MUCU ADOLESCENT HEALTH NEWSLETTER

POSITIVE PARENTING

November Newsletter
Issue 12

Dear Partner,

Makerere University and Columbia University (MUCU) are pleased to publish the **12th** issue of our newsletter on:

POSITIVE PARENTING

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 registered Non-Govermental 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.

Become A Member

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, USA. 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. 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, received a 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. In 2007, 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.*

NEWSLETTER SUBMISSIONS

The next newsletter will focus *on Risk Taking in Ugandan Adolescents* and will be published in May 2019. SAHU members are encouraged to submit member news, program updates and interesting cases 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, 2019. Please e-mail all submissions to: sabrinakitaka@yahoo.co.uk. Thank you in advance for your participation.

INCREASING OPPORTUNITIES FOR ADOLESCENT HEALTH TRAINING AT MAKERERE UNIVERSITY AND MULAGO NATIONAL REFERRAL HOSPITAL

Submitted by Sabrina Kitaka MD

The Makerere University Main Building

Background

Adolescent medicine is not a recognized specialty in most African countries and African healthcare providers receive little adolescent-specific training. Research indicates that the single most important barrier to care for an adolescent relates to a judgmental provider attitude. Using sexual health as an example, in many societies and cultures, adults have difficulty accepting adolescents' sexual development as a natural and positive part of growth and maturation. Adolescents may reject sexual health services for a variety of avoidable reasons including being treated without respect, feeling judged by the staff, not receiving confidential care and interacting with providers who try to dissuade them from having sexual intercourse. When adolescents are unable to access welcoming, non-judgemental confidential care they may give up—not on having sexual intercourse—but on utilizing sexual health services and on using contraception and condoms to prevent unintended pregnancy and sexually transmitted infections, including HIV.

Makerere University, Kampala (MUK) is Uganda's largest and third-oldest institution of higher learning, first established as a technical school in 1922. Today, Makerere University is composed of nine colleges and one school offering programs for about 36,000 undergraduates and 4,000 postgraduates. The College of Health Sciences has four different Schools including the School of Medicine which houses the Department of Paediatrics and Child Health. The Department of Paediatrics and Child Health was started in 1967, and has taught more than 300 paediatricians. In 2002 the curriculum incorporated two hours of specific training in adolescent health for the under graduate students and six hours for the post graduate students training in Paediatrics and Child Health.

Leveraging Opportunities

At Mulago National Referral Hospital adolescents aged 10-19 years are typically falling through the cracks with many not

knowing where to seek ambulatory or inpatient care. Through lessons learned from the Chronic Care Clinics, particularly the HIV Clinic and the Mental Health Clinic, integration of services for the adolescent patient has been enhanced. As a result of a needs assessment conducted in August 2003, the first adolescent health clinic was started at the Paediatrics Infectious Diseases Clinic (PIDC) at Mulago Hospital. The Makerere-Mulago-Columbia Adolescent Health Clinic (MMCAHC) delivers ***comprehensive services*** and immunization updates. Health care providers running this clinic seek training from existing services like the Naguru Teenage Center as well as externally from Columbia University's Adolescent Medicine Clinic in New York City, USA. Health care providers also take part in specific adolescent health care training and skills building sessions from the United Nations Development Partners (The World Health Organization (WHO), UNICEF and the UNFPA). In 2016 the WHO released a policy brief encouraging the training of an "Adolescent Competent Workforce" so that equitable health care for all adolescents could be attained. In order to improve health care provider attitudes, the WHO recommends that health care workers:

- Treat young people as respectfully as adults

- Avoid judging youth's behavior

- Work to develop solid and mutually trusting relationships

- Provide all staff with ongoing training in:

    - Adolescent development
    - Young people's needs and concerns
    - Confidential care

Staff may also need assistance in recognizing and changing attitudes that pose barriers to quality care. It can be very helpful and productive for staff to meet regularly and have the opportunity to review challenges, address concerns and, together, assess ongoing ways to optimize the above WHO goals.

