

ADOLESCENT HEALTH CARE — IS IT A FORGOTTEN AND NEGLECTED FIELD? CHALLENGES FOR THE TWENTY FIRST CENTURY. A REVIEW OF THE LITERATURE



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ABSTRACT

A large number of article reports have identified many gaps in adolescent health care. Adolescents/ teenagers represent a large proportion of the population and therefore have the potential for considerable morbidity, yet no coherent health strategies /policies exist in the majority of countries to cater for this age group.

This paper examines the areas that calls for concern and identifies some of the gaps in providing adolescent health care. Adolescents are a unique group, neither children nor adults and yet adolescent health care seems to be lumped together or included in paediatrics or adult health care. Other age categories seem to be planned for such as infants, under fives, adults and the aged. More changes take place in adolescence than in any other life stage, except for infancy. Without a wellness program or schedule the adolescent will continue to represent an underserved population. A lack of confidentiality, knowledge and attitude of health professionals, wellness programs relevant to adolescents and accessibility to health care are issues discussed in this paper. These were some of the many gaps identified in the literature and were seen as challenges to the health care professionals of the twenty first century.

This paper was delivered at an international conference with the theme: Improving adolescent health: Nurses and Midwives working in partnership with communities. The title of the paper presented was Adolescent health care: Is it a forgotten and neglected field? Challenges for the twenty first century.

UITREKSEL

Die leemtes in die gesondheidsorg van adolessente word in 'n groot aantal artikels aangedui. Adolessente/tienderjariges verteenwoordig 'n groot gedeelte van die populasie en vir hierdie rede bestaan die potensiaal vir 'n opmerklike morbiditeit. Nieteenstaande die bogenoemde feit bestaan daar geen samebindende gesondheidsstrategieë/ beleid vir hierdie ouderdomsgroep in die meerderheid van lande nie.

Hierdie artikel ondersoek die areas van belang en identifiseer sommige leemtes in die lewering van adolessente gesondheidsorg. Adolessente is 'n unieke groep, nie meer kinders nie en ook nie volwassenes nie. Tog word adolessente gesondheidsorg saamgevoeg of ingesluit in pediatrie of onder volwassegondheidsorg gekategoriseer. Ander ouderdomsgroepe word gekategoriseer as babas, onder vyfs, volwassenes en bejaardes. Met die uitsondering van babas vind meer veranderinge in adolessente as in enige ander lewensfase plaas. Sonder 'n gesondheidsprogram of 'n skedule sal adolessente steeds gereken kan word as 'n ondervoorsiene populasie in gesondheidsdienste. Gesondheidsorg aspekte soos die gebrek aan vertroulikheid, kennis en die benadering van professionele gesondheidsorgpersoneel, gesondheidsprogramme wat op adolessente van toepassing is en die toeganklikheid van gesondheidsdienste word in hierdie artikel bespreek. Hierdie is sommige van die leemtes wat in die literatuur geïdentifiseer is en wat as uitdagings vir professionele gesondheidsorgpersoneel in die een-en-twintigste eeu gesien kan word.

Hierdie artikel is voorgedra by 'n internasionale konferensie met die tema: Improving adolescent health: Nurses and Midwives working in partnership with communities. Die titel van die voordrag was Adolescent Health Care: Is it a forgotten and neglected field? The challenges for the twenty first century.

INTRODUCTION

The World Health Organisation (WHO) defines adolescence as the period between the ages of 10 and 19 years. This stage is further broken down into two groups i.e. young people, 10 to 14 years, and youth, 15 to 24 years (International Nursing Review 1997:78). At present more than 50% of the world population is below the age of 25 years. Some 80% of the world's one and a half billion young people are between the ages of 10

and 24 years (Friedman 1993:510).

Adolescence is a period of great risks and opportunities. The dramatic biological changes that accompany this transition have always been the same but the social context in which they now occur is very different from earlier times and continues to change rapidly thus adding to the risks and stresses of adolescent life (Millstein, Nightingale, Petersen, Mortimer and Hamburg 1993:1413).

