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HEALTH EDUCATION OF ADOLESCENTS

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EXECUTIVE SUMMARY

Adolescence, which occupies roughly the second decade of human life, is a vital stage of human development, yet it is virtually neglected by health care providers, by society at large and even by most parents. Adolescents come under neither paediatric nor adult medicine.

And yet adolescence is a period of turmoil, with drastic physical, biosexual and psychosocial changes. The nutritional needs of adolescents increase; their lifestyle is formulated, which can influence their current or future morbidity; their reproductive life may start prematurely while their intellectual abilities and their cognitive and affective faculties are still being fashioned. Far-reaching mental health problems (for example, depression, antisocial behaviour and scholastic underachievement) may arise. In addition they are vulnerable to exposure to the risks of smoking, drug addiction, alcohol and violence. This is also a time of high risk of contracting sexually transmitted diseases, including AIDS. All these changes are too drastic to be comprehended and properly faced by the adolescent on his or her own without adequate protective preparation.

Sexual maturation is by far the most challenging change, not only to the adolescent but also to parents, teachers, health professionals and society at large. Most parents somehow dismiss their responsibility of healthy dialogue with their children under the guise of being embarrassed, being ignorant or being too busy; they do not perceive the agony of growing up in their child. They may also surrender, all too conveniently, the responsibility to teachers, who in turn feel that the responsibility lies with the family and not the school. During this confusion other sources of information present themselves: peer groups, older siblings, street talk and the media.

A comprehensive package of adolescent health with emphasis on reproductive and psychosexual health is needed for facing these problems in the Eastern Mediterranean Region—where half of the population is under 20 years of age and where the number of adolescents was 85 million in 1990 and is expected to grow to 120 million by 2000. The five specific pillars of such a package are: nutrition and dietary habits; personal health and hygiene; healthy lifestyle for health promotion and disease prevention; mental health; and reproductive health and sexuality. In addition, there are two more role-setting pillars: the first is the institution of marriage and family, which is the best and most acceptable way of satisfying sexual and procreational drives. The second is the cultural and religious norms of the Region within which all the above activities should function.

Health knowledge, particularly sex knowledge, should be imparted to the adolescents within these cultural norms. This is a responsibility to be shared between parents, teachers, other school health professionals, youth-to-youth groups, nongovernmental organizations (NGOs), media specialists and enlightened religious leaders.

Finally, the 10 cardinal priorities in the health education of adolescents are:

1. Building up a healthy lifestyle for health promotion and disease prevention, including good dietary habits, good personal hygiene and exercise.

2. Compassionate but truthful dialogue with adolescents about their physical, biosexual and psychosocial changes. This should be done at appropriate times starting no later than puberty.

3. Emphasizing the institution of the family, with marriage as the only proper way of family formation.

4. Meeting the mental health requirements of a growing adolescent undergoing fundamental changes that may shape his or her future character and psyche. Prevention of sex discrimination is crucial for the mental health of adolescents.

5. For older adolescents entering into a marriage contract, contraceptive education can be provided with the consent of parents.

6. Postponing first pregnancy until a girl is biologically, emotionally and socially mature. Birth-spacing and proper timing of pregnancies should be the rule.

7. Prevention of smoking and drug and alcohol abuse.

8. Prevention of accidents and violence by and against adolescents.

9. Training of those responsible for adolescents: parents, teachers, school health providers, youth-to-youth leaders (e.g. Scouts), religious leaders, NGOs and media specialists. Guidelines to facilitate their task should be prepared.

10. National activities for adolescent health should be strengthened, and integration of adolescent health care into the national health system should be undertaken as soon as possible.

INTRODUCTION

Adolescence is a most dynamic period in human development occupying roughly the second decade of life. WHO considers adolescence to take place between the ages of 10 and 19; "youth" is between the ages of 15 and 24. Thus there is an overlap of five years. During adolescence, the future health character and cultural profile of an individual are formed, and biological and sexual maturation and psychosocial development take place. Additionally, intellectual abilities are stimulated while cognitive and affective faculties are nurtured.

Throughout these formative years, adolescents are subjected to many influences, including those of parents, teachers, peers, health care providers and especially religious and cultural norms. A recent arrival that is not always welcome, namely the media, has become an overwhelming presence for adolescents, mostly unintentionally.

Having recognized several of the influences on adolescents, one has no choice but to make the following observation. Adolescence is a time of confusion and vulnerability for young people. Perhaps the most disquieting violation of adolescents' rights is for their parents to observe them passing through adolescence without giving them a guiding hand. Parents may claim embarrassment or ignorance; or they may conveniently shift their responsibility to the school or some other third party.

The objectives of this paper are:

- To increase the awareness of all Eastern Mediterranean Region countries of the health needs of adolescents and their special requirements with a view to promoting the inclusion of adolescent health as a specialty in clinical and public health systems.
- To provide technological bases for developing guidelines for the impartation of health education to adolescents by parents, teachers, school health professionals, media specialists and Scout and other youth leaders, so that they can shoulder the responsibility of guiding adolescents under their supervision through the path of physical, emotional, biosexual and psychosocial changes.
- To identify and elaborate the major areas for health education of adolescents:
  - nutrition and dietary practices
  - personal health and hygiene
  - healthy lifestyles for health promotion and disease prevention
  - mental health
  - reproductive health and sexual maturation
  - the institution of marriage and the family.

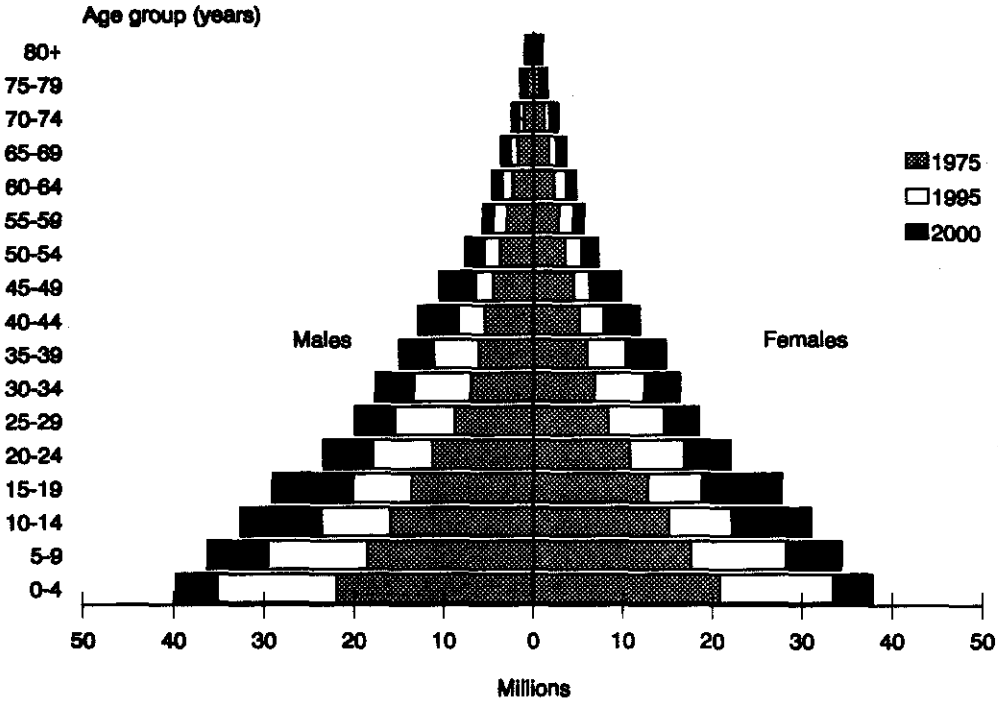
PART ONE: BACKGROUND ON ADOLESCENTS

1.1 AN EPIDEMIOLOGICAL PERSPECTIVE ON ADOLESCENTS AND YOUTH IN THE EASTERN MEDITERRANEAN REGION

1.1.1 Demographics of adolescents in the Eastern Mediterranean Region

The Eastern Mediterranean Region countries have predominantly younger age structures than the world population with over 60% under the age of 25 years and over 50% under the age of 20 years. The young age structure is evident in the Region's population pyramid (Figure 1), which shows a very wide base and narrow top in each of 1975, 1990 and 2000.

