum of sexual behaviors in adolescents. This type of behavior meets a biophysiological need, and basic propagation of species. The other end of the spectrum of sexual behavior is the ability to make choices, build a relationship and go through a process of completing sexuality development at a conscious level for expression of commitment, intimacy and procreation.

From an anthropological standpoint, in much of the animal world, sexual behaviors are only involved in the physical expression of their sexuality, and impregnation for the purpose of procreation. Other animals are involved with their mates for varying lengths of time; very few animals remain mates for a lifetime.

In human sexual behavior these evolutionary patterns have been paralleled and described by anthropologists (Simon Fraser University. Some humans do have sexual behaviors, which are of the most primitive forms and others show varying forms throughout the spectrum to completion of the process to commitment and partnership. For example humans may be mates for varying periods of time 18 months, three years, 5 years, 7 years, 13 years or more.

The progression of sexual development to its completion is variable in humans, the time of onset, the process of sexual development and its completion are all varied, biologically determined and genetically species specific. The course of development may be marked with inherent flaws such as arrest, premature onset, and delayed completion.

In light of this great variability in development, and the inherent risks involved with sexual intercourse in adolescents, it is important to develop comprehensive programs targeted at high-risk adolescents and their high-risk behaviors, with a harm reducing philosophy in mind. Youth require long-term, committed programs, which are geared to primary, secondary, tertiary and quaternary prevention. In addition, programs are needed for adolescents so that they may continue to grow and develop in spite of illness or pregnancy. As sexually mature humans, there will never be a situation where teens will never get pregnant or get sick because of their sexual behaviors. This is due in part to their desire to experiment and take risks. There are also influences such developmental delay, low self esteem, learning difficulties, impulsive behaviors and other human deviations in life.

The promotion of Young Peoples Growth and Development

The primary objective of adolescence is the acquisition of an identity, which defines each individual as a unique, independent, autonomous human being. Alienation of youth often occurs when under the pretext of the "common good" individuals are marginalized, discriminated against and mutilated because of their diversities. Authority in these cases is used to coerce, repress and manipulate, meanwhile trampling underfoot the moral dignity of individuals. All these factors need to be taken into account when developing programs for youth. The absence of discrimination and the respectful treatment of all individuals is paramount in program development.

The universal provision of basic needs of nutrition, clothing, living conditions, nurturing, caring, protective and safe environment is especially necessary throughout childhood and adolescence. The availability of education universally and programs that meet the special individualized educational needs of all youth with disabilities is also needed. From a medical perspective, programs that promote health,

prevent illness, support and rehabilitate all forms of disasters and disabilities that occur in life would greatly increase the quality of life of youth, and increase their overall life expectancy. From a monetary standpoint, preventative programs are always more cost effective in the long-term.

Programs also need to address the promotion of ethnic, cultural, religious, personal, individual sexual diversities. Youth will then realize their own potential, acquire an identity, a uniqueness, become independent autonomous and meet the challenges of growing up. Once grown up they need to see their futures as bright, exciting and challenging.

Isolation of youth from Adult Role Models

In the past adolescents spent a great deal of time with their elders, learning cultural values, moral values, religious values and family values. They apprenticed with elders learning skills and trades that were useful for adult life. With modern socialization there is a segregation of the age groups. At present, adolescents spend a vast amount of their time with peers. This can lead to a great deal of competition, isolation, and missing out on learning about adulthood. Typically many adolescents return from school, do their homework, have supper and "hang out with their peers". Some adolescents do not come home till late after school, others who do not attend school "hang out with peers" most of the day. Meaningful cross-generational interactions and activities are extremely important in growth and development.

This very important consideration can be incorporated into programs for youth by utilizing older youth, parents, grand parents and other caring adults appropriately trained to plan, organize and run programs for youth. This is especially true for programs in developed and developing countries. It is also applicable to programs for job training for youth, for teen mothers and fathers, programs for substance abuse prevention, harm reduction and treatment. Programs need to incorporate general health education, AIDS education, well being and mental health programs.

