**Seen but not heard**...

**Very young adolescents aged 10–14 years**
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Seen but not heard...

Very young adolescents aged 10-14 years
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Introduction

At a time when HIV threatens the lives of young people, when alcohol and drugs are widely available and globalization degrades traditional protection, increasing attention is paid to the dangers facing young people. However, society focuses its concern mainly on older adolescents. Programmes are often designed for those who are already sexually mature, engaged in health threatening behaviour or whose activities are regarded as antisocial. There is a strong case for saying that this attention comes too late—a missed opportunity to intervene before and during the profound changes that mark the end of childhood and the early years of adolescence. Adults need to understand the remarkable biological and psychological changes sweeping through young people in the years from 10–14 years of age. This is a time of transition when young people acquire the knowledge and skills they need for adult life. It is also the time when they first face choices and risks that completely derail their lives, if they go wrong. For most young people, these years represent an age of:

- **Maximum change** Puberty, the process of maturation, is an explosive social and psychological and physical development that affects almost every tissue of the body, with profound implications. Young adolescents feel impelled to test limits and to take risks, without understanding the possible effects.

- **Maximum vulnerability** A young person’s exposure to risk varies with the context of his or her life. Even at this young age, boys and girls can be snared by too early sex, alcohol, tobacco, drugs, violence and accidents with tragic or lifelong consequences. The best protection from risk is provided by parents who are closely involved with their children’s lives, who set expectations and limits and who encourage their children to think for themselves. However, in many countries the number of 10–14 year-olds who have the benefit of two parents and a supportive school environment is declining, because marriages and relationships break down, and because AIDS leaves children as orphans. Other adults, relatives, teachers, religious teachers and club leaders can help by monitoring and supervising the activities of young people.

- **Maximum opportunity** Most young people of this age live at home with at least one parent or close family member. Girls as
well as boys tend to be in school. This is therefore, perhaps, the last time when young people will be closely monitored by parents, caregivers and teachers.

Most 10–14 year-olds are listening and eager to learn, and still aspire to the values of parents and caregivers as role models. Young adolescents value advice and support from parents and want to be accepted into the world of adults, to respect that world and be respected by it. They have the optimism and energy to be assets to their communities. Developing skills and competencies at this age, potentially reduces the need to focus on problems and harm reduction amongst older adolescents whose attitudes and belief patterns are more firmly set, and who are less likely to ‘tune in’ to adult voices.

Very young adolescents are not exactly ignored by the adult world, but they are not always engaged. Very young adolescents tend to be seen but not heard. They tend to be healthy, and usually appear to be relatively happy; adults see them as enjoying the final stage of childhood in comparative calm and safety. Underneath however, problems can be developing which will affect their whole lives, particularly in the case of very young adolescents who are out of school and who lack the support of two parents at home. These years represent an opportunity for concerned adults to harness the optimism and resilience of young adolescents, to develop their competencies and skills in the transition to healthy adulthood and to build patterns of health-maintaining behaviours and attitudes. The focus of programmers should be on developing abilities and potential rather than on problems. Youth programmes and the school curriculum need to address the needs of young people at this critical age. This is the best chance to make the connections that keep young people safe from harm. This opportunity will soon pass and for some very young adolescents it may not come again.
Adolescence transforms the body, the emotions and the mind. In early adolescence the body experiences a growth spurt, and sexual development begins. Over the past 200 years the age at which puberty begins has declined by about three years. Puberty can now begin as young as eight years for girls and nine years for boys. For most young people major physical and physiological changes take place between the ages of 10 and 14. At the same time, as education has become more important for the development of society, the age at which young people take on adult roles has increased. Adolescence has become a physical and psychosocial process lasting most of the second decade of life.1

Figure 1
Developmental stages among 10–14 year-olds2

<table>
<thead>
<tr>
<th>Ages and developmental stages are approximate medians.</th>
<th>Early Adolescence (aged 10–12)</th>
<th>Mid-Adolescence (aged 13–14)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Development</strong></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>Growth of testes</td>
<td>Growth of breasts</td>
<td>Growth spurt</td>
</tr>
<tr>
<td>First signs of pubic hair</td>
<td>Pubic hair</td>
<td>First ejaculation</td>
</tr>
<tr>
<td>Growth of penis</td>
<td>First period</td>
<td>Masturbation</td>
</tr>
<tr>
<td>Growth spurt</td>
<td>Taller than boys</td>
<td>Growth spurt</td>
</tr>
<tr>
<td><strong>Brain Development</strong></td>
<td>Responds best to visual stimuli</td>
<td>Responds best to sound stimuli</td>
</tr>
<tr>
<td>Low impulse control</td>
<td>Impulse control low but greater than boys</td>
<td>Begins to gain some impulse control, increase in sensation seeking</td>
</tr>
<tr>
<td><strong>Social Development</strong></td>
<td>Sport and competition</td>
<td>Companionship and joint activity with other boys</td>
</tr>
<tr>
<td>Little interest in ‘girls’ issues’</td>
<td>Personal relationships begins concern over body image</td>
<td>Self-disclosure and interpersonal skills Concern over weight and body image</td>
</tr>
<tr>
<td><strong>Emotional Development</strong></td>
<td>Increase in physical aggression</td>
<td>Aggression channelled through avoidance or criticism</td>
</tr>
<tr>
<td><strong>Sexuality Development and Societal Response</strong></td>
<td>Becomes aware of masculinity in self ‘Feminine’ behaviours considered ‘deviant’</td>
<td>Becomes aware of femininity in self ‘Tomboy’ behaviours accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Messages

Puberty brings rapid changes in the body. It makes young people think and feel differently. Changes are both biological and the product of society.

1. Connections between Puberty and Psychosocial Development by Professor Pierre Michaud of the Multidisciplinary Unit for Adolescent Health, University of Lausanne, Switzerland. Presented at Very Young Adolescents: the hidden young people WHO, UNAIDS and UNFPA meeting, Geneva 29 April–2 May 2003. (Subsequent footnotes will refer to “Geneva April/May 2003.”)

2. Adapted from The Evolution of the Young Adolescent presented by Dr Cecilia Breinbauer, Child and Adolescent Unit, PAHO at Geneva April/May 2003. Dr Breinbauer uses ‘pre-adolescence’ and ‘early adolescence’ to cover the 10–14 year old age bands.
What do these changes feel like for young people? At the age of 10, they are still children, beginning to become more self-aware, and to see themselves as having an identity separate from their parents and families. Over the next few years they experience body changes with a mixture of pride and anxiety. They spend more time with young people of their own sex. Intellectually, this is a time of energy, creativity and optimism, when they begin to think in more abstract terms. Most still have a close relationship with their families, but conflicts may increase, particularly over autonomy. Adolescents become sexually aware and develop powerful emotional attractions as hormones surge through their bodies. Changes do not happen at an appointed age or at a steady rate; there is variation between young people at all stages of development. Emotional development also varies and may not keep pace with changes in the body. This is a period of acute sensitivity. Many young people feel embarrassed and are very sensitive to their own differences. Groups of young people can seem judgmental or even cruel as they enforce what they consider to be ‘normality’. Adolescence can be divided into:

- **Early adolescence** (10–12/13) characterized by a growth spurt and the beginnings of sexual maturation. Young people start to think abstractly.
- **Mid-adolescence** (13/14–15) during which the main physical changes occur, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group. Thinking becomes more reflective.
- **Late adolescence** (16–19) during which changes are completed as the body fills out and takes its adult form. An individual develops a distinct identity and more settled ideas and opinions.

These divisions are made to provide a framework for understanding the changes in young people. However, these categories are a guide and may not apply to any one individual. Age can be a confusion in understanding the needs of young adolescents,
because of variations in development and understanding.

In this 10–14 years age group biological sex differences and societal gender differences make themselves felt. Early adolescent girls tend to be taller than boys. Girls develop sexually earlier. The median age for girls to have their first period is 12 years and five months. The first ejaculation for boys is almost a year later (a median age of 13 years and five months).³

There are also differences related to the development of the brain. The frontal lobe of the brain where reasoning and decision-making takes place is relatively undeveloped, so that early adolescents tend to be impulsive, and hold beliefs uncritically. This ‘impulsive’ effect lasts longer in boys than in girls, because the frontal lobes develop more slowly. The often voiced belief of parents that adolescent girls seem more ‘adult’ than boys has a basis in science.

In the younger age group (10–11 years old) boys become aware of their masculinity. This group typically develops playful aggressive behaviour. Boys’ own sexual identity may appear unclear and confusing. Boys find friendship with girls difficult and spend more time with boys. However, they may also be fearful of being called ‘gay’. Boys who are unsure of their developing sexual identity may become introverted or depressed.

At the same age, many girls begin to show feminine traits and become concerned with their appearance. As with boys, sexual identity may be confusing. Girls spend more social time with girl friends. Less openly aggressive than boys of the same age, girls may use emotional weapons, such as criticising someone or ignoring them.

