MUCU ADOLESCENT HEALTH NEWSLETTER

CARING FOR THE ADOLESCENT

PRACTICAL TOOLS AND UNDERSTANING THIS DEVELPOMENTAL PHASE OF LIFE

November 2017 Issue

Dear Partner,

Makerere University and Columbia University (MUCU) are pleased to publish the **10th** issue of our newsletter on:

CARING FOR THE ADOLESCENT

PRACTICAL TOOLS & UNDERSTANING THIS DEVELOPMENTAL PHASE OF LIFE

The goal of this newsletter to is to provide some helpful hints and education about how to deliver sensitive and effective care to adolescents, as well as how to best manage parental concerns.

Confidential, adolescent-friendly reproductive, physical and mental health care and comprehensive health education is essential:
Access to this type of care can help optimize the health of adolescents, reduce their risk-taking behaviors & guide them through thoughtful decision-making that can capitalize on their strengths.

Providers get little education on adolescent health care and are best positioned if they are empowered to understand this unique phase of life.
Adolescents are neither big children nor small adults!

The Society of Adolescent Health in Uganda (SAHU) was launched November 2012 and is now a register Non Governmental Organization.
Uganda has a young population:
52% of its population is under the age of 15, and 25% is between the ages 10-19.

SAHU's Mission:

To promote comprehensive adolescent health, growth and development in Uganda through knowledge dissemination, research, advocacy and affiliation with other societies and bodies involved in adolescent health.

The Vision of SAHU:

Each & every adolescent will be provided with the opportunity to access his/her potential and grow into a healthy, responsible and independent adult.

Visit our website: www.sahu.ug
SAHU membership is $10 (ugx 30,000)
Become a member by e-mailing:
adolhealthuganda@gmail.com **or** info@sahu.ug
Include the following information in your e-mail:
☐ Name, title ☐ Job title ☐ Institution / Affiliations
☐ E-mail address

Meet the Newsletter Editorial Board

Co-Editors in Chief

Sabrina Kitaka M.D., *Senior Lecturer & Paediatric & Adolescent Health Specialist, Department of Paediatrics and Child Health, Makerere University College of Health and Sciences Kampala, Uganda and acting President of SAHU. Dr. Kitaka is passionate about promoting adolescent health and medicine in East Africa. For the past 15 years, she has taught Adolescent Medicine at Makerere University College of Health Sciences. Since 2006, she has collaborated with Dr. Betsy Pfeffer and her colleagues at Columbia University, and since 2010, they have conducted three annual in-service adolescent health workshops for East African health providers and four clinical and scientific meetings. She is the director of the Adolescent Program at the Paediatrics Infectious Diseases Clinic at the Mulago National Referral Hospital.*

Betsy Pfeffer, M.D., Associate Professor of Pediatrics at Columbia University Medical Center and New York Presbyterian Hospital, New York, U.S.A. Dr. Pfeffer is an adolescent medicine clinician who sees teens in an outpatient and inpatient setting, teaches medical students and residents and lectures internationally on multiple topics related to adolescent health care. She has been working together with Dr. Kitaka for over ten years and is committed to their efforts to help improve health care delivery to teens in Uganda. She is a lifetime member of SAHU and the Director of International Relations.

Editorial Team

Denis Lewis Bukenya *BSWSA, MPA is a social worker and an Adolescent Health Training Specialist and the Training Manager at the Naguru Teenage Information and Health Centre, a pioneer Adolescent Sexual Reproductive Health and Rights program in Kampala, Uganda, that provides advocacy and youth-friendly reproductive health and related services. Denis has nine years of progressive involvement in Adolescent Sexual Reproductive health services' delivery and trainings, psychosocial and behavioural support for children and youth, specifically on Adolescent Sexual Reproductive Health and Rights and HIV/AIDS. He also is the Vice Chair of SAHU.*

Godfrey Zari Rukundo M.D., *Child and Adolescent Psychiatrist, Senior Lecturer and Head of the Department of Psychiatry at Mbarara University of Science and Technology University (MUST). Dr. Rukundo is also the General Secretary of SAHU and the programme Director for MMed Psychiatry Training program. He has expertise in psychiatry through his research in schizophrenia, depression, and mental disorders secondary to general medical conditions. He has been an investigator in a number of funded research grants, with a number of publications coming out of this work. He has interest in quality improvement and has been the chair for the committees of Quality Assurance and Strategic Planning of the Faculty of Medicine at MUST for. He is the National Coordinator of Training in Child and Adolescent Mental Health. He is the Key Personnel for Mental Health Research Training in the ongoing NIH five years Research Training Grant (MURTI).*