Since teens spend a great deal of time together, it is important that adults organize themselves to run centers for teens in both urban and rural areas particularly in places where teens hang around. These should be targeted particularly for teens who drop out of school and hang around the malls. Therefore these facilities could be just outside malls and shopping centers.

The programs should include teen focused activities for all ages with access to information. These centers could provide information and support related to teen sexual health, general health clinics, back-to-school classrooms, and job training programs. An after school program in a teen-accessible location could organize homework clubs to allow the participants to sit down and complete homework in a socially supportive environment. Peer tutoring could provide both the tutors and students an invaluable opportunity to help each other and learn. Teens who have learning disabilities should be allowed to learn in the manner they can learn to develop life skills that will be useful for them as adults.

Adults must find time to be with adolescents sharing experiences with them, supporting them in their growth into responsible, productive adults. The alienation of youth from adults is an unhealthy cycle. Since teens like to spend time with peers, it makes sense to have trained mature youth participate in programs as front line workers, under adult guidance and supervision. Youth must be encouraged and welcomed in all committees that plan programs for youths.

Economically disadvantaged youth who live in housing projects, slums, on the streets and "runaways" all have very special needs. Teens who are from divorced and separated families, from families whose parents are abusive, alcoholic, drug abusers, irresponsible. In these cases, they need to have other adults in nurturing and supporting roles, such as grand parents, uncles, aunts, and retired adults. These adults can be excellent resources for youth and must be commandeered to fulfill these roles.

Parents and community leaders must anticipate and participate in advocacy roles for adolescent educational needs, employment needs, legislation that supports growth promotion of adolescents. Youth with disabilities need to be

addressed, as they have very special needs, related to daily life, education, peer support, having fun, sports participation, employment, long term plans, adulthood, relationships, and transport. The issues discussed here are important factors to consider when planning and evaluating programs for youth.

The International Perspective

There is ample and strong evidence that successful programs all share some common characteristics. They all treat children, adolescents and their families holistically, are implemented from an early age and provide continuity as the youth matures. They fulfill many basic needs, as well as providing enrichment and growth through development promoting activities (Dryfoos 1990, Resnick 1992, and Barker & Fuentes 1995). Although multi-dimensional programs tend to offer better overall results to more people, even single focused programs fare well if their clients' needs are met holistically. The longevity of the program is also important; as continued support is needed to break cycles of behaviors and patterns in future generations. Programming must be in place for primary, secondary, and tertiary prevention. Regardless of the time of entry to a program, holistic approaches with long-term involvement are now proven beyond doubt to be most effective.

Health problems are a common entrance and gateway to addressing the many issues of adolescence. This is an important fact, and should be utilized when planning programs for youth. Through medical treatment, youth become part of the system, which allows their needs to be comprehensively identified and addressed. Chronic and debilitating health issues can create an environment for poverty, as it is difficult for the youth to provide for themselves and enter the workforce. To add to this problem, poverty propagates ill health, from malnutrition, poor hygiene, and lack of affordable services. Untreated and inadequately treated mental illness similarly propagates poverty. Resources for chronic sick youth need to be addressed.

While it is difficult to create global programs that address all the needs of individuals, inclusive programs should be mindful of all adolescents, taking into account all diversities, be they sexual, physical, cultural, racial, or religious. On a smaller scale, individual programs to address particular needs must be available. Some of the groups that need special attention are youth who are developmentally delayed, physically disabled, mentally compromised, or mentally ill. The youth themselves are important resources when developing special programs. Their input in program development is invaluable to create an appealing and worthwhile program. Another global group that needs their special requirements met is the aboriginal youth.

International programming must take into consideration the political climate, as the specific needs of youth will vary accordingly. Youth living in war zones, areas of drought and famine, as well as those recently affected by natural or man made disasters, require immediate special intensive services, such as medical treatment. Emergency programs need to be available and mobile, so that they may quickly meet the additional needs of a population in crisis. There should be protective legislation and strict monitoring of execution of these laws. Forceful coercion, coercion with seduction or promises of emancipation and bribery must be eliminated, as is sometimes the case in desperate situations.