In the older age group (12–14 years) boys have less control over sexual feelings. They also begin to receive strong messages from mass media, from older peers or as part of cultural beliefs and myths that girls are sexually available, that boys are expected to initiate sex or that abstaining from sex can be physically harmful. They then receive a different message from adults who counsel restraint and respect. Boys have a desire for sensation. They begin to have erections at inappropriate times. Depending on culture many masturbate, although they may be told that it is wrong, and feel unclean.

In most cultures girls are encouraged to inhibit sexual arousal and are discouraged from all forms of sexual exploration. Girls become aware that the risks of sex are

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**Key Messages**

Girls develop earlier than boys. The frontal lobe of the brain that governs reasoning is not fully developed in young adolescents. It develops later in boys than in girls. This may be why boys act impulsively.

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greater for them. Girls may find it difficult to talk about sexual feelings, although they are usually more willing than boys to talk about emotions. For both boys and girls, sex and guilt are often closely associated.

**Anxiety and risk taking**

In North America, Professor Lawrence Neinstein found high levels of anxiety about body changes in this age group in both sexes. During adolescence 50% of boys have some breast development, while many girls have temporarily asymmetrical breast development.

Professor George Patton, at the Centre of Adolescent Health in Melbourne, Australia, working with the Social Development Research Group in Seattle, found that puberty accelerates a trend towards risk taking. As young people pass through puberty, whenever that happens, they are more likely to associate with friends who smoke. The effect is even stronger for early sexual behaviour. Changes in the body drive the young adolescent to experiment with ‘adult’ behaviour, while they have little understanding of risk and lack reasoning and judgement. The Pan American Health Organization (PAHO) found that boys in Latin America who mature early develop self-confidence and a positive self-image, but are more likely to engage in drug and alcohol use, truancy and early sexual activity. Early maturing girls are popular with their peers but are more likely to suffer low self-esteem, depression, anxiety and eating disorders. Girls with strong opposite-sex relationships can be psychologically vulnerable.

Young adolescents soak up popular culture, becoming concerned that they ‘fit in’. Their behaviour may therefore change to conform to peer group pressure, especially as they move from primary to secondary school. They may become very concerned with what they wear and how they look, reflecting a fear of appearing ‘different’.

Adults believe they know what their young adolescent children need, but this may not be the same as what young adolescents say they want. As these young adolescents begin to assert their growing sense of independence, conflict can arise between parents and children.

### Key Message

**Puberty accelerates young people aged 10-14 towards risk taking. Early maturers are at extra risk.**

### Figure 2

Young adolescents: wants and needs

<table>
<thead>
<tr>
<th><strong>WANTS</strong></th>
<th><strong>NEEDS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>Love, nurturing relationships</td>
</tr>
<tr>
<td>Social interaction</td>
<td>Acceptance</td>
</tr>
<tr>
<td>‘Grown-up’ experiences</td>
<td>Developmentally appropriate experiences and success</td>
</tr>
<tr>
<td>Novelty humour and fun</td>
<td>Opportunities, guidance expectations, limits and values</td>
</tr>
<tr>
<td>Music, videos</td>
<td>Safe and supportive environments at home, school and in local neighbourhoods</td>
</tr>
<tr>
<td>computer games, magazines, parties</td>
<td>Healthy nutrition, physical activity and adequate sleep</td>
</tr>
<tr>
<td>hanging out with friends</td>
<td></td>
</tr>
<tr>
<td>Fast foods, sports</td>
<td></td>
</tr>
<tr>
<td>Stay out late</td>
<td></td>
</tr>
</tbody>
</table>
In some countries, puberty marks the time when the world begins to close around girls. Many adopt adult roles because of a missing parent, demands in the home or because they are to be married. Access to social networks and safe spaces for girls narrows, in part to protect them from dangers outside the home. Sport is often one of only a few opportunities for girls to enjoy freedom of expression and the joy of movement.

**Kenya:** in Nairobi, Kenya, the Mathare Youth Sports Association (MYSA) is one of the biggest and best youth organizations, with thousands of members. Girls participate actively, particularly in the under 12s age group, although they are outnumbered 7000 to 2000 by boys. By the age of 14 the number of boys falls to 2000 but the number of girls also declines to 600. In the oldest age group (16–18 year-olds) girls almost disappear, a reflection of the pressure and adult roles placed on them.7

**Egypt:** rural girls are by far the most disadvantaged adolescents in Egypt. According to the 2000 Egypt Demographic Health Survey, fewer than half of rural girls aged 13–15 in Upper Egypt are enrolled in the school system, compared with more than 90% of boys. Adolescent girls are restricted in their ability to go out, have limited social networks, are susceptible to early or forced marriage and are in relatively poor health. They describe themselves as ‘ignorant’ or ‘doing nothing with their lives’. A consortium including Population Council, Save the Children and the Centre for Development and Population Activities (CEDPA), in partnership with the Ministry of Youth, designed the Ishraq (Enlightenment) programme, to create safe spaces for girls to learn, play and grow.8 Ishraq offers girls literacy, life skills and sports in an integrated curriculum that also includes health campaigns. Girls learn to raise and sell poultry or to repair home appliances and also learn basic financial skills. Those who qualify are able to return to school. The programme also reaches the girls’ families and communities. During a successful pilot phase Ishraq touched the lives of more than 200 girls and their families and won top level political backing. Ishraq was designed so that it could easily be scaled up. It is now expanding to three governates in the hopes of reaching an additional 5000 girls and their families. The Ministry for Youth is working to ensure that sports centres around the country move to greater gender equality.

HIV: the threat to adolescents aged 10–14

Children and young people are increasingly at the centre of the HIV pandemic. By 2004 about 14 million children in 88 countries had lost one or both parents to AIDS. An estimated 2.5 million children under the age of 15 are HIV positive. Many were infected as babies and some are now reaching sexual maturity, and are at risk of infecting others. However, 10–14 year-olds have also become infected through sex. It is estimated that 700 000 children under the age of 15 were newly infected with HIV during 2003. In the same year, about 500 000 children under the age of 15 died from AIDS.

Children who miss school and parents’ protection

At the age of 10, most children still live with their parents and attend school, but a significant number are already missing out. The model of a young adolescent with two parents at home and a supportive teacher at school is the exception in some settings. In Benin, Côte d’Ivoire, Ethiopia and Mali about one girl in five and one boy in three aged 10–14 is living with two parents and is also in school. In Kenya only half of 10–14 year-olds has this degree of protection.

In Burkina Faso only two in ten girls and three in ten boys aged 10–14 are still in school. In Ethiopia more than half of boys and more than 60% of girls this age have dropped out of school. Girls are especially likely to drop out. In Pakistan, for example, more than two thirds of boys but only a minority of girls aged 10–14 are still in school.

Orphans

By 2010, it is estimated that there will be 42 million young people who have been orphaned (where one parent has died) and most of them will have been orphaned by AIDS. Almost half of orphans (46%) fall into the 10–14 year-old age group, vulnerable to hunger, neglect, exploitation and abuse. Many programmes for orphans do not reach

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Key Messages

Most 10 year-olds live at home. In some countries a minority live with both parents and are still in school. Children who are out of school and do not have parental support may be vulnerable to unsafe work, such as domestic service, sexual exploitation, trafficking and substance abuse.
Figure 3
Percentage of 10–14 year-olds who are not in school, selected countries. DHS Data

Figure 4
Percentage of 10–14 year-olds who are living with both parents, and who are still in school, selected countries. DHS Data

Figure 5
Percentage of 10–14 year-olds who are living with neither parent, and who are also not in school, selected countries. DHS Data
this age group. There is also a rapid increase in the number of ‘double orphans’ who have lost both parents. Estimates of 5.5 million double orphans in Africa are expected to rise to 7.9 million by the year 2010.\textsuperscript{13} For many orphans the death of a parent means the end of schooling and good quality care. Many become family carers as soon as a parent falls sick. An orphaned child taken in by neighbours or extended families may be expected to work as a domestic servant. In Ethiopia,\textsuperscript{14} three quarters of child domestic workers are orphans. In Zambia,\textsuperscript{15} over half of orphaned children are physically stunted. Children who grow up without a closely concerned guardian or parent learn fewer skills

\textbf{Key Messages}

There is evidence that orphans are vulnerable to abuse. They feel much less optimistic than other young people.

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\textbf{Figure 6}

% of children under 15 predicted to be orphaned by 2010 by region.

