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FOR ADOLESCENT HEALTH

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PRO-TEEN

Scientific Events

Articles

Publications

PRO-TEEN

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News from the Association

Democracy Has its Price: A Few Minutes of Our Time Each Year.

The Association and its President need our help and support.

Our Association has in excess of 800 members but in Toronto, on Oct 30 2002, we could not gather enough of us to form the quorum needed for us to hold a General Assembly. I am sure that this was a great disappointment for our President, Dr Jean-Yves Frappier. He had an agenda, minutes, report, and financial statements ready to share with the membership. There were important issues to be discussed.

How is it that the highly successful CAAH conference and our popular journal can be so well received by the membership but our business meeting leaves too many of us voting with our feet ? Is it that we trust our President to manage our affairs and provide the benefits which we so clearly enjoy (inexpensive membership fees, web-site, journal, regional and national conferences). Is it that our association is just a loose network of differing cultures (francophone, maritime, western, anglophone Ontario) ? Is it that our country is so big that regional interests are our priority ?

I think we all agree that CAAH's work is valued (perhaps taken for granted). However, it may be time to think about how best to balance membership interests/services with efficient and economical governance of the legal entity that we are. How does a disengaged membership exercise due diligence when it comes to making decisions. Are we in need of a different approach to membership ?

Over the last few years the Association has struggled financially. Maintaining a credible membership list and collecting dues has been a challenge. A challenge that would be much reduced if each of us were better at responding to the first notice of dues that we receive. Perhaps paying ones dues should only be tied to receiving the journal and being eligible for reduced conference registration fees. Efficiency and democracy would be better served if paying our dues were not tied to the right to vote. Should CAAH offer dues payers the extra option of indicating whether or not they wish to receive services with (or without) voting rights ? This option might create a smaller voting membership but it would have certain advantages when it comes to managing regional affairs, conducting business meetings, or satisfying our legal requirements. It would not disenfranchise anyone who wishes to vote, attend business meetings etc but it would carry a greater responsibility to participate in CAAH's governance.

Our Association, like many others in the adolescent health field, moves forward in fits and starts. I believe that the Toronto meeting's success was a strong message about peoples' interest in and energy on behalf of our adolescents. We just have to find a way to be equally supportive of those who manage its affairs.

Dr. Roger S. Tonkin.

President's Report 2002

The state of membership in December 2002 is as described in the tables below.

This year, 66% of our members have paid their dues. The members of 1999 will probably not renew their membership but many members from 2000 and 2001 will renew in 2003 after several reminders. Sending three reminders per year has proved to be rewarding in terms of membership renewal. Our membership is stable as compare to last year.

We are loosing and gaining 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. There are more members in Québec and Ontario because more promotion of CAAH was carried on in those provinces (with National and Regional meetings).

85% of the members are women and 15% are men; 59% of the members want to receive their journal in French, 33% in English, while 8% want both.

49% of the members have a single membership; thus 51% are in a group membership. This includes members who have an institutional membership (185$ for up to 7 members).

22% of the members pay themselves their dues, 77% having their dues paid by their institution or organization; 1% are free members or other kind of payment.

Meetings

A Québec Regional Meeting was held in Montreal April 25th and 26th 2002. There was a French and English program and the meeting was well attended with 275 participants. The theme was "adolescents, the network, the family, the school and the team". It served also as the 2001 annual meeting, since the meeting had to be postponed in October 2001. The meeting was organized by the Québec section of CAAH, and the Adolescent Division of Ste-Justine Hospital.

The 2002 annual National Meeting was held in Toronto October 30th 2002. It was organized by the Adolescent Medicine Division of the Hospital for Sick Children. The theme was "Adolescence In The New Millennium: The Agony and the Ectasy". It was well attended with 200 participants who ended up very satisfied according to the evaluation.

Website

The website has now two entrance, the old one and a newly designed one for skilled internauts. Many issues of PRO-TEEN and PRO-ADO have been added as well as many documents and new links.

The website is visited by an average of 600-900 persons per week, of which about 130 access through the home page while other access indirectly through other links. There are usually more than 5000 hits per week on the site. The time spent on the site is interesting since it is above 5 minutes on average.

1999	104 (12%)
2000	89 (11%)
2001	115 (14%)
2002	453 (56%)
2003 (registered and paid since September 2002)	53 (7%)
TOTAL	**814**

PRO-TEEN, PRO-ADO

The journal is still popular. Many of our new members become members to receive the journal. We have to think about the orientation of this publication. However, publishing the Journal is time consuming and we welcome any articles for publication.

Sections

The committee Section Quebec is in function since three years; their members have developed their third program for the April 2002 regional meeting. We find among the members of the committee: Danièle Bouchard, Nurse; Ginette Ducharme, Nurse; Pierre Chartrand, Social Worker; Yves Lambert, Family Medicine; Judith Gaudet, Ph.D. student in Psychology and Jean-Yves Frappier.

In the constitution, CAAH was to develop sections in each province or region. This has not been possible and we will have to revisit that concept.

Committees

Advocacy. The Committee has limited financial or support resources. The activities were limited this year.

Members per provinces	
Québec	569 (70%)
Ontario	165 (20%)
British Columbia	37 (4%)
Nova Scotia	10 (1.2%)
Alberta	15 (2%)
Saskatchewan	6 (0.7%)
Manitoba	4 (.5%)
Newfoundland	2
New Brunswick	5 (.6%)
Yukon	1

Work Place (more than one choice)	
CLSC	36%
Private Office	10%
School	30%
Public Health	13%
City Health Department	0.2%
Hospital	17%
University	5%
Community Organization	6%
Youth Centres	5%
Children Aid Society (Youth protection)	3%
Custodial Facilities	2%
Governmental Organizations	4%
School Board	2%
Others	4%

Type of Work (more than one choice)	
Clinical Intervention	66%
Teaching	35%
Prevention / Promotion	59%
Health Education	41%
Clinical Coordination	12%
Group's Animation	27%
Community Work	18%
Public Health	20%
Research	10%
Administration	11%
Documentation, library	3%
Benevolent	3%
Media	2%
Street Work	2%
Program Development	15%
Others	3%
Not answered	9%

Professions of members			
Nurses	33%	Family Doctor	11%
Social Workers	13%	Paediatrician	6%
Psychologist	8%	Psychiatrist	1%
Teachers	2%	Other medical specialties	2%
School Counselors	3%	Librarian, Documentalist	2%
Child Life Worker, Occupational Therapist	4%	Nutritionist	2%
Community Workers, Street Worker	2%	Administrator	2%
Sexologist	1%	Others	9%
Coordinator	5%		

Fields of Interest (more than one choice)	
Parents/adolescents Relationships	72%
Behavior Problems	61%
Sexuality, Pregnancy, Contraception	69%
Handicap, Chronic diseases	37%
Sexual Abuse	60%
Anorexia Nervosa, Bulimia	64%
Suicide, Suicide Attempt, Depression	69%
STD and AIDS	57%
Drugs Use and Abuse	64%
General Health: growth, skin, ortho, sport	42%
Rights, Laws	41%
Adolescent Development	58%
Learning Disorders	41%
Violence	46%
Nutrition, obesity	47%
Psychosomatic Diseases	47%
Not Available	9%

Finances

CAAH is still in a difficult financial situation.

Future actions

We have to think about the structure of the organization. Decision should be taken as to the publication of the Journal and the development of the website with a possible restricted entrance with fees. It is difficult to develop outside Québec and Ontario.

Happy and productive year,

Jean-Yves Frappier
President

Budget 2001 (audited)

Revenues	
Grants	76,910
Membership fees	21,161
TOTAL Revenues	**98,071**
Expenses	
Administrative support	52,691
Project Assistant	34,904
Journal	6,974
Amortization	2,594
Maintenance	2,301
Data entry	1,705
Office supplies	1,618
Representation fees	342
Travel charges	306
Interest and bank fees	281
Tax and permits	62
Professional fees	1,025
TOTAL Expenses	**104,803**
Cumulated deficit (dec 2001)	39,614

Budget 2002 (not audited, approximation)

Revenues	
Grants	109,000
Membership fees	19,990
Regional meeting 2002	42,515
TOTAL Revenues	**171,505**
Expenses	
Administrative support	57,000
Project Assistant	41,000
Journal	6,062
Office, Maintenance	13,000
Travel charges	1,500
Professional fees	1,180
2002 National meeting	6,200
Regional Meeting 2002	29,600
GST	4,600
Reimburse (loan)	25,000
TOTAL Expenses	**162,642**

Scientific Events

3rd World Congress - Child and Youth Health 2003

May 11-14 2003, Vancouver, BC

The congress will provide you with an opportunity to better understand what we currently know and, more importantly, to set an agenda for the future; an agenda that we challenge you to be involved in and indeed take leadership in. The major areas of focus will be:

- Promoting healthy lives
- Providing quality education
- Protecting against abuse, exploitation and violence
- Combating HIV/AIDS

The 2003 Child and Youth Health Congress will focus on the Health Issues faced by children and youth within the context of the UN Special Session on Children. The Congress provides a setting for the international community to define opportunities and set priorities related to new knowledge development through research and the application of this knowledge to the health issues of children over the next decade.