More changes take place in adolescence than in any other life stage, except for infancy, in anatomy, physiology, mental and emotional functioning and social development. The passage to adult life from adolescence is a time of internal turmoil. The growing adolescent must be able progressively to shed the sheltered environment of childhood days and achieve self-reliance and independent living as a decision-maker (Schidlow & Fiel, 1990:1113).

It has been said that society is ultimately judged by its attention to its weakest members. Whilst not our weakest, the adolescent are the most vulnerable members of our society as they make the transition from childhood to adulthood (Editorials, 1993:1425).

OBJECTIVES OF THIS PAPER

The purpose of this paper is to identify some of the gaps in adolescent health care and to suggest strategies to improve the health of adolescents. Gaps, deficits, neglected and forgotten areas and barriers are used synonymously in this paper.

Literature review reveals numerous gaps in the health care services for adolescence but only four will be identified and presented here. The most frequently mentioned issues in the literature are:

- Confidentiality
- Knowledge and attitude of health professionals
- Wellness program for adolescence/preventative and promotive health programs
- Access to health care

GAPS IN ADOLESCENT HEALTH CARE

Confidentiality

This term refers to the privileged and private nature of information provided during the health care transaction. It is the cornerstone of the patient-health provider relationship and is essential to the adolescent's trust in the health care provider and thus to the willingness to supply information candidly to his or her benefit. Adolescents are more likely to seek necessary treatment, particularly issues of a sensitive nature, if they can do so without their parents' knowledge (Council Report, 1993:1420; Taylor, Miller & Moltz, 1991:724; English, 1990:1103). Confidentiality must not be seen, however as a desire to conceal information from parents, but like adults, adolescents also have a general desire for privacy and confidentiality in their relationship with the health worker. It is an expression of the process of individuation which adolescents are undergoing. This need for privacy should be seen as part of normal adolescent development in which the adolescent learns to assume greater responsibility for his or her own health. When the health care provider finds the adolescent capable of autonomous decision-making, he or she can

be treated as a full partner in the patient-health care provider relationship and this encourages open communication of information between the health care provider and the adolescent. Lack of confidentiality is a significant access barrier to health care (Proimos, 1997:326; Igra & Millstein, 1993:1415; English, 1990:1103-1104). A majority of adolescents have concerns they wish to keep confidential and have reported that they would not seek health services because of the confidentiality of these concerns.

In a survey carried out in New York (Cheng, Savageau, Sattler & Dewitt, 1993:1404) teenagers stated that if:

Parental knowledge was mandatory only	If assured of confidentiality an additional
45% would seek help for depression	18% would seek help for depression
19% for birth control	50% for birth control
15% for STD's	no figures reflected
17% for drug usage	49% for drug usage

Payment for services received by adolescents can also be a barrier to confidential care as often adolescents rely on parents' medical insurance. The insurance claim usually lists the services provided to the adolescent and would thus breach confidentiality (Cheng *et al.* 1993:1405). Perhaps publicly funded programs should be available for the adolescent.

The health care delivery system must be structured to allow confidentiality, with mechanisms for appointment scheduling, billing, record keeping and follow-up that allow privacy for adolescents. Adolescents need to be educated regarding their rights to confidential health care and how to access that health care.

The Council of Scientific Affairs made the following recommendations to the American Medical Association regarding confidentiality:

- the Council reaffirms that confidential care is critical to improving the health of adolescents;
- health workers should be encouraged to allow emancipated or mature minors to give informed consent for medical and psychiatric care without parental notification and for this to be in line with state laws;
- parents should be involved in medical care when it is in the best interest of the adolescent;
- health workers should discuss policies about confidentiality with parents and adolescents including financial arrangements for independent access to health care;
- adolescents should be allowed an opportunity for examination and counselling apart from parents;

- State medical societies should be informed of laws and regulations regarding confidentiality; and
- health care payers should develop a method of listing of services that preserves confidentiality for adolescents (Council Report, 1993:1422).

Health care providers must also be educated about consent and confidentiality guidelines. They need to be sensitive to confidentiality issues in interactions with adolescents and parents. This does not necessarily mean that parents have to be excluded during the interview of the adolescent. Parents and adolescents can be interviewed together, especially if the adolescents are young, handicapped or have complex chronic illnesses. Private time should then be made available to adolescents to discuss sensitive issues.

