Department of Child and Adolescent Health and Development

Adolescents, social support and help-seeking behaviour

An international literature review and programme consultation with recommendations for action

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Acronyms and abbreviations used in this report

AIDS	acquired immune deficiency syndrome
ASRH	adolescent sexual and reproductive health
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CESAC	Centro de Salud y Acción Comunitaria
FHI	Family Health International
FLE	family life education
HIV	human immunodeficiency virus
IEC	information, education, communication
NEPO	Núcleo de Estudos da População
NESA	Núcleo de Estudos da Saúde do Adolescente
NESDP	National Economic and Social Development Plan
NGO	non-government organization
PAHO	Pan American Health Organization
PHC	primary health care
RTI	reproductive tract infection
SRH	sexual and reproductive health
STI	sexually transmitted infection
TARSHI	Talking About Reproductive and Sexual Health Issues
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization

A

Justification and purpose of this document

Adolescence is widely defined as the time in life when the developing individual attains the skills and attributes necessary to become a productive and reproductive adult. Nearly all cultures recognise a phase in life when society acknowledges these emerging capacities of young people. What varies considerably by culture and context is whether the passage from childhood to adulthood is a direct and short passage, or whether there is a prolonged adolescence marked by a choice of identities and roles.

Numerous WHO consultations and studies have confirmed the importance of caring and meaningful relationships, as well as pro-social connections with individuals and social institutions, in reducing risks and promoting healthy and positive developmental outcomes.

While most of the world's adolescents make it through the period with no major problems, even those adolescents who have no significant personal problems or acute health-care needs have normative stresses and needs for help, support and orientation associated with making the transition from childhood to adulthood. In some parts of the world, research suggests that the normative tasks of adolescence are becoming more difficult in light of reduced social control by families, more varied opportunities (leading to greater confusion), increased individualism and declining importance of traditional cultural norms (Frydenberg, 1997). Programmes in South-East Asia consulted for this document reported that changes in the social structure and the economy – including increases in educational attainment, increasing urbanization and increased modern-sector employment opportunities for young women – have led to a weakening of traditional familial support. These changes are often cited as the causes of increasing rates of psychological problems such as family crises, emotional/identity crises and substance use. In addition, some adolescent health staff consulted for this document argue that increasing job insecurity in a globalizing economy means that adolescents have expanding normative needs for assistance in continuing their education, newer and more diversified job training, and enhanced services related to sexuality and reproductive health – particularly given later ages at marriage and earlier sexual activity.

Around the world, adolescence is a time of opportunities as well as vulnerabilities to risk-associated behaviours that can have lifelong consequences for health and well-being. Numerous World Health Organization (WHO) consultations and studies have confirmed the importance of caring and meaningful relationships, as well as pro-social connections with individuals and social institutions, reducing risks and promoting healthy and positive developmental outcomes. Many researchers, and various WHO documents, have also called for more attention to and more research on where, why and how adolescents seek help (i.e. their help-seeking behaviour) and the sources of and nature of help available to them in their specific contexts (i.e. social supports).

Before proceeding, it is important to define the terms that frame this document, particularly "help-seeking behaviour " and "social supports." There are few specific, agreed upon definitions of "help-seeking behaviour" in the adolescent health and development literature. Furthermore, when referenced, help-seeking generally refers to the use of "formal" supports, which we define as health facilities, youth centres, formal social institutions or professional care providers, either in the public or private sector. In many cases, "help-seeking" is used interchangeably with "health-seeking," which generally refers more narrowly to seeking services or remedies for a specific ailment or illness. In many of the documents cited in the bibliography, "help-seeking" refers to the use of health and other services in the case of severe or serious mental health issues, including substance use, depression and suicide. In only a few cases in the literature is the term "help-seeking" used in a more comprehensive way to refer to the use of both formal supports and informal supports, which we argue includes family, kinship networks, friends, traditional healers and/or religious leaders.

… the fact that adolescents generally have good health and that their overall use of clinic-based public health services is less than other segments of the population – adult women, younger children, the elderly, etc. – further underscores the need to pay attention to social supports outside of professional care-giving settings.

If we approach adolescent health and development as including a broad range of psychosocial, affective and health needs, which includes normative developmental needs as well as specific problem-oriented needs, then a broader definition of adolescent help-seeking behaviour is required. In addition, the fact that adolescents generally have good health and that their overall use of clinic-based public health services is less than other segments of the population – adult women, younger children, the elderly, etc. – further underscores the need to pay attention to social supports outside of professional care-giving settings.

Indeed, most adolescent health problems are related to behavioural and lifestyle issues, which the literature consistently confirms are more influenced by the social setting than by health providers or other professional service providers. Furthermore, research from around the world suggests that 80–90% of childhood disease is treated at home or outside the formal health care system, a pattern that likely continues into adolescence. This highlights even more the need to examine help-seeking more broadly than within the formal health care system.