Executive Director of Mulago, Dr. Byarugaba, signing the visitors' book at the MMCAHC, Dr. Sabrina Kitaka looks on

The Adolescent Clinic Flier

Increasing Training Hours

The Society of Adolescent Health in Uganda (SAHU) was founded by Betsy Pfeffer, Godfrey Zari Rukondo, Denis Lewis Bukenya and Sabrina Bakeera-Kitaka in December 2012 to allow for the strengthening of skills and knowledge of health care providers in Uganda. SAHU offers free on- line materials for learners (www.sahu.ug) including the Makerere University Columbia University (MUCU) Adolescent Health Newsletter that is published semi-annually. Additionally, the Makerere & Columbia University Departments of Pediatrics (MUCU) in collaboration with SAHU have conducted annual adolescent health-training workshops followed by clinical and scientific conferences in Kampala, Uganda since 2010. Participants included providers caring for adolescent populations from Uganda, Ethiopia, Tanzania, Rwanda and Kenya. Makerere University has also increased the time allotted for medical and post graduate student education in adolescent medicine. Undergraduates have increased their training from a paltry 2 to 6 hours with more opportunities whenever there is interaction with an adolescent client. The training hours for the post graduate students have also been increased from 6 hours to a total of 6 weeks during the 2nd year Masters of Paediatrics Rotation. The Adolescent Course is coordinated by Dr. Sabrina Kitaka, a Paediatrics Infectious Diseases Specialist, and Dr. Joseph Rujumba, a Paediatrics Sociologist. The Masters students conduct their practicums from the Makerere/Mulago/Columbia Adolescent Health Clinic (MMCHAC) which runs once a week on Friday as well as at the Naguru Teenage Center supervised by Denis Lewis Bukenya. Students working at the adolescent health clinic have shared testimonies of improved knowledge and skills: two examples include:

"Thank you for giving us the opportunity to learn how to treat adolescents…each adolescent has unique challenges."

"I have now appreciated the importance of confidentiality when interviewing an adolescent."

Overcoming Resource Constraints

The Adolescent Clinic is resource constrained and depends on several volunteer staff members. Small grant support has been obtained from:

1.The American Academy of Pediatrics (2013-2016) through the I-CATCH Grant. This particular grant funded skills building workshops for the clinic staff and some post graduate students

2. The Freidland Foundation (2015-2018)

3. Individual payments through the Society of Adolescent Health in Uganda (2012- to date)

4. Technical assistance from the Department of Pediatrics at Columbia University (2007 to date)

There is a lot of commitment and support from the Department of Paediatrics and Child Health of Makerere University, The Mulago National Referral Hospital, and undergraduate and post graduate students from both Makerere University and Columbia University. They have implemented needs assessment surveys in the adolescent clinic with the goal of improving both services and care. We continue to seek grant support to improve the clinic and conduct research which will inform policy. We also intend to conduct implementation science research on the existing cohort of over 3000 clients seen at the MMCAHC.

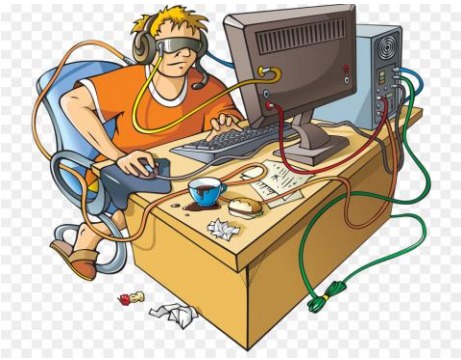
Introduction

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, all adolescents are an at-risk group susceptible to increased morbidity and mortality compared to other age groups. It is well known and reported that adolescents are at risk for substance and alcohol abuse, but one relatively new and underreported risk for adolescents is the consequences of unsupervised use of the internet. Keep in mind that adolescents often spend as much as nine hours per day using media.

Digital Media Addiction

Any adolescent who has an excessive and uncontrolled need to use digital media and who experiences negative effects on their personal health, happiness, and relationships from use could be addicted.

1. Internet Addiction



Examples of internet use include communicating in chat rooms for social and intimate relationships, shopping online, pleasure seeking, and downloading data. Eamples of things that can increase the risk of internet addiction include more time spent on the internet, exposure to enticing online incentives like making money, and the use of pornography. A study done in Hong Kong in 2014 showed that among adolescents 16-19 years of age the prevalence of internet addiction was estimated to be 6.7% (with a male: female ratio of 3:1). Some offline behavioral addictions, like addiction to illicit drugs or alcohol, could be associated with internet addiction. Alcohol consumption was found to be directly proportional to boys who reported addiction to cyberpornography.