Charles Emma Ofwono, *SAHU Web Administrator and Network and Systems Administrator, the B.Sc. degree in Software Engineering from Makerere University, Kampala, in 2012, and currently is pursuing his M.Sc in Information Technology from Walden University, Minneapolis, USA. In2007, he joined Naguru Teenage Information and Health Centre, as a peer leader in the Post Test Club, and in 2010 became the club coordinator. Since March 2013, he has been with the Department of Advocacy and Research, where he coordinates youth programs and ICT/Data. Emma is also the IT manager of SAHU.*

WE PROUDLY ANNOUNCE
THE 5th SYMPOSIUM OF MAKERERE-COLUMBIA (MUCU) & THE SOCIETY OF ADOLESCENT HEALTH IN UGANDA (SAHU)

11-12th APRIL 2018, HOTEL AFRICANA, KAMPALA, UGANDA

THEME:
Transitions in Care: Children to Adolescents to Young Adults

SUB THEMES:

Transitioning Adolescents with Chronic Medical Problems

Developmental Transitions and Family Support

Adolescent Responsive Programing in Schools

Registration fee 50,000ugx ($15)
Abstract Submission Deadline 14th Dec 2017 by 5PM
10 Local and 3 International Scholarships Available
Accepted Abstracts & Scholarships Announced 16th February 2018

IMPORTANT DEADLINES and INFORMATION:
Abstracts limited to 300 words with title & contact email
Content: Background, Methods, Results, Conclusion
OR Summary of Program, Program Activities, Lessons Learned
to: **conferenceSAHU2018@gmail.com**

NEWSLETTER SUBMISSIONS

The next newsletter will focus on Sickle Cell Disease in Adolescents and will be published in May 2018. SAHU members are encouraged to submit member news, program updates and interesting cases related to this newsletter topic with all patient identifiers removed. The editorial board will conduct a peer review process for all submissions. Submissions will be accepted from March 1st – April 15th, 2018. Please e-mail all submissions to: sabrinakitaka@yahoo.co.uk. Thank you in advance for your participation.

INTRODUCTION TO THE ADOLESCENT

Betsy Pfeffer MD Associate Professor Pediatrics Columbia University

There are more young people between the ages of 10-24 years today than at any other time in human history. More than one in every five people in the world is between the age of 10-24 years, and 90% of them are living in less developed countries. Nearly two thirds of premature deaths and one third of total disease burden in adults are associated with conditions or behaviors that began in youth, including tobacco use, a lack of physical activity, unprotected sex or exposure to violence. Promoting healthy practices during adolescence and efforts that better protect this age group from risks will ensure longer, more productive lives for many.

Adolescence is a developmental period that is comprised of physical, cognitive, psychological and social growth. During this phase of growing independence there is natural experimentation. Since adolescents often lack the knowledge and maturity to make sound informed decisions, without extensive support, compared to other age groups, adolescents are susceptible to increased morbidity and mortality due to poor choices and increased risk- taking behaviors.

Though there are many diverse ethnic groups in Uganda, they all share traditional values and conservative norms in relation to their expectations of adolescent behavior. Nonetheless, many Ugandan youth are not conservative in their behaviors and are experimenting and engaging in risk- taking activates. Prevalent problems in Uganda, similar to the problems that adolescents face worldwide, include early sexual debut (sex at of before the age of 14 year), unprotrocted sex, teenage pregnancy, poor use of contraception, HIV and sexually transmitted diseases, sexual coercion and violence, mental health problems, alcohol and drug use, and injury.

In addition to developmental vulnerabilities, Ugandan youth also face other hardships including poverty, unemployment, lack of education, poor access to medical services, lack of sex education, and inadequate knowledge about the consequences of risk-taking behaviors. If there is denial about the activities in which adolescents are partaking and the obstacles they may encounter, then opportunities to educate them and address their concerns, answer their questions and help them think about the choices they are making are not created. Without these opportunities, adolescents are often alone in navigating the challenges they may face and are susceptible to making uninformed choices.