Accordingly, we propose the following definition for adolescent help-seeking behaviour. This definition is based in part on the literature on adolescents and coping behaviour (Frydenberg, 1997) and to a limited extent on literature on health-seeking behaviour (Ward et al., 1997). For the purpose of this document, we propose defining help-seeking as:

> Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of a service (e.g. a medical consultation, clinical care, medical treatment or a counselling session), a referral for a service provided elsewhere or for follow-up care or talking to another person informally about the need in question. We emphasize addressing the need in a *positive* way to distinguish help-seeking behaviour from behaviours such as association with anti-social peers, or substance use in a group setting, which a young person might define as help-seeking or coping, but which would not be considered positive from a health and well-being perspective.

We propose three categories of adolescent help-seeking behaviour:

1. Help-seeking for **specific health needs,** including health services (in the formal health care system or from traditional healers and pharmacists), as well as seeking health-related information. This is generally called health-seeking behaviour.

2. Help-seeking for **normative developmental needs,** including help in completing school, or help related to vocational orientation/training, or employment-seeking; relationship formation and concerns; understanding the changes associated with sexuality or puberty; and/or other concerns that are frequently associated with adolescence.

3. Help-seeking behaviour related to **personal stress or problems,** as in the case of family crises; family violence or victimization by abuse; relationship stresses; acute financial needs; homelessness; and/or needs or problems related to chronic or acute ill-health. These are specific, problem-related psychosocial needs that go beyond the normative needs of young people.

Social support, like help-seeking, is a term that does not have a widely agreed-upon definition in the adolescent health and development literature. Social support is generally defined as a range of interpersonal relationships or connections that have an impact on the individual's functioning, and generally includes support provided by individuals and by social institutions. Reid (1989, cited in Costello, Pickens & Fenton, 2001) offers a broad definition of social support that includes four specific kinds of support:

Social support is generally defined as a range of interpersonal relationships or connections that have an impact on the individual's functioning, and generally includes support provided by individuals and by social institutions.

1. **Instrumental support,** which is direct support to an individual in the form of financial assistance, skills training, health services, transportation, etc.;
2. **Informational support,** which includes providing information about a need or referrals for help, including health-related information;
3. **Affiliative support,** which means simply, being with other individuals who have mutual interests; and
4. **Emotional support,** which includes close friends or family members, or professionals, who provide help for emotional needs or personal crises.

These definitions of social support converge with our proposed definition of help-seeking. Taken together, these two sets of definitions suggest that we can conceive of help-seeking behaviour as the *demand for help* or for social support by the adolescent. In turn, social support can be defined as *the supply of this help.* By focusing on both the individual adolescent and his/her help-seeking behaviour and on the sources of help available, we offer a more interactive and nuanced approach than merely focusing on the behaviour of the individual adolescent.

It is important to highlight from the start that help-seeking and having access to and using social supports are generally protective factors for many adolescent health and developmental outcomes. Having and using social supports is associated, among other things, with lower rates of suicide, safer sexual behaviour, lower rates of substance use, later sexual debut and lower rates of delinquency or perpetration of violence (Frydenberg, 1997; WHO & UNICEF, 2000). Some researchers interviewing adolescents across cultures find that youth who report positive connections with parents (one form of social support) are more socially competent and less depressed (Barber, in WHO & UNICEF, 2000). Being able to seek and find help – from formal or informal sources – is a protective factor for adolescent health and development and overall satisfaction with life (Baumeister & Leary, 1995, cited in Costello, Pickents & Fenton, 2001). Studies from various cultures have found that beliefs beyond the self and opportunities for expression and connection are associated with positive developmental outcomes. Research from Western Europe and North America on developmental assets and developmental supports – using those terms to refer to sources of help and support via the family, community or social institutions (schools, clinics, youth programmes, recreational activities, etc.) that assist adolescents with their health and development needs – has also largely confirmed that having more meaningful supports and connections is better than not having them.

Research also suggests that objective measures of social support are generally less important (and perhaps less valid) than the subjective meaning that an adolescent attributes to these social supports.

Research also suggests that objective measures of social support are generally less important (and perhaps less valid) than the subjective meaning that an adolescent attributes to these social supports. As Costello, Pickens & Fenton (2001) state: "The perception that social support is available seems to lessen – to buffer – the negative impact of a stressful event and to hasten recovery even if it is not actually verified, or used." In short, believing that he/she is supported or has a range of individuals who support them, even when or if the adolescent does not use this support, is the central concern.