Figure 1. Population pyramid, Eastern Mediterranean Region



In 1975, there were 57.5 million adolescents in the Eastern Mediterranean Region (Table 1). This figure grew to 84.7 million in 1990 and is expected to be 120.3 million by 2000. The combined size of both adolescents and youth (i.e. population between 10 and 25 years old) was 79.6 million in 1975, rose to 119.4 million in 1990 and is expected to be 177 million by 2000 [1]. It is therefore perplexing that almost one-third of the population could have been marginalized or simply forgotten for so long by health and social organizations and, for that matter, by their own parents.

TABLE 1. Age distribution of under 25s in the Eastern Mediterranean Region, 1975, 1990 and 2000 (000s)

Age group (years)	1975		1990		2000	
	Number	% of total population	Number	% of total population	Number	% of total population
0–10	78 868	32.4	126 438	31.6	148 138	28.8
10–19 (adolescents)	57 519	23.3	84 716	21.7	120 327	23.4
15–24 (youth)	48 483	19.6	73 645	18.9	102 137	19.8
10–25 (both)	79 595	32.2	119 410	29.3	177 046	34.4
0–25	158 463	63.1	245 848	62.2	313 884	61.0
0–20	136 388	56.2	211 154	53.3	268 485	52.2

Source: WHO/EMRO database 1995

1.1.2 Health vulnerability of adolescents

Adolescents and youths are vulnerable to a range of health risks that may affect them immediately (like infectious diseases, malnutrition, accidents or sexually transmitted diseases) or in the future (like cardiovascular diseases and cancers). These risks may originate as a result of the lifestyle and health status during adolescence. Still another risk is to the offspring of adolescents when teenage pregnancy takes place.

1.1.3 Health problems facing adolescents

(a) ***Problems peculiar to adolescence***

- mental health problems related to psychosocial development
- adolescent sexual growth problems
- teenage pregnancy.

(b) ***Problems facing youth disproportionately***

- reproductive health problems, including maternal mortality and morbidity
- sexually transmitted diseases (STD) including HIV/AIDS
- accidents and injuries
- drug addiction, smoking, alcoholism and drugs
- dental health problems
- nutritional problems
- certain communicable diseases such as tuberculosis, intestinal helminths, schistosomiasis and rheumatic fever originating in childhood from streptococcal infection.

(c) ***Lifestyle that may affect future health***

- inappropriate lifestyle based on excessive and unbalanced dietary consumption, lack of physical activity and smoking interact with each other, leading to obesity, cardiovascular disorders and diabetes.

(d) ***Conditions that may affect adolescents' offspring***

- low birth weight, high perinatal mortality
- low intelligence
- Vertical transmission of HIV.

1.2 HISTORICAL EVOLUTION OF ADOLESCENT HEALTH

Adolescence has, until very recently, been a neglected segment of human life. Adolescents are too old to be covered by paediatrics and too young to fit automatically into the field of adult medicine. Even in maternal and child health programmes they neither belong to the maternal nor the child component unless teenage pregnancy occurs.

Interest in adolescent health has been slowly but surely rising during the second half of the 20th century, especially after the Second World War. In the 1950s and 1960s, Tanner and his group published their fundamental work on the growth of adolescents [1]. Clinicians started to establish special clinics or centres for adolescence. The first such programme of "adolescent medicine" was established in Boston, Massachusetts, by Rosell Gallagher; the experience of the clinic was published in a text called *Medical care of the adolescent* [2]. The establishment of other clinics in the US and Latin America led to the formation, in 1968, of the Society for Adolescent Medicine (SAM), which publishes a specialist journal called the *Journal of adolescent health care* [3]. A sister association in the United Kingdom, the Association for Professionals in Services for Adolescents publishes the *Journal of adolescence*. Furthermore a special section on adolescent health has been established in the American Academy of Paediatrics [3].

These clinical efforts led the American Medical Association (AMA) to conclude in 1977 that the field of adolescent medicine fulfilled all the requirements for designation as a specialty in medicine [3]. Several textbooks on adolescent medicine have been published over the past three decades.

A more comprehensive concept of adolescent health including both prevention and health care measures, has been promoted by the World Health Organization. In 1965, WHO convened a technical expert committee to discuss health problems of adolescents [4]. A second technical expert committee was convened in 1977 to discuss the health needs of adolescents [5]. Then in 1990, the Adolescent Health Programme (ADH) was established at WHO headquarters in Geneva. Some NGOs have become interested in adolescent health. The recently established Global Commission on Women's Health evinced considerable interest in the health of adolescent girls.

The Regional Office for the Eastern Mediterranean (EMRO) has expressed increasing interest in adolescent health and has been advocating the establishment of adolescent health programmes as a component of national health care systems. Two intercountry consultations

in 1993 and 1995 identified facets of adolescent health about which reliable information from EMR countries is almost nil, and recommended steps to bridge this gap. Measures for responding to the special needs of adolescents through maternal and child health programmes and school health services were also recommended [6,7].

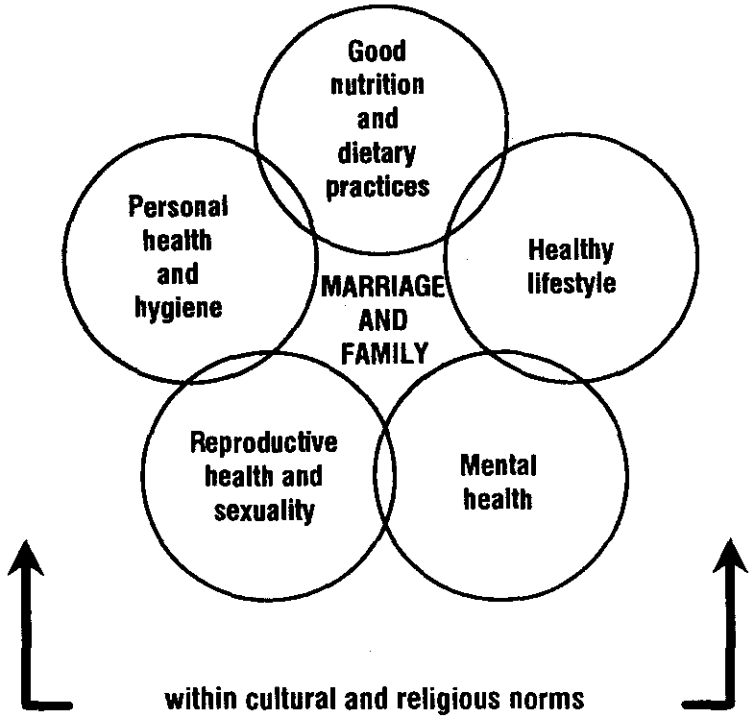
Islam, the predominant religion in this Region, devotes great attention to growing children and has promoted their treatment with compassion and empathy. Islam signals to parents and others that as early as the age of 10 a child is entering another phase in his or her life, a phase that needs more responsible parenting. According to a saying of the Prophet Muhammad, children are required, under their parents' guidance, to practice prayers regularly at the age of 10 years. Parents are requested to provide separate sleeping arrangements for their children as a means of encouraging individuality and the development of a unique personality. As well, adolescents and youths are enjoined to stay chaste and to get married as soon as they are fit, physically, socially and financially. They are also instructed to stay away from bad company, which may tempt them away from their cultural norms.

