



Review article

Adolescent Health and Well-Being: Background and Methodology for Review of Potential Interventions



Rehana A. Salam, M.Sc.^a, Jai K. Das, M.D., M.B.A.^a, Zohra S. Lassi, Ph.D.^b, and Zulfiqar A. Bhutta, Ph.D.^{c,d,*}

^a Division of Women and Child Health, Aga Khan University, Karachi, Pakistan

^b Robinson Research Institute, University of Adelaide, Adelaide, Australia

^c Centre for Global Child Health, The Hospital for Sick Children, Toronto, Canada

^d Center of Excellence in Women and Child Health, The Aga Khan University, Karachi, Pakistan

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 A B S T R A C T

Owing to child survival initiatives around the world in the 1970s and 1980s, a dramatic rise in the population of adolescents has been seen, especially in the developing countries. A quarter of world's population in 2012 comprised adolescents and young adults; of these, 90% lived in low- and middle-income countries. More recently, there has been a consensus on investing in adolescent health and development for the success of post-2015 developmental agenda. In this series of articles, we aimed to assess various interventions identified in our conceptual framework to evaluate their effectiveness in improving adolescent health. We took a systematic approach to consolidate the existing evidence. This article is an introductory article detailing the background, conceptual framework, and methodology used for synthesizing evidence, followed by seven articles summarizing evidence on interventions for sexual/reproductive health, nutrition, immunization, mental health, substance abuse, and accidents/injury. The concluding article of the series summarizes the findings of the all the previous articles in the series and the relevance of the evidence for action in the post-2015 Millennium Development Goals era along with evidence gaps and future research priorities.

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Adolescence is a critical age group as this is a period to develop specific expertise and hone individual skills to enter the mainstream workforce and contribute to the economic productivity. It is also a period when major changes in health and health-related behaviors such as smoking and substance abuse, unsafe sexual practices, poor eating, and lack of exercise occur,

which may substantially impact health outcomes in later life. Due to the success of child survival initiatives over the last few decades, there has been a dramatic rise in the population of adolescents especially in low- and middle-income countries (LMICs) [1]. A quarter of world's population in 2012 (1.8 billion) comprised adolescents and young adults (10–24 years) [2]; of these, 90% lived in LMICs [3]. It is expected that the proportion of the world's young population, particularly in Africa, will rise from 18% in 2012 to 28% in 2040 while the proportion in all other regions of the world will eventually decline [3].

There is an unacceptable rate of mortality among adolescents, as an estimated 1.3 million adolescents died in 2012; 70% of these deaths occurred in Africa and Southeast Asia [4]. Unintentional injuries such as road traffic accidents and drowning are the leading causes of death in adolescents, while suicide, violence,

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* Address correspondence to: Zulfiqar A. Bhutta, Ph.D., Centre for Global Child Health, The Hospital for Sick Children, 686 Bay Street, Toronto, Ontario M6S 1S6, Canada

E-mail address: zulfiqar.bhutta@sickkids.ca (Z.A. Bhutta).

infectious diseases, and teenage pregnancy are other important causes of mortality in this period [4]. An estimated 330 adolescents die every day of road traffic accidents while 180 adolescents die every day from interpersonal violence [5]. Among females aged 15–19 years, pregnancy-related deaths are the second leading cause of death after self-harm while road traffic accidents and interpersonal violence are the main causes of death among males in this age group [6]. The odds of dying during youth are almost two times higher in South Asia and four times higher in Sub-Saharan Africa than those in other regions [4]. Besides mortality, adolescents are also at risk of many nonfatal diseases and conditions that contribute to years lost to disability and disability-adjusted life years (DALYs) burden. Neuropsychiatric disorders, unintentional injuries, and infectious and parasitic diseases contribute to an estimated 70% of the years lost to disabilities for 10- to 24-year-olds. The main risk factors for incident DALYs in 10- to 24-year-olds include alcohol, unsafe sex, iron deficiency, and illicit drug use [7,8]. In every region of the world, impoverished, poorly educated and rural adolescents are more likely to be adversely affected than their wealthier, urban and educated counterparts. Moreover, variations have also been observed between males and females, as 52% of deaths in male adolescents are attributed to violence while these attribute to 30% of deaths among female adolescents [9].