However, it is important to point out that not all social supports – peer, parents or other adults or institutions – are in fact supportive. In some cases, young people may turn for help to peers who encourage

anti-social behaviour. Similarly, while parents and other family members can be sources of support, providing help and facilitating access to other sources of help, they may act in negative ways or restrict adolescent access to services or positive sources of support because of their own values about the given need for help (for example if the need is sexual in nature). When family members or other adults in the community ignore family violence or sexual exploitation, close social supports become complicit with the abuse. In some settings, families or the state may make decisions for and force help on adolescents, in the case of counselling for substance abuse, for example. Likewise, when adolescents turn to their peers for information on sexual health, they may find important affiliative support, but the information provided by their peers may be inaccurate. Similarly when a young person seeks health services from an untrained abortion-provider, for example, the outcome from the help-seeking and instrumental support may be negative. Ascertaining what is a positive or negative social support, or help-seeking behaviour, is sometimes unclear.

With this brief introduction and justification, this document presents:

- The findings from an international literature review on the topic of adolescents and help-seeking behaviour.
- The results of a programme consultation with 35 adolescent health programmes (including public health sector programmes, university-based adolescent health programmes and non-government organizations (NGO) working in adolescent health) from Latin America (10), the Western Pacific region (4), Asia (20), and the Middle East (1), and the results of six key informant interviews. These results are incorporated into the literature review where relevant. The complete report from this consultation of programmes is found in Appendix 1.
- Recommendations for action, including a brief outline for developing a set of guidelines for the rapid assessment of social supports to promote the help-seeking of adolescents.

This document is part of a WHO project to identify and define evidence-based strategies for influencing adolescent help-seeking and identify research questions and activities to promote improved help-seeking behaviour by adolescents. To achieve this objective, the consultants, with WHO guidance: (1) carried out an international literature review of the topic; (2) sent 67 questionnaires and received 35 questionnaires back from adolescent health programmes on the topic of adolescents and help-seeking in the four regions; and (3) carried out key informant interviews with nine individuals (three in Latin America, three in the Pacific region and three in South Asia). The consultants also developed short case studies of illustrative approaches in promoting help-seeking behaviour.

B

Introduction to and limitations of the literature review

While there is no field *per se* and relatively little research that has focused on adolescent help-seeking behaviour and social supports for adolescents in the broad way we propose here, there is nonetheless an extensive range of research on adolescent coping, risk and social support that provides important insights on how to promote, or at least understand, adolescent help-seeking behaviour and social supports. To carry out the international literature review, we conferred with colleague organizations and consulted the following on-line databases:

- MEDLINE
- POPLINE
- Bireme/Adolec
- Adolescence Directory On-Line/University of Indiana (US)
- US Centres for Disease Control and Prevention
- American Academy of Child and Adolescent Psychiatry (US)
- American Academy of Pediatrics (US)
- Youthnet (International Youth Foundation, US).

To extend our literature review beyond "help-seeking," we also searched under the terms "health-seeking", "coping", "social supports" and "vulnerability" and identified additional sources this way. At the regional level, consultants conferred with colleagues and consulted local or national websites.

A quick glance at the literature (by perusing the titles in the bibliography listed at the end of this document) serves to confirm two points: (1) the vast majority of the sources found were from industrialized countries; and (2) most studies on help-seeking examine a specific adolescent health problem (HIV, sexually transmitted infections (STIs), adolescent sexual and reproductive health (ASRH), mental health, suicide, substance use, etc.) rather than examining help-seeking and social supports in the broader sense that we propose.

In the following section, we provide a critical discussion of this literature review together with relevant conclusions from the consultation with programmes and key informant interviews. Before presenting this critical review, however, it is important to present some of our initial conclusions, caveats and comments based on the literature.

- *As previously stated, there is a lack of research from developing countries that uses the concept of help-seeking and social supports that we propose.* A variety of other terms are used in the international literature, including "social support", "connections", "developmental assets" and "coping", but again most of this research is from Western Europe, North America and Australia.

- *One of the limitations of this body of research that emerges mostly from industrialized countries is that in these countries there is an assumption (and frequently a reality) of the existence of a substantial formal infrastructure of health and social services that is often underused.* In these settings, providers and researchers have often been concerned with promoting increased use of existing specialized and non-specialized adolescent health and social services. On the other hand, in many developing

countries, formal public health and other social services for adolescents (and the general population) may be lacking and those that do exist are often stressed with the number of patients they already accommodate. Both in the literature and in the programme consultation, providers in many developing country settings, perceive themselves to be overwhelmed with the number of patients, clients or participants they already have rather than being concerned about increasing clinic use and promoting adolescent help-seeking.

- *The literature consulted and identified, confirms the relative difficulty in measuring, assessing and studying the informal social supports* (family, peers, other adults or community members, religious leaders, etc.) that the majority of key informants report, as did most survey respondents, as being more important to adolescents than clinic-based or centre-based supports. Indeed, there is only a limited research base that takes into account both the informal social support and clinic-based or other centre-based supports.