In Christianity, great attention is given to the child and the adolescent. The church takes a primary role in the religious upbringing of children and offers counselling on sexuality at the appropriate time. Christianity also advises against keeping bad company and strongly endorses chastity until marriage.

PART TWO: AREAS FOR HEALTH EDUCATION OF ADOLESCENTS

Adolescent health programmes should be viewed as a package of several components that are complementary and that all fall within cultural and religious norms of the Eastern Mediterranean Region. These are depicted in Figure 2 and will be discussed below.

Figure 2. Components of adolescent health programmes in the Eastern Mediterranean Region



2.1 NUTRITION AND DIETARY HABITS

2.1.1 Nutritional problems

Adolescence is a period of rapid physical growth, with a corresponding increase in nutritional requirements to support the increase in body mass and to build up stores of nutrients. At menarche adolescent girls require 10% more iron than boys because of blood loss in menses. Girls from poor families will in addition have a heavy workload in the home. There is also the possibility of sex discrimination in intrafamilial food distribution in some families. If pregnancy occurs prematurely (before 18 years of age), nutritional requirements will significantly increase.

The nutritional problems in adolescents of the Region include:

- ***Undernutrition***, which results from the consumption of an inadequate quantity of food (i.e. less than the daily requirements) over an extended time. This prevails in poor families and with chronic infection, such as tuberculosis.

- ***Specific deficiency***, resulting from a relative or absolute lack of a nutrient. Examples include iron deficiency anaemia, which is prevalent in the Region (in many countries of the Region, more than one-third of adolescent girls have nutritional anaemia) [8]. Deficiencies of vitamin A and iodine are common in many EMR countries [9].

- ***Overnutrition*** (malnutrition of affluence), resulting from the consumption of unbalanced and excessive quantities of food, especially starches, sugar and fat, over an extended time. The most common manifestation of overnutrition is obesity, which is prevalent among adolescents girls, particularly in the affluent countries of the Region [7].

- ***Dental caries*** is another health problem related to excessive intake of sweets, chocolate, ice-cream, cakes and soft drinks, with or in between meals. This is a common practice in urban areas, especially in affluent countries. A contributing factor is the regular consumption of bottled and/or desalinated water, which contains low levels of fluoride [10].

2.1.2 Improving the nutrition of adolescents

Adolescent nutrition in the Eastern Mediterranean Region can be improved through several measures, including [11]:

- Recognition of increased nutritional requirements of adolescents;

- Nutrition education for the promotion of healthy dietary habits such as:
  - having an adequate diet
  - control of excessive indulgence in food, especially those high in sugar and fat
  - minimizing the intake of sweets and snacks in between meals
  - regular physical exercise;

- The guiding principle of moderation in food intake. Inculcation of sound dietary practices should start in adolescence;

- A balanced diet, which should have appropriate amounts of foods from different categories, such as energy-giving, body-building and protecting foods. In general terms, the daily diet should contain cereal, beans, milk, meat, vegetables and fruit;

- Control of parasitic infestation;

- Control of environmental deficiencies (e.g. iodine and fluoride);

- Clean water and sanitation, as well as food safety, which should be regarded as an essential requirement for health promotion. The dangers of contaminated water, common in poor environments, should be stressed in health education;

- Safe and hygienic handling of food.

2.2 PERSONAL HEALTH AND HYGIENE

Adolescents should be encouraged to develop a good regime of personal health and hygiene. Such a regime might include:

- personal hygiene in general
- dental care by brushing of teeth or use of *siwak*
- physical exercise individually or in groups
- appropriateness and cleanliness of dress and surroundings
- routine medical care.

2.3 A HEALTHY LIFESTYLE FOR HEALTH PROMOTION AND DISEASE PREVENTION

Although lifestyle has always been a factor in the occurrence of disease, it is only recently that it has been brought into the forefront of health promotion and disease prevention. A prominent example is the recent decline in cardiovascular disease (CVD) mortality in developed countries through deliberate modification of lifestyle *en masse* for that purpose. Thus, a low fat/low cholesterol diet has replaced the rich diets of earlier times; fish consumption has increased; vegetable oil has been replacing animal oil; dieting and control of obesity has been given top priority; regular physical exercise has been adopted by millions; hypertension and diabetes as risk factors have been controlled; and last but not least anti-smoking campaigns have been extremely successful. Countries in eastern Europe and the former Soviet Union, which have not modified their lifestyle, continue to suffer rising rates of CVD mortality [12]. These risk-reducing lifestyle modifications have their greatest impact if they are started in adolescence or even in childhood.

The foundation stones of a healthy lifestyle

- Prevention of disease through personal hygiene, sanitation, immunization, chemoprophylaxis, early diagnosis and prompt treatment through routine health care.

- Not starting or quitting smoking, which has been proven unequivocally to be a risk factor in cardio- and cerebrovascular disorders, cancers and other clinical disorders.

- Prevention of alcohol and drug abuse.

- Physical activity and sports.

- Regular sleeping habits.

- Good dietary practices.

- Personal hygiene.
- Marriage is the best of lifestyles or ways of life.

The Holy Quran and the *hadith* (sayings and traditions of the Prophet) are very rich in guidance for the promotion of healthy lifestyles.

2.4 THE MENTAL HEALTH OF ADOLESCENTS

If physical health of adolescents is subsumed in the general health system, mental health concerns rarely come to the attention of parents and school health programmes. And yet it is logical to expect and screen for mental health problems that accompany the drastic and rapid physical, biosexual and psychosocial changes that occur in adolescence.

2.4.1 Clinical conditions

The mental health of adolescents is of considerable importance since it greatly influences behaviour patterns in adulthood. However, this fact has not attracted the attention of those responsible for adolescent health. Some clinical conditions common to adolescents are: attention deficit disorder; personality disorder; oppositional disorder; conduct disorder; disorders of affect: moodiness, anxiety, depression; cognitive disorder: confusion; somatic disorder (tics); hypochondriasis; sleep disorders; anorexia nervosa; bulimia; schizophrenia; suicide ideation [13].

The extent and magnitude of these and other mental health disorders in the Eastern Mediterranean Region is not fully known and requires intensive and extensive investigation.

2.4.2 Adolescent concerns about puberty

Adolescents can become much concerned, sometimes to the point of depression, when changes happen to their bodies that are not properly explained to them. Some examples are:

- An adolescent boy notices that one of his testicles is lower than the other, which is normal. He gets concerned, suspecting that he is abnormal.
- An adolescent girl after puberty notices fine hairs around her nipples, which is normal, and becomes afraid that she is changing into a man.
- In some areas of the Region, myths and ignorance about the wedding night abounds. Young females may be terrified about the first intercourse. A young male may not be informed of the possibility that first intercourse with a virgin may not be accompanied by bleeding.

In all these cases, appropriate counselling will overcome the harmful effects of such mental concern.

2.4.3 Sex discrimination or inequitable treatment of children

Sex preference is a common trait in many developing countries. Discrimination against female children overtly or covertly is common in some countries of this Region. The Quran condemns the feeling of shame and great disappointment that a parent may express when he or she learns that a new child is a female. This feeling may later take the form of actual discrimination against girls with respect to treatment, societal position and even food distribution in the family. The adolescent girl becomes acutely aware of this constant discrimination. There may be some cultural acceptance of this differentiation between boys and girls, but the bitter feelings live with the female child, the adolescent girl and the young woman. On examination, such discrimination is tribally based but not religion based.

2.4.4 Mitigating factors regarding mental health in the Eastern Mediterranean Region

There are, however, some innate belief systems in the countries of this Region that may protect, at least partly, from mental health disorders. Some of these are:

- a complete belief in destiny, which may neutralize some of the stress and act as a soothing factor
- control of interpersonal conflicts that may lead to mental pressures
- relative content on the principle that "Whatever the Lord has given me, is my share. I have no contest"
- low prevalence of alcohol and drug abuse.