The Congress will bring together child and youth health leaders, scientists, health workers, governmental and non-governmental organizations and industries from the international community. Participants will have the opportunity to hear more than 170 internationally renowned speakers, building on existing knowledge and establishing partnerships which will form the basis for new developments.
The plenary sessions, seminars and posters will be focused on responding to four questions:

What is our current state of knowledge in relation to science, practice and policy and what are the strategies for moving forward in the next decade?

What are the indicators that we can use at a regional, national and international level to measure our success over the next 10 years?

What opportunities exist for national and international collaboration in research, application or policy to improve the success of these strategies?

How can we engage youth to take interest in the health issues of children and support their career development in science, practice and policy?

Here are some of the plenary sessions that will be available at the congress: Environment, Sexual Health, Parenting, War, Disability, Influences on Development, Respiratory Diseases, Aboriginal Health…

For more information, please contact:

Child and Youth Health 2003
c/o Venue West Conference Services
645-375 Water Street
Vancouver BC V6B 5C6
Tel: (604) 681-5226
Fax: (604) 681-2503
Email: congress@venuewest.com
Web: www.venuewest.com/childhealth2003

NASP 2003 Annual Convention – Toronto April 8-12 2003.

NASP: National Association of School Psychologists

The NASP 2003 Annual Convention offers school psychologists and related education and mental health professionals five days at the world's largest gathering of school psychologists.
This year's program offers:

- More than 600 workshops, presentations, and special events
- Career Services Center and Job Fair
- More Advanced Professional Workshops than in previous years
- Presentation strands on topics related to the convention theme
- Cutting edge research and skills training
- Leading experts (Keynote by Elliot Aronson)

The NASP convention is a great opportunity to:

- Learn about changes in education policy and law that offer new challenges and opportunities for school-based mental health services
- Expand your ability to serve as a resource for your school/district
- Learn creative approaches to improving outcomes for students with even the most difficult learning, emotional, and behavioral issues
- Stay abreast of the latest research and best practices in the field
- Learn how to access additional funding for school-based mental health services
- Build relationships with other professionals who can be resources for information and ideas throughout the school year
- Train with leading experts on current issues such as culturally competent assessment, positive behavioral supports, school safety, and crisis prevention/response

The program is composed from featured sessions which are specifically relevant to the convention theme, here are some which will be presented:

- Might the Columbine Massacre Have been Prevented? You Bet Your Life!; Elliot Aronson.
- And Words Can Hurt Forever: How to Protect Adolescents From Bullying, Harassment, and Emotional Violence; James Garbarino.
- School Psychology and the Culture Wars: Forty Years of Advocacy, Research, and Practice; Irwin A. Hyman.

There is also special sessions which are sponsored by NASP leadership, symposia presentations which includes three or more papers on a common theme presented together. And of course workshops, they are selected carefully to offer the best in:

- The latest trends and issues in school psychology.
- In-depth coverage, current research, and field tested procedures.
- Intensive skills development.
- A variety of topics for the many different challenges school psychologist face.
- Hands-on learning and discovery.
- Invaluable networking opportunities.

For more information:
NASP 2003 Annual Convention Questions
402-4340 East West Highway
Bethesda MD 20814
Phone: 301 657-0270 ext: 216
Email: mharvey@naspweb.org
Web: www.nasponline.org/conventsions

Academy for Eating Disorders
2003 International Conference on Eating Disorders

May 29-31 2003, Denver, CO.

The theme of the 2003 International Conference on Eating Disorders is Clinical and Scientific Challenges: The Interface Between Eating Disorders and Obesity.

The meeting will be held at the Omni Interlocken Hotel just outside Denver, CO, May 29-31. To make room reservations, call the hotel directly at 303-438-6600 and indicate you are with the AED program to receive a discounted room rate.

There will be Half Day Clinical Teaching Day Workshops, Plenary Sessions:

- Body Weight Regulation
- Eating Disorders and Obesity in the Pediatric Population
- Classification of Eating Disorders
- Treatment of Binge Eating Disorders

Conference Activities:

- Workshop Sessions & Paper Sessions
- Poster Session and Reception & Discussion Panels
- Special Interest Group Meetings & Academy Annual Business Meeting

For an up-to-date listing of audiotapes and CD's, from all of the AED's educational programs, please go to the AED's web site: www.aedweb.org.

For information: www.aedweb.org

Articles

United Nations Special Session on Children: Canadian National Plan of Action

Dear Partners:

In fulfillment of its commitment undertaken at the United Nations Special Session on Children in May 2002, the Government of Canada will be preparing a National Plan of Action.

The Prime Minister has asked the Honourable Anne McLellan, Minister of Health and the Honourable Jane Stewart, Minister of Human Resources Development to accept joint responsibility for the National Plan of Action. The Prime Minister has also asked me to continue as his personal representative to the process. Part of my role is to ensure that we respect our international commitments to children and part of it is to communicate with as broad a representation of Canadian society as possible, including children and youth. This is why I am writing you today.

The document on which our National Plan of Action is to be based is "A World Fit for Children" available on my website at www.sen.parl.gc.ca/lpearson under "What's New?". The best framework for our work is the *Convention on the Rights of the Child* as expressed by Canada in support of the UN General Assembly resolution of November 20, 2002, on the promotion and protection of the rights of children:

Canada firmly believes that our actions must be guided by the Convention on the Rights of the Child. The Convention remains THE instrument of reference, THE essential legislative basis for the achievement of children's rights. The primacy of this approach needs to be strongly reflected in our words and actions to improve the lives of children.

Both the Convention and "A World Fit for Children" strongly support the central role of parents and families in safeguarding the rights of children. Both documents also reinforce the obligation of the State and the duty of all members of society to help families meet their basic needs and fulfill their responsibilities.

As you are aware, the federal, provincial and territorial governments agreed in January 1997 to work together to develop the National Children's Agenda, a comprehensive strategy to improve the well-being of Canada's children. What emerged from public discussions held during 1999 were goals that define what Canadians want for their children in four areas: physical and emotional health; safety and security; success at learning; and social engagement and responsibility. Our National Plan of Action will build on this initiative.

"A World Fit for Children" was negotiated over three years by the nations of the world and adopted by consensus at the Special Session. It comprises three parts: a) Declaration; b) Review of progress and lessons learned; and c) Plan of Action. The Plan of Action focuses on four main themes: i) promoting healthy lives; ii) providing quality education; iii) protecting against abuse, exploitation, and violence; and iv) combating HIV/AIDS.

Within these themes, specific issues are identified which will be of particular interest to many of you -

early childhood care and development, for example, or the role of the media or sexually exploited children.

Outside the specific areas of concern raised by the Action Plan in "A World Fit for Children" there are a number of mechanisms that will have to be in place if the nations of the world are to be successful in improving the situation of the world's children. So the document calls for structures to protect and promote the rights of children at the national level, for capacity building, for research, for monitoring and evaluation. It also underlines the importance of partnerships in creating and implementing National Plans of Action, particularly partnerships with and for children. We will be consulting with as many different categories of groups as possible.

Please take the time to read "A World Fit for Children". When you have read it and focused on your particular areas of interest, we would invite you to imagine the Canada and the world you would like to see in the year 2015. With this in mind then,

1. List your priorities for action on behalf of children either in Canada or abroad or both.
2. Indicate some strategies for getting there.
3. And, from your perspective, identify emerging issues of concern.

A reply by email or written letter (maximum 2 or 3 pages) should be sent to:
The Honourable Landon Pearson
The Senate of Canada
Room 210, East Block
Ottawa, Ontario K1A 0A4
E-mail: pearsl@sen.parl.gc.ca

Face to face consultations in various forms and locations are planned for the spring leading to a second draft which will be posted on my website for comment in June. A final draft will be written in the summer leading to the process of approval necessary for it to be submitted to the United Nations in December 2003.