- *In discussions with some key informants several limitations to the concept of help-seeking emerged.* Perhaps first and foremost is that help-seeking is largely an individual-centred, behavioural concept in which the motivation for seeking help is seen to reside within the individual. Various authors, in the HIV field and other public health arenas, have confirmed that the presumption of the importance of individual agency and individual action is highly questionable or extremely limited, particularly in settings where the social group, family, power dynamics in intimate relationships or local culture may take precedence over or dominate individual decision-making (King, 1999; Mane, 1996). Furthermore, much of the literature on help-seeking assumes a "rational actor" whom supplied with sufficient information will make the "right" health-related decisions. However, the adolescent development and health literature is consistent in affirming that even when adolescents (and adults for that matter) have access to information, they frequently still engage in risk-associated behaviours. Thus, it may be preferable to pursue a research agenda on social support in addition to help-seeking behaviour, and to seek to change group and contextual social norms rather than focusing solely on the individual adolescent (King, 1999; Rice, Herman & Peterson, 1993). Indeed, as we look at evidence bases for changing adolescent behaviour, we should keep in mind that, as one key informant from Brazil argued, the research suggests that adolescent health programmes and initiatives per se do not lead to major changes in the lives of adolescents. According to our key informant in Brazil: "Our research finds that you change very little in the adolescent's history. You can change the behaviour of individuals in relation to services, but then you have to change how he or she acts in his life, his or her lifestyle, … that is where I see a lot of limitations…".

- *We also observe in the literature and the adolescent health and development field, a tension between highly specialized areas – which are becoming even more specialized – and the notion that all adolescents have normative needs and require integrated and non-specialized support and services.*[1] In some countries, and in some databases, we see an increasing specialization in adolescent health and development, with research focusing on specific needs and problems. In some countries, services for adolescents have also followed this trend, with specialized services offered for adolescents with specific problems or needs (parenting or pregnant adolescents, adolescents with substance use problems, adolescents living with HIV, etc.). Simultaneously, in other countries and regions (and sometimes in the same regions), we have seen a trend towards the integration of existing services for young people, sometimes even including informal supports, and sometimes combining specialized services with more general services.[2] In many cases, services for adolescents are being integrated with the assumption that providing an array of services will: (1) better meet the needs of adolescents; and/or (2) lead to increased use of such services by adolescents. All of these trends

[1] Researchers at the Chapin Hall Center for Children at the University of Chicago (United States) have referred to these supports as "primary supports", recognizing that they are fundamental to the development of all children and adolescents, not just those with special needs or problems (Costello et al., 2000).

[2] By integration of services, we refer to deliberate efforts to create linkages among services, and to offer multiple health and social services for adolescents. This integration may take place within the same institution or community, or may involve creating referral mechanisms.

have implications for help-seeking behaviour, which have only been superficially explored and remain mostly unconfirmed in terms of impact evaluation.

- There is a large body of research in the adolescent and child development fields on coping, stress, and life transitions as well as normative and non-normative stresses and daily "hassles" (Rice, Herman & Petersen, 1993). This literature, as well as research from the field of resilience, contributes to the understanding or framing of help-seeking but does not directly provide an evidence base on the impact of programmes and policies in increasing adolescent help-seeking behaviour. However, this literature is key to studying help-seeking and social supports in that it confirms that pro-actively seeking help and connection with other individuals, and the perceived ability and accessibility of help, whether by individuals or via institutions, are all positive (or nearly always positive) for adolescent development outcomes.

- Our review of the literature also confirms that much of the international (non-industrialized country) literature on adolescents and help-seeking comes from the field of adolescent sexual and reproductive health (ASRH). In ASRH, research has been carried out on: (1) factors that impede or encourage use of health services, (2) evaluating criteria for offering adolescent-friendly services, and (3) differences between adolescents who use clinics and those who do not. Some of this research is synthesized here (but clearly not all of it), but it is important to reaffirm that most of these studies have not used a wider definition of help-seeking behaviour and social supports, and instead have mainly focused on reducing barriers to adolescent use of ASRH services and information provided by formal supports. Furthermore, when we present literature from the field of ASRH we must also keep in mind that the sensitive nature of discussing adolescent sexual activity – which in many cultures is highly taboo – may not be analogous to some other kinds of adolescent needs for help.

- Another limitation of the literature is that most studies have described adolescent help-seeking and the factors associated with it, but have not necessarily been concerned with providing programme and policy implications. We were able to locate only a handful of studies that might be called operations research or evaluation research with clear programme or policy implications.

- Finally, it is important to affirm that while there is a substantial body of research on factors that influence or affect help-seeking behaviour of adolescents, there is not a substantial evidence base confirming that interventions to promote help-seeking are effective. Relatively little research has measured or sought to measure increased help-seeking behaviour by adolescents as a result of policies or programme interventions. This of course does not mean that promoting help-seeking is without merit, rather that few experimental, or quasi-experimental, impact evaluation studies have been carried out to confirm empirically that promoting help-seeking by adolescents works (or that such studies are not readily found in the adolescent health and development literature).