2.5 REPRODUCTIVE HEALTH AND SEXUALITY

Reproductive health, as defined by WHO, is a state of complete, physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes [13].

Sexuality is a term that refers in common use to all sexual aspects of human life.

2.5.1 Phases of development in adolescence

The physical and psychological changes that are experienced during adolescence do not necessarily take place at the same time for all adolescents. Nevertheless, the period of adolescence can conveniently be divided into three phases with varying degrees of overlap:

- early adolescence : age 10–14 years
- middle adolescence : age 15–17 years
- late adolescence : age 18–19 years.

The three main phases are depicted for easy reference in Table 2 according to the type of change that occurs at different phases.

TABLE 2. Growth and maturation during the different stages of adolescence

	Early adolescence (10–14)	Middle adolescence (15–17)	Late adolescence (18–19)
Physical growth	Rate of growth accelerates to a pubertal spurt. Increase in height and weight. Muscles build up and shoulders broaden, more in boys than girls. Girls may start growing one year earlier than boys.	Growth rate decelerates but adolescent reaches 90+% of adult stature. Muscles continue to build in boys while characteristic fat deposition in girls moulds them into the shape of a woman. Pelvis in girls widens. Marriage at this age is premature, and pregnancy is classified globally as high risk.	Growth is virtually complete. Linear growth especially of the long bones is not complete until the age of 18 in girls; peak bone mass is not achieved until two or more years later.
Biological or sexual change	Secondary sexual characteristics appear. Hair grows in armpit and in pubic area around genitalia. Early growth of female breasts. Wet dreams (boys) and sex dreams (girls). Menarche occurs at mean age of 13 in Eastern Mediterranean Region countries (range: 9–18).	Hair on face (boys). Change in voice (boys). Feeling pleasure when genitalia are stroked or manipulated; discovery of masturbation (both sexes). Curiosity about how babies are made and how they are born. Acne may become a problem.	Sexual maturation complete. This is a suitable age for marriage.
Psycho-social change	Peer group affiliation. Morphological changes are associated with psychological changes, day-dreaming and apprehension of the unknown. Child may compare his/her genitalia with those of older siblings or peers and may become depressed or inquisitive.	Peer group defines behavioural code. Increasing curiosity about members of other sex. Thinking becomes more abstract. More romantic day-dreaming and preoccupation. May be introduced to smoking, risk-taking, violence, drug use and risk of STD/HIV, accidents, suicidal behaviour.	Influence of peers recedes to individual friendships. Future orientation. Intellectual identity established. Child-parent relationship changes into adult-adult relation.

Three kinds of change are seen, namely:

- physical growth
- biological/sexual maturation
- psychosocial change.

Physical growth reaches a high rate during early and mid adolescence (being exceeded only by growth in childhood); this includes what is known as the pubertal spurt. Incremental increases in height and weight and muscle growth (especially among boys) occur. The shoulders of boys become broader. In girls, the shoulders do not grow as broad as boys' shoulders while the pelvis widens gradually. A girl's physical growth is virtually complete by age 18, including the linear growth of long bones. Peak bone mass, however, is not completely acquired for a few more years, usually by age 20.

Biological or sexual maturation starts during early adolescence under influence of hormones. An obvious change is the appearance of secondary sexual characteristics including hair growth in the armpits and in the pubic area. The size of the sex organs, and breasts in girls, also start to increase in early adolescence. Wet dreams for boys and sex dreams for girls usher the onset of puberty. Menarche in girls starts between age 9 and 18 (mostly 13 in the Region). It may be delayed in case of gross undernutrition. Boys begin to grow hair on their faces, and their voices deepen. Children and adolescents feel pleasure when their genitalia are stroked or manipulated and may discover masturbation (males and females) accidentally or at the suggestion of older peers. Adolescents become more curious about how babies are made and how they are born.

All these changes are under the control of sex and other hormones, which may produce the nagging complexion problem of adolescents known as acne.

In late adolescence, sexual maturation is complete. This is an acceptable age for early marriage—at age 18 or 19. By that age, a person should be physically, biologically and sexually mature and be ready for marriage and its responsibilities. This is called early marriage because it occurs soon *after maturation*. It would be wise, however, to postpone the *first child* until after age 20. Therefore contraceptive knowledge should be provided to those engaged to get married, of course with parental consent.

Far reaching psychosocial changes accompany the physical and biosexual changes and unless properly handled may result in future ill-effects. Peer group affiliation is usually sought, and by mid adolescence, the peer group usually defines the behavioural code. During this tender stage adolescents may be introduced to smoking; risk-taking, accidents and violence; rejection of authority; drug and alcohol use; and premarital sexual relations (with concomitant risk of sexually transmitted diseases).

Future orientation and intellectual identity are usually established during late adolescence. The child–parent relation changes into an adult–adult relation, while the influence of peers, as a group, may partly or totally recede, giving way to individual friendships. Sexual problems may also arise for those seeking marriage; the issue of virginity and its proof in girls is a traditional preoccupation.

NOTE: AN INTRIGUING CULTURAL NOTE ON PHASES OF DEVELOPMENT

It is of interest to find a 14th century reference to phases of human development with specific names in the Arabic language. These were provided by the great 14th century theologian Ibn Qayyem al-Jawzia (famous as Ibn Al-Qayyem—died 1350 AD). These were found in his book on religious rules for the growing child from *Tuhfat al-mawdoud* by Ibn al Qayyem [14].

The phases of development according to Ibn Al-Qayyem are:

Suckling infant
Weaned infant
Toddler child
Growing child (age 7–10)
Reached puberty
Youth (age 20–40)
Mature (middle age 40–60)
Ageing (age 60+)
Elderly/advanced age
Advanced ageing and weakness

These phases of Ibn al-Qayyem reflect the Quranic verses on successive stages of creation and development:

> *Allah is He who created you out of weakness, then formed after weakness strength, then after strength came weakness and greying.* *Al-Roum: 54*

2.5.2 Age at menarche and marriage

Formerly, girls in this Region used to get married as soon as they began to menstruate which used to be at age 17 or 18 years.* Now that age of menarche has fallen four or five years (the average age at menarche in the Region is 13 years) it is unrealistic to make this also the age for marriage. Girls at this age are not yet physically, socially or psychologically mature enough to get married.

Studies in the Region found that a good proportion of adolescent girls are married by age 20. In Bahrain, for instance, 18% of mothers are first pregnant between the ages of 11 and 15 years, and about 43% between 16 and 19 years [16]. In Oman 85% of women were married before they were 20 years old. In Saudi Arabia 45% of women had their first pregnancy before age 20 [17]. In many countries, the age of marriage has been rising, in part because more women are being educated for longer, and they postpone marriage until after their studies, and also because young people cannot afford to get married. This postponement of marriage raises another problem—the sexual behaviour of young people between puberty and eventual marriage. Another custom in the Region is that the first pregnancy should come as soon after marriage as possible, to prove the wife's fecundity and the husband's virility.

* Imam Abu Hanifa adopted 17 or 18 as the age for marriage. The Ottoman empire followed his school of jurisprudence.

With premature marriages, teenage pregnancy occurs and carries great risks to the health of the mother and child [18].

2.5.3 Adolescent pregnancy

The majority of teenage pregnancies in the Eastern Mediterranean Region happen within marriage; however, a few happen, unfortunately, out-of-wedlock.

Pregnancy before age 20, and particularly before 18, is considered globally to be "high-risk pregnancy" since it carries higher risks of morbidity and mortality compared to pregnancy at 20 and older. The most common pathological conditions associated with early pregnancy are: pre-eclampsia, urinary tract infection, delay in intrauterine growth; dystocia of presentation and position, fetal-pelvic disproportion, premature rupture of membranes, prolapse of umbilical cord, fetal distress, profuse haemorrhage, vesico-vaginal fistula, high maternal mortality, high perinatal mortality of the offspring and low birth weight of the surviving child.