\textbf{Figure 7}

Ten countries in sub-Saharan Africa where more than 15\% of children are orphaned

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\textsuperscript{13} Children on the Brink. op. cit.
\textsuperscript{14} Ethiopia, Child Domestic Workers in Addis Ababa: a Rapid Assessment. Abiy Kifle, July 2002.
and find it less easy to make social connections. Such children are particularly vulnerable to abuse throughout their childhoods and the rate of abuse increases as young people reach puberty. There are strong relationships between being orphaned, becoming involved in the worst forms of child labour, such as selling sex for money, food or protection, and the risk of HIV infection. In Zambia, for example, two thirds of young people in the sex industry have lost one or both parents. A study in Uganda showed that orphans are more pessimistic about the future. They have lower expectations of a long life and are much less likely than other children to look forward to marriage or having children. Most young people are very optimistic that they will be in school or work (even where unemployment is high) but a significant proportion of orphans are not.

Refugees
Young adolescents aged 10–14 make up just over 10% of the total refugee population. Many of the two million refugees of this age are in overcrowded camps and not in school. Many child refugees are also members of other vulnerable groups, having lost a parent and being out of school. Many start sexual activity at an early age with little or no protection. Sexually transmitted infections, including HIV, and unwanted pregnancies are a high risk in this population of vulnerable young people.

Street children
Street children have long been familiar in the cities of Asia, Africa, Latin America and North America and are now familiar in Central and Eastern Europe. Children are pushed onto the streets by problems at home, abuse, or through substance abuse. Children are pulled onto the streets by economic need, commercial exploitation, poor access to school and the lure of freedom. But not all street children are totally outside family life. Many children aged 10–14 work in or near street markets alongside their parents. They may go home at night or even attend school. Some rural children go to the cities when the harvest fails and go home when things are better. Other children live on their wits, abandoned by the adult world.

Children may live or work on the streets from the age of eight. Many 14 year-olds have already lived in this way for five years. In such a high-risk environment hygiene, nutritional status and health are at risk. Younger children who live unsupported on the streets may swiftly follow older ones into drug use and sexual activity. The key to preventing long-term problems is to reconnect very young adolescents with family and school as quickly as possible.

18 Patterson Njogu, UNHCR, presentation at Geneva meeting April-May 2003.
Dr Don Kaminsky runs an organization for street children in Tegucigalpa, Honduras—Fundacion Desarrollo, Amistad y Respuestas (FUNDAR). He sees a small window of opportunity to reintegrate street children back into their family and into school before long-term problems set in. “The material conditions of living in the streets overpower other societal and cultural factors, so that the health status of the homeless street children is more or less the same everywhere. Since these problems become worse the longer the children have lived in the streets, we find a strong rationale for early intervention. “You work with the child and family to see whether you can achieve a rapid reintegration. If you cannot reintegrate the child, then you look for some legal mechanism to get a young child to an alternative adoptive situation.”

Agencies need workers in the streets to detect and attempt to work with young street children within the first two to four months. In Tegucigalpa this means being present in the city market where thousands of people earn their living—from wealthy merchants to those who don’t even have a stall. FUNDAR focuses on the lower end of the scale. The focus is on the working children in order to provide integrated services and prevent them entering into a pattern of living in the streets.

“We provide basic needs, counselling and attempt to determine their family structure and the reason why they are in the streets. For almost all these children the most important person in their life is their mother. “I am convinced that one of the important reasons why we get very good results is we have a strong relationship with the mother—usually the fathers are not there or are not interested. We are regularly in contact with mothers, counselling them, giving them training at a school for parents (Escuela para padris)—school without walls. “The mother is the entry point. We reinforce the importance of what they are doing. The child receives primary health care, and so does the mother. They are in the formal school system, so that they work half a day and they go to school half a day.”
Early sex is a high-risk activity

Adults do not want to believe that young people aged 10–14 are involved in sexual activity, and may believe that it is a very rare event. But sex at this age is much more common than most realise. It is also a high-risk activity. Young people lack knowledge about risks and consequences, and they are liable to be exploited. A high proportion of sex with young people is coerced.

Men may target a young girl because they believe she is less likely to be infected and this will be safer (for themselves). But girls whose bodies are immature are more vulnerable to sexually transmitted infections (STIs), and therefore more vulnerable to HIV. When there is a large age gap and the man is sexually experienced, there is a higher chance that he is infected with a STI. Girls already infected with an untreated STI are up to ten times more likely to get HIV if they have unprotected sex with an infected man.

Adolescents aged 10–14 have little power to put decisions into effect. Young people are often urged to abstain from sex, but this does not address power relationships, exploitation or abuse, where their ability to say “no” to adults is compromised. A high proportion of early sexual encounters are forced or coerced. Sexual abuse is common around the time of puberty. Girls who have sex with older men are at risk of STI or HIV. Abuse can result in mental health problems.
Another reason why teaching about abstinence is not enough is that it fails to address the fact that young people experiment in a sexualised society. However, young people can be supported to delay their first sexual experience. Advising young people to wait for the right time and the right person emphasizes that sex is a significant choice to be made at the right time within a relationship. Such an approach does not encourage early sex, especially if it connects sensitively with a society’s culture and with what young people are feeling. Delaying sexual activity, even by two years, makes a big difference to a young person’s physical and psychological health.

High levels of sexual activity are found across continents. In the USA almost four in ten young people have had sexual intercourse by the age of 15 (Figure 10). In many European countries, around one third of 15-year-olds have had sexual intercourse and 10% of Europeans have had unprotected sex by the age of 15 (Figures 10 and 11). There is also a high level of early sexual intercourse in Latin America and a hidden level in Asian countries where early marriage is common (Figure 8).

In 14 African countries (Figure 9), 15% or more of young people reported that they had had sex by the age of 15. Research carried out by Straight Talk in Uganda found that very early sexual experience was often non-penetrative, and driven by curiosity. Many young people had only one sexual experience, because their curiosity was satisfied or they did not like it. However, there are deeply held beliefs that encourage sexual activity. Some young people believe that a vagina will rot or a penis will atrophy if not used, and that bodily fluids such as semen help to build the body. Combating such myths is an important part of encouraging young adolescents to delay sexual debut.

Encouraging young people to abstain and to delay sexual debut are complementary policies, which require young adolescents to be aware of the same dangers and to learn the same skills. Information about protection is also vital for sexually active young people. Teaching young people to protect themselves against unwanted pregnancy also addresses issues of protection against sexually transmitted infections and HIV.

**Too early marriage means too early sex**
The risks of early sex are also high within marriage. Very young adolescents who marry have their first sexual experience

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27 Straight Talk, Kampala, correspondence.
**Figure 8**
Too early marriage

**Countries where 10% or more of girls were married by the age of 15**

- Bangladesh: 27%
- Niger: 27%
- Guinea: 20%
- Chad: 19%
- Mali: 19%
- India: 17%
- Central African Republic: 16%
- Ethiopia: 14%
- Mozambique: 14%
- Nepal: 14%
- Nigeria: 14%
- Nicaragua: 13%
- Madagascar: 12%
- Cameroon: 11%
- Dominican Republic: 10%

**Figure 9**
Too early sex

**Countries where 15% or more of girls had sex by the age of 15**

- Mozambique: 30%
- Guinea: 28%
- Cameroon: 26%
- Mali: 26%
- Central African Republic: 25%
- Chad: 22%
- Côte d’Ivoire: 22%
- Zambia: 22%
- Togo: 21%
- Madagascar: 20%
- Malawi: 17%
- Nigeria: 17%
- Kenya: 15%
- Tanzania: 15%

* NB: DHS data for Figures 11 and 12 was collected by asking older adolescents aged 15–19 about their current and past sexual experience or date of marriage. It therefore records what older adolescents recollected and were prepared to say.

Source for Figures 11 and 12: DHS Data presented by Population Council 2003: *A Summary of Selected DHS Data on Very Young Adolescents*

**Figure 10**
% of 15-year-olds in USA and Europe who reported having had sex.

**Figure 11**
% of 15-year-olds in Europe and USA who reported using condoms during sex

Source for Figures 13 and 14: *Health Behaviour in School Aged Children (HBSC) Survey 1997/98*. A cross national study in collaboration with WHO European Office. * France was represented by regions. ** Survey of Jewish secular 15 year-olds
before they have fully grown and matured. The husband may be infected with a STI and is unlikely to use a condom. A young wife has little control over safer sex. Early marriage is often followed by early childbirth that is risky for mother and baby. In Bangladesh, for example, more than one quarter (27%) of girls are married before the age of 15 (Figure 8) and 7% give birth before the age of 15 years.

**Children involved in sex work**

An estimated one million children each year enter sex work, a worldwide trade in abuse that involves as many as 10 million young people aged 10–17 years. Children as young as 10 are coerced in violation of their rights and dignity. Under the UN Convention on the Rights of the Child, governments are obliged to protect children from prostitution and promote recovery and social integration of those who have been exploited. There is little protection for children who are not within families. Homeless, runaway and abandoned children, the children of sex workers and children who are sexually abused are very vulnerable. One report found that 50% to 90% of adolescents rescued from brothels in south-east Asia were infected with HIV. HIV infection amongst child prostitutes was measured at 17% in Thailand and 5% in Viet Nam. Unwanted pregnancies and unsafe abortions place girls at high risk. Few young mothers in the sex industry receive maternity care.