Sincerely,
Senator Landon Pearson
Advisor on Children's Rights to
The Minister of Foreign Affairs

United Nations Special Session on Children: A World Fit for Us

We want a world fit for children, because a world fit for us is a world fit for everyone. We are not the sources of problems; we are the resources that are needed to solve them. We are not expenses; we are investments. We are not just young people; we are people and citizens of this world. Until others accept their responsibility to us, we will fight for our rights. We have the will, the knowledge, the sensitivity and the dedication. We promise that as adults we will defend children's rights with the same passion that we have now as children. We promise to treat each other with dignity and respect. We promise to be open and sensitive to our differences. We are children of the world, and despite our different backgrounds, we share a common reality. We are united by our struggle to make the world a better place for all. You call us the future, but we are also the present.

A World Fit for Us, May 8, 2002

Gathered in New York on May 5-7, 2002, nearly 400 young people took part in the Children's Forum that preceded the United Nations General Assembly Special Session on Children. Two young delegates to the Children's Forum were chosen by their peers to deliver the powerful statement, *A World Fit for Us,* to world leaders. On May 8th, Gabriela Azurduy Arrieta, 13, from Bolivia, and Audrey Cheynut, 17, from

Monaco, were the first children ever to address the UN General Assembly on a substantive issue.

Between May 7-10, 2002, some 64 heads of state and governments (including two queens, one king and other royalty), 250 parliamentarians from 79 countries, 700 NGOs from 119 countries, and 250 children who were part of the official delegations from 132 countries, came together to chart a course for the future well-being of children, including adolescents. At the opening ceremony, Secretary-General Kofi Annan addressed his remarks directly to the children and youth of the world.

The Canadian delegation was led by Deputy Prime Minister John Manley and comprised: Minister for International Cooperation Susan Whelan; Senator Landon Pearson, Personal Representative of the Prime Minister to the UN Special Session on Children; other Members of Parliament, representatives of UNICEF Canada and the Canadian Coalition for the Rights of Children; and five young persons from across Canada accompanied by a representative from Save the Children Canada.

The General Assembly defined two objectives for the Special Session:

1. A review of the achievements in the implementation of the Declaration and Plan of Action adopted at the 1990 World Summit for Children

2. A renewed commitment and a pledge for action for children in the next decade

A record 193 countries have now signed or ratified the Convention including the USA which has signed but has given no indication that it will ratify soon.

Three Official Roundtables

Three Special Session Roundtable discussions were held on the theme, "Renewal of commitment and future action for children in the next decade".

Canada participated at the second roundtable, co-chaired by Presidents Tarja Halonen of Finland and Vincente Fox of Mexico. One of Canada's five youth delegates, Candis Clarke (Saskatoon), spoke about child and youth participation. More than fifty speakers took part in the meeting, including a number of other child delegates speaking with their country representatives. To encourage frank and uninhibited dialogue, the General Assembly decided to close the roundtables to the media and general public.

The Final Negotiations

Canadian negotiators worked diligently to secure rights-based language within the outcome document, *A World Fit for Children,* during the second and third preparatory committee meetings and a number of intersessionals. In the end, Canadian priority issues for children were incorporated into the document concerning "indigenous children and children belonging to minorities"; "children with disabilities and children with special needs"; "play, sport, recreation, artistic and cultural expression"; and the inclusion of "neglect" in the definition of child abuse. However, Canada registered dissatisfaction with the debate on sexual and reproductive health in a statement, *Canada's Explanation of Position*.

A large portion of the outcome document had already been agreed to by September 2001 before the Special Session was postponed by the events of 9/11. Therefore, the final negotiations focused on certain controversial issues. Important language with respect to the Convention on the Rights of the Child, adolescent reproductive rights, development assistance, humanitarian aid, child labour and the environment was either dropped or weakened during the final negotiations. On the other hand, the European Union managed to get a reference to the abolition of the death penalty for crimes committed by children (para. 44.8). Most of the text, however, is positive, forward-looking and useful.

The last paragraphs of the outcome document were negotiated in the final hours by five groups consisting of the European Union, the SDC (Some Developing Countries), the Like-Minded group (12 developed governments, including Canada), the Rio Group (19 Latin American governments) and the USA. After 24 months of intense negotiations, the UN General Assembly Special Session on Children finally adopted *A World Fit for Children,* by consensus.

The Outcome Document

…a world in which all girls and boys can enjoy childhood – a time of play and learning, in which they are loved, respected and cherished, their rights are promoted and protected, without discrimination of any kind, where their safety and well-being are paramount, and where they can develop in health, peace and dignity.

Endorsement of *A World Fit for Children* commits heads of state and governments to achieving a set of targets for children by 2010. The outcome document includes a declaration, a review of progress and lessons learned and a detailed plan of action. The Plan of Action addresses four major areas: 1) promoting healthy lives; 2) providing quality education; 3) protecting against abuse, exploitation and violence; and 4) combating HIV/AIDS. It outlines how to create a world fit for children through specific goals, strategies and actions; mobilizing resources; and follow-up actions and assessment. These goals and actions are linked to the achievement of the 2015 Millennium Development Goals.

Overall, there are 21 specific targets for child health, education and protection over the next decade.

Goals, Strategies and Action

According to the report of the UN Secretary-General, *We the Children*: "The cost of realizing universal access to health, education and water and sanitation was estimated by the United Nations and the World Bank to be, in 1995 prices, an additional $70-$80 billion per year – easily affordable."

1. Promoting Healthy Lives (only those related to adolescents shown her)

Reduction in the maternal mortality ratio by at least one third, in pursuit of the goal of reducing it by three quarters by 2015.

Reduction in the proportion of households without access to hygienic sanitation facilities and affordable and safe drinking water by at least one third.

Development and implementation of national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health.

Access through the primary health-care system to reproductive health for all individuals of appropriate ages as soon as possible and no later than 2015.

2. Providing Quality Education (only those related to adolescents shown her)

Eliminate gender disparities in primary and secondary education by 2005; and achieve gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.

Improve all aspects of the quality of education so that children and young people achieve recognized and measurable learning outcomes especially in numeracy, literacy and essential life skills.

Ensure that the learning needs of all young people are met through access to appropriate learning and life skills programmes.

Achieve a 50 percent improvement in levels of adult literacy by 2015, especially for women.

3. Protecting Against Abuse, Exploitation & Violence

Protect children from all forms of abuse, neglect, exploitation and violence.

Protect children from the impact of armed conflict and ensure compliance with international humanitarian and human rights law.

Protect children from all forms of sexual exploitation including paedophilia, trafficking and abduction.

Improve the plight of millions of children who live under especially difficult circumstances.

4. Combating HIV/AIDS

By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 percent and by 25 percent globally by

2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.

By 2005, reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010: by ensuring that 80 percent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them; by increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions of HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care.

Canada's Contribution at the Special Session

We have before us the largest and youngest generation the world has ever known with children representing over one-third of the world's population. No less than the survival of this planet – the peace and prosperity in which we all seek to live – depends on the extent of the protection and respect we accord our children. Of all the issues which we face as a global community, there is none more universal than this; none more fundamental; and none more urgent. Speech by DPM John Manley, May 9, 2002

Canada is committed to 'youth participation' and acknowledges the 'meaningful involvement of youth' as an approach to developing responsible citizenship. At the 1990 World Summit for Children, the "right to participation" was not addressed. At the beginning of the Special Session process, Canada identified as a priority the "meaningful participation of children and youth in the preparatory process, both nationally and internationally, as well as during the Special Session". Canada was the ONLY country to include young persons on their official delegation to the First Substantive Session of the Preparatory Committee. And youth were included on all subsequent Canadian delegations to the preparatory committee meetings. During the Special Session, 132 countries included youth on their official delegations; children and youth were everywhere throughout the Session, chairing meetings, questioning their leaders, sharing their experiences and views, making a real difference.

Micronutrient Programmes. Canada announced a contribution to the Global Alliance for Improved Nutrition (GAIN), an international partnership that helps save lives and improve health, productivity and cognitive function by eliminating micronutrient deficiencies.

War-Affected Children in Colombia. During the Special Session, Canada announced a contribution up to $3.5 million over three years to help Colombian children and youth displaced by violence build peace in their country.