2. Computer Game Addiction

Home gaming systems (e.g. PlayStation), online, and computer gaming devices have been made widely available to numerous customers at affordable prices. The study done in Hong Kong in 2014 reported 94 % of 503 high school students surveyed had played video or internet games and 15.6 % had a gaming addiction. Video game addiction is defined as video game overuse, pathological or compulsive/excessive use of computer games, and/or video games. Cognitive factors such as distorted perception of one's intelligence and gaming skills may contribute to pathological gaming. Not playing may lead to possible withdrawal symptoms including feelings of restlessness and/or irritability, preoccupation with thoughts of previous online activity and/or anticipation of the next online session. Gaming addiction could be a significant health hazard with harmful impact on

physical, emotional, mental and social health. It is is associated with sleep deprivation, eating irregularities, physical strain and fatigue, obesity, mood disorders, social incompetence, and isolation from friends and family. Many adolescent pathological gamers also have lower academic achievement, conduct problems, poor skills in problem solving and emotion management. Playing games may help with mood and result in excess gaming by providing excitement, relief and escape from daily stressors. Many pathological gamers have positive appraisal of their intelligence and gaming skills but a negative view of their social competence in interpersonal relationships. It has been reported that young men with poor social skills and low self-esteem are most susceptible to gaming addiction because they could design "a powerful persona" within games to win recognition and esteem among players.

Summary of Risk Factors for Digital Media

Addiction

Many adolescents now have easy access to computers, smart phones/tabs, and the internet. There are individual, family, and social risk factors for digital media addiction.

Individual Factors: Irritability, male gender, presence of other addictions, anxiety issues, fear of being left out, low self-esteem, neurotic personality traits, experience of recent stressful events, intellectual disability or depression.

Family Factors: Family dissatisfaction, family history of mental illness, low family economic status, intra-family conflict, family history of habitual alcohol use, perceived caregiver's attitude towards the use of internet or poor supervision of an adolescent's use of digital media.

Social Factors: Peer pressure, living in an unsafe environment or use of online social networking sites.

Case Examples

Case 1

AG is a 15-year-old observant Christian girl in one of the best boarding secondary schools in Uganda. Her parents were not "hands-on parents" and never really supervised her, mostly because they were so occupied with caring for her older sister who suffered from a panic disorder. AG's parents were called into the school when her performance in class deteriorated and her behavior worsened. She was found to be sad most of the time, anxious, and withdrawn. AG had very few friends, felt like people were judging her and was so distressed she once tried to jump over the school fence to go home. Her parents brought her to an adolescent psychiatrist who created a safe, non-judgmental space that allowed AG to speak openly and honestly. She disclosed that she liked to watch pornography on the internet because it helped her feel better. The psychiatrist found AG to be depressed and anxious so he started her on medication. He decided to address these first and then re-assess her interest in internet pornography on follow-up. As AG began to feel less depressed and anxious she started socialzing more and watching less pornography. Because AG was "feeling better" she often forgot to take her medications and missed her mental health follow-up appointment. Over time, her depression and anxiety recurred. She again began watching pornography on the internet to help relieve her symptoms.

Risk factors: Permissive parenting, adolescent age, and family history of panic disorder.

Learning points: Always create a safe non-judgmental space for open and honest communication This is the most effective way to open doors of communication and allow an individual to speak honestly and then access useful support. Finally, continuity of mental health care is key because lack of it can result in worsening of the patient's mental health condition.

Case 2

AK, a 14-year-old male, walked from his home to the Butabika Children's Clinic. He lived with his mother and sister just outside of Kampala in a low income suburb with a high crime rate. He said that his mother and older sister had told him to come to hospital because of his "bad manners", school truancy, and constant desire to play video games with his friends, 3 of whom worked at a video library. His only concern was that he would often forget things. When interviewd by the healthcare provider he endorsed feelings of hopelessness and sadness, denied suicidal ideations, and mentioned that he likes jogging because it makes him feel "like a new soul". His mother was contacted by phone and she explained that his altered behavior started after the death of his father in 2017. She added that after his father's death he also started using illicit drugs, became violent to his siblings/peers, rude to his mother when she didn't give him whatever he wanted, and had even spent a night in prison for disciplinary action. After seeing AK, the provider noted that AK did have insight into his problems. AK endorsed missing his father and stated that he wanted to stop playing video games for hours and begin focusing more on school. Because he felt that his drug use was affecting his memory, he also asked if he could get some help with this problem. The provider suggested that he follow-up at the Butabika Children's Clinic for Addictions & Bereavement Counseling. To his credit, AK not only made the appointment, but showed up for it. The first thing he happily reported was that he was now jogging daily because it helped him feel better.

Risk factors: Death of his father, having friends who worked at the internet café, unclear family system with no father figure, and living in a low income unsafe suburb.

Learning points: Collateral history, from family/ friends, can help fill in a history that the adolescent may not reveal. Acessing how motivated an adolescent is to change is key. In this case AK was motivated. If an adolescent is not yet ready for change, don't force it, just open up a discussion about the pros and cons of the behavior and have ongoing appointments to re-assing the readiness to change. Optimizing any positive coping strategy, like AK's jogging, is always useful. People are more likely to make changes when they come up with the ways that would best work for them rather than being told by others what they need to do!.