In the past there have been numerous ways of coping with crisis situations. For example, during the 2nd world war situation, children and youth were evacuated from war zones to foster homes in hopes of safety. This temporary solution had its pros and cons. While the children's physical safety was better insured, the psychological trauma of the separation from family and community may have had lasting negative effects. However, this plan afforded the children a better chance at a future, rather than sending the youth to fight wars, and to be used and abused as has occurred in many countries over the last half a century.

In summary, international programming should address the ongoing needs of youth, and provide holistic, supportive programs over a long period of time. At the same time, it is important to have emergency measures programs that are mobile and available to provide short-term aid in crisis situations. The input of youth, especially when developing programs

for adolescents with special needs, is vital to obtain program appeal and success.

The Exploitation of Youth

Another serious problem youth face on an ongoing basis is exploitation. Due to their status in society, youth are very vulnerable to abuse and exploitation. In recent years, there have been efforts to publicize and update the Convention on the Rights of the Child, and in turn, better protect children and youth. While these efforts are recognized, much change is still needed. Some areas that need attention include the following: commercial sexual exploitation of youth, exploitation of children in the workforce, children forced into armed conflict as soldiers or hostages in war situations, and the welfare of orphaned children. All these factors have enormous negative repercussions on the health and well being of youth. For this reason, these issues must be identified, and prompt and effective actions must be taken to ensure the welfare of youth.

Sexual exploitation of children and youth can range from familial abuse to commercial exploitation. It is important to note, that while many of victims of this type of abuse may be female, male youth are also at risk. The nature of the abuse varies from country to country and takes on many forms. For example, in Asia, there is widespread occurrence of sex trafficking, where child prostitutes provide services to local men, or do so as part of a "sex tourism" set-up. These children are often kidnapped, or coerced into these situations when separated from their families. In other areas, such as South America, young people who move to the cities to work find themselves in desperate situations, and seek protection. In many cases, they are desperate for money or drugs, and fall prey to a life of prostitution, where they are usually dominated by abusive pimps. In many industrialized countries, organized pedophile rings and high tech information services leads trafficking of young children with lesser financial resources to wealthier areas in efforts make money. In Middle East and Africa, many children are sold or employed as domestic servants, and are expected to perform sexual acts. In all these situations, youth often fall victim to physical and mental abuse, often become involved in illicit drug abuse, and exorbitantly increase their risk of sexually transmitted diseases and pregnancy.

Child workers are often exposed to many hazards in the workplace, and tend to be employed illegally, in unregulated workplaces to save on labor costs. In addition to suffering from a potentially abusive situation, children who are working do not have the opportunity to study and gain an education. Consequently, their future options are severely limited, and they often continue to work under these unhealthy work conditions into adulthood, unless they become ill or disabled. According to Article 32 of the Convention on the Rights of a Child, "children have a right to be protected form exploitation and from work that is hazardous. Exploitation means taking advantage of someone for your own profit. Work is hazardous when it involves dangerous or risky activities". In light of this, governments need to be aware of this potential exploitation, even in industrialized countries, and should develop laws to protect these young workers.

It is also important to protect children in hostile situations, such as war or civil unrest, where they are often exploited. In these types of volatile situations, children and youth are often neglected by government protection agencies. In war-torn areas, children are often kidnapped, forced to become soldiers, or forced out onto a battlefield as distractions and "easy targets". In this way, many children are killed, or suffer permanent physical and mental damage. As for those transported to refugee camps, many children are separated from their families and often suffer from physical and sexual abuse, as well as malnutrition. Even after the conflict ends, youth are not compensated for their injuries or their loss of education. As well, their previous homes may no longer exist, or be unsafe to live in, as is the case with land mines in many countries. Many children are killed, or suffer devastating injuries from land mines, even decades after the end of the war. Young children are especially vulnerable, as they cannot read the signs posted in some areas indicating the presence of land mines. In a war-torn country, these children do not have access to a high standard of medical care, and often suffer needlessly. The future generation needs to be better protected,

and rehabilitated in these circumstances.

Orphaned children are the targets of many of the abuses and exploitation discussed above. They can easily "slip through the cracks" and disappear. For these reasons, governments need to pay close attention to children under the care of the state, as they may be at higher risk of a negative outcome.

Why Should we Invest in Adolescents?