Workshop on Discrimination and Disadvantage. The Government of Canada, in cooperation with sponsored a Special Event on Children, Discrimination and Disadvantage. Senator Landon Pearson was invited to give the opening and closing addresses. The panel was chaired by Zuhy Saheed, Canadian Association for Community Living. One of the Canadian youth delegates, Myron Wolfchild, also took part. The purpose of the workshop entitled "Preventing Discrimination Against Children and Ensuring Inclusion of All Children" was to:

- Create an international forum for dialogue on discrimination and disadvantage for children, in light of the Convention on the Rights of the Child and in a way that integrates perspectives on disability, gender and ethno-racial diversity;
- Outline key issues of discrimination and disadvantage, from these perspectives;
- Point towards elements of a common global agenda to address these issues.

Unofficial Discussion Papers. Five thematic papers were prepared by the Office of the Honourable Landon Pearson to further discussion around areas of concern with regard to the UN Convention on the Right of the

Child. Please note that these discussion papers are are not official Government of Canada policy.

1. Child Rights and the Family: What is the Controversy? What does the Convention on the Rights of the Child Say?
2. What does the "best interests of the child" mean?
3. Reflections on "Rights" and "Well-Being" from the Perspective of Child Development
4. What does the 'evolving capacities of the child' mean?
5. A Rights-Based Approach

Millennium Development Goals

By 2015, all 189 United Nations Member States have pledged to:

1. Eradicate extreme poverty and hunger

Reduce by half the proportion of people living on less than a dollar a day;

Reduce by half the proportion of people who suffer from hunger

2. Achieve universal primary education
Ensure that all boys and girls complete a full course of primary schooling.

3. Promote gender equality and empower women
Eliminate gender disparity in primary and secondary education preferably by 2005, and at least at all levels by 2015.

4. Reduce child mortality
Reduce by two thirds the mortality rate among children under five.

5. Improve maternal health
Reduce by three quarters the maternal mortality ratio.

6. Combat HIV/AIDS, malaria and other diseases
Halt and begin to reverse the spread of HIV/AIDS;

Halt and begin to reverse the incidence of malaria and other major diseases.

7. Ensure environmental sustainability
Integrate the principles of sustainable development into country policies; reverse loss of environmental resources;

Reduce by half the proportion of people without sustainable access to safe drinking water;

Achieve significant improvement in lives of at least 100 million slum dwellers by 2020.

8. Develop a global partnership for development
Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. Includes a commitment to good governance, development and poverty reduction – nationally and internationally;

Address the least developed countries' special needs. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral countries committed to poverty reduction;

Address the special needs of landlocked and small island developing States;

Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term;

In cooperation with the developing countries, develop decent and productive work for youth;

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries;

In cooperation with the private sector, make available the benefits of new technologies – especially information and communications technologies.

For more information and the complete list of documents see; at www.sen.parl.gc.ca/lpearson

Pediatricians' Knowledge, Perceptions, and Attitudes towards Providing Health Care for Lesbian, Gay, and Bisexual Adolescents

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Background: Pediatricians are often the first health-care contacts for gay, lesbian, and bisexual adolescents who are developing their sexual orientation.

Objective: This study investigated pediatricians' attitudes and practices towards gay, lesbian, and bisexual adolescents.

Method: We sent anonymous self-administered questionnaires to 112 pediatricians in the Ottawa area.

Results: Of those who responded, 36 per cent reported hav-ing treated lesbian, gay, or bisexual patients, and 70 per cent reported not addressing the issue of sexual orientation. Reservations in discussing sexual orientation were due to fears of offending patients, and a lack of knowledge regarding their needs. Furthermore, 59 per cent of these pediatricians were unfamiliar with community resources for homosexual youths, and 78 per cent reported wanting more information with regards to the care of this population.

Conclusion: Many pediatricians experience difficulties in discussing issues of sexual orientation, and generally feel inadequately prepared to address issues pertaining to the health-care needs of these adolescents. While certain issues remain controversial, the overall attitude of pediatricians towards homosexually oriented patients is positive in that they are interested in becoming more aware of issues of homosexual orientation, to better serve this population.

Introduction

Similar to heterosexual adolescents, many homosexually oriented adolescents first discover their sexuality during adolescence.(1) Pediatricians are in a position to be the first to interact with a gay, lesbian, or bisexual youth regarding issues of sexual and general health. Thus, pediatricians who care for teenagers should understand the medical and psychosocial issues facing homosexually oriented youth.

In coming to terms with their sexual identity, homosexually oriented youths are at a high risk for developing problems that include social isolation, chemical dependency, depression, suicide, sexually transmitted diseases (STDs), running away, and prostitution.(2,3) By identifying the needs of these adolescents, appropriate preventive or supportive measures can be implemented.

While there is growing awareness among pediatricians of a need to address these issues, gaps exist in the knowledge about the health-care needs of homosexual youth in Canada. One survey (5) indicated that pediatric residency programs provide insufficient training to deal with adolescents psychosocial and sexual health needs. Thus, pediatricians display varying levels of comfort in addressing these issues, which may result in insufficient health care.

Although there have been several American studies investigating the care of homosexual youth from a medical perspective,(4) research in Canada has been

limited. Due to differences in demographics and the health-care system, it is difficult to generalize American findings to Canadian populations. Thus, this investigation was conducted to gain more information on pediatricians' attitudes and practices with regard to the health care of gay, lesbian, and bisexual youth in Ottawa.

Methods

The names of pediatricians in the Ottawa area were se-lected from continuing medical education department files. Included with the questionnaire were a letter explaining the purpose of the survey, and a return envelope. Pediatricians were informed that all mail-back responses would remain anonymous and confidential. To increase the response rate, a second mailing was sent eight weeks after the first.

The questionnaire used (4) had been formulated with the aid of two lesbian, gay, and bisexual focus groups in Washington, D.C. It identifies issues of primary importance to pe diatricians, such as knowledge about mental health issues and gay health issues, awareness of insensitive practices including assumptions of heterosexuality and human immunodeficiency virus (HIV) status, and confidentiality.

Written permission was obtained to use and modify East and El Rayess's questionnaire. Modifications were related to differences in health-care systems and demographics. Furthermore, an adolescent was defined as "a youth between the ages of 12 and 19 years of age." The questionnaire was revised and retested by four practising pediatricians with experience in adolescent health. Additional pretesting was conducted on seven medical students and family practice residents. Adjustments were then made to help clarify the questions. The final survey included questions on demographics, practice patterns, attitudes, style of assessment of sexual orientation, awareness of health-care concerns of lesbian, gay, and bisexual adolescents, barriers to delivery of services, current knowledge of available services to homosexual youth in the community, and interest in further training in this area.

Due to the extensive pretesting of East and El Rayess's questionnaire, pilot testing was deemed unnecessary, regardless of the differences in Canadian demographics. Permission was granted to conduct this study by the chairman of the ethics review board of the Children's Hospital of Eastern Ontario Research Institute.

Data were coded for each question, and basic descriptive statistics were computed. Reported percentages were calculated from the total number of responses for each respective question.

Results

We sent questionnaires to 112 pediatricians in the Ottawa area; 61 (55 per cent) responded. Three were returned with unknown addresses, and two specialists declined to complete the questionnaire, as they deemed it inapplicable to their practice (Table 1).

Of those who responded, 37 per cent (n=21) reported seeing between 40 to 100 adolescents, and 63 per cent (n=36) reported seeing <40 adolescents per month. Half of the respondents reported that their training in adolescent medicine was sufficient for their practice needs.

Three percent (n=2) of pediatricians reported taking a patient's sexual history from adolescents under 12 years of age; 40 percent (n=24) between the ages of 12 to 13; 23 per cent (n=14) between the ages of 14 and 15; 10 per cent (n=6) between 16 and 17; and 23 percent (n=14) reported not taking their patients' sexual history. When asked whether sexual orientation was included in the history, 70 percent (n=40) reported that it was not considered, whereas the remainder reported asking about orientation depending on the patient's age (between 12 to 17 years of age). Of respondents, 34 percent (n=20) reported not engaging in safe sex counselling, whereas the remainder reported counselling patients between the ages of 12 to 17.

Two percent (n=2) reported using a questionnaire to approach patients on the issue of sexual orientation, 16 percent (n=12) used nonverbal cues, 28 percent

(21) responded to patients' questions and comments, 24 percent (n=18) asked directly, and 30 per cent (n=23) reported not addressing the issue. Respondents used more than one method to approach the issue. Reservations about discussing sexual orientation were due to a lack of knowledge about the needs of homosexual patients (44 percent, n=22) and the fear of offending patients (44 percent, n=22). Two per cent (n=1) reported that it is the parent's job to discuss such issues, 24 percent (n=11) reported that it may offend the parent, 12 percent (n=5) reported time constraints, and 32 percent (n=16) reported not knowing how to ask the question. While four percent (n=2) of pediatricians reported not attending to any lesbian, gay, or bisexual patients, and 36 percent (n=21) reported seeing homosexually oriented patients, 60 percent (n=33) reported not knowing their patients' sexual orientation. Of the pediatricians who have had patients disclose their homosexuality, 67 per cent (n=16) reported that they always make a note in the patient's chart, 21 percent (n=5) only note it down sometimes, and 12 percent (n=3) reported never noting it down.