Internet Addiction in Uganda

Internet addiction in Uganda seems to be on the rise. There are widespread Wi-Fi spots in town and many activities take place via social media including networks for social teen-events and chat rooms with different topics of discussion. In addition, Africa has become the second largest mobile market in the world in terms of the number of subscribers. Access to the internet has increased over time across Africa: 12.4% in 2011 compared to 2.4% in 2005. In 2005,

increased expansion of internet access allowed for anytime-anywhere connectivity. More so, with increasing prevalence of alcohol consumption among adolescents in Uganda, the prevalence of sexting, cyberpornography, and gaming is likely to increase. Parents, providers, and adolescents need to be aware of these potential behaviors so that early interventions can be put into place to prevent the development of addiction.

Role of the Healthcare Provider

It is prudent for healthcare providers to acquaint themselves with the risk factors related to media addiction. Because media use is so prevalent assessing what type of media a patient prefers, how long it is used for, and screening for addiction has become an important part of any non-acute healthcare visit. As always, it is helpful for the health care provider to create a safe, confidential, non-judgmental space where adolescents can discuss concerns and questions related to any private behavior, and find support for healthy development. For some adolescents, a visit with a health care provider presents an opportunity to discuss important parts of their lives. The more comfortable a provider is in asking personal questions the more likely the adolescent will answer the questions honestly.

Useful Scripts

1. How to open a comfortable dialogue:
   "It is my goal to help you feel comfortable sharing sensitive and personal information with me. Remember I do not make judgments, I respect you and appreciate your thoughts, feelings, and experiences that you share with me."
2. How to ask about media use:
   "Many teens spend time using a variety of media like watching TV, playing video games, or exploring activities on the internet. The range of things available on the internet is endless and includes activities that can be done with others to more private activities that are often done alone like interacting in chat rooms or watching pornography. What type of media do you enjoy and how do you like to use the internet?"

Additionally, healthcare provides can also educate patients and families about netiquette: the correct or acceptable way of communicating on the internet.

Internet Addiction Screening Test

Dr. Kimberly Young, a professor at St. Bonaventure University and director of the Center for Internet Addiction Recovery, developed the Internet Addiction Test (IAT) to assess symptoms of Internet addiction. Dr. Young's IAT Manual (netaddiction.com/wp-content/uploads/2015/11/IAT-Manual.doc) describes the IAT which is a 20-question test (Table 1) with each item rated by the examinee on a 5-point scale ranging from 0 to 5 with a maximum score of 100. The IAT total score is the sum of the ratings given by the examinee for the 20 item responses. Total scores that range from 0 to 30 points are considered to reflect a normal level of internet usage; scores of 31 to 49 indicate the presence of a mild level of internet addiction; 50 to 79 reflect the presence of a moderate level; and scores of 80 to 100 indicate a severe dependence on the

internet. As described in her manual, The IAT can be administered and scored by paraprofessionals, but it should be used and interpreted best by professionals with appropriate clinical training and experience especially in assessing potential co-morbid mental health problems that may exist.

Suggestions on How to Help Children and Adolescents Learn to Use the Internet in a Positive Way

Adults can learn and then teach appropriate usage of the internet beginning in childhood. It is helpful for adults to continually monitor children and adolescents' activities on the internet, disucss concerns, and help implement safety measures.

Resource: https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/American-Academy-of-Pediatrics-Announces-New-Recommendations-for-Childrens-Media-Use.aspx

Children and adolescents can be encouraged to spend time with friends and family in place of spending time using media. It is also helpful to know who young people are socializing with and commend healthy relationships but discuss relationship concerns, should they exist.

Additionally, adults can serve as role models for healthy habits. They can also help children and adolescents think about the choices they are making through open honest non-judgemental communication that facilitates solutions to existing or potential problems.

Conclusion:

Adolescents are vulnerable to a number of risk taking behaviors including overuse and addiction to digital media use. Parents and other significant adults play an important role in helping children and adolescents navigate media and learn to use it in a positive way. It is best for the parent to know what their child is exploring on the internet, set parental controls when appropriate and set expectations and boundaries. Overall, parents can help guide their children to make healthy choices by implementing positive parenting which includes directing a child's activities in a rational, issue-oriented manner, offering support and setting rules that are appropriate for the child's level of development. Problems begin when media use displaces physical activity, in person social time with family and friends, sleep, and homework time for example. Addiction to the internet starts with too much unsupervised time with digital media, but for those with symptoms of addiction, there are various resources available that can help our adolescents adopt healthy habits and grow into well-adjusted productive adults.