The Ugandan Ministry of Health adopted a national adolescent health policy in 2004 recognizing adolescence as a unique stage of life and endorsing the development of adolescent-friendly heath centers to deliver comprehensive care to help promote healthy choices and improve the health of young people in Uganda. However, most services in Uganda are offered to people of all ages with

few places focused exclusively on youth. Even when more specialized services are offered, adolescents frequently do not access them because there is a lack of confidentiality, rudeness among providers, ignorance about the existence of the services, and fear of embarrassment. Of further concern is the fact that, while 90% of Ugandan adolescents aged 12-19 years live in a rural area, access to health services is even more limited in those locations. For some adolescents, a visit with a health care provider presents the sole opportunity to discuss personal and private matters.

A provider who understands what components help optimize a successful adolescent visit are IDEALLY positioned to be a resource to the patient that they care for. Providers are fortunate enough to be "let in" to a patient's personal life once confidentiality is assured, trust is established, and a relationship begins to form. Health care providers caring for adolescents can play a crucial role in helping every adolescent think about the choices they make, address their vulnerabilities, capitalize on their strengths, and ultimately assist their growth into healthy adulthood.

ADOLESCENT DEVELOPMENT

In all countries adolescence go through the same stages of psychosocial development but the age ranges may vary:

ADOLESCENT STAGES OF DEVELOPMENT

EARLY ADOLESCENCE: USA ages 10- 13 years

- Test authority with parents
- Preoccupied with self/self-exploration
- Hang out in same gender cliques/travel in packs
- Compare themselves to others
- Learn by trial and error
- Retain concrete thinking
- Sexual maturation begins

MIDDLE ADOLESCENCE: USA ages 14- 17 years

- Peak parental conflicts, struggle for independence
- Influenced by peers
- Awareness of self as sexual being/ May begin sexual relationships
- Peak risk-taking behaviors
- Puberty usually completed/Physical growth slows for girls, continues for boys
- Thinking tends to be less childlike, more abstract, introspective and analytic

LATE ADOLESCENCE: USA ages 15- 21 years

- Integrate diverse views of self
- Ability for abstract thinking
- Less impulsivity and greater ability to compromise
- Often reaccept parental values
- Set practical realistic goals for future
- Emphasis on intimacy and relationships

THE ADOLESCENT BRAIN

Adolescence is a developmental period characterized by suboptimal decisions and actions that are associated with an increased incidence of unintentional injuries, violence, substance abuse, unintended pregnancy, and sexually transmitted diseases. Recent studies suggest that there may be a biologic basis for increased risk taking and impulsivity seen during adolescence.

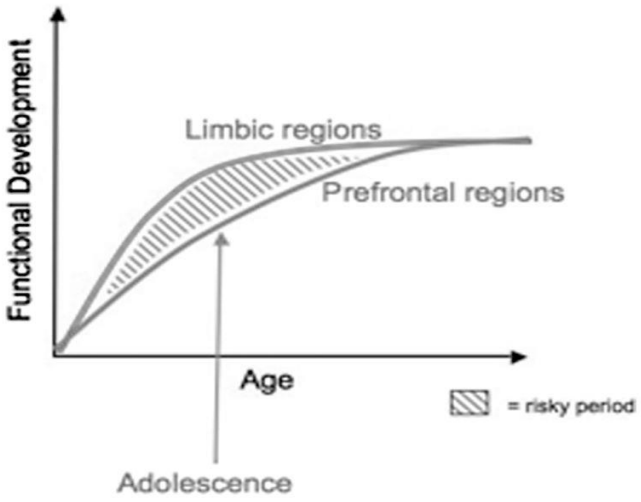
The limbic system, the brain's emotion, develops early. The limbic system is responsible for:

- Increased drive for reward
- Sensation seeking
- Emotions
- Memory
- Aggression
- Pleasure reactions
- Fear
- Response to a tiger in the woods…

The prefrontal cortex, is among the last to mature, reaching maturity by around age 25 yrs. This area of the brain is responsible for "executive" brain functions including:

- Attention
- Complex Planning
- Decision Making
- Impulse Control
- Logical Thinking
- Organized Thinking
- Personality Development
- Self-Awareness
- Risk Management
- Short-term memory

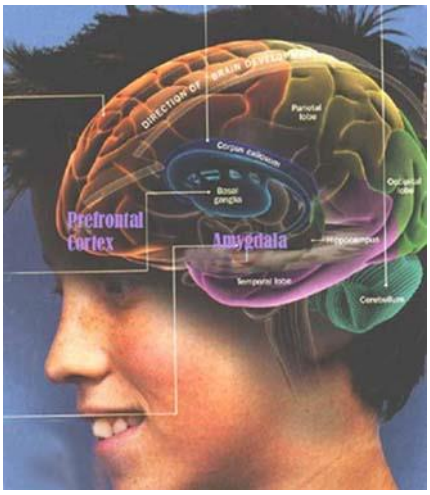
During adolescence, there is an imbalance in development of the limbic system relative to the prefrontal control which has been implicated in risky choices.