Knowledge and attitudes of health professionals

After confidentiality, the knowledge and attitude of health professionals seem to be the next barriers to health care provision to teenagers. There is rising concern over the competency of health care professionals to meet the health needs of adolescents (Taylor, Miller & Moltz, 1991:723; Levenson, Pfefferbaum & Morrow, 1987:171; Veit, Sanei, Coffey, Young & Bowes, 1996:132; Klitsner, Borok, Neinstein & Mackenzie, 1992:630).

Insufficient training by doctors, nurses, social workers, psychologists and nutritionists was identified in the areas of eating disorders, sexual orientation, conflict issues, school based problems, behaviour problems, chronic illnesses, delinquency, drug use, obesity, anorexia, bulimia, high risk behaviours and development. Family physicians who often provide care to adolescents felt they were not well trained to deal with many of the psychosocial problems of adolescents as these are often not considered to be medical. Disorders seen in adults and in the youth present different management opportunities depending on the developmental stage of the adolescent (Figueroa, Kolasa, Horner, Murphy, Dent, Ausherman & Irons, 1991:443; Millstein, Nightingale, Petersen, Mortimer & Hamburg, 1993:1414). This is further complicated by the fact that the physical morbidity of youth are increasingly related to social malaise.

The more sensational adolescent health issues of adolescent pregnancy, drug abusing teenager, and the "run away" are dealt with more often than the skills required in the more routine aspects of development and prevention such as sex counselling, substance abuse prevention and family conflict. Such skills are grounded in a fundamental understanding of normal behaviour, development and the physiology of normal growth. A basic understanding of the interaction among sociology, psychology, physiology and an appreciation that each offers valid and important insights to understanding morbidity and health is needed (Blum & Bearinger, 1990:292; Schuster, Bell, Petersen & Kanouse, 1996:910).

Few professions mandate any significant adolescent health content in training their clinicians, yet once in practice,

providers are faced with the multiple health care problems of the youth.

Discomfort and lack of preparation were the major reasons given for avoiding services to adolescents. Deficits of providers need to be met in their professional training. Early exposure to adolescents within their professional training might help providers to be more receptive to young people (Friedman, 1993:512).

There is a need for health workers to be specifically trained to teach adolescents in developmentally appropriate ways. An organised curriculum in adolescent health care needs to be included for all health professionals. Many of adolescents' problems are as a result of developmental needs being satisfied within a social ecology that is hazardous to their health. A traditional approach to problem intervention focussed on the presenting symptom complex will afford only interval relief. An integrated, developmentally sensitive and bio-psycho-socially based approach however explores the origins of the problems, thus leading to a more comprehensive management plan (Millstein *et al.* 1993:1415).

Interpersonal communication with the adolescent requires a special skill, as s/he is in an in-between age, neither child nor adult. Effective interviewing skills are necessary as adolescents are acutely self-conscious, have a short time perspective and many have a limited ability to understand abstract concepts. How much to involve parents requires the judgement of the health care provider, which needs to be individualised for each case. The skills required are therefore complex and need to be flexible (Coupey, 1997:1355).

How to communicate effectively with the adolescent is of vital importance for client outcome i.e. diagnosis and management. Psychosocially orientated interviewing techniques i.e. asking direct questions about psychosocial issues, making statements of support and reassurance, and making statements indicating sympathetic and attentive listening are necessary. Health care providers need to develop the non-verbal skills of recognising and expressing emotions accurately as well as techniques of verbally communicating sensitivity to patient's feelings (Coupey, 1997:1356).

Research indicates that stress, depression, anxiety and health concerns are recurrent themes that may be translated into somatic concerns. The teenager may present one concern but it may be another issue entirely with which he or she wants assistance. It is imperative for the health care provider to identify the hidden agenda during the visit. The somatic complaint may be the "ticket of entry" to the health service for the adolescent (Mackenzie, 1990:1093). A study of male adolescents found that 26% of clients had documented gonococcal disease but only 8% offered a genito-urinary complaint. It is also important to teach teenagers how to ask for assistance and for health care providers to know how to offer assistance without a direct request. Most adolescents reported that their physicians did not discuss sexual matters and risk prevention with them. Health workers need to be more

aggressive about discussing these topics (Schuster, Bell, Petersen & Kanouse, 1996:912-913).