1. Every youth that reaches adulthood healthy, with adequate education, happy and wholesome emotionally, spiritually, is an asset to himself/herself, family and the nation and the world.

2. An attitude of fixing problems that went wrong, instead of preventing these problems pays a far greater price, both economically, and from a human suffering point of view.

3. Anticipating the needs of all groups of youth, those at high risk, low risk and no risk as all are equally important individuals.

4. There are no "bad" youth, they are all special. Regardless of challenges they may face, such as physical disabilities, learning difficulties, poor social skills, lack of basic life needs, poor support systems and abuse, they all have their needs. Some have much greater needs than others do. If the differential needs are not foreseen and met, those in most need will suffer the most, and become the poorest of society. This sets up a vicious cycle where the most needy also become the most impoverished.

Suggestions for Developing Programs for Adolescents

As a first step in the development of effective programs, it is important to listen to the needs and issues of youth, the needs and issues of parents, and the needs and issues of service providers. Much information has already been collected in needs assessment studies, however, this information needs to be assimilated and utilized.

Long-term programs are needed to see adolescents through to the completion of adolescence. Youth tend to be very receptive to positive influences, but also vulnerable to negative ones. Adults, as role models, have the opportunity to be a major influence on the lives of youth. This influence should be recognized and used to its fullest positive potential.

The location of these programs is key to the success of the project. Delivering their needs to them where they are, be it at school, home, sports settings, clubs, bars, down town areas, malls, on the street, in war torn zones, at the cinema halls, or where ever teens hang out makes these programs accessible and more appealing. Advertising services should be used abundantly, to make programs accessible to the teens. Programs should be made user-friendly, by having young adults and youth in positions of responsibility. In this way, youth would feel more involved and capable of bringing about change in their environment.

Programs should be comprehensive with Holistic approach, providing specific needs of adolescents, food, clothing, shelter, medicines, birth control, information, support, counseling, money, travel expenses or transportation. Programs need to address safety, shelter, housing, education, as well as provide information on job training and employment. Some obstacles are that certain teenagers will have major problems with motivation and compliance, and being able to follow through with plans and suggestions. These are some of the challenges of meeting the needs of adolescents. Recognizing that there may be a cause for such apathy will lead to finding solutions to address such situations rather than abandoning a youth that appears to not care or has a negative attitude.

Strong Comprehensive Programs

Presently, several services are funded by various agencies such as: substance abuse programs, educational programs, life skills building programs, and best start programs. Through the affiliation with these agencies, the workload is shared and gives workers the chance to gain valuable work experience through their interaction with other programs. CIDA offers a wide range of programs that help both youth and populations in need. For example, there are a number of internship programs that send students to learn while help-

ing, for example, youth are placed for 6-8 months with sustainable development organizations in Latin America, Africa, Eastern Europe, and Asia. Once on location, they assist in community decision-making on natural resource management, as well as building new information and communication technologies for sustainable development. This is just one of the many internship programs offered by CIDA, all of which emphasize growth through learning and helping others.

Other programs offer intensive integrated approaches such as providing a home for pregnant teens moms. Through the interactions with the staff, many of the needs of teenage mothers are better identified. Those who have alcohol and drug problems, have dropped out of school, smoke heavily, and/or require financial support have an increased chance of receiving support. In addition, these types of programs allow young mothers to receive antenatal care, postnatal care, well baby care and housing, in a non-threatening environment.

Building comprehensive networks by connecting with existing services, bringing in the public health department as a partner and other community resources as partners is very effective in sharing knowledge and services and service providers. These types of networks have been established in the case of teen pregnancy care programs for young mothers. Teen fathers can also be served through these young women's contacts. The sexual health clinics can come to the homes for teen moms to deal with future contraceptive care for the young mothers and fathers. This is an example of effective and efficient use of service, service delivery and networking all under one roof so that the teens receive the support services they need.

Identify Target population

The range of needs of youth differs greatly across the board. Youth in high-risk situations need to be identified and helped before their difficulties escalate. The greater the contact, high-risk teens have with a supportive group, the more likely it is that their needs will be addressed, and their knowledge of where to find helpful resources will be increased. Some high-risk groups that need special attention are: substance abusing teens, homeless youth, pregnant teens, delinquent teens, imprisoned youth, and mentally ill youth.