A study in five countries of 475 young people in the sex industry\textsuperscript{28} showed that three quarters (73%) had been physically assaulted while working, and six out of ten had been raped. Two thirds of these young people met diagnostic criteria for post-traumatic stress disorder. It is important for policy makers to understand how the sexual trade in young adolescents is driven by the willingness of adult men to pay for sex and not by the young people’s own wishes. Children and young adolescents are the victims of this trade.

**Mixed messages**

Young adolescents are frequently exposed to pornography, and sexualized messages in the media. Pornography portrays women as always willing for sex, even if they say no, and often presents women as wanting men to demand sex by force. Boys at an impressionable age gain a distorted view of what women want. Pornography is the extreme example of such distortion, but even mainstream media often promotes sexual ‘conquests’ as part of becoming a man.

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Injecting drug use

Injecting drug use is a major driver of the HIV epidemics in Eastern Europe and South East Asia. HIV amongst injecting drug users has risen swiftly in cities as diverse as Odessa, New York, Edinburgh, Bangkok, Ho Chi Minh City and Santos, and in regions of China, India and Myanmar. A WHO study found that the most injecting drug users start below the age 25, and that many inject below the age of 14.29 In Russia one quarter of the 30 000 new HIV infections in 2000 were in adolescents aged 13–19 years. The longer that injecting drug users share contaminated equipment, the greater the risk of HIV infection. However, an adolescent may be infected the first time he or she experiments, using non-sterile injecting equipment.

Football passions raise gender awareness in 8–12 year-old boys

In football-crazy Brazil, many boys grow up copying macho behaviour that blends aggression with sexuality. The Pan American Health Organization has inspired soccer coaches to teach 8–12 year-old boys different lessons from the passion of football.30 Coaches explain that soccer is a team game where it is better to work together than go it alone. Boys learn about fair play and think about how they feel when someone cheats. They look at the consequences for the team if a player loses his temper and is sent off. They examine passion in soccer, why players kiss when they score and reassess what they think of as ‘masculine’ and ‘feminine’. They think how a team ‘bonds’ even when players are very different from each other. They learn about nutrition, how to stay fit and how drugs have damaged the careers of famous players. Young soccer player Juan said, “I want my rights to be respected on the soccer field and outside as well.” Another boy summed up what he had learned about team play. “We are different sizes but we can play together if we respect each other.”

Key Messages

Injecting drug users who share equipment are at high risk of HIV. Some users start to inject below the age of 14.

Programming for Very Young Adolescents

Boys play football in front of a mural of Brazilian soccer players outside Rio de Janeiro. Picture: AP Wide World Photos / Renzo Gostoli

30 Promoting Health and Gender Equity in Adolescent Boys 8–12 Through Soccer, Dr Matilde Maddaleno, Pan American Health Organization, presentation, Geneva April/May 2003.
Interviews with young people in four African cities about their experiences revealed high levels of sexual activity before the age of 15 with practices differing according to local cultural patterns. Interviewers asked 15–20 year-olds in Cotonou (Benin), Yaoundé (Cameroon), Kisumu (Kenya), and Ndola (Zambia) about past and present sexual experiences.

In Kisumu, Kenya, and Ndola, Zambia, more than 40% of boys and more than one-quarter of girls had had sexual experience before the age of 15, compared with 20% of boys and 17%, or less, of girls in Yaoundé, Cameroon, and Cotonou, Benin.

In West Africa there was a pattern of sexual experimentation without condoms, at social gatherings—even at funeral parties. Dr Pieter Remes who heads the research team31 said, “In many cases young people talk about it as something that just happened. There is little communication, there is no planning, and that is one reason why there is no protection.” In some cases it was unclear whether there had been penetration or ejaculation, but there had been genital contact which could transmit infections.

In Kisumu, Kenya, and Ndola, Zambia, one fifth of sexually-active girls said that their first sexual experience was forced or coerced. This was often with a boyfriend involving presents such as food, clothes, books or hair lotion in return for sex. One young man reported, “I used to give her money and when I asked her for sex she was giving it to me.” In Ndola two young men admitted taking part in gang rapes of a girl friend of a friend. In West Africa girls had more autonomy and were better able to negotiate.

In all four cities girls had sex first with older men. In Ndola, Zambia, and Kisumu, Kenya, the men were at least five years older while in Cotonou, Benin, and Yaoundé, Cameroon, the gap was ten years. Although there was no evidence of the classic ‘sugar daddy’ (much older rich men), young girls had relationships with men with jobs such as bicycle taxis, porters or market traders who were not rich, but who had an income and who therefore could afford ‘presents’.

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31 Study on adolescents’ sexual behaviour in four African cities with different levels of HIV infection. (Yaoundé, Cameroon; Cotonou, Benin; Ndola, Zambia and Kisumu, Kenya). Institute of Tropical Medicine, Belgium, TDRC, Zambia, UCAC, Cameroon, CERRHUD, Benin, Funded by Wellcome Trust, UK.
There are ethical problems in gaining consent from young people for interviews on sensitive issues, such as parent child relationships and sexual behaviour. Even if these can be overcome, it may be difficult to obtain parental consent.

Dr Pieter Remes used in-depth interviews to ask older adolescents in Benin, Cameroon, Kenya and Zambia about sexual experiences before the age of 15 (see facing page). Others use computer-based surveys to allow young people to answer questions without embarrassment. Professor Lawrence Neinstein from the University of Southern California found that nine out of ten young people preferred a computer quiz to a questionnaire or personal interview. Those who answered questions on a computer gave more complete answers and said that they had felt able to give truthful answers. However, few young people in developing countries have access to computers.

Professor Pierre-André Michaud from the Centre Hospitalier Universitaire Vaudois in Lausanne, Switzerland, believes that researchers must work with young people to design surveys and to shape qualitative research on behaviour and attitudes through interviews and focus group discussions. Youth must also be involved afterwards in implementing programmatic work based on research.

Research also has to inform and influence policy. The Alan Guttmacher Institute is researching sexual issues in Burkina Faso, Ghana, Malawi and Uganda, in partnership with African Youth Alliance (AYA) and other organizations. Research focuses on 5500 adolescents in each country; results will be fed back to policy makers, health care providers, programme administrators and journalists.

‘We feed back to policy makers and politicians as a matter of course. In Kisumu, the District Medical Officer was very much in favour of what we were doing. He ordered health workers to do more outreach where youth are found—the first time he had sent health workers out at night.’

Dr Pieter Remes, HIV/STI Research and Intervention Unit, Institute of Tropical Medicine, Antwerp.

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32 Overview Clinical Issues - Young Adolescents, Professor Lawrence Neinstein, Geneva April/May 2003.
33 Connections between Puberty and Psychosocial Development, Professor Pierre-André Michaud, Geneva April/May 2003.
34 Protecting the Next Generation: Understanding HIV Risk Among Youth, Jennifer Nadeau, Alan Guttmacher Institute, Geneva April/May 2003.
10–14 year-olds: also vulnerable to other risks

The threat from HIV has raised awareness of the dangers facing adolescents and the need to intervene at a very young age. But there are also other risks to young people aged 10–14 years. Indeed the factors that make young people vulnerable to one health risk factor may also increase their vulnerability to other risks. There are common lessons to be learned about interventions that can help to protect young people on their journey to adulthood. Not all succeed in negotiating the dangers. Some lose their lives. If this is a lottery, it is not one where every young adolescent has an equal chance. The chances of a child surviving depends largely on where he or she lives and with what protection.

◆ Europe: during the ten years from 5–14, one child in every 5000 dies.
◆ Western Pacific: the risk of death doubles—one child in every 2500 aged 5-14 dies.
◆ South East Asia: the rate is 3.5 times higher—one child in every 1428 dies.
◆ Sub-Saharan Africa: the rate is 17.5 times higher—one child in every 286 dies.

In the 10–14 year-old age group boys are at extra risk, with a 6% ‘excess mortality’ for boys over girls. Road accidents, falls and other accidents are leading causes of death and disablement. Around the age of 13 the nature of accidents begins to change, with a greater incidence of accidents with guns and knives.

However, looking at the numbers of young people who die or are injured between the ages of 10 and 14 is not a sufficient measure of health risks. Problems that develop at this age and remain unaddressed can accumulate and close off positive choices, with calamitous effects on health and development in later adolescence and adulthood.

Key Messages

Young adolescent boys have many accidents. However, the biggest risks may be unseen. Problems not addressed at this age can have a very serious effect in later adolescence.

Figure 13
Visits to hospital emergency departments in Ethiopia and Mozambique. Top five causes for injuries to 10–14 year olds. (The way information has historically been gathered does not allow this data to be disaggregated into more precise age bands.)