All respondents reported that they would never notify the parent if an adolescent reported that he or she was attracted to a person of the same sex. In the event of circum stances that may pose risk to the patient, however, such as having a much older partner, 45 per cent (n=23) of pediatricians would notify the parents.

When asked about familiarity with community re-sources for homosexually oriented youth, 59 per cent (n=34) reported being unfamiliar, 38 per cent (n= 22) were somewhat familiar, and three per cent (n= 2) were very fa-miliar. Furthermore, when tested on their familiarity with Ottawa community resources for gay, lesbian, and bisexual youth, 60 per cent (n=36) of respondents could not recognize any of the services in a multiple-choice selection.

With regards to the care of lesbian, gay, and bisexual youth, 14 percent (n=7) of pediatricians thought that they were knowledgeable, 78 percent (n=43) wanted more information, and 49 percent (n=24) wanted further training. Of pediatricians, 48 percent (n=24) reported never receiving any formal training about lesbian, gay, and bisexual health issues while at medical school or during residency. This holds true for pediatricians trained before the mid-1980s.

The responses of most pediatricians indicated a positive attitude towards homosexuality. This was determined by asking questions presenting stereotypes that are often en countered with homosexuality. Participants were asked true or false questions (Table 2), and were asked about the de-gree to which they agreed with certain statements (Table 3).

Discussion

Adolescence, particularly between the ages of 14 to 16 years, is a period when self identity and sexual orientation develop.(8) Adolescents who are homosexually oriented may undergo stress due to misconceptions about gay, lesbian, and bisexual individuals. Homosexual youth are two to three times more likely to attempt suicide than their heterosexual peers.(9, 10) Furthermore, this group accounts for up to 30 percent of completed suicides among young adults. Because pediatricians are in a position to be the first to interact with these adolescents regarding sexual activity, practitioners must be cognizant of the issues and resources, and be able to openly discuss sexuality issues with their patients.

Standards of care require that all pediatricians who treat adolescents should be able to elicit a comprehensive sexual history. This study indicates that sexual history may not be recorded, and that sexual orientation is infrequently addressed in doctor-patient interviews.

The discussion of sexual orientation with adolescents is a difficult task.(6,7) Despite this, pediatricians in this investigation agreed that discussing homosexuality with adolescents is appropriate, as it could be the first step towards preventing associated medical problems. While almost a third of the respondents reported experience with adolescents disclosing their sexual orientation to them, responses indicate that they probably would have been poorly equipped to deal with these situations.

Pediatricians should be able to direct adolescents to other community services that may provide information and support. Responses in this study, however, show an inade quate awareness of the resources available. Such findings highlight the urgent need to make all pediatricians comfortable enough, both in communication and background knowledge, to maximize the benefits of interaction with adolescent patients. These issues should be addressed through continuing education programs. The need and desire for more information was expressed by most respondents to this study. Those who did not feel the need for more information were generally subspecialists, or pediatricians treat-ing younger patients.

Pediatricians considered issues of confidentiality to be paramount, and would never disclose information about patients to parents, unless extreme circumstances warranted immediate intervention. When seeing adolescent patients, physicians may need to emphasize the confidentiality of the doctor-patient relationship. Once trust is gained, open dis-cussions on sexual orientation may surface. This in turn may prevent the development of maladaptive coping strategies.

This investigation does have several limitations, for example, the use of a self-report questionnaire. Also, since not all pediatricians completed the questionnaire, the findings must be interpreted with caution due to potential response bias. Further exploration is needed to be able to generalize these results. A future study should include other provinces. The information collected in this study, however, is a useful starting point to illuminate important issues in the care of homosexual adolescents in Canada.

Conclusion

This study reveals that the discussion of sexual orien-tation is rare among pediatricians in Ottawa. Pediatricians further report a lack of knowledge regarding available community resources targeted for gay, lesbian, and bisexual youth. These issues should be addressed in continuing education programs to help prevent associated health problems, such as suicidal behavior, psychological maladjustment, and STDs, as the pediatricians in this study indicate a desire to learn more about the needs of their homosexual patients.

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Table1 Frequencies and Percentages of Demographic Features		
Demographic features		N (per cent)
Gender	Male Female	31 (51) 30 (49)
Age	25 to 35 36 to 45 46 to 55 56+	6 (10) 23 (38) 17 (28) 14 (23)
Ethnicity	Caucasian Asian Other	52 (86) 7 (12) 1 (2)
Practice setting	Academic Private clinic Public clinic	34 (56) 26 (43) 1 (1)
Medical school training	Canada Abroad	49 (82) 11 (18)
Year of graduation	1960 to 1969 1970 to 1979 1980 to 1989 >1990	8 (21) 12 (32) 14 (37) 4 (11)

Table 2 Frequency (Percentage) of True or False Statements on Homosexuality		
Statement	True n (per cent)	False n (per cent)
Sexual activity is a poor indication of whether a person is gay, lesbian, or bisexual.	51 (88)	7 (12)
The mean age of self-identification for gays, lesbians, and bisexuals is 19 to 23.	17 (31)	38 (69)
One of three gay and bisexual youths attempt suicide.	39 (72)	15 (28)
Compared with the general adolescent population, gay and bisexual male youths have higher rates of HIV infection.	44 (75)	15 (25)
One should assume that all gay and lesbian adolescents are HIV positive until proven otherwise.	16 (28)	41 (72)
Most lesbian, gay, and bisexual teens trust their doctors with regards to confidentiality.	9 (17)	45 (83)
Many lesbian, gay, and bisexual teens see few circumstances when a doctor needs to know their sexual orientation.	51 (88)	7 (12)
It is important to know and adolescent's sexual orientation and sexual practices before contraceptive counselling.	45 (78)	13 (22)
Lesbian adoelscents are at greater risk of contracting STDs than heterosexual female adolescents.	6 (11)	50 (89)
Few self-identified lesbian women report having had sex with men.	17 (32)	36 (68)
Current recommendations for Pap smear screening are the same for lesbian and heterosexual women.	45 (85)	8 (15)

Table 3
Frequency (Percentage) of Agreement to Statements on Homosexuality

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	18 (31)	15 (25)	14 (24)	5 (8)	7 (12)
2	0 (0)	1 (2)	7 (12)	16 (27)	35 (39)
3	0 (0	2 (3)	12 (20)	13 (22)	32 (54)
4	18 (31)	31 (53)	6 (10)	3 (5)	1 (2)
5	44 (75)	11 (19)	2 (3)	0 (0)	2 (3)
6	39 (67)	13 (22)	6 (10)	0 (0)	1 (2)
7	0 (0)	3 (5)	5 (8)	15 (25)	36 (61)
8	4 (7)	12 (20)	8 (14)	15 (25)	20 (34)
9	25 (42)	22 (37)	9 (15)	2 (3)	1 (2)
10	2 (3)	1 (2)	8 (14)	9 (15)	39 (66)
11	32 (54)	16 (27)	9 (15)	2 (3)	0 (0)
12	0 (0)	0 (0)	11 (19)	15 (25)	33 (56)
13	28 (48)	15 (26)	11 (19)	1 (2)	3 (5)
14	12 (20)	10 (17)	23 (39)	5 (8)	9 (15)
15	4 (7)	6 (10)	17 (29)	17 (29)	15 (25)
16	20 (35)	21 (36)	10 (17)	3 (5)	4 (7)

1. I would be benefical to society to recognize homosexuality as normal.
2. Homosexuals should not be allowed to work with children.
3. Homosexuality is immoral.
4. Homosexuals are mistreated in our society.
5. Homosexuals should have equal opportunity in employment.
6. Homosexuals should be allowed to openly serve in employment.
7. Homosexuality is a mental disorder.
8. Homosexuality endangers the institution of the family.
9. Homosexuals should be accepted completely in our society.
10. Homosexuals should be barred from the teaching profession.
11. There should be no law against homosexual sex.
12. I avoid homosexuals whenever possible.
13. I would feel comfortable treating female homosexual patients.
14. Homosexuals should be allowed to marry.
15. Homosexuals should not be allowed to adopt children.
16. I would feel comfortable treating male homosexual patients.