These complications are a result of incomplete growth of the adolescent, poor antenatal care and lack of access to blood transfusion and emergency obstetric care in rural areas and poor yet rapidly growing urban areas.

Pregnancy out of wedlock increases these risks as well as causing the psychological stress of the mother-to-be, the stigma of pregnancy out of wedlock may deter the woman from seeking such antenatal care as is available. Such shame may also cause a new, unmarried mother to abandon her newborn on the steps of a mosque or church, or even to commit infanticide.

2.5.4 The media and sexuality

Because parents are virtually silent on sex instruction of their young, a situation that is compounded by the ambivalence of school curricula, the mass media have a profound influence on the sexual behaviour of adolescents. Adolescents are being exposed to the intensive influence of features with sexual overtones through the cinema, the video, the television, the radio and the press. To these is added a dangerous trend—making available to teens suggestive video songs and X-rated movies via cable and satellite television and by the underground trade and out-of-control peer-groups or gangs. Sex is not the only thing promoted in them; violence, smoking, alcohol and hard drugs are equally forcefully pushed. It is unfortunate that often the media lead adolescents away from their cultural norms. And that is where the real danger lies; and it needs to be confronted. It is of interest to note that even the authorities in developed countries have been getting worried about the increasing amount of sex and violence in the media. Studies have been undertaken to measure the effect of such exposure on adolescents. These studies in the United States of America showed that:

- adolescents spend more time watching television than studying
- exposure to sex and crime in the media increases the acceptability of premarital sexual relations in adolescents
- juvenile delinquency and antisocial behaviour is correlated with the amount of exposure to portrayals of such behaviour in the media. [19–21].

2.5.5 The sexual behaviour of adolescents and the prevention of STD/HIV

The lifestyle adopted by adolescents and youth will decide, in large part, the risk of sexually transmitted disease (STD) and HIV infection. It is to be remembered that these age groups are vulnerable to such infections. For example, ages 20–24 usually have the highest incidence of HIV infection followed by those 15–19 years of age [22].

There are three profiles of adolescent sexual behaviour in the Eastern Mediterranean Region. The first is a conservative culture in which adolescents, with family direction, conform to the religious norm of keeping chaste until marriage. This group is virtually completely protected from STD. The second is the diametrically opposed profile of youth imitating the decadent behaviour of some American and European adolescents. They have boyfriends and girlfriends, they drink and use drugs and may have premarital sex. This is a small yet increasing group and is exposed to STD and HIV from sexual contacts. The third group has a mixed profile; they are not as restrictive as the first group and are not as permissive as the second. They are less likely to be exposed to STD than the second group, but they are at risk. Unfortunately, this group is also increasing in number.

2.5.6 Contraception for married adolescents

As soon as teenagers enter into a marriage contract, they should receive adequate instruction about contraceptive methods. The parents' consent, should, of course, be sought.

The purpose of contraception is to delay the first pregnancy until age 20 or beyond and to space subsequent pregnancies.

2.5.7 Elimination of female genital mutilation

One of the most horrifying experiences female adolescents have to undergo in some societies is genital mutilation. This means removal of parts of the external genitalia of the female, including sometimes parts of the clitoris. The degree of mutilation depends on local practice and can result in psychological and physical trauma for girls, besides cutting down their sexual enjoyment after marriage. More drastic forms of mutilation, such as infibulation, have serious health and obstetric consequences. There is no sound evidence in religion in favour of this practice, and its elimination is a priority for this Region [23].

2.6 THE INSTITUTION OF MARRIAGE AND PREVENTION OF ABERRANT SEXUAL BEHAVIOUR

All religions and subcultures within the Eastern Mediterranean Region consider the family as the basic social unit and marriage as the only way of family formation. Marriage, in religion, provides tranquillity for each of the spouses and provides them with protection from immoral sexual behaviour. Marriage is considered the only acceptable way to satisfy the sexual needs of young people, to prevent out-of-wedlock pregnancy and to protect them from sexually transmitted diseases such as HIV/AIDS.

Marriage itself is a God-given institution, an institution that God Himself considers among His signs as declared in the Quran:

> *And of His signs is that He created for you mates [spouses] of yourselves that you might find tranquillity in them. And He ordained between you love and mercy.*
> *Al-Roum: 21*

The Prophet stresses:

> "*Marriage is one of my institutes; he who repudiates it will not be one of my followers*" (i.e. is not a Muslim).

The institution of marriage and family is crucial for the continuation of our culture, and the protection of family genealogy, honour and future generations from contamination and break-up. Marriage also provides a home for the proper upbringing of children with love and care. Studies in the developed world have shown that a stable and happy marriage is the best environment in which to bring up children, and that, on the whole, children from broken homes fare worse than children from well-functioning families. Mental problems and juvenile and later delinquency have also been found to be associated with poor upbringing in childhood.

For marriage to be successful the two partners should be prepared biologically, socially, financially and psychologically. Until marriage takes place young people should be patient and should preserve themselves for their beloved partners.

The Quran says:

> *And let those who cannot arrange marriage keep chaste till Allah gives them sufficiency of His bounty.* *Al-Nour: 33*

and the Prophet says:

> *O young people let those who possess the means [sexual and financial] get married, which is the way to lower your gaze and protect your chastity. But those who cannot [do not have the means], let them take to fasting, for fasting is a good restraint of the sexual desire.*

Marriage is likewise the norm in Judaism and Christianity. In the Old Testament, marriage was considered the way for Adam:

> *Then the Lord God said, "It is not good that the man [Adam] should be alone; I will make him a helper fit for him."* *Genesis 2:18*

In Christianity, the church condones sexual relations only within marriage, the only acceptable alternative being abstinence.

Says St Paul in his first letter to the Corinthians:

> *To the unmarried and the widows I say that it is well for them to remain single as I do. But if they cannot exercise self-control, they should marry. For it is better to marry them than to be aflame with passion.* *1 Corinthians 7:8–9*

Extramarital relations are prohibited by all religions and are not accepted by the culture of the Region.

In the Quran, we read:

> *Do not commit adultery, for it is foul and improper.* *Isra': 32*

and

> *And that you draw not near to lewd things [adultery] whether overt or covert* *al-Ana'm: 151*

In the Old Testament, the seventh of the ten commandments given to Moses was

> *Thou shalt not commit adultery.* *Exodus 20:14*

In the New Testament, adultery is categorically prohibited, and St Paul warned against even mixing with fornicators

> *I wrote to you in my letter not to associated with immoral men.* *1 Corinthians 5:9*

It can be concluded that sex is restricted in religion, which allows it only within marriage. Thus each spouse should preserve himself or herself for the other.

On homosexuality

Homosexuality has been condemned by both Islam and Christianity.

The Quran says

> *Lo! you come with lust unto men instead of women. Nay, but you are wanton folk.* *Al-Ar'af: 81*

The Prophet Muhammad says:

> *The worst that I fear for my nation is what Lot's folk have done.* *Narrated by Abn Maja*

In Christianity, in his first letter to Timothy, St Paul says

> *The law is not laid down for the just but for the...immoral persons, sodomites...."* *1 Timothy 1:9–10*

In his letter to the Romans he says:

> *For the wrath of God is revealed from heaven against all ungodliness and wickedness of men....*
>
> *For this reason God gave them up to dishonourable passions: their women exchanged natural relations for unnatural, and the men likewise gave up natural relations with women and were consumed with passion for one another, men committing shameless acts with men.* *Romans 1:18, 32*

The conclusion derived form the above discussion on marriage coincides with that drawn by the 1991 regional consultation on the role of ethics and religion in the prevention and control of AIDS or other sexually transmitted diseases, namely:

> "Marriage is a major solution to these problems, as it protects young people. Nevertheless, it is tremendously difficult to achieve. It is just not enough to advise young people to abstain from sexual activity while all around them is inviting and full of temptation. We must therefore facilitate marriage and remove all financial, social and traditional obstacles that prevent it [24]".