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36 Injuries among Very Young Adolescents, Kidist Bartolomeos, Department of Violence and Injury Prevention, WHO. Geneva.
Malnutrition and eating disorders

Malnutrition affects millions of adolescents in poor communities who day in, day out, lack enough to eat. Long-term malnutrition prevents young adolescents reaching their potential height and results in life-long ill health. There is evidence that stunted children are less able to cope with stress in later life.\(^{37}\) In 2001, 30% of rural 10–13 year-olds in India were severely malnourished. Young people aged 10–14 in rural India take only one third of their recommended daily dose of Vitamin A and malnutrition is more common among 10–12 year-olds than in older adolescents (Figure 14). In South Africa too, 60% of children live in poverty and one in five children is physically stunted.\(^{38}\)

Although poverty is by far the major problem, affluence brings its own concerns. The same study in India found that a quarter of children from high-income groups in Delhi were overweight and one in 13 was obese. The South African study found the same percentage of nine year-olds (14%) overweight as undernourished. Research in affluent countries suggests that 8% of girls aged 12–14 have regular ‘binge eating’ sessions and 4% of girls this age practice self-induced vomiting. Pro-anorexia web sites advise adolescent girls how to conceal the fact that they have stopped eating and how to fool their doctors.

This underlines the vastly different conditions that very young adolescents face. The Internet and bulimia are a lifetime away from the experience of girls and boys in rural Africa and Asia where stunting and hunger are endemic where many children drop out of school because they get no midday meal. Malnutrition is by far the greatest cause of disease in adolescence, more than double the next cause (poor water and sanitation).\(^{39}\)

Lack of clean water and adequate sanitation

There are 1.1 billion people in the world who lack access to clean water and 2.4 billion who lack adequate sanitation.\(^{40}\) Most of them live in Asia or Africa. Waterborne diseases are a major cause of death in young children under the age of five. But unsafe water and sanitation is also an important factor in the lives of 10-14 year olds. Schools

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**Key Messages**

Malnutrition affects the healthy development of young adolescents.

An increasing number of affluent young people have eating disorders.

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**Table 1**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt;50% of RDA</th>
<th>50%-70% of RDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>10–12 Boys</td>
<td>16.8</td>
<td>39.0</td>
</tr>
<tr>
<td>10–12 Girls</td>
<td>8.5</td>
<td>34.9</td>
</tr>
<tr>
<td>13–15 Boys</td>
<td>10.3</td>
<td>34.0</td>
</tr>
<tr>
<td>13–15 Girls</td>
<td>5.8</td>
<td>24.0</td>
</tr>
<tr>
<td>16–17 Boys</td>
<td>6.6</td>
<td>25.9</td>
</tr>
<tr>
<td>16–17 Girls</td>
<td>5.9</td>
<td>23.9</td>
</tr>
</tbody>
</table>

Source: Prof. Umesh Kapil, Department of Human Nutrition, All India Institute of Medical Sciences, New Delhi, India.

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\(^{37}\) Nutritional status of young adolescents in India by Prof. Umesh Kapil, All India Institute of Medical Sciences.

\(^{38}\) Very young adolescents A longitudinal perspective from South Africa: The Birth to Twenty Study by Linda M Richter: Child, Youth & Family Development. University of Natal, and Shane Norris: Dept Paediatrics & Child Health, University of the Witwatersrand.

\(^{39}\) WHO Burden of Disease Databases (EIP) and Disability Adjusted Life Years (DALY), 1995.

\(^{40}\) Global Water Supply and Sanitation Assessment 2000 Report, WHO and UNICEF.
which have poor sanitation can become centres of waterborne diseases, while children burdened by diarrhoea or parasitic infection develop more slowly, both physically and in their education.

When they are young, girls and boys relieve themselves in open spaces. As they reach puberty and start to menstruate girls have stricter hygiene and cultural requirements. Girls need access to safe, separate and private sanitation facilities at school, especially once they start menstruating. Where such facilities do not exist, many girls leave school. More than a half of girls who drop out of the top end of primary school do so because of lack of sanitary pads, separate toilets and easy access to water, according to the Forum for African Women Educationalists (FAWE).41

**Tobacco smoking**

Worldwide, one in five 13–15 year-olds smokes and more than 82 000 young people take up tobacco smoking every day.41 Tobacco dependence is set to become the world’s single largest cause of premature death and years with disability. The tobacco industry uses a images of music, fun and freedom to target young people and replace adult smokers who quit or who die. Smoking begins at all ages, but there is evidence that attraction is strongest at ages 10–14. About half of those who start smoking in adolescence continue to smoke for at least 15 years.

- In developing countries, one in five 13–15 year olds becomes addicted to tobacco.42
- In the Philippines, 40% of adolescent boys smoke. Most began in their early teens. One quarter of today’s youth in the Western Pacific Region will eventually die from smoking.43
- In Africa children are starting to smoke at a younger age. In Nigeria one third of 13–15 year-olds are exposed to tobacco smoke at home, and half are exposed to tobacco smoke in public places.44

Boys light up next to an anti-smoking poster in Kiev where the Health Ministry expressed concern at the number of children who smoke by the age of 11. AP Wide World Photos/Efrem Lukatsky.

In India, China, the Philippines and Russia, more than half of adolescents aged 13–15 are exposed to cigarette smoking by other people in the home and in public places.\textsuperscript{45}  
13–15 year-old girls were smoking at the same rate as boys in half the sites surveyed for the 2003 Global Youth Tobacco Survey.\textsuperscript{46}  
Adolescents who believe their parents disapprove are less likely to take up smoking.  
Tobacco use amongst adolescents is a predictor of substance or drug use.\textsuperscript{47}  
In May 2003 the World Health Assembly adopted the WHO Framework Convention on Tobacco Control. Within 10 months 100 countries had signed up.\textsuperscript{48}  
The Global Youth Tobacco Survey, part of the WHO Tobacco Free Initiative, asks children aged 13–15 about their smoking, and encourages states to design, implement and evaluate prevention programmes. Environmental control and the example of parents and other trusted adults are major factors determining whether children take up smoking. Bans on tobacco advertising, increasing the price of tobacco products and creating smoke-free schools, colleges, health facilities and sporting venues are effective interventions.

Alcohol use
Alcohol use is a serious threat to health and well-being. There is no scientific evidence for a safe limit of consumption, particularly for children and young adolescents. Although excessive alcohol use is a greater problem amongst older adolescents, young people who start drinking before age 15 are three to four times more likely than other people to become alcoholics.\textsuperscript{49}  
Many young people develop their attitude to drinking alcohol before the age of 14; the drinking problems of older adolescents may be set at this age. Young people may use alcohol because it feels good, to reduce stress, to feel grown up or to fit in. There are strong links between high-risk drinking (‘binge drinking’ or mixing alcohol with other psychoactive substances), violence, unsafe sexual behaviour, and accidents. Young adolescents may be initiated into a drinking culture by older peers or by family members. In Africa some young people help the family brewing business by serving or delivering drinks.

Key Messages

The ages 10 to 14 are when many young people start to smoke regularly. Banning tobacco advertising, increasing taxation and creating smoke free areas are effective ways to support young people.

Key Messages

There is evidence in some countries that young people are starting to drink at younger ages. Early drug or alcohol use can lead to intractable problems in later life.

\textsuperscript{45} Global Youth Tobacco Survey Data, Enis Baris and Ayda A. Yürekli, World Bank.  
\textsuperscript{46} WHO Press Release 7 August 2003.  
\textsuperscript{47} The Facts About Tobacco, Health Canada http://www.hc-sc.gc.ca  
Alcohol use at a young age is also increasing in developed countries. More than 10 million current drinkers in the United States are between the ages of 12 and 20. On average, they began drinking at 13.1 years of age. In the USA, during the 1960s, only 7% of 10–14 year-old females used alcohol; by the early 1990s, that figure had risen to 31%. Young people at risk of developing serious alcohol and drug problems include those:
◆ with a family history of substance abuse
◆ who are depressed or have low self-esteem, and
◆ who feel they ‘don’t fit in’.
Young adolescents are often victims of the consequences of drinking by family members, resulting in family breakdown, economic and emotional poverty, neglect, abuse, and violence. For example, 4.5 to 7.7 million children under the age of 18 in the European Union are living in families suffering from the effects of alcohol.

**Depression**

Puberty can increase the risk of depression in adolescents. An international collaborative study between Melbourne, Australia and Seattle, USA, found that girls aged 12–14 were more likely to show depressive symptoms after menarche than before. Girls who experienced early menarche were twice as likely to become depressed as pre-menarcheal females and boys. There are no WHO estimates for depression amongst young adolescents in developing countries. However, early onset of depression often continues into adulthood. According to the US National Institute of Mental Health (NIMH) more than 6% of this age group suffer from depression which often goes undiagnosed because it is dismissed as an adolescent mood swing. Depression in children and adolescents is associated with increased risk of suicidal behaviour. This risk may rise, especially among adolescent boys, if depression is accompanied by conduct disorder and alcohol or other substance abuse. In 1997, suicide was the third leading cause of death in 10–24 year-olds. It is known that 7% of children and adolescents who develop major depressive disorders commit suicide as young adults.