C

A proposed framework for understanding adolescent help-seeking behaviour and use of social supports

In this section we will present insights from the literature review and the programme consultation in an effort to arrive at some conclusions about what we know about adolescent help-seeking behaviour and their use of social supports. To frame this inquiry, we developed the following chart (Chart 1) that presents an individual decision-making model within a given social context. Thus, the model presents both individual factors and exogenous factors related to the nature of available social supports. To the extent possible, we have sought to provide an interactive model for understanding adolescent help-seeking behaviour within their social context. In the text in this section, we provide a review of literature that provides insights on the various elements of the model, including: (1) individual factors associated with help-seeking; (2) exogenous factors associated with help-seeking, including the array and characteristics of social supports available; (3) help-seeking and social supports for special needs; and (4) programme efforts and policy initiatives to promote adolescent help-seeking. For each of these elements, we provide examples of factors and trends found in the research, along with comments from the programme consultation and key informant interviews.

1. Individual factors associated with help-seeking

As we can see in the model, numerous individual factors – including personal motivation, perception of need, self-agency, internalized gender norms, and perceptions of social supports as positive, among others – influence the help-seeking behaviour of adolescents. Within individual factors, we also include a feedback loop. As cognizing actors, adolescents approach a given social support or a decision about help-seeking with past experiences and positive, negative or neutral affect based on those past experiences, which in turn influence subsequent decisions about seeking help.

Personal beliefs about what constitutes a need for help

There are tremendous individual differences related to what adolescents define as a need for help. Studies in the United States (US) find that adolescents are more likely to report family problems as issues for which they require and seek help (Bowles & Fallon, 1996). In the consultation with programmes, staff reported a common set of personal problems for which adolescents sought help: sexuality/intimate relationships; employment; normative adolescent role transitions; homelessness; family violence and sexual abuse; and substance use, among others. Looking specifically at health needs, the programmes consulted reported a predictable range of health needs that are consistent with international data on adolescent morbidity; sexuality/puberty-related needs; mental health needs; accidents/violence; substance use; and primary health care.

As we look at the array of adolescent needs – expressed by adults affiliated with adolescent health programmes – we should be conscious that important decisions about services offered for adolescents are often made by adults based on their perceptions of adolescent needs, and not by adolescents themselves. Indeed, the array of services offered to adolescents in a given setting serves to structure or categorize needs. For example, if the only adolescent health services available in a given area are related to sexual and reproductive health (SRH), service providers will focus on those needs and may exclude others. Research in Chile and Brazil suggests that there is often a mismatch between adult perceptions of adolescent needs and adolescents' perceptions of their own needs. Research in Brazil found that adolescents often worried most

about issues such as school completion, trust and relationship issues with their parents and the risks of losing close friendships. Parents and other adults, however, viewed unwanted pregnancies and substance use as the main worries of their adolescent sons and daughters (Gunther, 1996, cited in Berger, 2001). If adults who make decisions about which services are offered to adolescents believe that adolescents need SRH services and substance use prevention and treatment, they may neglect some of the normative needs that adolescents often define as their most pressing concerns.

To understand why young people seek help, and what help they seek, requires understanding how adolescents define their needs, in addition to understanding the perceptions and biases of parents, service providers, policy-makers and other adults.

Of course many adolescents do have pressing needs for SRH services and information. The important point here is that the definition of the "need" and thus the help offered depend heavily on the perceptions of adolescents themselves and the adults around them, who structure and offer both informal and formal support. To understand why young people seek help, and what help they seek, requires understanding how adolescents define their needs, in addition to understanding the perceptions and biases of parents, service providers, policy-makers and other adults.

Internalized gender norms related to help-seeking

While gender is socially constructed as an exogenous variable, the way young people internalize gender norms and act on them suggests a combination of individual and exogenous factors. There are also tremendous regional and cultural variations to be considered.

For example, studies from a number of industrialized countries confirm that girls are generally more likely to seek help than boys. Research from North America, parts of Latin America, Australia and Western Europe finds that boys are more likely to deny and repress problems and tend to react in a more externally aggressive way than girls in moments of stress. Boys are also generally at higher risk of substance use in times of stress. Girls are more likely to use social support systems – i.e. to seek help – than boys, whereas boys more frequently try to manage on their own. Research in various settings, including in some developing countries, also finds that girls are generally more likely to pay attention to health-related issues and use health services (Frydenberg, 1997; Barker, 2000). Research with adolescent and adult men also suggests that in the case of support for various health needs, including mental health concerns and substance use, that boys and men generally delay seeking help longer than women and girls and may only seek help when the need has already led to significant personal consequences. (Ward et al., 1996).