PART THREE: ADOLESCENTS AND BIOSEXUAL INFORMATION

3.1 THE NEED FOR INFORMATION

Correct, carefully measured, properly timed and empathetically provided biosexual information is crucial for adolescents. This is to help them learn about their bodies and the functions of their reproductive system. The system should be viewed within cultural and religious norms; any deviation is abuse of the system. Adolescence is the critical decade when biological and sexual maturation takes place. Adolescents cannot comprehend or handle the rapid changes on their own. Information and guidance are prerequisite for a healthy adolescence.

And yet, some parents believe that children and young adolescents should be left alone and be protected from exposure to any sex information that could open their eyes to things that otherwise would not be awakened. When sex questions arise in the presence of or are posed by children, parents get embarrassed and quickly change the subject or dismiss the child on the assumption that children should not hear these things. This may be true of very young children, but can hardly apply to adolescents undergoing changes leading to puberty and sexual maturation, which are shocking to many unprepared adolescents. In a recent study in Tunisia [25], adolescents aged 15 years and over, when interviewed, indicated that they wished to have proper information on their sexuality (physiology of puberty, sexual behaviour, sexually transmitted diseases and marriage). Of those interviewed, 15% of boys and 14% of girls were surprised by puberty (i.e. were not prepared beforehand); 36% of girls and 11% of boys were shocked and apprehensive of the stressful events of puberty (i.e. they did not get enough preparation or support during a difficult time).

Parents should realize that there are many different sources of sex information that can influence their adolescents, many of which are not appropriate or even factually correct and might lead the adolescent to adopt risky behaviour.

3.2 IMPARTING BIOSEXUAL KNOWLEDGE TO ADOLESCENTS

The succession of different phases of sexual maturation and psychosocial development require that the information provided to the adolescent should be tailored to each stage. For that reason four stages will be considered here:

- pre-puberty : 10–12 years } early adolescence
- puberty : 13–14 years }
- post-puberty : 15–17 years middle adolescence
- late teens : 18–19 years late adolescence

3.2.1 **Pre-puberty** 10–12 years of age

This is the age of becoming responsible. The information required in this stage is simple. The child is informed that he/she has grown up now enough to pray regularly like an adult. He/she is provided with separate sleeping arrangements. He/she is to request permission, at certain times of day, when entering a room where there are adults resting. He/she should be made, on different occasions, aware of the family and its role in keeping

relatives together and in helping one another. Parents are loved and respected. Children are loved, guided and provided for.

Children may casually be made aware that families are made by men and women who are married. They should be comforted about the early appearance of secondary sexual characteristics like pubic hair in boys and girls and development of breasts in girls.

3.2.2 **Puberty** 13–14 years of age

Adolescents by this age should have been prepared for signs of puberty. The father or mother may be suited to discuss wet dreams with the boys. The mother or another female in the family is the best to prepare a girl for menarche. Girls should be told that this is a part of natural growth, and that all adult females start their adulthood this way. Girls must be advised on personal hygiene during menstruation. During menstruation, no prayer, no fasting and no entering the mosque are the rule. A ritual bath at the end of the menstrual period re-establishes the state of ritual purity required before praying, fasting and entering the mosque. The same with the boys after wet dreams. Girls also have sex dreams and should have the ritual bath accordingly.

Girls should be reassured if the period is irregular, too heavy, too light or delayed. If menarche has not occurred by age 18, medical advice should be sought, especially if the girl is not overtly undernourished. Severe cramps and premenstrual syndrome (PMS) may also require medical attention.

Masturbation may be discovered by adolescents by accident or suggested by peers. There is no explicit textual prohibition in religion but the practice is not encouraged. Some parents may choose not to talk about it with their children, others may do so. The literature gives a number of health consequences, some of which are exaggerations. In any case, moderation is safest. There is one problem, however: some adolescents become compulsive masturbators, both boys and girls, and may continue to masturbate even after marriage.

At this early age, it may not become necessary to discuss sexual intercourse and how pregnancy occurs. The main thing a parent or teacher should emphasize is that *with puberty, pregnancy becomes a possibility*, although normal practice is to wait until marriage before becoming pregnant. There may be questions by adolescents about sperm and ova that need to be answered.

Continued enrolment in school of adolescent girls is one way of raising the age of marriage till after sexual maturation. After marriage girls should not be denied continuing their education.

3.2.3 **Post-puberty** 15–17 years of age

This is a most vulnerable age and needs extra attention. It is the age of premature marriage, teenage pregnancy and in some cases drug use and sexually transmitted diseases. All these ills should be tackled. Kind but firm dialogue with adolescents should continue.

They should be aware of the anatomy of the male and female genital systems and how a woman becomes pregnant. To be emphasized here is that a drop of semen can produce pregnancy, even without intercourse, if sperm enter the vagina. In fact a drop of semen contains millions of sperm of which only one is needed for fertilizing a egg.

Marriage should again be emphasized as the only way for sexual gratification. Adolescents should preserve their chastity until they get married. The virtues of virginity are too great to miss. The concept of virginity expressed in a "modern" way has been aptly stated in a recent communication [26]:

> "Instead of virginity being something we 'lose' or have to 'save' for someone, it could mean our physical, spiritual and emotional wholeness, our self-respect and our bodily integrity and our freedom to make a choice. When we make choices about sex, our feeling of self-respect and 'virginity' we will more likely put ourselves into a situation we can be glad about."

The danger of premature marriage at this age is that of early pregnancy, which is risky for both mother and fetus. High maternal mortality and severe maternal morbidity are calculated risks.

Another danger for adolescents in this age group is that they may consider themselves old enough to view X-rated movies, suggestive video songs or pornographic magazines or, under peer pressure, to experiment with sex. This is very disturbing because it may lead to three ills of adolescence:

- unwanted pregnancy, possibly followed by abortion
- sexually transmitted diseases
- introduction to smoking, alcohol and drug use and violence.

Dialogue with adolescents in this age group may include advice to shun peers who might have a bad influence on them and avoid media with sexual content.

The more education an adolescent girl receives, the more she is empowered; it is a way of raising the age at marriage to 18 or older and a way of sublimation. An educated mother is crucial for future generations.

3.2.4 **Older adolescents** 18–19 years of age

The advice listed above applies here as well.

- Marriage at this age, however, is acceptable and is what is meant by early marriage in the Eastern Mediterranean Region.

- Contraception should be emphasized for married teens to postpone the first pregnancy and space the subsequent ones.

3.3 SOURCES OF INFLUENCE ON ADOLESCENTS

Throughout the growth years, adolescents are subjected to a variety of influences. Some of the influences are internal (the process of biosexual maturation and psychosocial development) and others are external. Familial sources include family structure and cohesion,

parental characteristics, parent-child communication and influence of siblings. Migration of the parent(s), especially the absence of the father (which is not uncommon in the Eastern Mediterranean Region), may have a negative influence on growing adolescents. Family problems between the parents will influence the psyche of adolescents, the worst of which is divorce. Information gleaned from the behaviour of maids and servants may lead adolescents astray.