**Figure 15**

Adolescents in eighth and tenth grades in USA reporting depression and difficulties in coping


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52 WHO Declaration on Young People and Alcohol 2001.
54 International Youth Development Study, Centre for Adolescent Health, Melbourne & Social Development Research Group, Seattle.
This is also a time of opportunity

The ages of 10–14 years provide the best opportunity to intervene with young people to address a range of health risk behaviours. At this age adolescents are still listening and most problems are latent rather than out of control. Prevention programmes have the greatest chance for success if they intervene before harmful effects are evident. For example, drowning is a significant cause of death in 5–9 year-olds, so children should be taught to swim at a very young age. Death and injury from fire is significant in 10–14 year-olds, so children must learn about the risks before the age of 10.

Prevention initiatives targeted on 10–14 year-olds best address conditions with the greatest impact in the 15–19 year-old age group. A programme that could influence depression and poor mental health, help young people to become more aware of significant health risks and to acquire the life skills to avoid them, would address almost every top ten cause of death and disability adjusted lost years (DALY) in the 15–19 year-old range.

The World Health Organization defines life skills as "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". These are the skills they use to make judgements about what is safe and not safe, right and not right and how to get on with those around them. They include the skills needed to solve problems and to make good decisions; communication and assertiveness skills, and skills to cope with stress. They allow young people to set goals, to know their own strengths and weaknesses and to think critically about choices and actions. Life skills help young adolescents work towards their goals and put decisions into effect. They help young people to make judgements about who to choose as friends, and when to walk away from a potentially dangerous situation. They allow young people to decide about sexual activity, smoking, drinking, glue sniffing or drugs, and to act on their judgement rather than drifting into action. They help a young person know when and where to go for help if things go wrong.

Life skills can be demonstrated by adults and taught through interactive sessions in schools and innovative schemes in the community. Ultimately, every young person has to learn how to put these skills into effect where it counts—in their real world.

Schools can help to protect young people by giving them a sense of connection. Research shows that a positive school environment helps to protect young adolescents from substance use, while a positive relationship with teachers protects against early sexual initiation and a positive attitude towards school protects against depression. How do schools nurture this sense of connection?

One good teacher can make a difference for young people in one class, but to achieve results on a significant scale, schools need to improve the health and life skills of students and become healthy settings for living, learning and working. Health Promoting Schools create a healthy environment, engage every pupil and involve community and families as well as students. A Health Promoting School practises what it teaches, with policies and practices that respect each student’s self-esteem, provide opportunities for success and acknowledge effort and intention as well as achievement.

WHO works with Education International, UNAIDS and UNESCO to support teacher organizations in helping young people to prevent HIV transmission, and schools to create policies and programmes to counter HIV, STIs and discrimination. As part of the WHO Global School Health Initiative, Health Promoting Schools also address the physical environment, nutrition, and smoking.

WHO Europe carried out the Health Behaviour in School Aged Children Study, covering 123,000 10–14 year-olds in 28 countries inside and outside the EU, including the Russian Federation. The study showed a strong correlation between young people who smoke and drink, and those who have difficulty in talking to their parents or teachers. Adolescents who smoke are more likely to feel dissatisfied with how teachers treat them and lack of support from other students.

‘Connectedness between young people and their families is fundamental to their perceptions of themselves and their behaviour...

What happens in schools is also a very strong indicator for what happens outside’

David Rivett
WHO Regional Office for Europe

57 Young people’s health in context: selected key findings from the Health Behaviour in School-aged Children study, WHO Europe Fact Sheet EURO/04/04 June 2004.
The Centre for Adolescent Health in Victoria, Australia, has built a social profile of 4.5 million 12–17 year-olds in the State, mapping risks and protective factors from a questionnaire filled in by young people.

The survey—Improving the Lives of Young Victorians—measured risks and protective factors in relation to community, school, family and peers. They found that more than one quarter of Year 7 children (12 and 13 year-olds) were already using alcohol. By Year 11 one fifth of the children were involved in binge drinking. The survey also showed that 15% of young people were carrying a weapon by Year 7, and that there were high rates of depression. Girls were rapidly catching up with boys for risks such as smoking and drinking.

Family conflict at home and a low commitment to school were associated with these risk factors. Being bullied at school was a risk factor for self-harm.

The Gatehouse Project worked with schools to reduce drug taking and disruptive behaviour. However, instead of devising programmes that directly addressed these issues, they worked mainly on the quality of the relationships in school between teachers and students and between students and each other. The main interventions were to support teachers in creating a good classroom atmosphere and to implement an effective anti-bullying policy.

This broad policy was designed to improve daily school life for the majority of young people and therefore have a greater impact on the school by providing protective factors for large numbers of young adolescents. This was thought likely to be more successful than targeting harm reduction programmes on the relatively small number of students who were at high risk.

The Gatehouse Project measured substance use, disruptive behaviour and mental health indicators in 26 schools over a four-year period. It found that interventions in the schools improved communication, with the largest impact on substance use and early sexual activity, which halved over four years.

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An environment to ensure support and protection

Most young people aged 10–14 enjoy life and learning and find time for leisure, sport and fun. However, some 10–14 year-olds are already living in dangerous circumstances while all young people this age need guidance and support. If policy makers are to set the agenda for this vulnerable group of young people, they need to be aware of how puberty is a driving force for risk taking, and how risk and protective factors are associated with multiple behaviours. They also need good information from research about the condition of young people in their communities, and about effective interventions.

Young adolescents need to develop skills, so that they can successfully make the transition to older adolescence and adulthood. In addition all 10-14 year-olds need access to information, skills learning and protection against abuse, violence, HIV, other STIs, drug use, depression and other factors that can destroy lives.

For most young people transition to older adolescence is eased through close connection with a parent or parents, staying in school, learning life skills and gaining a sense of self-worth and self-respect. Protective policies strengthen such connections by supporting families to stay together, supporting young people to stay in school and making schools attractive, relevant and stimulating environments for young people. Policies are needed to ensure that young people have access to sport and leisure facilities and that they have information appropriate for their age about the consequences of health risk behaviours. Such policies can broadly be categorised as promoting and strengthening the community environment in which young adolescents grow.

This policy framework should cover all young people of this age, but also needs to target young adolescents whose lives lack the security of parents, family, school or supportive adults. Finding out what is happening to very young adolescents who have dropped out of school—and helping them to return—is a priority. Such a strategy should include outreach programmes to identify and contact 10–14 year-olds who have become involved in drugs, become trapped into prostitution or have otherwise come to the attention of the criminal justice system. Policies should ensure that young people involved in drugs or prostitution are rehabilitated, rather than punished.

Policy makers also need to reach agreement on how to target messages about sex and protection. Policies to help young people abstain from sex, delay their sexual debut and
protect themselves if and when they are having sex are all needed. They are complementary rather than alternatives. Young adolescents differ from one another and therefore no single policy will be effective for all. Policy makers need to encourage a range of approaches to maximize the number of 10–14 year olds who abstain from sex or delay their sexual debut beyond this age and to protect those who start, or are coerced into, a sexual relationship. Condoms and relevant services must be available to sexually active people in this age group, as well as access to health services that test for and treat STIs. Multiple services will help the broadest possible range of young people to reduce their health risks, rather than focusing on a single model of youth behaviour.

Policy makers also need to address ethical issues around medical procedures, confidentiality and the age of consent. In many countries health workers are not able to offer tests for STIs or treatment for children this age without first gaining the consent of a young person’s parents or guardians. Sometimes, medical staff have to seek permission from the same adult who put the young person at risk in the first place. Such issues need resolving.

Clear policies needed to end health dilemmas

Clear policies are needed to allow health and other staff to support young adolescents. A decade ago the International Conference on Population and Development in Cairo declared that “Information and services should be made available to adolescents that can help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility.” Ten years on, health staff still face a dilemma about offering a young adolescent an HIV test or a pregnancy test. Do they have to seek parental permission? To whom do they have to give the results? Do parents and adults always act in the best interests of the child? What happens if the rights of the child conflict with the rights of the parents? Countries need clear policies that allow young people who have used drugs or taken part in risky sex, to seek tests and, where necessary, treatment, without having to seek prior permission.

‘Policy makers need to address ethical issues around medical procedures, confidentiality and the age of consent’

Acquiring accurate data about what young people are doing and thinking is an essential step towards addressing policy priorities and adjusting the legal framework to support those policies. Today’s 10–14 year-olds are important and significant in their own right, and they are also tomorrow’s 15–19 year-olds, and therefore the gatekeepers to well-being and health for all adolescents. Policy makers who address the needs of 10–14 year olds today, will also protect older adolescents, young adults and families tomorrow.