Wellness program/preventative and promotive health programs for adolescents

Research has shown that many health problems have their roots in childhood and adolescence and much of adolescent morbidity and mortality can be attributed to preventable risk factors. Some of the unhealthy behaviours include: sedentary life style, poor nutritional habits, substance abuse, unsafe sexual practice and risky vehicle use. The negative consequences of these behaviours can have a lasting effect. Providing effective and comprehensive physical, mental and preventative health care has been a complicated issue for health care providers (Kaplan, Calonge, Guernsey & Hanrahan, 1998:32; Beuhring, Wunderlich & Renick, 1996:1768; Cavanaugh & Henneberger, 1996:70; Elster & Levenberg, 1997:1367-1370). Effective preventative measures can improve quality of life throughout the lifespan.

Health promotion programs directed at young people can therefore be seen as an efficient way of reducing the incidence of risk factors for diseases and of fostering positive skills and behaviours for health (Igra & Millstein, 1993:1409).

Health workers are well acquainted with the rationale for regular "well child" clinic visits. These visits provide an opportunity to assess development and provide anticipatory guidance for the child from birth to six years. The rapid rate of adolescent physical and psychological development and the magnitude of the health problems warrants offering a full range of clinical preventative services also to adolescents and their parents. The preventative services could provide the opportunity to:

- reinforce and encourage behaviours that promote healthy lifestyles;
- detect physical, emotional and behavioural problems early and intervene immediately;
- provide health guidance that might deter adolescents from participating in behaviours that may jeopardise their health; and to
- ensure vaccination against infectious diseases (Elster & Levenberg, 1997: 1370-1372).

The American Medical Association has developed the incorporation of a comprehensive health service into routine medical care called Guidelines for Adolescent Preventative Services (GAPS). These guidelines help health care providers to offer adolescents a comprehensive set of services that include screening for biomedical, emotional, and behavioural problems; updating immunisations, and offering health guidance to both adolescents and parents (Elster & Levenberg, 1997: 1370-1375).

Another option to improve the health of adolescents is by consistent health promotion messages from schools, parents, the community and health professionals, which may be effective in reducing risk behaviours. Comprehensive health education should be taught to all children, starting in kindergarten and continuing throughout high school. An age appropriate, sequential approach to school based health education will provide children with the foundation of knowledge for risk reducing and health promoting behaviours.

As early as 1979 in Britain it was realised that education in health for human relations is a basic educational right for every child in all primary and post primary schools. The school community ideally should be involved in developing programs. Students should be assisted to engage in activities that foster physical development and the understanding of the workings of the human body and the social forces that shape personal health and wellbeing.

The school curriculum needs to be developed according to the different stages. For the younger adolescent one needs to try to tap into their natural curiosity about their changing bodies and about the human body in general. For older adolescents the curriculum needs to attend to the social context in which behaviours occur. Nevertheless all programs need to reflect the adolescent's need for increasing autonomy and independence, for peer friendships and for support from caring parents (Millstein *et al.* 1993:1416).

Schools can be a primary vehicle for promoting health, as adolescents spend a large part of their lives in school and teachers probably provide the most frequent adult contact. Therefore schools can provide adolescents with accurate and meaningful information and skills to make informed, deliberate and constructive decisions in their lives. Life skills training can be a vital part of this decision-making process (Millstein *et al.* 1993:1414; International Nursing Review, 1997:73). To encourage schools everywhere to become involved in promoting health and to educate students in health matters, the WHO has launched a Global School Health Initiative where partnerships at local, national and international levels are being developed.

Accessible Health Services

Adolescents are an underserved population lacking adequate access to health care. Accessibility is influenced by some of the factors already presented in this paper, i.e. attitude, training skills and confidentiality. Adolescents need a non-threatening setting where young people can learn about health generally and sexual health in particular. Teenagers are usually intimidated by clinical settings and therefore rarely use local facilities (Little, 1997:44). The American Academy of Paediatrics established access as the current priority in improving the health of adolescents (Fischer, Juszczak, Friedman, Schneider & Chapar, 1992:619).