Programs for these youth should be age and developmental stage appropriate, for example, 11-15 year adolescents often benefit from preventive activities, with recreation, community services, which help to build self esteem and competence. In addition, family service needs, empowerment of youth workshops, problem solving and decision making skills session, assertiveness training. How to effectively use social support services.

Location of Services

The accessibility of service is paramount to the success of a program. Programs that are affiliated with larger organizations may be restricted by policies, but also may benefit in membership and longevity by providing a constant inflow of potential candidates. It also allows for a certain amount of funding. Larger organizations also possess the ability to recruit further funding from multiple sources. For example, school based/school linked sites, churches synagogues and other religious institutions, community centers, youth networks, and mobile units will often be more available to youth populations. These types of affiliations make it easier for potential members to learn about the services and programs, and make them easier to find. In situations where there is less centralization, efforts need to be made to inform youth about the services available. These may include programs in low-income housing projects; high crime and gang infested neighborhoods, downtown teen drop-in centers and shelters.

When considering the location of a potential program, it is essential that the program image be taken in account. The youth population tends to be a demanding consumer group and programs that have an undesirable location or image will have a tendency to be shunned. Therefore, it is important to consider the "image" of a program, especially when the program is affiliated with a larger organization such as a school or religious institution. Youth may be wary of becoming involved with school or church group, for fear of being branded as "uncool" by peers. In these cases, increased autonomy from the umbrella organization may result in a more successful pro-

gram. In light of the ever-changing needs of youth programs, maintaining contact with institutions that have facilities to share and experts to give opinions is an extremely valuable resource. In this way, there are many opportunities to consult with and to create partnerships, as well as to study and evaluate program design.

Staffing Issues

Very often childcare workers who are inadequately trained to work with teenagers are employed to work with teens. These workers may not have the skills to manage difficult adolescents and they may use force and violence to control, which discourages adolescents and scares them from using services. Staff must be adequately trained to anticipate and identify risky behaviors and how to handle them age appropriately. They must be supported adequately and be aware when to ask for medical support and assessment. Recognizing diversity in teens, gender identity issues, racial, ethnic, developmental stage, and disabilities and sensitivities is very important. Staff support and strong positive leadership are also needed to maintain a cohesive environment for youth and increase staff well being.

Maintaining Integrity

Issues of consent are bound to surface in programs with youth. Confidentiality is essential, however, in some cases parents need to be involved, for legal or moral reasons. In these cases, the youth must be kept well informed and encouraged to be part of the active process. In this way, trust is less likely to be violated, and helps the youth feel in control of their life decisions.

Programs need to be evaluated on an ongoing basis, by analyzing data, documenting innovative programs, beneficial outcomes, service costs and cost savings. In this way, we can learn from existing programs, find what works and what does not, be better able to set up new programs, as well as improve upon existing programs. This is why the impact of new programs, participants' reports, component agencies' involvement and the social service systems should be examined. By documenting program successes and failures, organizations can remain current and better achieve optimal successes in the program.

Policies and legislation

The community infrastructure can have a major impact on the youth population. This type of infrastructure can help promote overall well-being of youth by protecting and overseeing programs and services that promote health, prevent problems, protect youth, provide necessary care and rehabilitation. Policies need to take in account the many needs of the youth population, such as: health, education, social welfare, population, national defense, as well as laws governing religious and cultural practices. The legislation in these areas can have great impact on the development of youth. However, it is important to remember that these services may not be well perceived and consequently not well utilized by youth. It is therefore important to develop cohesive policies that are able to attract youth and provide services that are developmentally appropriate and that address their physical, mental and social needs. This may be achieved by taking action to recruit diverse services, to help cover the range of needs and promote the programs to a greater number of people.