Treatment modalities and/or protocols for internet addiction have not yet been standardized, but it is helpful for healthcare providers to know mental health referral resources available to them in their location.

In Kampala, anyone may walk into Butabika Hospital Children's Clinic or Mulago Hospital Mental Health unit and access help Monday through Friday. No consultation fees are charged.

Mulago Hospital Mental Health clinic is on New Mulago Hill road, part of Mulago National Referral Hospital Complex, P.O Box 7051, Kampala Tel: +256 414541250.

Butabika Hospital Children's Clinic is part of Butabika Hospital, plot 2 Kirombe-Butabika road, P.O Box 7017 Kampala. Email: buthosp@infocom.co.ug, Tel: +256 414504376

TABLE 1

Table 2: Internet Addiction Items.

1. Do you prefer the excitement of the Internet to intimacy with your friends or family?
2. Do others in your life complain to you about the amount of time you spend online?
3. Does your job/school performance or productivity suffer because of the Internet?
4. Do you become defensive or secretive when anyone asks you what you do online?
5. Do you block disturbing thoughts about your life with soothing thoughts of the Internet?
6. Do you find yourself anticipating when you will go online again?
7. Do you try to cut down the amount of time you spend online and fail?
8. Do you try to hide how long you've been online?
9. Do you choose to spend more time online over going out with others?
10. Do you find that you stay online longer than you intended?
11. Do you neglect household chores to spend more time online?
12. Does your work suffer (e.g. postponing things, not meeting deadlines, etc.) because of the amount of time you spend online?
13. Do you check your e-mail before something else that you need to do?
14. Do you find yourself saying "Just a few more minutes" when online?
15. Do you form new relationships with fellow online users?
16. Do you fear that life without the Internet would be boring, empty, and joyless?
17. Do you snap, yell, or act annoyed if someone bothers you while you are online?
18. Do you lose sleep due to late-night log-ins?
19. Do you feel preoccupied with the Internet when off-line, or fantasize about being online?
20. Do you feel depressed, moody, or nervous when you are off-line, which goes away once you are back online?

Dr. Dorothy Gingo is a young medical doctor in the process of studying for her Master of Medicine in Paediatrics and Child Health in Makerere University. She is very passionate about the health of children and adolescents and is looking forward to starting her research project focusing on adolescents living with HIV.

LET'S WORK TOGETHER TO HELP OUR ADOLESCENTS ADOPT HEALTHY HABITS AND GROW INTO PRODUCTIVE ADULTS

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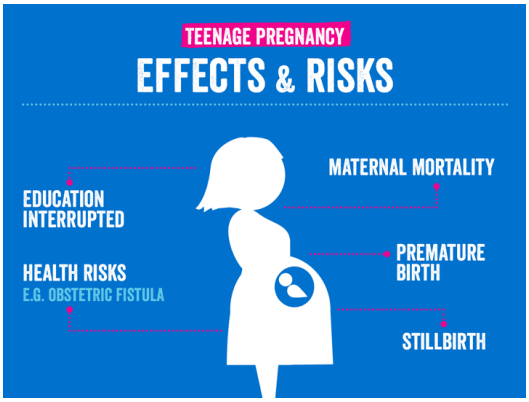
Adolescent Pregnancy and Childbirth are a Worldwide Concern

Adolescent pregnancy and childbirth affect more than 16 million young women worldwide and are commonly associated with adverse psychosocial, educational, and poor child health outcomes. In fact, in East Africa, almost 10% of young women give birth by the age of 16. It is Uganda, however, that holds the highest proportion of women giving birth prior to age 20 (63%), and the highest total fertility rate (6.2) in all of East Africa, according to the Ugandan Bureau of Statistics. Uganda's 2016 Demographic and Health Survey estimated that 25% of girls from age 15 to 19 years either have a child or are pregnant, which is an increase in pregnancy rates from the prior survey in 2011. It is known that these adolescents face unique challenges when they become pregnant. In fact, the leading causes of death and disability among Ugandan female adolescents from 15-19 years of age are complications from pregnancy, abortion, and childbirth.



Unique Challenges Faced by Adolescent Parents

Because the teen pregnancy rate is high in Uganda, many teens find themselves as parents at an early age. Just as giving birth to a child as a teen is associated with negative outcomes, so is raising a child as an adolescent. It is known that pregnancy is more likely to be unexpected in adolescence, and pregnant teens are more likely to be unmarried. Because they are more likely to be single parents, they are likely to have poor social and financial support from their families. Teen parents are often forced to leave school, or choose to do so in order to raise their baby. This results in lower academic achievement and decreased future earning potential, which places the family at financial disadvantage and is associated with poor child outcomes. Children of teen parents are, consequently, more likely to live in poverty, to drop out of school, and to become teen parents themselves.