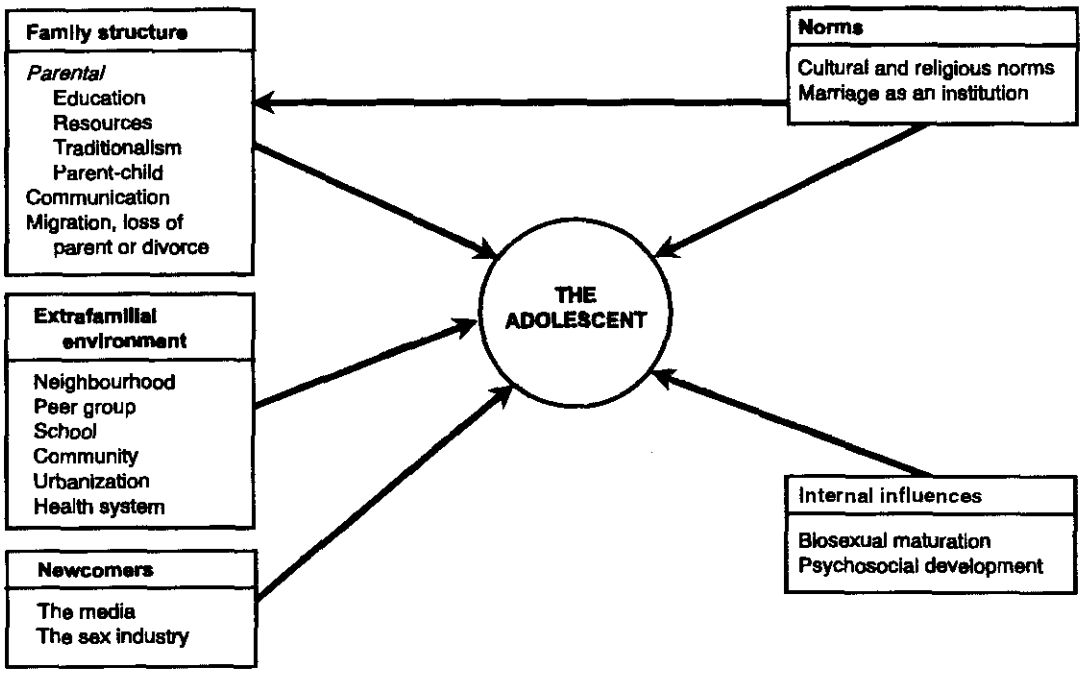
The extrafamilial environment has a great influence on the adolescent especially if parents are silent on sexual issues. This environment includes the neighbourhood, the school, the peer group, the community at large and, last but not least, the health system in and outside school.

The cultural and religious norms in the family and community have far-reaching effects on the upbringing of the adolescent. *Central to all these is the institution of marriage, which can be entered into at age 18 or later.*

The media overwhelm adolescents with sex information, quite often leading to sexual misbehaviour with untoward consequences.

Figure 3 illustrates the various influences on the adolescent.

Figure 3. Influences on the adolescent



3.4 SHARING THE RESPONSIBILITY FOR EDUCATING ADOLESCENTS ABOUT SEXUALITY

3.4.1 The primary interest group

This group, which should shoulder the responsibility of health education of adolescents, especially about sexuality, includes parents and other family members, teachers, school health professionals and enlightened religious counsellors. Parents naturally should be the first to watch for the early signs and subsequent stages of physical growth and sexual maturation. They should start counselling their children, but they will need the cooperation of other members in the family, the teacher, health personnel and the religious counsellors. All those counselling adolescents need to be trained in the technique of counselling [27].

3.4.2 Community youth-friendly groups

Ideally some community action groups should be established as nongovernmental organizations cooperating closely with the primary interest group. Other important groups are the youth-to-youth organizations, particularly the Scout Movement (for boys and girls), which can organize adolescent orientation to complement the primary interest group [28].

3.4.3 Promotion of the employability of youth

The following are suggestions that might enhance young people's opportunities for finding worthwhile work.

- Enhancement of knowledge and skills of young people.
- Continuation of girls' school enrolment and/or education even after early marriage.
- Promotion of special talents of adolescents in sports, music, literature, art and other activities.

3.4.4 Recruiting the mass media

It is possible to use the mass media to educate adolescents and young people in all areas related to growth and maturation; however, this has to be done in an appropriate manner.

3.4.5 A guide for parents and teachers

There is a need for a guide to help parents, teachers, health professionals and all others concerned with adolescents. It should include simple and direct answers to questions that young people ask.

PART FOUR: CONCLUSIONS AND RECOMMENDATIONS

Adolescence is the critical second decade of human life that links the vulnerable period of infancy and younger part of childhood to adulthood. It is marked by profound biological and psychosocial changes. In spite of this, adolescence is a neglected area, as evidenced by the absence of reliable health related information as well as any focused attention through appropriate health coverage.

The urgent need to focus attention on adolescent girls to ensure safe motherhood is being increasingly recognized. There is also increasing recognition of the vulnerability of adolescents to sexually transmitted diseases and substance abuse in certain social and cultural settings. The importance of inculcating proper health-related behaviour in adolescence to serve as a sound foundation for a healthy adulthood has been accepted as an essential goal in health education. The promotion of healthy adolescence deserves special consideration in the health care system.

The following are the main elements in initiating national strategies for the health education of adolescents.

1. To sensitize decision and policy-makers regarding the special health and psycho-social needs of adolescents

Once this important first step is achieved, national mass-awareness campaigns for social mobilization and for creating "pressure groups" in society can be organized. The health, education, information and social welfare sectors of the government in close collaboration with nongovernmental organizations must take a leading part in organizing such measures.

National seminars and conferences will have to be organized to sensitize the relevant sectors of the government, nongovernmental organizations, and political, social and religious leaders about the importance of this stage of human life, and the special need to support adolescents in establishing desirable health behaviour for their future adulthood.

2. To secure more information about adolescents

Information is lacking on adolescents' health, their attitude and behaviour in this Region; neither is it fully known how they respond to their physical, biological and sexual growth. It is therefore essential to conduct well designed and comprehensive studies to assess the status of adolescents to enable planning of realistic ameliorative measures. Adolescent health status and adolescent health behaviour deserve special consideration in such situation analyses.

3. To educate for a healthy adolescence through schools

The foundations of healthy behaviour in adulthood are laid in childhood. Undesirable dietary habits, lack of physical activity and exercise and indulgence in smoking are common examples of risky health behaviour in adult age which can be traced to adolescence. Health

education in childhood and adolescence imparted through several sources, such as home, schools, community gatherings and religious congregations, each complementing the others, has been found to be profoundly effective in establishing a healthy lifestyle in adulthood. However, schools may be made to have unique advantages for imparting health education to adolescents, complementing the role of parents.

School health services, either as a separate programme in the health care sector or as a component of maternal and child health programmes (and in some countries as a separate programme in the education sector) are expected to provide health care to all schoolchildren, both primary and secondary. School dropouts and adolescents in rural areas should be covered by and educated in maternal and child health or primary health care programmes.

4. **To provide knowledge on reproductive health and sexual issues to adolescents**

Reproductive health is an integral part of the general health development of individuals. Adolescents, during their "growing up" process, have to be aware of the issues related to reproduction in the same manner they have to learn about appropriate dietary intake, personal hygiene and physical activity. School health education is thus an ideal approach for this purpose and should be properly utilized. This responsibility should however be shared among teachers, school health providers and parent and community groups.

The curricula should be properly designed according to the age of the adolescents. By and large, the topics should be carefully selected in three phases: pre-pubertal, pubertal and post-pubertal, and include structure and function of the reproductive system, pubertal changes and the reproductive process itself.

Education of older adolescent boys and girls in reproductive health issues should be designed for these major reasons: postponing pregnancy till the girl is biologically and emotionally mature and preventing unwanted pregnancy. The importance of marriage and family formation should be emphasized to all age groups, but especially to this age group.

Schoolteachers need proper support through appropriate training manuals and teaching aids.

As to the role of the parents and family, this should be supported so that parents can share in imparting knowledge to their children. Examples:

- Active participation in educating their children about health during their adolescence. They should be persuaded to abandon the policy of keeping children in the dark in regard to sex. Parents have the unique position (and responsibility) to impart religious values to their children and to encourage chastity before marriage.