Pediatric Residents' Knowledge, Perceptions, and Attitudes towards Homosexually Oriented Youth

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Background: Pediatric residents must have clinical exposure and specific training to meet the health-care needs of gay, lesbian, and bisexual adolescents. Homosexually oriented youths have medical and psychosocial needs that these future pediatricians must fulfil.

Objective: This study investigated the knowledge and attitudes of pediatric residents in the management of gay, lesbian, and bisexual youth and related health-care issues.

Method: Twenty-nine pediatric residents at the University of Ottawa were sent a survey questionnaire.

Results: Many respondents indicated that they experience difficulties in discussing issues of sexual orientation, and feel inadequately prepared to address the health-care needs of homosexual youth. Furthermore, respondents showed a lack of awareness regarding resources available to gay, lesbian, and bisexual youth in the community.

Conclusion: While knowledge is limited, residents' atti-tudes towards homosexual youth are generally positive. Also, most respondents indicated an interest in continuing education, and in gaining more information to better serve their homosexually oriented adolescent patients.

Introduction

Many gay and lesbian youths first become aware of their sexuality during adolescence.(1) These adolescents face potential problems such as social isolation, violence perpetrated by homophobic individuals, chemical dependency, depression, suicide, sexually transmitted diseases, running away, and prostitution.(2,3) Many of these problems develop from societal misconceptions about homosexuality, and the resulting fear of disclosing one's sexual orientation. Because pediatricians are in a position to be the first to discuss sexuality with patients, these health-care providers should be knowledgeable and supportive regarding patients' sexual orientation. Training in this area has been minimal in past programs.(5) As future pediatricians, residents can play a paramount role in the development of these youths. Consequently, residents should be instructed to assess sexual orientation, to be cognizant of the stages of homosexual orientation development, and to provide appropriate anticipatory guidance and supportive counselling.(1)

A few residency training programs invite guest speakers from homosexual and bisexual populations to lecture and conduct workshops. This provides an opportunity for group discussion, role playing, and the clarification of myths and stereotypes concerning homosexuality. Open discussions can also help residents overcome covert homophobic attitudes, and develop a gender-neutral language.

While homosexuality was removed as a psychiatric illness from the DSM in 1973, misconceptions still prevail. Despite new convictions about homosexuality as a natural sexual orientation, homosexually oriented youths are still referred for psychoanalysis and psychotherapy to rid them of "notions" that they are homosexual.(4) With adequate training and increased sensitivity, these practices will de-cline.

Homosexual adolescents must be assessed for psychiatric disorders, as should all adolescents if necessary. They must then be referred appropriately for therapeutic intervention.(5) Because homosexually oriented adolescents may face additional stressors, they should be referred to psychiatrists, psychologists, and other professionals who are not only sensitive to and supportive of the special needs of adolescents, but who are also aware of the stages of homosexual development. Such caregivers should be identified before youths and their families are referred for supportive care. The gay and lesbian communities of all regions in Canada have directories and Web sites that list community resources and information. It is uncertain, however, whether these resources are made known to residents.

This investigation explores the knowledge, perceptions, and attitudes of pediatric residents regarding the health-care needs of gay, lesbian, and bisexual youths in Ot-tawa.

Methods

All pediatric residents from the July 1999 to June 2000 academic year (n=29) at the University of Ottawa received the questionnaire during an academic half-day session. Included with the questionnaire was a letter explaining the purpose of the survey, and a return envelope to mail back the survey anonymously. There was a second distribution of surveys at a half-day session approximately four weeks after the first, to increase the response rate.

We used a questionnaire developed by East and El Rayess (6) that was modified to suit the Ottawa pediatric residency program. Written permission for the use of the questionnaire in this study was obtained from Dr. East.

The questionnaire was pre-tested on family practice residents. As with the original East and El Rayess questionnaire, the survey items included demographics; awareness of health-care needs; barriers to care; and concerns of lesbian, gay, and bisexual adolescents. In addition, methods of addressing these concerns and interest in further training were investigated.

Data were coded for each question, and basic descriptive statistics were computed. Reported percentages for each question were calculated from the total number of responses for each respective question.

Results

Of the 29 questionnaires that were handed out, 19 (66 per cent) were completed and returned (Table 1).

Of those who responded, 74 per cent (n=14) had completed an adolescent medicine rotation. Overall, 37 per cent (n=7) reported adequate exposure to adolescent patients, and 63 per cent (n=12) reported inadequate exposure. Of the respondents who had completed a rotation specific to adolescent medicine, 43 per cent (n=6) reported that their exposure was adequate. Of participants, 63 per cent (n=12) have had gynecological examinations as part of their training.

The age at which residents routinely start taking patients' sexual histories ranged from 12 years to 17 years of age: 16 per cent (n=3) reported beginning at an age younger than l2; 32 per cent (n=6) reported taking a sexual history between the ages of 12 and 13; 47 per cent (n=9) reported beginning between the ages of 14 and 15 years; and five per cent (n=1) reported starting between the ages of 16 and 17. While all respondents reported taking patients' sexual history, 26 per cent (n=5) would not conduct abstinence counselling, and five per cent (n=1) would not conduct safer sex counselling.

When asked whether they would include questions about sexual orientation in taking sexual histories, 37 per cent (n=7) of respondents reported that they would exclude it. With regards to how the issue of sexual orientation is approached, 53 per cent (n=10) reported that they asked directly, five per cent (n=1) reported the use of a written questionnaire, 16 per cent (n=3) reported responding to nonverbal cues, and 37 per cent (n=7) reported that they responded to patients' questions or comments. Many respondents had reservations about approaching the issue of sexual orientation (Table 2).

When asked whether a lesbian, gay, or bisexual patient has ever disclosed their sexual orientation, 3 7 per cent (n=7) reported yes, of whom 14 per cent (n=1) reported not noting it down in the patient's file. Of the respondents, 21 per cent (n=4) reported that they had an adolescent patient who was questioning sexuality, and who discussed the matter with a resident. Overall, 63 per cent (n=12) reported treating a homosexually oriented patient.

All respondents reported that they would never notify an adolescent's parent if the adolescent had reported he or she were attracted to a person of the same sex. In the event of extreme circumstances, such as a significantly older part-ner, 42 per cent (n=8) of pediatric residents would notify the parents.

Formal training regarding issues of sexual orientation occurred in medical school via lectures or workshops for 52.6 per cent (n=10) of the respondents, while 42 per cent (n=8) had no specific education in this area. Of the respondents, 32 per cent (n=6) reported that they had received either a lecture or other form of teaching on the topic of health care needs of homosexual youth.

When asked about familiarity with community resources for lesbian, gay, and bisexual youths, 58 per cent (n=11) reported being unfamiliar, and 42 per cent (n=8) reported being somewhat familiar with such resources. In a multiple-choice question, however, only 21 per cent (n=4) could recognize that the Pink Triangle, P-Flag (parents for lesbian and gays), The Jewish Lesbian Group and Gay Asians, and Friends in the Capital were all resources avail-able in the Ottawa region.

While 68 per cent (n=13) of respondents felt that they were not knowledgeable in the area of lesbian, gay and bisexual youth health issues, 89 per cent (n=17) reported a de sire for more information, and 89 per cent (n=17) reported a desire for further training in this area.
Overall, the responses indicated that general attitudes toward homosexuality were positive (Tables 3, 4).

Discussion

This study identified the training needs essential for improving the skills, comfort level, and awareness of pediatric residents with regards to the health-care needs of homosexual youth. All pediatric residents who treat adolescents should be able to elicit a comprehensive sexual history, including questions about sexual orientation. Unfortunately, 37 per cent of respondents did not think it necessary to ask at any age about sexual orientation. This may be attributed to reservations in asking what may be perceived as a personal question. In addition, the age of self awareness of sexual orientation was identified by 21 per cent of residents to be in the range of 19 to 25 years, when the established age is 14 to 16 years. This error may lead a resident to miss the opportunity to address the developmental needs of younger homosexual adolescents. (10)

To help homosexually oriented adolescent patients, pediatric residents should not only feel comfortable in their manner of communication, but must also attain background knowledge regarding resources. This investigation demonstrated a poor awareness of community resources available for gay, lesbian, and bisexual youths. Pediatric residents must be better educated about the available resources to help direct their adolescent patients to social supports.