B.J. Casey et al, The Adolescent Brain, *Ann N Y Acad Sci*. 2008 March; 1124: 111–126.

SO, WHAT DO WE KNOW...

- We know that adolescence may be characterized by reward seeking and risk-taking behaviors
- We know there may be a biologic basis for this increased risk taking and impulsivity in adolescence



The health paradox of adolescence is that compared to children adolescents have improved strength, speed, reaction time, mental reasoning abilities, increased resistance to cold, heat, hunger, dehydration, immune function, however overall worldwide morbidity and mortality rates increase from injury, HIV, suicide and violence from childhood to late adolescence. According to the WHO, all the measures of death, disease and disability tell a similar story about adolescent health. Generally, there is remarkable consistency across ages, sexes and regions and between low and middle-income countries and high-income countries. The mortality and morbidity/disability patterns of adolescence reflect the transition from childhood to adulthood and the impact of the developmental processes taking place during this period.

WHAT CAN WE DO...

Since ALL Adolescents are potentially an at-risk population, all providers who care for adolescents are best served by performing a psycthehosocial assessment during the visit. By doing this the provider can identify the patient's strengths and vulnerabilities and discussions can then begin between provider and patient to work towards healthy outcomes.

CONFIDENTIAL VISIT

The psychosocial assessment is ideally conducted with the adolescent both privately and confidentially. Confidentiality is paramount to the adolescent visit and means that all things discussed between provider and patient will not be disclosed to the guardian without the adolescent's permission. The reason for this is that adolescents often will not open up if confidentiality is not assured. The only circumstance that confidentiality should be breached is if the adolescent is found to be unsafe. Before beginning the psychosocial assessment, it is essential to explain to both the guardian and the adolescent the reasons for this confidential time. This includes the respect of healthy adolescent development as they gradually separate from their guardian and develop a "private self" and begin to navigate decisions independently.

A provider's role is to serve as another adult resource for all adolescents to help answer questions, address concerns and guide them towards healthy decision making. To help gain the respect of the guardian, it is always helpful to assure them that nothing replaces a guardian/family/friends but also stress the importance of having as many available supportive adults to adolescents so they can help them successfully navigate their world.

THE HEADDSS ASSESSMENT

One useful way of obtaining a psychosocial history is by using the HEEADSSS acronym. This approach assesses **H**ome environment, **E**ducation and **E**mployment, **E**ating, peer-related and other **A**ctivities (including hobbies and interests), **D**rug use, Depression, **S**uicidality, **S**exuality, **S**afety and **S**pirituality. A benefit of this approach it that it begins by asking adolescents about less sensitive information, thus affording an opportunity for the health care provider to build rapport before asking more sensitive questions.

Health care providers who become adept at conducting a psychosocial assessment during all medical visits comfortably highlight the adolescent's strengths, assess their vulnerabilities, and create a safe and pleasant platform for dialogue with their patients. Learning to reserve judgment about patients' behaviors is crucial because once an adolescent feels judged, the provider is no longer seen as a resource. One way for health care providers to reserve judgement is to understand that adolescents often view their activities as solutions to other challenging

aspects of their lives rather than as problems. Some healthcare providers may feel uncomfortable discussing sex, depression, suicidality and drug use for example. However, with practice, one can learn to skillfully and competently discuss these topics with ease and help adolescents better engage in conversations about these issues.

The goal is for the health care provider to create a safe, confidential, non-judgmental space where adolescents can openly discuss concerns and questions related to their private lives and the choices they are making. By doing this, adolescents can find support for healthy development. For some adolescents, a visit with a health care provider presents the sole opportunity to discuss this natural and important part of their lives and almost all adolescent visits provide an opportunity to discuss these sensitive matters.

CONDUCTING THE PSYCHOSOCIAL PART OF THE VISIT

It is always helpful to establish rapport and trust with adolescent patients Discussing personal matters takes practice; the more comfortable you become doing it, the more likely it is that you will have a productive conversation with your patient. Of course, the adolescent also has to be comfortable participating in the dialogue and answering personal questions. Assessing for this is best done by reinforcing that the purpose of this is to deliver good care and help answer any questions. If an adolescent seems comfortable move forward but if there is any discomfort, it is helpful to acknowledge what you see. When an adolescent's discomfort goes unacknowledged, the conversation may come to a halt or not yield an accurate history.

