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Adolescent Social Development: A Global Perspective

Implications for Health Promotion Across Cultures

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The effective promotion of adolescent health in all societies requires a clear understanding not only of health, defined by the World Health Organization (WHO) as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1), but of development—the unfolding of the individual's full potential within a given cultural context. The successful transition from childhood to adulthood is highly valued perhaps because it contains within it the implicit ideal man and woman; it is that which we want our children to become. Nevertheless, while greater attention is beginning to be given to adolescent health in many countries of the world, adolescent development is less commonly addressed by the health community, particularly social development. If we fail to consider the meaning of adolescent social development to people in each culture when we promote health, we run the risk of engendering resistance because of a perceived threat to deeply held values. These values need to be made explicit through research with different sectors of the community in each society and apply this knowledge to health promotion in order to work within and not against the overarching values of the cultures in which adolescent health and development are being promoted. In this paper, some of the challenges that arise from the different perspectives in which adolescence is viewed are identified and action proposed.

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Adolescent Development

Adolescence is a period of dynamic transition from childhood to adulthood marked by interrelated changes in the body, the mind, and in social relationships. Functions and behavior become more complex. The body develops in size, stamina, reproductive capacity, and becomes more sexually defined. Psychologically, the individual becomes more capable of abstract thinking, foresight, and internal control, and acquires a greater awareness of the environment, capacity for empathy, and idealism. Socially, the close relationship and dependence on immediate family begins to give way to more intense relationships with peers and adults outside the family (2) as new challenges are experienced, new behaviors are required, new pleasures are experienced, and new responsibilities are given. However, the physical, psychological, and social changes often occur unevenly in the individual, differently between individuals of the same gender, manifest differently, to some extent, between genders, and, especially with regard to social relationships, are widely different from culture to culture. These differences can be the source of great anxiety to adolescents and their families, and these anxieties may be compounded by health promotion in so far as it goes against the grain of acceptable and valued norms of

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behavior. This may be especially the case when adolescents are called upon to make a wider range of decisions for themselves, must choose among norms of the school, the workplace, religious institutions, community leaders, the mass media, peers, and their families. It is compounded for them when they experience situations of which the adults in their communities had no parallel experience when they were young. And, as we shall see below, that is increasingly the case in the modern world.

The Changing Social Environment

At present more than 50% of the world is below the age of 25 years, and about 80% of the world's 1.5 billion young people between the ages of 10 and 24 years live in developing countries (3). There has been a vast explosion of mass telecommunications across cultural boundaries often explicitly directed at youth—increased travel, tourism and migration, rapid and accelerating urbanization such that almost half the world will live in cities by the year 2000 (4), generally easier access to harmful substances of tobacco and drugs, and an overall decline of the extent and influence of the family from the extended multigenerational family, to the nuclear family, to the single-parent family, to the "no-parent" family of street children. These combined factors are eroding traditional values in communities, some of which have only recently begun to change, but which are changing with unprecedented rapidity. Except where it has plateaued in industrialized countries, the mean age of the onset of puberty is continuing to decline for most of the developing world, while the mean age of marriage is rising. The huge increase in the world's population in the second half of the 20th century has increased competition for education, training, and jobs, while technological progress has generated a need for specialized skills, all of which put increased pressure on the young. The successful transition to adulthood requires both support and structure, the primary source of which is usually the family, and opportunity for the development of new relationships, roles, behaviors, and skills. Yet it is precisely the family that appears to be most weakened in relation to other societal factors as societies become more "modern".