60 The full text of the ICPD Declaration of Action can be found on the UNFPA website at http://www.unfpa.org/icpd/.
Research shows that young people take parental involvement seriously, listen to what parents say and notice what they do in their own lives. Young people may not always seem to be listening, but inside each one there is a child who needs attention, approval and support.

Dr Brian Barber from the University of Tennessee heads a Cross National Adolescence Project that questioned 11 000 school-going adolescents aged 11–14 across a wide range of cultures and economic backgrounds in nine countries. His team found that a strong connection between a young person and his or her mother is a protective factor against depression and against anti-social behaviour including stealing, vandalism, truanting, drugs and alcohol. Connection implies a positive relationship based on mutual respect, although there may be periods of disagreement. At the same time parents need to regulate young people by having reasonably high expectations, monitoring their behaviour and activities and enforcing appropriate rules in a loving and reasonable way. This research draws a clear distinction between a caring family and psychological control. Parents who issue instructions, use threats or withhold love and affection increase the risk of depression in girls and antisocial behaviour in boys and girls. As well as regulation, young people need freedom to think for themselves.

Birth to Twenty, the longest running study of child health and development in Africa, interviews each year more than 2 000 South African children born since 1989 (‘Mandela’s children’) and their parents. The children place high value on praise by parents and schools. Nine out of ten reported that their parents had clear family rules and regularly checked up on them.

Dr Rae Simpson, Program Director for Parenting Education and Research at the Massachusetts Institute of Technology, has produced Raising Teens: A Synthesis of Research and a Foundation for Action. Dr Simpson believes that five key roles for parents and adults caregivers hold good across cultures:

- **Love and connect**—offer support but acknowledge that the adolescent is becoming increasingly mature.
- **Monitor and observe**—let them know you are aware and ask where they are.
- **Guide and limit**—set clear but evolving boundaries with both negotiable and non-negotiable rules. “Loosen up but don’t let go.”
- **Model and consult**—teach by example.
- **Provide and advocate**—you cannot control their world but you can add to it.

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61 The Cross-National Adolescence Project, Dr Brian K. Barber, Department of Child and Family Studies, University of Tennessee.
62 The Birth to Twenty Study by Richter: and Norris op. cit. (38)
Adolescents need a safe, supportive environment to protect against factors that can derail development—such as alcohol, drink, drugs, too early sex or depression. WHO reviewed evidence from more than 50 countries around the world and found factors linked to health risk behaviours and other factors that provide protection. Adolescents whose environment includes positive relationships with adults at home and in the broader community, a positive school environment and peers who have pro-social attitudes and behaviours are better protected.

◆ **Families matter:** adolescents who have a positive relationship with parents are less likely to have early sexual initiation and less likely to become involved with tobacco, alcohol and psychoactive drugs or to suffer from depression. Parents who set boundaries and who encourage adolescent children to express themselves, are protective. Adolescents in families where there is conflict are more likely to experience depression.

◆ **Schools matter:** a positive school environment helps to protect young adolescents from substance use, a positive relationship with teachers protects against early sexual initiation and a positive attitude towards school helps to protect against depression.

◆ **Community connections matter:** adolescents who have a positive relationship with other adults in the community are less likely to experience depression.

◆ **Beliefs matter:** having spiritual beliefs is also protective against early sexual initiation, substance use and depression.

Risk factors include

◆ **Conflict in the family:** when there is conflict at home, young people are more likely to suffer depression and use substances.

◆ **Friends who are negative role models:** adolescents are influenced by their friends. If their friends are negative role models, young people are more likely to experience early sexual initiation and to use drugs or other substances.

◆ **Engaging in other risk behaviours:** risk behaviours tend to be found in clusters.
There is a hole at the heart of policy making for 10–14 year-old adolescents—lack of reliable and accurate information. Health services collect data for the 5 to 14 and 15 to 29 age bands, so broad that they obscure adolescents’ life paths and cannot be easily or accurately analyzed. Other data come from household surveys. These are often filled in by the head of the household and are not designed to collect sensitive information about young adolescents. They do not give a reliable snapshot of what very young adolescents are doing now, let alone a picture of what happens to them over time, or what they are thinking. A challenge for countries is to include 10–14 year-olds in existing and new data collection systems and in reports on morbidity and mortality. Those who collect data must ensure that they can be used flexibly—it may be important, for example, to compare data on 8–12 year-olds with that for 13–15 year-olds, and to look at what these young people are thinking and feeling, as well as what they are doing.

How data are best collected is open to discussion. It can be difficult to ask very young adolescents about behaviours and determinants. Some researchers prefer to ask older adolescents about what they did when they were this age.

There is a need for more information about the leading causes of death (road traffic accidents, drownings and burns) and the leading causes of injury (road traffic accidents, falls and burns). There is an urgent need to find out more about 10–14 year-olds who are not in school and who may be more vulnerable to sexual exploitation, unsafe work and substance abuse. There is a need to uncover the health risk behaviour patterns in this age group and the determinants of those behaviours, especially those that adversely affect young people in later adolescence and in adulthood.

There is also a need for research to uncover more about the relationship between puberty and other developmental changes and behaviours.

By including 10–14 year-olds in existing and new data collections researchers will begin to collect the right numbers for this age group, bringing into sharper focus young people’s health risk behaviours, attitudes and opinions.
‘They think that nothing is going to happen to them—they cannot get AIDS, they cannot get pregnant’

Young people want to learn, but they also want fun. Programming for young people aged 10–14 must be able to offer a sense of adventure, identity and belonging.

**CORA** guidance centre for adolescents (Centro de Orientacion para adolescentes) has been working in Mexico for 25 years using radio, TV, and drama to reach young people. CORA focuses on sexual and reproductive health for 10–25 year-olds and has developed innovative approaches for the younger 10–14 years age group.

Formal talks and ‘lessons’ easily bore young people and so CORA developed games and activities that allow young people to learn while being entertained.

One board game *Acquiring New Responsibilities* allows players to make life choices as they go around the board. Although they can make the choices they please, every decision leads to new responsibilities.

Dr Marcos Velasco, Executive Director of CORA, says, “Early adolescents have certain characteristics that are different. They think that nothing is going to happen to them—they cannot get AIDS, they cannot get pregnant. We show them how to look to the future; to make decisions. We try to get them to delay sexual intercourse. But there is going to be a group who even if I tell them ‘please don’t do it’, are going to do it. For that group we have to provide condoms and access to other services. We give them skills to learn how to negotiate their first sexual intercourse. We show them how to negotiate the use of contraceptives.

“Teaching these skills does not promote promiscuity. Studies show that they are more likely to delay their first sexual intercourse and that those who are going to have sex will take care, because they know there is a chance of AIDS.”

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65 Centro de Orientacion para Adolescentes (CORA), was founded in Mexico City in 1978.
Young people aged 10–14 tune in to mass media and take note of what they see and hear on television and radio—but they do not always like what they see.

Adolescents Speak asked 12–15 year-olds in 11 Latin America countries about the media they use and the messages they receive. On average each young person spent five to seven hours a day either watching television, listening to radio, using the Internet or reading. They felt that one message that the mass media fed them was that violence was an acceptable way of solving problems.

Young people believe that health promotion campaigns are important, but they are critical of the way they are done, and their criticism increases with age. They criticized the quality of health promotion campaigns compared to commercial productions. Campaigns were also too vague or did not address their questions. For example, one campaign promoted condoms without saying where to get them or how to use them. A 14 year-old complained that it was not helpful to be told to ‘postpone’ sex without being told what to do about sexual feelings, asking, “How do I manage my desires?” This younger age group got most of their health and medical care information from parents and school. The research will be used to improve health promotion mass media strategies and build a network of Latin American researchers interested in mass media and social communication.

The HEART campaign in Zambia uses TV, radio and posters to promote abstinence and consistent condom use to adolescents of all ages. The content and design of the media campaign is drawn up by slightly older young people, aged 15–22. Radio spots feature young people making decisions about sex, with slogans such as “AIDS—You cannot tell by looking”, “Abstinence is lich” (cool), and “Virgin Power, Virgin Pride”. HEART also uses mass media to train health workers and neighbourhood health committees about malaria, tuberculosis (TB) and eye health. Holo Muchangwe Hachonda IV, Youth Communications Coordinator for the HEART Programme, says, “You have to form partnerships with young people to identify points for information giving and for behaviour change. You have to work with them on risk perception because they do not think that they are at risk of AIDS.”