A number of strategies have been identified in the literature that could improve access to health care facilities for adolescents.

School Based Adolescent Health Program

School based health care has been promoted as a strategy to improve both access to and to provide services for the health needs, risks and behaviours of youth in the community. A comprehensive centre staffed by a multidisciplinary team, rather than a school health care delivered from a nurse's office, is preferred to promote the health of adolescents. This type of health care centre can be integrated into the health services of the community, i.e. it must be an integral part of the community's health care system such as a District Health System (Lear, Gleicher, Germaine & Porter, 1991:451; McCord, Klein, Foy & Fothergill, 1993:97).

School based clinics offer a potential means of providing health services to those otherwise deprived of high quality health care. The whole range of primary health care activities would be carried out at these facilities. Health promotion on a broad range of topics on a one to one basis, classroom and at community level can also be carried out.

This model of adolescent health care delivery has great appeal for the following reasons:

- It reduces the physical barrier to health, improves compliance and follow up.
- It focuses on early identification of high risk problems.
- It provides an array of services that can be customised for the adolescent population.
- It integrates health promotion into the school environment.
- It provides accessible affordable health care to all adolescents.
- It decreases absenteeism, school dropout and failures (McCord *et al.* 1993:96-97; Kaplan, Calonge, Guernsey & Hanrahan, 1998:27).

Teenage Health Club

It could be argued that the adolescent would see the school based clinic as a formal setting and therefore a less formal setting would be welcome. A teenage health club might be utilised better. This club would be situated away from the school setting but still within easy reach of teenagers. The club label gives this facility a place for teenagers to go to after school, which is like a youth club with a health focus.

A survey carried out in Alexandria near Glasgow where such a club was opened revealed the following i.e. what young people wanted from a clinic:

- be easy to get to;
- require no appointment;
- be welcoming;
- accept a friend brought for support;
- be completely confidential;
- provide a broad range of services;
- have staff who like young people and can communicate easily with them; and
- have female as well as male staff (Little, 1997:44).

This club provided recreation in the form of quizzes and games where teenagers learned about safe sex, substance abuse and HIV. Videos seen were followed up with discussions. Staff sat with members and talked about health issues. The adolescents invited outside speakers to talk on various topics. Exercise sessions could be organised and condom vending machines could be readily available. The workers at such a club need to be non-judgemental and have an open attitude for such a club to be maximally utilised (Little 1997:46).

Youth friendly Health Services

A challenge to all health care professionals is to create innovative youth- friendly health services that are sensitive to the needs and problems of young people. These services must be based on trust, acceptance, and genuine understanding of young people's perceptions, concerns and needs. Health care workers must provide services with sensitivity, confidentiality and with the full participation of young people (International Nursing Review, 1997:74).

Implications for Public Policy

In order to implement all the recommendations suggested in this paper there may be a need for public policy to be reformulated. There is also a need to analyse whether institutions are functioning in ways consistent with healthy adolescent development. In the health care sector there is a need for comparative studies to be conducted on different methods of organising, financing and delivering health care services. Mechanisms to support linkages and co-ordinate different social institutions need to be developed and tested (Millstein *et al.* 1993:1415). Legislation to limit adolescent exposure to health damaging activities needs to be introduced such as non-smoking policies in schools, banning cigarette vending machines where teenagers meet, instituting severe penalties for selling alcohol to minors and limiting adolescent exposure to lethal weapons. A national data monitoring system is needed in order to upgrade and to improve the adequacy of national statistics on health status of youth is needed. Information on health-promoting and health-damaging behaviours needs to be collected in order to evaluate the effects of health policies. Funding mechanisms need to be developed for sustaining health promotion programs for adolescents. In general, adolescents need to be placed higher on the national agendas in order to reduce the morbidity of adolescents significantly (English, 1990:1109).

CONCLUSION

'Healthy young people equal a brighter tomorrow'. This was the theme of the International Nurses day for 1997. This theme needs to be continued throughout the years until the health of the youth has improved drastically. As a society we

must value our children enough to make a universal commitment to their future. Responding to the challenge of promoting the health of adolescents in the 21st century will require a concerted effort from all the stakeholders: the government, the community, the health care providers, parents and the adolescents themselves.

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