This changing social environment has important implications for adolescent development because adolescents have to deal not only with their individual transition from child to adult, but, in many societies, with unprecedented rapid societal transitions. These changes—in so far as they include separating too early from the secure stable relationships of families—will require of youth considerable resilience if they are not to sustain adverse psychological affects (5). These rapid social changes often radically alter the nature of the new relationships with other young people and adults at a time when patterns for future relationships are being set (6) and that are likely to have profound (if as yet not precisely known) impact on young people's development (7). While human development is to be welcomed and can certainly be described as individual progress, the societal changes that take place are not necessarily for the better. They are likely to go in the direction of greater individual autonomy and greater peer than parent orientation. In some Western societies (e.g., the United States), these two factors—autonomy and peer orientation—are associated with adolescent problem behavior (8). We must be very careful when we talk about "developing countries" in comparison with "developed countries" to remember that what we are referring to is, in the main, economic development. Let us look at some of these changes as they affect the individual adolescent.

Differing Patterns of Social Development in Puberty and Marriage

If we look at the major changes that take place in adolescence, perhaps the most significant is the advent of puberty and the beginning of a process which for most young people will eventually lead to the formation of new families. Of all aspects of adolescent development this is perhaps most closely linked with health in its broadest sense, and the development of new relationships is central to social development in adolescence. Also, while not all adolescents use tobacco or drugs, nor experience accidents and injuries—issues of considerable relevance to adolescent health and health promotion—all will experience puberty. Puberty is a phenomenon that is universally accompanied by the development of reproductive capacity, greater differentiation between the genders, and changes in the sexual response system. The social and behavioral manifestations of puberty, however, differ widely in different settings.

To take two examples that might be said to be at the extreme end of the continuum, there is the traditional early marriage prevalent in some South Asian and Eastern Mediterranean societies and the late marriage or cohabitation prevalent in parts of North America and Western Europe. In the former, marriage is often arranged during childhood be-

tween the respective families of the designated bride and groom and is likely to take place shortly after the onset of puberty. A demonstration of the fertility of the bride will be expected as soon as possible after marriage, she will be assumed to be a virgin, and will be younger than her husband, though he too may be an adolescent. After marriage, they will live with the extended family of the groom or bride depending on the culture and only much later are likely to have a home in which they are in authority. A dowry is likely to be part of the arrangement as will other considerations of importance to the two families and consonant with their traditions and expectations for the future. Those who arrange the marriage will be concerned that the choice will be pleasing and fitting to their offspring and may allow a "veto," but generally it is understood by the younger generation that this is an acceptable and desirable way to safeguard their future happiness. There are, of course, many gradations of the arranged marriage along the continuum allowing for greater freedom of choice, but the basic pattern described above remains prevalent in some societies.

Now let us look at some of the characteristics of this marriage. It is likely to be stable (divorce is very uncommon, though an infertile wife may be rejected), secure because the whole family will provide support in times of need, compatible in the sense that the partners will come from similar social, cultural, and economic backgrounds, and family oriented because many children are likely to be born. The young bride will be prepared for marriage in all its aspects by older female members of the family as the groom will be by older male family members. She is not likely to have any further formal education or training for work outside the home, but she will gradually assume greater responsibility and authority within the home and family setting. What are the health risks for this couple? First will be the increased risk of morbidity and mortality to the young mother and child in early adolescence during pregnancy and childbirth. Contraception will not be used, and induced abortion will not occur. They will be at low risk of sexually transmitted diseases including human immunodeficiency virus (HIV) infection. They are likely to live in a rural area so that the quality of medical care for her may be less than ideal, but they will live in an environment in which there is much local experience with antenatal care and childbirth. She will experience pride in giving birth and gain considerable respect from others, but she will suffer greatly if she is not able to bear a child (even if the source of the difficulty lies with her husband).

At the other end of the continuum is the adolescent in some parts of the "western world" who is living in a culture where free choice and considerable autonomy are given to the adolescent. The young adolescent is expected to "date" others and may be perceived as a social failure if he or she does not do so. Sexual experimentation at an early age is frequent, and false assumptions may be made about the young person's knowledgeability of sexuality, techniques of contraception, how and where to procure and use contraception, how and where to procure an induced abortion if that is desired, and how sexually transmitted diseases are contracted. Sexual relations are likely to have taken place with several partners long before marriage takes place; and if marriage occurs, it is likely to be after adolescence and be decided upon exclusively by the two partners.