Other studies suggest that gender norms related both to perceived parental roles (mothers' roles versus fathers' roles) as well as gender norms for adolescent sons and daughters, affect the nature of adolescent-adult trust and conflict, and whether an adolescent turns to a parent for help (and to which parent) (WHO, 1997). In many western settings adolescent boys and girls say they more frequently rely on or trust their mothers than their fathers. In addition, studies on help-seeking in several settings in Western Europe and North America find that older girls are more likely to seek help, suggesting that both age and gender interact to influence help-seeking (Frydenberg, 1997).

… while internalized gender norms have different manifestations depending on context and culture, gender norms are key to understanding the help-seeking behaviour of adolescents, and to the nature of social supports offered, and must be considered when studying and promoting adolescent help-seeking.

In other parts of the world, however, internalized gender norms and external manifestations of these norms mean that boys are more likely to have access to social support outside the home. In much of Asia, the Middle East and Africa, internalized gender norms, particularly taboos and restrictions on the sexual behaviour and mobility of young women, limit young women's

use of and access to formal health and other social services. In Bangladesh, for example, young girls report that they are frequently put off using available health services by feelings of shyness and fear, especially if the doctors are male (Mitra et al., 1997). Indeed, in many Asian countries, young women are likely to face family and community censure, are shyer or more embarrassed about accessing services and are more likely to face negative attitudes from providers. In some countries, married adolescent women face specific barriers to service use related to seclusion norms, a lack of decision-making authority (with their spouse or with the extended family setting they live in) and resources to make use of services.

In sum, while internalized gender norms have different manifestations depending on context and culture, gender norms are key to understanding the help-seeking behaviour of adolescents, and to the nature of social supports offered, and must be considered when studying and promoting adolescent help-seeking.

Perceptions of others and helping institutions as helpful and trustworthy

Whether young people trust or view others (e.g., parents, other adults, peers and social institutions) as helpful – that is whether they view their available social supports as helpful – is an important factor in help-seeking behaviour. Research suggests that youth may ignore health-related and help-related information because they do not trust the source or see it as unreliable. Research from Asia and sub-Saharan Africa finds that even when parents and adolescents report frequent conflict, parents continue to be a major source of support and adolescents continue to value their connections with their parents (WHO, 1997). Adolescents may trust or rely on their parents for certain needs, while not relying on them for other needs. For some needs – those related to autonomy, to conflicts within the family itself or sexual relationships, among others – adolescents may be in conflict with their parents and turn to other sources of support. For example, in many developing country settings, adolescents are more likely to say they trust an extended family member or a source of formal support (e.g. health educator) rather than their parents when they seek help related to sexual health (Newton, 2000; WHO, 1997).

Trust is of course interactive; it requires staff (and other providers of help) to be sensitive to the needs of adolescents as well as adolescents to trust these providers of help. A review of various studies on ASRH services suggests that the "single most important action any reproductive health programme for young adults can implement is the selection, training and supervision of staff members to work with adolescents, with a major emphasis on attitude, respect for young people and the development of interpersonal skills to promote provider-client communication" (Senderowitz, 1999).

Various studies on coping have suggested that trust, rather than the need for help per se, is the key variable in determining whether a young person seeks help; a young person's perception of a potential helper as a good listener rather than simply proffering advice is central (Frydenberg, 1997). Indeed, when asked why they do not make use of existing social supports, adolescents in many western settings frequently report lack of trust and past disappointment or perceived betrayal on the part of providers of help.

Various studies on coping have suggested that trust, rather than the need for help per se, is the key variable in determining whether a young person seeks help.

Trust in professional help-providers can be particularly complicated in regions where the behaviour of adolescents is often seen as "deviant" or where the provider of help is also responsible for controlling or reprimanding the behaviour of adolescents. In Malaysia, for example, in-school counselling for adolescents was started in the 1980s, with training offered to teachers who volunteered to be in-school counsellors. However, as reported by a key informant in Malaysia, these in-school counsellors were designated as both "counselling and discipline teachers," which means that the same teachers who offer counselling are also those responsible for administering punishment.

Research on the health-seeking behaviour of adults has also highlighted the issue of trust and familiarity when seeking primary health care. A study in Uganda found that many people had lost trust in public health services and generally sought basic health care from people they know, i.e. traditional healers,

family members or other members of their social networks (Birungi, 1998). Similarly, research in urban slums in India has confirmed that even when qualified professional health services are available, adults often prefer lesser qualified private practitioners because of their familiarity with and trust in these service providers (Zoysa et al., 1998).