Understanding Child Behavior

The Developing Brain

Teens typically have less knowledge about both child development and effective parenting approaches than do more mature adults. This knowledge gap can negatively affect the way by which adolescent parents raise their young children. And, understanding normal child development is paramount to obtaining the skills needed to successfully shape behavior in a healthy way.

The most effective parenting strategies for raising young children are based upon the understanding that the brain is developing rapidly throughout infancy and during early childhood and adolescence. Thus, children will respond differently to internal and external pressures, due to their

developmental ability to do so. Furthermore, the immature brain requires very special handling. As a child's brain develops, only neural connections that are reinforced and utilized frequently will be maintained and strengthened. So, if a child is engaged in good coping skills, empathy, and positive interactions, the brain will strengthen these behaviors. If the child is not, the brain will prune away any weak neural connections.

Adolescents typically have fewer life experiences and an underdevelopment of successful coping strategies, which can affect the way by which these teens approach parenting their children. These risk factors lead adolescent mothers to be less likely to engage in emotionally supportive and responsive parenting. Children born to teen parents are at a disadvantage in acquiring cognitive and language skills and social and emotional skills like self-regulation and self-confidence.

Parenting as a Choice

It is now widely accepted that the parenting choices made during child-rearing can positively or negatively affect a child's development. During planned pregnancies, parents often reflect on the type of parent they wish to be, or on the methods by which they plan to raise their children. As mentioned previously, adolescent parents are more likely to have unplanned pregnancies, a paucity of personal life experiences and knowledge, and are more likely to be operating as single parents. They may not see parenting as a "choice," and thus they may not understand that their words and actions will have lasting consequences for their children.

Evaluating Parenting Styles and Child Temperament

Problems relating to child behavior are common parental complaints and topics of discussion during non-urgent healthcare visits, so it is important that providers address these concerns thoroughly and effectively. Because adolescent parents have unique hurdles to overcome, it is of utmost importance that these issues be addressed by providers. After obtaining specific parental concerns about their child's behavior, the provider can educate the family by explaining that a child's behavior is simply a manifestation of his or her emotions. It is also directly related to a "need" to achieve a "goal." Because children are in different developmental stages, a child may not have acquired the skills needed to achieve their goals effectively, causing the unwanted behavior, or "mis-behavior." To truly understand a child's behavior, the approach must be multi-faceted, taking into account a child's unique stage of development, the child's innate temperament, and a parent's unique parenting style. It is important to keep in mind that behavior can, additionally, be shaped by other factors, including atypical child development, chronic medical or mental health conditions, and toxic home environments.

Parenting Styles

It is important to know that a child's environment shapes their development. Psychologists categorize a parent's approach to childrearing within the three parenting styles, as described by Baumrind et al. These are the permissive, authoritarian, and authoritative. The permissive parent exhibits an accepting, non-punitive approach toward a child's behavior. This type of parent is highly supportive, but they offer few or inconsistent rules and a lack of structure in the home. The child of a permissive parent learns very little

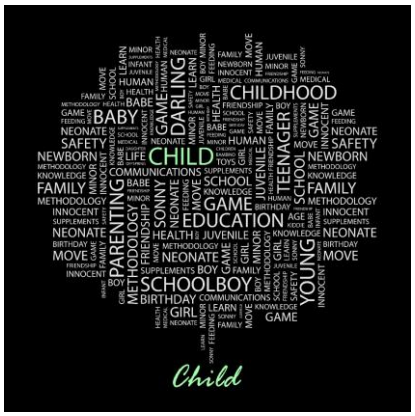
self-regulation, and as a result, can develop insecurities. In contrast, an authoritarian parent seeks to shape behavior based on a set of acceptable codes, using the concept of higher authority and enforcing highly punitive consequences, while offering little support. Children reared in more authoritarian households tend to have lower self-esteem and a propensity toward maladaptive behaviors, such as bullying. The most effective type of parent, according to the researchers, is an authoritative parent. This type of parent attempts to direct a child's activities, in a "rational, issue-oriented manner." He or she offers needed support and sets rules that are appropriate for the child's level of development.

A fourth parenting style, or *uninvolved parenting*, was later added by Maccoby and Martin et al. to describe parenting that is largely unresponsive to a child's needs, and in which very few rules are established. The uninvolved parent infrequently monitors the child and assumes that the child will learn how to negotiate the world on their own. Children reared in this environment are at risk of developing impulsive and delinquent behavior.