The marriage is not likely to last throughout the couple's lives as divorce or separation will likely intervene. Access to health care during maternity is likely to be better than in the example above; however, if the young woman comes from an impoverished innercity group, many other conditions will work against having a healthy baby. The young woman and man will be older when they marry and are likely to have had more sexual experiences than the first couple but will have learned what they know about sexuality and marriage more from friends and mass media than from family. The model they will have for marital relationships is increasingly likely to come from "broken" families. The decision to marry will be based primarily upon mutual attraction and possibly on the existence of a pregnancy. But many adolescent girls, especially among the economically disadvantaged groups, will have a baby during adolescence without marrying (9). Those that don't bear a child are more likely to continue with formal education through high school and beyond and will have greater opportunities for training and work outside the home than her sister in the first example. During adolescence, the Western teenager will be at increased risk for sexually transmitted disease (STD), HIV infection, failed contraception, and induced abortion in varying circumstances.

Let us turn to a third example, that of a society in transition, which is particularly common when rapid urbanization is taking place as, for example, is the case in much of Africa and Latin America. In many African settings, young people increasingly leave a rural home in which traditional communal values of early marriage are prevalent for an urban or peri-urban environment in which all possibilities coexist. The circumstances of life are radically different from

that of the parental home although they may be living with other members of the family. Preliminary findings from the 11 African country narrative research studies done by WHO with the World Assembly of Youth and the World Organization of the Scout Movement suggest the following: The girl will be subject to pressures from her family to remain chaste. She will also be subject to powerful pressures from other sources—young and older men, mass media entertainments and advertising, the need or wish for money to buy things not available in rural societies, and loneliness—to have sexual relations. This is likely to lead eventually to a pregnancy—possibly a botched abortion, ejection from school if she is matriculated, and, increasingly, childbirth without marriage. The economic pressures on her increase as an unwed mother, which may lead her to seek further support from another man who most likely will also give her another child. The health risks to her are very great for poor nutrition and care during pregnancy and childbirth, or of septic or incomplete induced abortions done in clandestine and dangerous circumstances, possibly self-initiated. She will have little knowledge or access to contraception and have a high risk of STD and HIV infection.

The adolescent girl in these circumstances will have a model for social relations and marriage that exists in her village, but not in the town. She has sudden exposure to more Western models of behavior, but not the same economic opportunity. How is she to relate to older men who don't treat her with social correctness, but attempt to seduce her? How is she to relate to adult employers who are not concerned about her welfare? How is she to deal with adults who challenge the authority that the adults in her family have exercised? She and the male adolescent are living in a world that their families have never known, making it more difficult to go to them for guidance. All the stresses associated with the changes that take place in adolescence are compounded by being adrift in a society that is losing its traditional structure but has not yet settled into another.

These three examples are, of course, far from comprehensive but neither are they caricatures. Rather, they are representative of some predominant realities. Let us now turn to issues of adolescent health and health promotion.

Adolescent Health

The health of adolescents is particularly dependent on their own behavior (10) which is, in turn, heavily influenced by the environment in which they live. Many of the health problems that currently have their origin in adolescence arise from behaviors begun in adolescence including the use of tobacco, alcohol, or other drugs that variously have long-term consequences of increased risks of cancers, cardiovascular, respiratory, and liver disease (11). The use of alcohol and other drugs heightens immediate risks of accidental and intentional injury including suicide and homicide, the potential of shared needles in the case of drug abuse leading to HIV infection and acquired immunodeficiency syndrome (AIDS), and uninhibited sexual behaviors. Unprotected sexual activity in adolescence brings with it dangers of too early or unwanted pregnancy, induced abortion often in hazardous conditions, sexually transmitted diseases, and infection with the AIDS virus. While significant progress in public health to reduce many passively acquired infections has been made through cleaner water, sanitation, and immunization (although there is some backsliding owing to deteriorating economic conditions), behavioral issues are becoming more widely recognized as the key to health. At the same time, it is clear that many of the behavior patterns that influence health have their origin in adolescence, one of the reasons why this period of life is now receiving greater attention from the health community. Those behaviors, however, are highly social in nature—sexual relations between two individuals most commonly begin in adolescence, the use of tobacco, alcohol, and other drugs rarely begins as a solitary activity but rather in a social setting (12), much risk-taking in adolescence is done with the expectation of peer approval, the choice of food, especially among adolescent girls, will be linked to how they will look to others and, of considerable significance for our purposes, the extent to which a young person will ask for help from anyone such as health services, school teachers, counselors or the police will be heavily dependent on how they expect to be received.