Pediatric residency programs need to inform residents about the high risk of suicide attempts in gay and lesbian youth. Research indicates that one in three homosexual and bisexual youth attempt suicide each year. (7,8) While many pediatric residents are aware of this statistic, its implications must be highlighted in clinical practice. Indeed, increased awareness is necessary to identify possible psychological problems or maladjusted behaviours in these adolescents, and to help reduce the risk of suicidal behaviour.(9)

Pediatric residents considered issues of confidentiality to be paramount, and would never disclose patients information to parents, unless under extreme circumstances warranting immediate intervention. (11) Furthermore, respondents indicated the need for more information about sexual orientation and available services.

Conclusion

The pediatric residents' responses revealed that the discussion of sexual orientation is difficult for many. Residents also reported a lack of knowledge, and a lack of confidence in the ability to approach the topic of gay and lesbian health issues, and to direct the adolescent to the appropriate resources.(12) These issues must be addressed in training to help prevent and manage associated health problems among this youth population. Most importantly, however, the pediatric residents surveyed indicated a desire to learn more and to better understand the needs of their homosexual patients.

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Table1
Frequencies and Percentages of Demographic Features

Demographic features		N (per cent)
Gender	Male	13 (68)
	Female	6 (32)
Age	21 to 25	3 (16)
	26 to 30	14 (74)
	31 to 36	2 (10)
Ethnicity	Caucasian	14 (74)
	Asian	1 (5)
	Other	4 (21)
Years of training	First	3 (16)
	Second	3 (16)
	Third	4 (21)
	Fourth	9 (47)
Medical school training	Canada	19 (100)
	Abroad	0 (0)
Year of graduation	1995 to 1969	2 (11)
	1997 to 1979	5 (26)
	1999 to 1989	2 (11)
	2001 to 2002	4 (21)
	No answer	6 (31)

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Table 2
Pediatric Residents' Reservations Regarding Discussing Issues of Sexual Orientation with Adolescent Patient

Cause of reservation	**n (per cent)**
It is inappropriate at this age	1 (5)
It is solely the parent's job	0 (0)
It may offend parents	6 (32)
It may oofend patients	6 (32)
It's against my religion	0 (0)
It would take too long	2 (11)
I don't know how to ask the questions	5 (26)
I don't know enough about their needs	9 (47)

Table 3
Frequency (Percentage) of True or False Statements on Homosexuality

Statement	True n (per cent)	False n (per cent)
Sexual activity is a poor indication of sexual orientation.	19 (100)	0 (0)
The mean age of self-identification for gay and bisexual males 19 to 23.	5 (26)	14 (74)
One of three gay and bisexual youths attempt suicide.	17 (89)	2 (11)
Compared with the general adolescent population, gay and bisexual male youths have higher rates of HIV infection.	10 (56)	8 (44)
One should assume that all gay and lesbian adolescents are HIV positive until proven otherwise.	0 (0)	18 (100)
Most lesbian, gay, and bisexual teens trust their doctors's confidentiality.	5 (26)	14 (74)
Many lesbian, gay, and bisexual teens see few circumstances when a doctor needs to know their sexual orientation.	18 (95)	1 (5)
It is important to know and adolescent's sexual orientation and sexual practices before contraceptive counselling.	2 (11)	17 (89)
Lesbian adoelscents are at greater risk of contracting STDs than heterosexual female adolescents.	0 (0)	19 (100)
Few self-identified lesbian women report having had sex with men.	14 (74)	5 (26)
Current recommendations for Pap smear screening are the same for lesbian and heterosexual women.	0 (0)	19 (100)

Table 4
Frequency (Percentage) of Agreement to Statements on Homosexuality

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	11 (58)	5 (26)	1 (5)	1 (5)	1 (5)
2	0 (0)	0 (0)	0 (0)	5 (26)	14 (74)
3	0 (0	0 (0)	0 (0)	8 (42)	11 (58)
4	8 (42)	10 (53)	1 (5)	0 (0)	0 (0)
5	16 (84)	3 (16)	0 (0)	0 (0)	0 (0)
6	15 (79)	4 (21)	0 (0)	0 (0)	0 (0)
7	0 (0)	0 (0)	1 (5)	8 (42)	10 (53)
8	0 (0)	1 (5)	1 (5)	10 (53)	7 (37)
9	11 (58)	6 (32)	2 (11)	0 (0)	0 (0)
10	0 (0)	0 (0)	0 (0)	5 (26)	14 (74)
11	11 (58)	7 (37)	0 (0)	0 (0)	1 (5)
12	0 (0)	0 (0)	0 (0)	6 (32)	13 (68)
13	10 (53)	8 (42)	1 (5)	0 (0)	0 (0)
14	8 (42)	6 (32)	5 (26)	0 (0)	0 (0)
15	0 (0)	2 (11)	5 (26)	3 (16)	9 (47)
16	10 (53)	9 (47)	0 (0)	0 (0)	0 (0)

1. I would be benefical to society to recognize homosexuality as normal.
2. Homosexuals should not be allowed to work with children.
3. Homosexuality is immoral.
4. Homosexuals are mistreated in our society.
5. Homosexuals should have equal opportunity in employment.
6. Homosexuals should be allowed to openly serve in employment.
7. Homosexuality is a mental disorder.
8. Homosexuality endangers the institution of the family.
9. Homosexuals should be accepted completely in our society.
10. Homosexuals should be barred from the teaching profession.
11. There should be no law against homosexual sex.
12. I avoid homosexuals whenever possible.
13. I would feel comfortable treating female homosexual patients.
14. Homosexuals should be allowed to marry.
15. Homosexuals should not be allowed to adopt children.
16. I would feel comfortable treating male homosexual patients.

Canadian Health Network
and
Youth Gambling

What is the Canadian Health Network?

CHN is a national, non-profit, bilingual web-based health information service. CHN's goal is to help Canadians find the information they're looking for on how to stay healthy and prevent disease. CHN does this through a unique collaboration - one of the most dynamic and comprehensive networks anywhere in the world. This network of health information providers includes Health Canada and national and provincial/territorial non-profit organizations, as well as universities, hospitals, libraries and community organizations.

CHN's mission is to support Canadians in making informed choices about their health, by providing access to multiple sources of credible and practical e-health information.

Its vision is to become "Your preferred choice in Canada for helpful, e-health information you can trust."

CHN's core values are:

- To maintain health information as a public good
- To not recreate existing health information
- To present quality, credible, and practical information from multiple perspectives
- To be socially-inclusive and respectful of diversity
- To exemplify ethics and integrity

CHN offers:

- Links to more than 12,000 English and French Canadian web-based resources that pass a rigorous quality assurance process to ensure that the information is timely, accurate, and relevant.
- In-depth information on 26 key health topics and population groups, with resources on how to stay healthy and prevent disease and injury.
- High-quality national health information, and regional resources from Canada's provinces, territories and local communities.
- Information on societal health issues such as violence prevention, environmental health and workplace safety.
- Monthly feature articles on current health issues, special guest columnists, and 'behind the news' information and analysis.
  CHN is non-commercial and assures complete privacy and confidentiality.

CHN offers many search choices to explore its large collection of Canadian health resources in either English or French.

CHN helps users take a critical look at other health web sites, with tools to assess their accuracy, timeliness, relevance and possible bias.

Another checklist aims to show Canadian consumers and health intermediaries what to look for in a health-promoting Web site.

CHN's Advisory Board reflects the diversity that makes CHN a network of health information networks. Members of the Advisory Board come from both within and outside government, and represent a broad cross-section of Canadians in terms of age, language, gender, cultural background, occupation, and geography. The Advisory Board helps to guide the growth and evolution of the network by making recommendations to the Deputy Minister of Health on future strategic directions.

The CHN address is www. Canadian-health-network.ca

The Youth Section of the CHN website

Youth is a vital period for developing skills and a sense of self that will influence future directions in health, life, work, and relationships. Youth is defined as anyone between the age of 12 and 24.

Once connected to the CHN website, one can click on Youth in the list of 8 groups offered (children, men, women, seniors, etc.). The Youth section of CHN is designed to meet the health information needs of youth, their parents and adults who work with youth.

A Youth Affiliate consortium is responsible for developing this section of the CHN website: The consortium is composed of: TeenNet, University of Toronto; The Canadian Association for Adolescent Health and la section de médecine de l'adolescence de l'hôpital Ste-Justine, Montréal; Kids Help Phone; McCreary Center Society, Vancouver; the Adolescent Division of the Toronto Sick Children Hospital.