Child Temperamental Traits

It is also widely accepted by psychologists that children are born with an innate set of characteristics that are responsible for their unique interaction with the world. Doctors Chess and Thomas described these characteristics, or a person's in-born temperament, as a combination of traits. These are activity level, distractibility, intensity, regularity, sensory threshold (approach or withdrawal), adaptability, persistence, and mood. The understanding that children interact uniquely with the world around them, based on their own individual combination of these traits, is key to understanding their behavior.

Positive Parenting as an Effective and Beneficial Method of Child-Rearing



"Positive Parenting" is a concept that has become widely accepted as a most effective parenting strategy within the field of developmental pediatrics, and it has been proven to produce secure child-caregiver attachments, to build confidence as children grow, and to prevent child maltreatment. Somewhat based on the American psychologist B.F. Skinner's "principle of reinforcement," the concept of Positive Parenting focuses on rewarding acceptable and wanted behavior with positive reinforcement, while at the same time setting developmentally appropriate limits to prevent problematic behavior (Skinner, 1938). Utilizing this approach, parents are constantly giving specific praise and positive encouragement when their child is being "good," in order to reinforce desired behaviors. Techniques used should be sensitive and flexible based on cultural differences in expectations, parenting styles, and differences in child temperament. An effective positive reinforcement tool for shaping child behavior is verbal praise that is both specific and timely for a desired behavior. Telling your child exactly what the favorable thing that he or she did, at the time that they are doing it, reinforces the behavior. The child will seek similar praise in the future by repeating it. Other effective means of positive reinforcement include giving a hug, a "high five," or pat on the back. Small rewards

like stickers or task-appropriate privileges are also effective.

The concepts of Positive Parenting are built on a foundation of parental nurturing, or the creation of numerous and frequent positive parent-child interactions beginning in the immediate post-partum period and continuing throughout childhood. Nurturing begins with immediate bonding of a newborn with his or her parents, and is exhibited when parents are responsive, in a loving way, to the infant's needs throughout the day and night. Nurturing encourages parents to give love and support freely and often. Beneficial outcomes of nurturing include the early development of secure parent-child attachment, the facilitation of language acquisition and development, and the creation of routine. As previously discussed, behavior is directly related to achieving a goal. Through nurturing, parents become more attune to the child's wants and desires, so that, together, they can create common goals.

A parent who spends more quality time nurturing their child is more likely to be in tune to their child's wants, needs, and stressors. Human behavior can be predictable, thus parents can pick up on antecedents for misbehaving, or specific triggers and situational stressors that cause their child to misbehave. Some may be age-or development-based, such as language difficulty, hunger, fatigue, an overwhelming number of options, or the need to assert independence, and others may be specific to the temperament and inborn characteristics of a specific child. By looking for these behavior-predictors, parents can intervene prior to misbehavior, ensuring that a child will react to situations in a more constructive, beneficial way. After the antecedents are identified, parents should intervene by addressing needs such as hunger or fatigue and by redirecting attention when a child is fixated on something unwanted or dangerous to them. Redirection can be performed by offering an alternative, age-appropriate toy or activity or engaging the child in a favorable parent-child interaction.

Setting Limits

It is important to know that Positive Parenting strategies effectively combine nurturing and bonding, while also setting age- and developmentally-appropriate limits for the child. Setting healthy limits for a child promotes emotional regulation and socio-emotional development, can help parents and children tolerate separation, and allows parents to set and communicate clear and consistent expectations. When parents understand the concept that "to discipline is to teach," they can effectively shape a child's behavior. The limits set should be clearly defined for the child and consistently enforced by all caregivers.

During our discussion of the developing brain in early childhood, we mentioned that a young child's neural connections are immature and pliable. Therefore, young children do not have the ability to retain information as do older children and adults. So, it is important that a good parent must explain rules frequently and often, because young children may not remember what is expected of them in different situations. Children learn exponential amounts of information each day, so it can be developmentally normal for children to forget what was said or expected in past experiences. By explaining often, parents improve the chance that their child will behave in an expected manner.

Physical Punishment as an Ineffective and Harmful Method of Discipline

Physical punishment, or punishment inflicted by physically spanking or hitting a child, has long been employed throughout most cultures as a means to shape child behavior. In fact, research has shown that adolescent parents are more likely to engage in harsh parenting, like yelling and spanking. The results and effectiveness of forms of physical discipline have been studied and hotly debated; however, current research concludes that it is ineffective and harmful, and academic pediatric communities advocate against its use in child-rearing. Large, meta-analyses conducted in developed countries have consistently confirmed that physical punishment in childhood is linked to adverse outcomes, such as adult and child mental health problems, antisocial behavior, and negative child-parent relationships. Research in low- and middle-income countries is limited, however, severe psychological and physical abuse has been reported to be more common in households where parental attitudes toward corporal punishment were favorable. Children who receive physical punishment are more likely to become victims of domestic abuse later in life than are those who do not.