Considerable progress has been made in placing adolescent health on the agenda in many countries, perhaps most in the region of the Americas. WHO has been formally interested in adolescent health since 1965 when the first of a series of four Technical Reports drawing on Expert Committees and Study groups was published (13–16). The Technical Discussions held during the 1989 World Health Assembly on the Health of Youth gave a further boost to attention by the (then) 166 Member States of WHO to both the needs of young people and the role that they can play (17). This was followed by the formal

establishment of the WHO Adolescent Health Programme in 1990 building on and expanding the work begun in the mid-1970s with continuous support in the area of the reproductive health of adolescence from the United Nations Population Fund (UNFPA). The joint WHO/UNFPA/UNICEF statement on Adolescent Reproductive Health: a strategy for action was published in 1989 (18). In recent years, a series of resolutions have been passed by the World Health Assembly on many aspects of young people's health including health education, health at the workplace, tobacco, alcohol, and other drugs, injury prevention, sexually transmitted diseases, the need for maturity before pregnancy, and an overall resolution on the health of youth calling for both attention to the health of young people and to the importance of their involvement as a resource for health (19). The WHO Regional Committees have simultaneously raised the priority of adolescent health; and a leading role in the Americas is being played by the Pan American Health Organization/ WHO Regional Office for the Americas.

In addition, many of the international nongovernmental organizations with activities in the field of youth, including the International Planned Parenthood Federation, the World Assembly of Youth, the World Organization of the Scout Movement, the World Association of Girl Guides and Girl Scouts, the World Alliance of Young Women's Christian Associations, and the International Federation of Red Cross and Red Crescent Societies, are actively dedicated to the promotion of adolescent health and development as are the key professional associations such as the Society for Adolescent Medicine, the International Association for Adolescent Health, the Society for Research in Adolescence, and the International Pediatrics Association.

It is not only policy, but programs and projects that are burgeoning throughout the world, and a recent survey of activities devoted to adolescent development (20) brought many of these to WHO attention. Perhaps the longest established area of activity in the health sphere is that of the reproductive health of adolescence, and I should like to turn to that area of health promotion to look for the implications of differing patterns of adolescent social development to see what we may learn.

Adolescent Social Development: Current Health Practice

Perhaps the most central health issue that faces all young people eventually are those aspects associated with sexual identity behavior, and reproductive health. How are these issues dealt with in the contemporary world? In many countries, some form of "sexual education," more commonly called "family life education," exists in the school system. Where it does, sexual behavior is usually left out. The biology of reproduction may be covered, often taught by the biology teacher, with little reference to emotional aspects. Contraception is unevenly addressed; and abortion is rarely discussed. While condom use may be mentioned it is within the context of HIV prevention and not related to pregnancy and STD reduction. Additionally, it is discussed using euphemisms rather than correct names for human genitalia. Young people are instructed on dangers of sex, encouraged to abstain, and frequently in developing countries, they are reminded of their countries' population policies as an inducement to refrain from sex and so avoid overpopulation. The adolescent is not given specific practical information, the teacher is not trained to talk about, or more importantly, to listen to young people's needs in this area, and the subject remains shrouded in embarrassment, secrecy, and shame. There are many exceptions to this rule and many valiant people in the field who work well with adolescents, but effective human sexuality education is not common in either industrialized or developing nations. However, there is a significant message for us in the school setting. What is emphasized? The importance of chastity among adolescents, of morality, of acceptance of adult guidance, of respect for religious teachings, of respect for family and societal values. There is also fear. Fear that providing information to young people in a way that was not used with their parents will make them promiscuous, irresponsible, disobedient, and contemptuous of authority.