BEST PRACTICES: CONDUCTING A SUCCESSFUL INTERVIEW:

- Reassure confidentiality and privacy
- Praise successes and accomplishments
- Interview adolescent separate from physical exam
- Pay attention to nonverbal cues
- Face adolescent at same eye level and make eye contact
- Ask developmentally-appropriate questions
- Minimize note-taking while listening and talking
- Summarize to demonstrate understanding
- Listening, respecting, being non-judgmental all help build rapport

There are some approaches to interviewing adolescents that can be alienating and are thus best to avoid

The Why Question:

Teens do not often have insight to know "why" they think a certain way or have engaged in a particular behavior. In addition, being asked "why" is often be perceived by patients as the health care provider being judgmental, even when that was not the intent.

Rather than asking:

"Why don't you use condoms if you don't want to get pregnant or get a sexually transmitted disease?"

*A b*etter choice to open up a discussion is:

"You don't want to get pregnant or get a sexually transmitted infection, how do you plan to accomplish this?"

Assumptions:

Avoid assumptions high functioning adolescents can engage in risk taking sexual behaviors and risk-taking adolescents have numerous strengths; find them and applaud them.

Judgment:

Avoid judgmental comments for example:
"You are such a good student. I am sure you haven't struggled with depression, right?"

You are human and may have negative reactions to your adolescent patients' beliefs practices and behaviors. Your adolescent patient is not you, your family, or a friend. If you find yourself feeling judgmental or the need to try to "fix" your patient, take a few minutes to regroup. If you cannot regroup, do what you can at the visit and then refer the adolescent to another health care provider for services.

marijuana. Would you mind sharing with me your understanding of possible cconsequencesc to doing this ?"

- Ask permission to fill gaps in knowledge
  Example: "You have a good

Judging behavior, attempting to convince an adolescent to stop or trying to "fix" it is ineffective ways to promote healthy changes.

CLOSING THE PSYCHOSOCIAL VISIT

There is often a lot going on for adolescents. Everything does not have to be addressed at one visit. REMEMBER adolescents may see their choices as solutions and often without support and guidance are unable to alter their behaviors.

Together, with the adolescent, determine what behaviors, if any, the adolescent would like to work on changing and help guide them into a reasonable achievable plan

BEST PRACTICES:
PROMOTING HEALTHY CHOICES

- Assess the adolescents understanding about the potential consequences to their current practice
  Example: "I appreciate you being honest with me about how often you are smoking

understanding about some of the health consequences of daily marijuana use, may I explain some of the other consequences to you"?

- After discussing the information shared assess the adolescent's motivation to change the identified behavior

- If the teen is motivated to make any changes, PUT a concrete plan in place to begin replacing unhealthy behaviors with healthy behaviors AND help the teen think through how to implement the new plan

- Acknowledge how hard change is and give the teen permission to fail

- Early follow up to assess what worked and what didn't work; plan can be continually modified

- If the adolescent is NOT motivated to change ask the teen to think about what has been discussed and then ask the adolescent to return for follow up and reassess readiness to change

CONCLUSION

In summary, adolescence is a transitional time comprised of rapid physical, cognitive, psychological and social growth. It is a period of both vulnerability and potential. Like all adolescents, Ugandan adolescents are susceptible to risks inherent to this stage of development but many also suffer at the hands of other external deprivations and have private struggles with few places to turn for support. To successfully minimize the morbidities of Ugandan adolescents and maximize their potential it is imperative that resources for adolescent care become a priority. Providers who create a welcoming physical space and deliver confidential, non- judgmental care can help guide adolescent into healthy adults. Ideally the entire adult community including gaurdians, providers, teachers, religious and community leaders, and extended family could band together to act as synergistic mentors delivering consistent, accurate and honest messages about health and wellness and be available to the adolescent community to listen, respect and support their growing youth. Undoubtedly, investing in the health of the adolescent population in Uganda will be a worthwhile investment in Uganda's future.

REFRENCES

World Health Organization Adolescent health July 2015
UNFPA Sate of the world population 2014
Neema, S. et al., Adolescent Sexual and Reproductive Health in Uganda: A Synthesis of Research Experience, 2004, Guttmacher
Uganda National Adolescent Health Policy 2004
Pfeffer B et al., Interviewing Adolescents about Sexual Matters, Pediatric Clinics of North America, April 2017
Adolescents in Uganda, Facts in Brief, Guttmache, 2006