Experts in the field of developmental pediatrics find that the most effective forms of child discipline are immediate, consistent, and illustrative. The discipline is aimed to teach the child "why" their mis-behavior is ineffective or unwanted within the family and within the greater society. Physical discipline does not achieve this goal for families. Instead, goal-oriented discipline techniques shape child behavior in more constructive ways.

Positive Parenting Education for Families

How do families learn effective positive parenting strategies?

Giving anticipatory guidance is an important part of healthcare visits, and parenting advice is a frequent topic of discussion sought by families. In fact, research concludes that families both desire and expect advice on child development and behavior from their pediatric providers. However, there is a great deal of inconsistency in the amount of such information addressed during patient encounters, and the extent to which medical students and trainees are trained on parenting topics varies among institutions. Because adolescent parents typically have a lower fund of knowledge on these topics as do their mature parental counterparts, anticipatory guidance given during the healthcare visits can be invaluable.

Dr. Keown Teaching Positive Parenting

In addition to parent education through provider anticipatory guidance, numerous Positive Parenting programs have been designed to address child-rearing and to promote formative strategies. To meet the diverse set of needs that different parent-child pairs face, programs range from infrequent, low-cost, community- or clinic-based interventions to intensive, frequent, and costly programs delivered by highly-specialized behavior specialists. Some of the programs can even be tailored to specific needs or concerns. These programs have been implemented and studied within varied environments, all across the world, and positive cognitive, developmental, and social outcomes have been shown to result from positive parenting education. When studied in developed countries, favorable parental outcomes from the programs include greater parental sensitivity and knowledge, less harsh discipline, decreased maternal stress, and improved parent-child interactions. Positive child outcomes include improved cognitive development scores, improved peer interactions and behavior problems.

The current research on such programs in low- and middle-income countries is not robust, however favorable outcomes have been found by a number of high-quality studies. For example, a parenting intervention in South Africa was found to create more sensitive and less intrusive parenting, as well as a more secure infant attachment, than those found within the control group. (Cooper et al., 2008). In Ethiopia, researchers found that parents exhibited more sensitive, responsive, and optimistic interactions with their children, following a parenting intervention. There is consistent evidence that parents from both developed and developing nations can learn nurturing skills and can reduce harsh and coercive discipline practices, thereby preventing child maltreatment. Because teen parents are more likely to engage in harsh parenting than do their more mature counterparts, they can benefit greatly from positive parenting training and education.

Summary and Recommendations

Parenting choices are highly important to child-parent bonding and child developmental outcomes. By understanding parenting style, child temperament, and stage of development, and through partnering with their healthcare providers, parents can make more effective and healthier choices in child-rearing. Adolescent parents may not intuitively approach parenting in the reflective manner than do more mature parents, but healthcare providers can help support these young families by educating them about effective, positive parenting techniques.

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Dr M. Katie Keown is a general pediatrician and Assistant Professor of Pediatrics at Columbia University Medical Center (CUMC). She has special interests in maternal and child mental health and parenting. She is a member of the Early Childhood Task Force at CUMC, where she is working collaboratively to implement a parenting curriculum for pediatric residents and trainees. Dr. Keown currently serves as the chairperson for the Committee for Underserved Children with the American Academy of Pediatrics. Her international work includes serving as a Helping Babies Breathe neonatal resuscitation program trainer in Mbale and in Kampala, Uganda, and she has been an invited lecturer at Mbale Regional Hospital. She is currently co-designing a positive parenting curriculum for expectant mothers in Kampala, Uganda.

CONCLUSION

We continue to work hard to keep our readers updated on the latest in many areas of adolescent health and we hope that you have enjoyed receiving our semi-annual newsletter. Please continue to submit updates on your work with adolescents and feel free to email Dr. Kitaka at **sabrinakitaka@yahoo.co.uk** with suggestions of topics that you would like for us to cover in future newsletters. Thank you!

STAY TUNED…….

PLANS FOR THE 2019 MAKERERE-COLUMBIA UNIVERSITY (MUCU) & THE SOCIETY OF ADOLESCENT HEALTH IN UGANDA (SAHU) ADOLESCENT HEALTH CONFERENCE ARE UNDERWAY

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