The Youth Section offers 706 resources in English: some are documents describing a problem or the solution to a problem, some are giving access to website of interest, some are giving tips on the prevention of certain health condition. You will find an FAQ zone with answers to questions on dating, suicide, relationships and others. In the guided search zone, the surfer can access the 706 resources or choose from a list of 19 topics and thus access the related resources: sexuality, active living, healthy eating, substance use, violence, injury prevention, STD, workplace, relationships, mental health and others. There is also a keyword search and a quick search. By clicking on the quick search, the surfer can choose from a list of interesting topics and access the related resources: youth and sexuality, youth and suicide, youth and stress, etc.

As an example, we present a resource that one can find in the quick search under Youth and Gambling.

The new gambling environment

Today's youth are the first generation to grow up in an environment of legalized gambling in Canada. Government-owned gambling outlets such as casinos, slot machines, and video lottery terminals expanded dramatically during the 1990's. The expansion of legalized gambling has continued into the 21st century. Governments see gambling as an excellent source of new revenues, without taxation. As the number of gambling venues increases, so do the number of gambling-associated problems. We are just starting to come to terms with how this new gambling environment is impacting on the lives of youth.

Youth problem gambling a growing concern

Approximately 70% of Canadian youth engage in some form of gambling. Gambling is not always a negative activity for youth if it is done for recreational purposes and if it is done within limits. It is when it turns into problem and pathological forms of gambling that there is concern. What is of concern in recent years is the high and steady rate of problem gambling among youth. These rates are higher than the rates of adults. Recent research shows that 4.8% of adolescent gamblers are categorized as pathological, and 14.6% are categorized as problem gamblers.

According to McGill University's International Centre for Youth Gambling and High-Risk Behaviours:

- More males gamble than females;
- The rate of problem gamblers among youth is two to four times that of adults;
- Gambling problems among youth are associated with poor coping skills;
- Youth with serious gambling problems are at a greater risk for thoughts of suicide and suicide attempts; and
- The shift from social to problem gambling is more rapid for youth.

Gambling takes on many guises in terms of both legal forms (publicly regulated) and illegal forms. Youth do not typically have access to most legal forms of

gambling because of age restrictions or because they do not have the credit cards required to participate in online forms of gambling. Nonetheless there is increasing evidence that not only are underage minors participating in these activities, but also that they are doing so with other adult family members.

Why youth gamble

Youth do not gamble only with money. Youth also gamble with other items that they deem of value, which could include running shoes, CDs, Discmans, etc. As well, youth do not gamble for financial rewards alone, they also do it for a whole range of reasons, including the 'rush' of it and the self-esteem of proving they can be 'winners'.

Youth gamble for enjoyment, to win money, excitement, to make friends, and for relaxation. According to recent research, youth problem gamblers are more likely to gamble to escape problems, unhappiness or loneliness than social or recreational youth gamblers. Certain risk factors such as substance abuse, juvenile delinquency and problems at school also have been associated with problem gambling among youth.

Signs and symptoms of problem gambling

Gambling problems among youth can have an impact on families and communities. Youth gambling problems can be associated with substance abuse, depression, suicide and crime. They can cause relationship difficulties and problems at school. Some signs of gambling problems include:

- Spending large amounts of time gambling,
- Placing larger and more frequent bets,
- "Chasing" losses,
- Emotional highs and lows,
- Gambling over other activities,
- Growing debts, and
- Preoccupation with gambling.

Lack of awareness among health professionals, teachers, and the general public, as well as a lack of screening tools, has led to an under-appreciation of the problem of youth gambling.

Keeping it safe

Youth gambling is an emerging public health issue. We are only at the beginning stages of recognizing its importance, impact and relationship to other mental health issues and addictive behaviours.

At the University of Toronto, the TeenNet project, based in the Department of Public Health Sciences, has focused its research on using technology for health promotion with youth. The newest TeenNet website, www.YouthBet.net, was launched in May 2002. This website addresses youth gambling problems from a prevention, harm reduction and health promotion perspective. The goal is to promote informed, balanced attitudes and behaviours about youth gambling; prevent youth gambling related problems, and to protect vulnerable and at-risk youth.

The health promotion approach addresses both the positive and the negative dimensions associated with youth gambling. Youth can learn competencies in the areas of numeracy, literacy, and decision-making, as well as coping strategies for disappointment, loss and winning. There is an opportunity to promote self-efficacy and informed choice around leisure and lifestyle decisions and health behaviours.

The Youth Bet website features a neighbourhood scene representing the areas where gambling occurs in the lives of youth. Environments featured on the site include a schoolyard, a back alley, a corner store, a casino, a library, and a community centre. The site includes games on money management, time management, and decision making skills; gambling assessment tools; a risk perception tool; and information on odds, randomness and probability. There is a range of information on the site including signs of gambling problems, definitions of gambling, stories about winning and losing, information on the gambling industry, information on Internet gambling, and links to other gambling organizations. Help resources are located in each area, including links to telephone help lines and links to the gambling bulletin board where they can talk to other youth about gambling and related issues.

Publications

Medico-Legal Reporter

The publication: A monthly review of the most recent legal decisions with implications for Medical Professionals, Licensing/Disciplinary Bodies, Medical Institutions, Professional Associations, Government, Faculties of Medicine and Nursing, Unions, Insurers and their Legal Council.

The Online Research Service: A free service which allows subscribers to search by topic or with a search engine and find, review and print articles published in previous volumes.

For more information:

Health Law Infosource
Box 72038, RPO Glenmore Landing
Calgary, Alberta T2V 5H9
www.edlawcanada.com

Sexually Transmitted Diseases Treatment Guidelines 2002

These guidelines for the treatment of patients who have sexually transmitted diseases (STDs) were developed by the Centers for Disease Control and Prevention (CDC) after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on September 26–28, 2000. The information in this report updates the 1998 Guidelines for Treatment of Sexually Transmitted Diseases (MMWR 1998;47[No. RR-1]). Included in these updated guidelines are new alternative regimens for scabies, bacterial vaginosis, early syphilis, and granuloma inguinale; an expanded section on the diagnosis of genital herpes (including type-specific serologic tests); new recommendations for treatment of recurrent genital herpes among persons infected with human immunodeficiency virus (HIV); a revised approach to the management of victims of sexual assault; expanded regimens for the treatment of urethral meatal warts; and inclusion of hepatitis C as a sexually transmitted infection. In addition, these guidelines emphasize education and counseling for persons infected with human papillomavirus, clarify the diagnostic evaluation of congenital syphilis, and present information regarding the emergence of quinolone-resistant Neisseria gonorrhoeae and implications for treatment. Recommendations also are provided for vaccine-preventable STDs, including hepatitis A and hepatitis B.

You can get a copy of the guidelines at the CDC website: www.cdc.gov/STD/treatment/default.htm

Sexuality and Disability Webliography

The Wellness and Disability Initiative of the British Columbia Coalition of People with Disabilities is pleased to announce the publication of its first web-based bibliography "Sexuality and Disability Webliography".

Available in both HTML and a 50 page PDF format, the webliography may be found at http://www.bccpd.bc.ca/wdi/sex&dis.html.

This extensive listing of resources available on the internet includes curricula, articles, books, newsletters, magazines, videos, audiotapes, websites, discussion forums, organizations, programs, practitioners and researchers worldwide. Specialized topics include 16 types of disability, and resources on children and youth, women, gay and lesbian, and sexual abuse assault.

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA), in its continuing efforts to promote better mental health for all Americans, has responded to these mental health concerns and created a set of fact sheets especially for families coping with crisis. These fact sheets are now available to the public in print and on SAMHSA's National Mental Health Information Center Web site.

Simple Strategies for Families Coping with Crisis and Uncertainty, at www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0137/default.asp, provides practical coping strategies for families.

Age-specific Interventions at Home for Children in Trauma: From Preschool to Adolescence, at www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0138/default.asp, suggests age-appropriate activities to help children share recovery feelings and experience at home.

The Long-term Impact of a Traumatic Event: What to Expect in Your personal, Family, Work, and Financial Life at www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0139/default.asp, cites examples of personal uncertainties, family relationship changes, work disruptions, and financial worries that may contribute to the long-term impact of traumatic event.

Anniversary Reactions to a Traumatic Event: The Recovery Process Continues, at www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0140/default.asp, describes common anniversary reactions among victims of traumatic events and their role in the recovery process.

Printed versions of these fact sheets can be obtained by contacting the National Mental Health Information Center at
Phone: 1-800-789-2647
Fax: 301-984-8796
Email: ken@mentalhealth.org