Achieving youth Involvement

To achieve the goal of an integrated society, youth, at 50% of the population, needs to play an active role in their futures. Program goals should keep this in mind, and find meaningful roles for youth to play, such as tutors, mentors, peer counselors, information disseminators, organizers, role models, and program designers. The involvement of youth in all areas of program implementation, organization and day-to-day activities empowers youth and will help to draw other youth into the program. In this way, the youth of the world feel a responsibility to their own futures, as well as the future of their peers. The sense of responsibility brings ongoing involvement and dedication, both of which should be encouraged and supported. It is by encouraging youth development through an active network of programs that we better ensure a brighter future for the youth of today.

This paper looks at a number of important factors that need to be identified and addressed

when creating programs for youth. By first identifying the target group, we can better assess the range of needs that should be met. Consequently, we offer some suggestions for programs and investigate some special considerations that need to be implemented for specific populations

Acknowledgments

Sara A. Ingram, for her editorial support and research.

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Publications

Take Five Newsletter

Sexual Health Network of Eastern Ontario Evaluation Report

In order to meet the requirements of the Ministry of Health's 1997 Mandatory Health Programs and Services Guidelines sexual health component, the Take Five information newsletter, focusing on sexual health issues for youth, was developed. The Sexual Health Network of Eastern Ontario, a collaborative health unit committee with membership from six health units in Eastern Ontario, developed the Take Five newsletter. The purpose of the newsletter is to:

- provide parents and other adults who work with youth with information on an ongoing basis that will assist them in their role as the primary sexuality educators of their children
- promote awareness about youth sexuality to parents, caregivers and those persons who work with youth
- promote communication between parents/ caregivers and youth.

Evaluation of the Take Five newsletter was undertaken in order to determine readership and use of the newsletter and to improve future issues of the newsletter. Knowledge attainment regarding sexual health issues for youth, as well as awareness of sexual health issues for youth and comfort level in discussing sexual health issues with youth were also explored.

A self-report survey of all readers in Eastern Ontario was carried out to evaluate the Take Five newsletter. Surveys were circulated with the October 1999 issue of the newsletter. Two hundred and thirty four readers responded to the Take Five Reader Survey.

A summary of the findings from the evaluation is as follows:

- 90% of respondents reported that they read the newsletter
- the highest percentage of respondents were healthcare providers (42%), youth service providers (25%), educators (30%), and parents (14%)
- Take Five was rated as being "excellent" in its usefulness of information (61%); easy to read (61%); and attractiveness of design (57%)
- respondents reported using the information in Take Five to improve own knowledge base (72%), to counsel youth (49%), for referral information (42%), for teaching (38%), and accessing resources (36%). Other uses include, background information for projects, program planning, assignments, and articles, identifying needs for youth, sharing information with own children, and resource for staff
- respondents reported that their knowledge of sexual health issues for youth (60%), awareness of sexual health resources and services in the community (58%), and comfort level in discussing sexual health issues with youth (65%) had improved "somewhat" as a result of the information provided in Take Five
- respondents reported reading the newsletter themselves (87%); circulating it to staff and/or colleagues (51%); filing it away for future use (45%); leaving it in waiting rooms for clients and/or customers (35%); and photocopying and distributing it (20%)

In response to the suggestions provided by readers of the Take Five newsletter regarding format and content, the following changes have been made in order to improve future issues of the newsletter. Look for these changes in the up-coming issues of Take Five:

- feature articles will appear on the front page of the newsletter

- an index of past issues of Take Five will be included as an insert to the October 2000 issue of the newsletter. An up-dated index will be available every two years
- you can find past issues of Take Five on our web site at www.rmoc.on.ca/healthsante/en/public.htm/takefive

In conclusion, the Take Five newsletter is a well-received resource related to sexual health issues for youth. It is read by a variety of persons, including health care professionals, educators and youth service providers, among others. According to its readers, Take Five contains highly used to improve the reader's knowledge base, or is used when counselling youth regarding sexual health. Take Five is fairly useful in improving the reader's knowledge of sexual health issues for youth, improving awareness of sexual health resources and services in the community, and improving comfort level in discussing sexual health issues with youth.

Back issues of Take Five cover: Youth speak: let's listen / Set the trend: peer pressure / Human papilloma virus / Teen pregnancy / Raves / Inside & out (gay issues) / No means (date rape) / Abstinence / Sexual health clinics / Choosing a contraceptive / Parenting youth.

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