Around the world, whether because of access issues, cost or trust, or all three, as many key informants affirmed, adolescents are more likely to seek treatment for health needs first by non-professional providers or family members whom they personally know or who are closer at hand than trained medical or other social service providers. Even when clinics exist and adolescents know about them, this trend continues. In Bangladesh, for example, more than 50% of ever married 10–14 year olds and nearly 70% of 15–19 year-olds reported the existence of a satellite clinic in their community. However, only half of the younger adolescents and three-quarters of the older adolescents who knew about these services had used them – and this among married adolescents, many of whom are already pregnant or parenting and have immediate health needs (Islam, 1995).

Indeed, the cumulative experience of staff who work with adolescents suggests that trust and familiarity are key issues that must be given high priority when studying or promoting help-seeking. Adolescents seem far more likely in many cases to seek help or support from people and places they know – and where they feel some degree of belonging – rather than making calculated assessments of the quality of the help or service. For the most part, however, there is limited research on how trust and familiarity go into adolescent help-seeking.

Personal coping skills

A young person's ability to resolve (or the belief that he/she can resolve) his/her problems is also an important factor related to help-seeking. The ability of young persons to cope with problems and stress on their own varies tremendously by individual. Literature on resilience offers some insights on this issue, suggesting a variety of personal and family traits that lead to greater resilience (optimism, greater verbal abilities, sociability, etc.). Some key informants suggested that in many cases adolescents may have an exaggerated sense of their ability to cope with problems and risks.

Closely related to the concept of coping, resilient individuals are generally defined as those who do not react in predicted ways to environmental and biological risk or insult; they are individuals who in effect defy the odds and react in positive ways to stressful life circumstances (Blum, in WHO, 1999b). Some researchers have debated whether resilience is an innate, temperamental attribute, or if resilience is a complex set of learned coping strategies. In any case, numerous researchers have confirmed that the subjective meaning a young person attributes to life stresses and normative developmental processes is a major factor associated with whether a particular risk factor has subsequent negative developmental implications, and is related to whether an individual seeks help in a stressful situation (Cohler, 1987). Individuals also show tremendous variation in the threshold of defining a problem or need. Some adolescents may believe that they require the help of others, while some adolescents cope well on their own and seem never to have problems.

Many researchers affirm that help-seeking and coping are learned behaviours. Young people observe and internalize the ways their parents and other adults around them cope with stress and in which situations their parents tend to seek help. Thus, how adolescents internalize local norms about coping and help-seeking is important. That help-seeking and coping are learned implies that it is possible to influence and encourage them. Frydenberg (1997) suggests that the conditions necessary for the conscious development or learning of coping skills are: (1) self-awareness; (2) motivation to change; and (3) skills to achieve desired outcomes. Efforts to promote adolescent coping in Western European and North American contexts have included role playing, telling life histories and teaching assertiveness.

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Previous experiences with seeking help

If help-seeking is a learned behaviour, it is influenced by past experiences of seeking help, as reflected in Chart 1. Adolescents who have had negative experiences in seeking help may be reluctant to trust such persons or services in the future. This indicates the need for targeted efforts to overcome mistrust and win trust, a point that various key informants also stressed. As suggested previously, young people often report having turned to social support (persons or institutions) in times of need and lost trust because of the ways those individuals or institutions responded to their need – i.e. in judgmental terms, by betraying their confidence, by offering advice instead of listening or by rejecting or ridiculing the young persons (Frydenberg, 1997). In one study with young people seeking STI treatment in Zambia, adolescents confirmed that they preferred traditional healers and private health practitioners, because such services were faster and more private and because in their past experiences at public clinic settings, they reported being scolded for being sexually active (Newton, 2000).

Self-efficacy and self-agency

Applied to help-seeking behaviour, self-efficacy and self-agency refer to the belief that one has the ability to seek help and that seeking help will make a difference. Research from Australia found that adolescents who sought help had lower self-concept, which might mean a temporary reduction in self-concept during a stressful moment, or in this context might suggest that adolescents who seek help consistently have lower self-concept (Bowles & Fallon, 1996). In other settings, adolescents with lower self-concept or lower self-esteem may be less likely to seek help. In the case of suicide and depression, as we discuss later, those individuals who are the most depressed and the most suicide-prone are often the least likely to seek help.

Some young people clearly lack the ability to seek help because of low self-agency, or they are objectively unable to seek help, for example when living on the street, in the case of young women in some restrictive settings, in extreme poverty or when victimized through sexual exploitation. In other cases, adolescents in such at-risk settings may have the self-agency to seek help but appropriate help is unattainable.

Identity and other specific characteristics of the young person

A variety of individual characteristics, which in turn interact, have implications for help-seeking behaviour, among them age, ethnicity, marital status, sexual orientation, educational attainment, social class and sexual debut status, among others. Studies in the ASRH field have repeatedly confirmed that different approaches to behaviour change communication and promoting clinic use must be used for adolescents with different needs. For example, adolescents who are not yet sexually active have far different needs for services than sexually active adolescents. The same is true for adolescents who are pregnant or parenting, or adolescents who are married. Differing cultural norms and differential treatment from family members, partners and health service providers are often applied to adolescents based on whether they are married, are parents or parenting or whether they are already sexually active. In addition to these special concerns, research has confirmed that use of STI treatment facilities – whether traditional healers, pharmacists or trained health professionals – is affected by age, race, gender, and income status (Brackbill, Stern & Fishbein, 1999).