A year after the radio spots began, a survey showed that those who had heard them were 46% more likely to be abstaining from sex, while those who were having sex were 67% more likely to be using condoms.
The African Youth Alliance (AYA) is working with children aged 10–14 in Botswana, Ghana, Tanzania and Uganda. In Ghana, a survey in five regions showed that 18% of boys and 11% of girls have had sex before the age of 15. AYA is working with a popular radio presenter to reach a young audience with a discussion programme about adolescence and sexuality. AYA sponsors a comic promoting a message, “It pays to wait”. This mass media approach is backed up with a life skills programme. Ghana AYA Co-ordinator, Dr Robert Mensah, said, “We teach girls how to be assertive. We tell them that if a man wants to have sex with you and you say, no, he will take one step back and then try to take two steps forward. You must be able to look right into the man’s eyes and say ‘no’.”

In South Africa new programming such as Soul City and loveLife uses the high production techniques and stories to get their messages across. Judy Nwokedi, Managing Director of Public Broadcasting Services in Johannesburg, says that young people want stories, not lectures. “They are preoccupied with love and relationships. Most of what they are given is so serious; no wonder adolescents cannot relate to adults. Everything is dull and boring and about dying and they want to have fun.” loveLife uses ideas created by adolescents to develop hard hitting TV spots using the slogan “Talk about it”. Judy Nwokedi said, “The commercials created uproar because there were nine and 10 year-olds talking about sex. But you only have a few seconds to get the attention of this age group. The payoff was that 69% of teenagers who have seen loveLife say it influenced them to reduce the number of sexual partners, while 63% have become more assertive in the use of condoms.”

Judy Nwokedi recently commissioned Thetha Msawawa, a drama focused on adolescent rights. She said, “Two very talented young black women developed this drama series out of their own experiences. One is Zulu and the other one is coloured and they are very rooted in their communities. They had a desire to work with this young age group; they had a passion for the material.”

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68 African Youth Alliance (AYA) is a collaborative program between the United Nations Population Fund (UNFPA), the Program for Appropriate Technology in Health (PATH), and Pathfinder International to reduce the incidence and spread of HIV/AIDS and other sexually transmitted infections (STIs). http://www.ayaonline.org. Comments made during interview at Geneva May 2003.

69 loveLife is at PO Box 45, Parklands, 212, South Africa and online at http://www.lovelife.org.za. Comments by Judy Nwokedi made during interview at Geneva May 2003.
One of the most successful AIDS awareness campaigns in Uganda is *Straight Talk*. The newspaper and radio programme has had an impact on secondary school children’s knowledge and thinking. It was founded after a 1992 report convinced the Uganda Government to act to reverse spiralling rates of HIV. The paper and radio programme have contributed to a delay in young people having sex, and to a fall in adolescent pregnancies.

Soon the publishers began to get letters from teachers, parents and children also wanting something for primary school children. There were few people aged five to 15 with HIV but this age group was seen as a critical target for prevention. In 1998, *Young Talk* was launched as a four-page monthly paper for 10–14 year-olds. Today, 400 000 copies are distributed each month through schools, NGOs and church groups and *Young Talk* is also inserted into a national newspaper. *Young Talk* uses big pictures, easy words and keeps things simple. Anne Fiedler, Programme Director, says, “We get about 300 letters a month and the letters breathe the content into *Young Talk*. Menstruation is always an issue. We emphasise rights as well—a right to play, a right to education a right to protection, a right to health care. “From the letters sent to us, we realised they did not really know about their bodies; they did not understand about menstruation, why pubic hair was growing, why their breasts were growing, why they were having wet dreams. We had to take a step back and start with ‘this is what is happening to your body’.

“We thought it would not be age appropriate to talk about condoms, but young people of 13 were writing to us and saying they were having sex. They want to know about and condoms and HIV and AIDS. We cannot refuse to answer because they are 13. “We go to visit young people and teachers in schools and ask what the issues are. In many African families young children are not taught to express themselves. We have this expression ‘children should be seen and not heard.’ Yet self-expression and relationship forming is vital.”

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70 Straight Talk Foundation, PO Box 22366, Kampala, Uganda, www.straight-talk.or.ug.
71 Anne Fiedler’s comments, interview, Geneva May 2003.
Entre Amigas (Between Friends) works with 10–14 year-old girls, parents and teachers on the outskirts of Managua in Nicaragua. Usually, their mother is the girls’ best confidante, but they find it difficult to talk to her about sexuality or HIV and AIDS. Mothers tend to be suspicious and give instructions rather than listen. Girls do not trust information from friends and are embarrassed to talk to health providers; 80% are in school, but teachers do not know how to counsel them. This project improves parents’ and teachers’ knowledge and skills and helps them to talk to young people.

Girl Guiding / Girl Scouting has nearly 10 million members in 144 countries. The Bharat Scouts and Guides Association in India has over three million members. In West Bengal many girls marry young, and others are coerced into sex. There is a low level of contraception and a considerable number of abortions. The Healthy Adolescent Project in India® (HAPI) aims to improve reproductive and general health for 10–13-year-old girls and boys. About 900 Girl Guides and Boy Scouts have become peer educators, leading discussions about the human body, physical and emotional changes and giving information to more than 22,000 young people. The project is run by the Bharat Scouts and Guides Association, with support from the World Association of Girl Guides and Girl Scouts (WAGGGS) and Family Health International.

The Young Women’s Christian Association (YWCA) works on education programmes with women and children in more than 40 countries.

- Bangladesh YWCA provides schooling for 1000 children aged nine to 16. Girls learn about reproductive health, violence and child labour and the impact of early marriage.
- Botswana YWCA runs Peer Approach and Counselling by Teens (PACT) focusing on HIV prevention for 9–16 year-olds.
- Kenya YWCA works with other local organisations on a programme to protect young girls from early marriage.
- Zimbabwe YWCA supports anti-AIDS clubs in schools.

The Redeemed Christian Church of God in Nigeria formed a Redeemed AIDS Program Action Committee (RAPAC) with the philosophy that “it is better to train a child than to repair an adult”. Peer educators encourage young adolescents to protect themselves against HIV by abstaining from sex. RAPAC believes that:

- very young adolescents should be taught sexuality education in churches,
- parents and other adults should serve as health educators,
- young adolescents should express themselves and make informed, guided choices.

72 The Healthy Adolescent Project in India was launched in December 2000 as collaboration between Family Health International (FHI), the World Association of Girl Guides and Girls Scouts (WAGGGS) and the Bharat Scouts and Guides Association (BSG).
Puberty brings rapid changes in the body. It makes young people think and feel differently. Changes are both biological and the product of society.

The part of the brain that governs impulsive behaviour is not fully developed. It develops later in boys.

Most societies expect girls to control their sexual feelings and actions. Boys receive contradictory messages. Pornography is an extreme example.

Puberty accelerates adolescents aged 10–14 towards risk-taking. Those who mature early are at extra risk.

This generation of 10–14 year-olds is critical in the fight against HIV and AIDS.

Sex among 10–14 year-olds is more common than policy makers recognise. Girls who have sex with older men are at particular risk of STIs and HIV.

Telling young adolescents to abstain is not enough. A first sexual experience is often the result of force or coercion. They need adult support to delay.

Early marriage results in too early sex, Young brides are at risk of too early pregnancy, STIs or HIV.

Out-of-school children need special attention. Street children need rapid reconnection with their families.

Summary of Key Messages

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A million young people are coerced into sex work each year.

The 10–14 age group is the best chance to connect with and protect adolescents.

Malnutrition harms development and hunger makes pupils drop out of school. At the same time some young people have eating disorders.

Poor sanitation is a contributory factor for girls leaving school.

Young adolescents especially boys, are at high risk of accidents.

Experiments with smoking, drug use or alcohol at this age can become entrenched problems later on.

Parents play a critical role in supporting very young adolescents. Children without parental support are vulnerable to unsafe work, sexual exploitation, and substance abuse. Orphans are especially vulnerable.

Prevention programmes need to take effect before problems become chronic. The 10–14 age group is a key period.

Parents, teachers and other adults need to connect with and regulate young people. Relationships should be based on love and respect, not only on control. 10–14 year-olds need to learn to think for themselves and to develop life skills.
The World Health Organization, The United Nations Population Fund and UNAIDS organized a meeting in Geneva in conjunction with The Population Council, from 29 April to 2 May 2003. More than 50 experts from around the world met to address the needs of very young adolescents, who have been neglected in research, policy making and programming. The meeting produced an action agenda for policies, programmes and research. This document is intended to highlight for policy makers and programme managers the needs of very young adolescents, whose voice is rarely heard.

Photos: Peter McIntyre

Focusing on very young adolescents

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Photos: Peter McIntyre

Back cover pictures:
Photo: Christine Norton UNICEF
Botto. Boys outside the offices of the Mathare Youth Sports Association, Nairobi, Kenya. In 2003 MYSA was nominated for the Nobel Peace Prize.
Photo: Sayyid Azi, AP/Wide World Photos

At the Geneva meeting young people presented a series of dramas to challenge adults to take adolescents seriously. The young people, from many countries, were part of the English speaking congregation of the Lutheran Church in Geneva.