Globally, around 16 million babies are born to adolescent girls between the ages of 15 and 19 years [10]. Although rates of births among adolescent girls have declined in all regions since 1990 but still remain high in Africa, Asia, Latin America, and Caribbean. Nearly 50% of all women aged 20–24 years in Asia and Africa are married by the age of 18 years, placing them at a higher risk for early pregnancy, maternal disability, and death [10,11]. Child marriage is also common in the Middle Eastern countries such as Yemen and Palestine, where about half of young people under the age of 18 years are married [12]. Every year, around 10% of adolescent girls in LMICs give birth, compared to <2% in high-income countries (HICs). Girls under the age of 15 years account for 2 million of the annual total 7.3 million new adolescent mothers, and this could rise to 3 million a year in 2030 if the same rate persists [11]. Pregnancy in adolescence is associated with greater risk to the mother and newborn—including anemia, mortality, stillbirths, and prematurity—especially since the adolescent girls are not yet physically mature themselves [13]. In many contexts, their situation is further complicated by a number of factors including poverty, lack of education and employment, restricted access to care, weak health systems, abuse, unplanned or unwanted pregnancies, and the absence of autonomy or support in their social arrangements.

Adolescence and young adulthood accord with key changes in health and its determinants later in life. The Lancet Adolescent Health series in 2012 reported that adolescents are more exposed to substance abuse, sexually transmitted infections, and other risks than in the past, in addition to facing other emerging challenges such as social media [2,9,14,15]. Adolescence is also an optimal time to target health-related behaviors, as the interventions/behaviors will have more time to take effect and thus will maximize the impact on enhancing an individual's health in the years ahead. Recently, there has been a growing interest in adolescent's nutrition in LMICs as a means to improve the health of women and children. The World Health Organization organized a study group for adolescent health and development along with United Nations Children's Emergency Fund and United Nations Framework for Population Activities in 1995

[2,14–16]. More recently, there has been consensus on investing in adolescent health and development for the success of post-2015 developmental agenda [17]. The United Nations' reports that with such large numbers of young people, it is imperative that they should be given the economic and social power as well as the right to a healthy life to handle the future and their own lives. There has been an increased focus on adolescent health with the launch of a Lancet commission on adolescent health and well-being involving a network of academics, policy makers, practitioners, and young health advocates with broad expertise in adolescent health. This commission outlines the opportunities and challenges for investment at both country and global levels [18].

The purpose of this extensive review of eight articles [19–21] (Faqqah A et al; Salam RA et al; Arshad A et al; Das JK et al, unpublished) was to build upon the existing work in adolescent health and development, by synthesizing the available information to determine the effectiveness of various evidence-based interventions targeting adolescents and to list a set of interventions which are proven to be effective and could be recommended for scale-up in countries. This would aid the growing focus on adolescent health and well-being and help set priorities to achieve the global targets to improve adolescent health.

Domains of adolescent health—a conceptual framework

The newly developed agenda for Sustainable Development 2030 has recognized a need for greater accountability especially for the Global Strategy for Women's, Children's and Adolescents' Health [22]. It has also called for increased participatory frameworks across a range of areas relevant to young people including infections, noncommunicable disease risks, obesity, women's health, mental health, and nutrition [18,22]. We developed a conceptual framework through existing conceptual frameworks [2,23] and consultations and deliberations with the global experts in the field of adolescent health (Toronto, February 2014), and based on the recommendations, we identified a set of interventions to be incorporated in our review process. The interventions were chosen from the existing work on the basis of proven and potential effectiveness to improve adolescent health outcomes and access to primary health care and commodities for adolescents [2,9,14,15]. Our focus was on adolescent age group, defined as adolescents aged 10–19 years, however, since many studies targeted adolescents along with the youths (aged 15–24 years), we expanded our scope to include interventions for adolescents and youth and reported disaggregated adolescent data, where possible.

Various individual and general risk factors throughout the life cycle can have implications at any stage of the life cycle. The various stages of the life are not independent of each other and impacts early in life are carried to the next stage of life while some can also have intergenerational effects. We will not divulge further into this as the purpose of this series of articles was to review the potential interventions which could alleviate the risk factors of the adolescent age group only and impact quality of life thereon. Figure 1 shows the conceptual framework focusing on adolescent-specific interventions to guide our review. In order to organize the existing body of knowledge on adolescent health, our conceptual framework revolves around risk factors, potential interventions to prevent and manage risk factors, and outputs and impacts at individual, community, and societal levels.

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