Now let us turn for a moment to the health sector and adolescent sexuality. How is adolescent sexuality dealt with by doctors, nurses, and other health workers? Our experience working with young people in many developing countries over the years strongly suggests that young people anticipate a highly negative reaction if they approach health workers with a problem that implies that they have had premarital sexual relations. The anticipated negative response has as a consequence a reluctance to use health services for pregnancy detection, pregnancy termination, diagnosing and treating sexually transmitted diseases, discussion of sexual orientation, or anything related to sexuality. As a consequence, there is an orientation to self-care, adolescents come to health services late if they

come at all, and they are at higher risk of health damage and death as a result of the delay.

The vast majority of adolescents who use health services will have access only to services that are not especially designed to meet their needs. Additionally, health workers are not trained in adolescent development, health, or sexuality, nor in interpersonal communication skills with young people. Increasing the gulf between provider and adolescent is the reality that many youth health problems, as noted earlier, are usually the result of voluntary behaviors. And, given the adolescent's aversion to seeking professional help, problems may be exacerbated when they finally come to care. While delay is often the consequence of less information, knowledge, experience, and money than adults, health professionals tend to hold the adolescent accountable. Additionally, health professionals are the voice of popular morality which may condemn the adolescent for his/her behavior. Unable to turn to parents for guidance, this stance of the health-care community only serves to isolate further adolescents from adults.

Now let us look for a moment at the way in which health is often promoted by those of us who work in the health sector. In truth, we often fail to address the needs, questions, and concerns of young people, and concurrently we tend not to do for them what we believe and know to be optimal out of fear of public criticism. Let me give a couple examples:

- At the Technical Discussions on the Health of Youth during the 1989 World Health Assembly, a group of young people presented a series of role plays to the assembled delegations from 166 countries. The first of these depicted an adolescent girl going to her mother with a question, the mother sent her to the father for the answer who sent her to her teacher who sent her to the doctor who sent her back to the mother. This was greeted by a roar of immediate recognition in that distinguished audience. There are two important messages to learn from these young people: the first is that their questions are not now answered, and the second is that each of these groups wants the girl to become knowledgeable but doesn't know how to help her. Each may also fear that the others might disapprove, but they are not really sure.
- The second example is from the health-care provider perspective. Nearly 20 years ago, research was conducted in a Caribbean country examining the view of the medical profession about the restrictive abortion law. Some 90% of the doctors sampled felt that the law needed to be liberalized to save lives, some 90% of the doctors felt that their colleagues would disagree with them. This, too, has a message for us. Much of the present policy and practice in countries is based on fear that is not founded on knowledge but on assumptions.

Conclusion

At WHO, we have worked in many societies in recent years which have widely differing policies, traditions, and practices, but our experience with each suggests that there is always genuine concern about how to join health needs to social mores. The challenge to us is to harness the prevalent moral energy, the commitment to sound child and adolescent development and the concern in all societies for the welfare of young people. The best way to do that is to listen, to elicit peoples' values and objectives, to provide sound scientific information, and to help people make their own decisions about what is best in their own cultures regardless of the national stage of economic development.

There is no shortcut to the promotion of adolescent health and development, and there is a danger of counter-reaction when we go too fast on a single issue, to a single "target group," or with a singe 'message.' On the other hand, we have an immense opportunity, as this field opens up, to lay the groundwork for the societies of the future by working toward healthy development of young people, as well as health.

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