- Parents should be helped to prepare themselves to respond to children's questions about sexual and biological issues, including references to sex in religious texts, read or heard in the media or elsewhere.

- As children reach puberty, parents should instruct them in religious rituals, e.g. bathing after wet dreams or menstruation, and how to keep clean.

- As mixing of the sexes is increasing in some countries (in schools or at work) it will be advantageous to allow limited mixing in the family under the supervision of parents.

- Parents should exercise their right to vet what their children and adolescents see on television or videos. They should ban sex films and should protect their children from bad company.

- Parents should allow their adolescent girls to continue their schooling even after engagement or marriage.

- It should be emphasized again that teachers should be trained and provided with guidelines about health education of adolescents with model answers about important questions, including those expected from adolescents. Local language is useful.

5. To support other sources of information on reproductive health for adolescents

In addition to schools as a repository of information on reproductive health and on sexual issues, there are other important sources, who should be supported so that they can perform their role in more effective manner. These include:

- parents
- health providers in schools and in the community, such as primary health care workers
- youth organizations, such as the Scout movement
- religious leaders in the community.

Leaders of local youth organizations will need support in order to impart correct information about adolescent health. Guidelines and simple manuals in local languages will have to be prepared for this purpose.

Health providers, especially primary health care workers, should be trained to respond to the needs of adolescents and providing them with correct information.

6. Strengthening and reorganization of maternal and child health programmes for responding to the needs of adolescents

Maternal and child health programmes for adolescent health promotion are of considerable importance, especially in rural areas where most adolescent girls have dropped out from school and are not covered by school health education. Unfortunately, adolescent pregnancy, with its associated high morbidity and mortality, is common among this population.

Maternal and child health programmes in most cases do not have any activity specifically designed for adolescent girls. Steps should be taken to incorporate weekly sessions for adolescent girls in the form of "adolescent clinics" in which, apart from health protection and promotion through usual preventive and curative measures, educational programmes can be arranged for imparting knowledge on reproductive health, and for older married or engaged adolescent girls, with the explicit consent of parents, relevant information and advice about birth-spacing and safe motherhood.

REFERENCES

1. Tanner I et al. *Growth at adolescence*, 2nd ed. London, Blackwell Scientific Publications, 1968.

2. Gallagher JR et al. *Medical care of the adolescent*, 3rd ed. New York, Appleton-Century-Crofts, 1977.

3. Cited in Silber JJ. Adolescent medicine, the development of a new discipline. In: *The health of adolescents and youth in the Americas*. Washington, DC, World Health Organization/Pan American Health Organization, 1985.

4. *Health problems of adolescents. Report of a WHO expert committee*. Geneva, World Health Organization, 1965 (Technical Report Series No. 308).

5. *Health needs of adolescents. Report of a WHO expert committee*. Geneva, World Health Organization, 1977 (Technical Report Series No. 609).

6. *Consultation on school mental health programmes, Islamabad, Pakistan*. Alexandria, Egypt, World Health Organization, Regional Office for the Eastern Mediterranean, 1993 (WHO-EM/MNH/138).

7. *Intercountry consultation on the promotion of the health of adolescent girls through MCH programmes, Nicosia, Cyprus*. Alexandria, Egypt, World Health Organization, Regional Office for the Eastern Mediterranean, 1995 (WHO-EM/ADH/004).

8. Amine EK. *Bahrain nutritional status survey*. Abu Dhabi, United Arab Emirates, UNICEF, 1980.

9. *Towards a national nutritional policy: guidelines for countries of the Eastern Mediterranean Region*. Alexandria, Egypt, World Health Organization, Regional Office for the Eastern Mediterranean, 1990 (WHO EMRO Technical Publication No. 17).

10. Sheer B. Caries in children, the dietary factors. *Middle East dentistry*, 3: 20–22.

11. *Nutrition: highlights of recent activities in the context of the World Declaration and Plan of Action for Nutrition*. Geneva, World Health Organization, 1995.

12. Omran AR. *The epidemiological transition in the Americas*. Monograph under publication by World Health Organization/Pan American Health Organization and the University of Maryland, USA.

13. Shearin RB. *Handbook of adolescent medicine*. Michigan, Upjohn Co., 1983.

14. *Achieving reproductive health for all. The role of WHO*. Geneva, World Health Organization, 1995.

15. Ibn Qayyem al-Jawzia. *Tuhfatul-mawdoud bi-ahkam al-mawloud* [Arabic].

16. Musaiger AO et al. *Health and nutrition status of mothers and children in Bahrain* (in preparation).

17. Musaiger AO. *Health and nutritional status of Omani families.* Muscat, Oman, UNICEF, 1992.

18. Cited in Musaiger AO. *Some health and nutritional indicators for adolescent girls in the Eastern Mediterranean Region.* Paper presented at the intercountry consultation on the promotion of the health of adolescent girls through MCH programmes, Nicosia, Cyprus, 1995.

19. Strasburger VC. Children, adolescents and the media, five crucial issues in adolescent medicine. In: *Adolescents and the media.* Philadelphia, Pennsylvania, Hanley and Belfus, 1993.

20. Bryant J. Effect of massive exposure to sexually oriented prime time television programming on adolescents' moral judgement. In: *Media, children and the family.* Hillsdale, New Jersey, Laurence Eribaum Associates, 1994.

21. Morgan M. Television and school performance. In: *Adolescents and the media.* Philadelphia, Pennsylvania, Hanley and Belfus, 1993.

22. Wahdan MH. *The epidemiology of HIV/AIDS.* Paper presented to the consultation on the role of religion and ethics in the prevention and control of AIDS, Alexandria, Egypt, 1995.

23. *Islamic rulings on circumcision* [in Arabic]. Alexandria, Egypt, World Health Organization, Regional Office for the Eastern Mediterranean, 1995 (Health Education Through Religion, No. 8.)

24. *The role of religion and ethics in the prevention and control of AIDS.* Alexandria, Egypt, World Health Organization, Regional Office for the Eastern Mediterranean, 1992 (Health Education Through Religion , No. 6).

25. Mzid J, Zarrouk AM. *A study of knowledge, attitudes and perceptions of school adolescents on family health.* Tunis, Tunisia, Ministry of Public Health. Unpublished.

26. Haddad, W. *Adolescent sexuality.* Paper presented to the intercountry consultation on health of adolescent girls in EMR countries, Beirut, Lebanon, 1993.

27. *Counselling skills training in adolescent sexuality and reproductive health.* Geneva, World Health Organization, 1993.

28. World Organization of Scout Movements, Arab Region. *Promotion of adolescents' reproductive health through NGOs' collaboration.* Programme report, September 1990 to October 1991.

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Forty-third Session

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Agenda item 11(a)

TECHNICAL PAPER ON HEALTH EDUCATION OF ADOLESCENTS

Summary of recommendations

1. Decision-makers and policy-makers should be sensitized regarding the special physical and psychosocial health needs of adolescents.

2. The health, education, information and social welfare sectors of the government should join hands with political, social and religious leaders in creating mass awareness of these needs.

3. Comprehensive situation analysis studies should be conducted to collect more information about the present status of adolescent health and its major determinants.

4. Educational programmes should be developed that provide culturally appropriate information about reproductive health and sexual issues to adolescents as a component of health education curricula, especially the school health curriculum.

5. School health programmes should be strengthened to respond to the special health needs of adolescents.

6. Health education should be imparted through other sources as well, such as places of worship and community gatherings.

7. Guidelines and simple manuals in local languages should be prepared to enable the following support groups to impart information about reproductive health issues to adolescents: parents, health providers in schools and the community, nongovernmental organizations and religious bodies in the community.

8. Maternal and child health programmes should be strengthened and reorganized in order to undertake a major role in promoting the health of adolescent girls.