Other studies have found that educational attainment is associated with the kinds of services sought, with individuals with higher educational levels being more inclined to use formal health services. Age can also be an important factor in help-seeking, and often interacts with other factors, such as gender. One study in Australia found that older teens reported more interpersonal relationship problems and were more likely than younger teens to seek formal help for these needs (Bowles & Fallon, 1996).

In some Asian, Middle Eastern and African countries, as previously alluded to, the marital status of adolescents can be a major issue in terms of access to formal services. In Bangladesh,

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for example, existing adolescent health services focus mainly on meeting the reproductive health and maternal health needs of married adolescent mothers with little or no provision in the public sector for the needs of unmarried adolescents. (In many cases research on adolescents in these countries has also focused mainly on those adolescents who are already married, particularly in the case of young women.) The Bangladesh Demographic and Health Survey (BDHS) provides information only on married adolescent women, finding that a third of currently married 15–19 year-olds reported visits or contact with family planning field workers during the six months preceding the survey, while less than half this proportion (14%) of younger adolescents girls had any such contact. The data show that adolescent women were the age group least likely to have access to family planning services, but with the largest unmet family planning needs. In addition, nearly 70% of adolescent mothers in Bangladesh receive no prenatal care, with even higher rates reported in rural areas and among girls with no education (BDHS, 1995).

Perceived stigma associated with the need for help

Seeking help – from either formal or informal sources – is also affected by whether the need for help is associated with stigma or whether seeking help for the need is perceived as a sign of weakness or personal inadequacy.

Seeking help – from either formal or informal sources – is also affected by whether the need for help is associated with stigma, or whether seeking help for the need is perceived as a sign of weakness or personal inadequacy. For example, seeking help for an STI (including HIV), suicidal thoughts, victimization by violence or depression are often highly stigmatizing needs in many cultural settings. For example, research with men who had been victims of sexual assault found that only 31% of the men sought help for their victimization, suggesting the highly taboo nature of the problem, and issues of self-blame, among others (King & Woollett, 1997). A study in Brazil found that adolescents with chronic health problems frequently viewed these health needs as a sign of personal weakness or failure, which led to resistance to seek needed health care (Kuschnir & Cardoso, 1997).

Perceptions of stigma can also influence the kind of help sought. A study with Hispanic young women in the US found that they tended to seek informal help when the need was sexual or psychological, because those needs were seen as particularly sensitive (Rew, 1997). Stigma associated with STIs may also be associated with delays in seeking treatment, which have been reported in numerous studies (Riche et al., 1997).

In considering the sensitivity of a given adolescent need in a specific setting, it is also important ask: For whom is the need sensitive? Several key informants mentioned the fact that staff and adults are sensitive about issues that adolescents perceive as "normal" or matter of fact. One key informant from Bangladesh said: "Policymakers and other adults are embarrassed by the issues (that adolescents face), not the adolescents."

Some conclusions on individual factors related to help-seeking

This short review of the individual factors associated with help-seeking behaviour serves to question some of the emphasis on adolescent health problems that we find in many adolescent health programmes and policies. To be sure, adolescents in many parts of the world have numerous unmet needs for specific health care and information. But key informants, and some of the research cited here, call attention to the unmet needs that adolescents have for assistance with normative developmental issues – taking on new roles, acquiring the education and skills necessary to acquire employment, conflicts with parents and relationship issues. The research reported here also underscores the importance of trust in understanding and promoting help-seeking. There was a common refrain among programmes consulted and key informants that adolescents in many regions are criticized or turned away when they seek help for issues that adults find to be sensitive. Finally, the research calls our attention to the importance of gender norms in influencing whether adolescents seek help, or are able to seek help.

2. Exogenous factors associated with adolescent help-seeking

As seen in Chart 1, we define exogenous factors as community-level, family and broader social and cultural influences related to help-seeking. These include cultural and community norms about help-seeking, availability of services and other social support, cost of services, and the characteristics of adults or staff who provide help, among others. These are issues that are related to the nature of the supply of help, or the nature of social supports. As we have repeatedly stressed, these issues interact with individual factors.

Cultural and community norms related to help- and health-seeking behaviour

Studies on the health-seeking behaviour of adults, as well as parents' use of health services for child health needs, in most cultural settings confirm a general preference for informal supports over formal supports. As previously mentioned, this may partly be a function of trust and familiarity but is likely also an issue of cultural and community norms.

Indeed, research in a variety of settings and programmes consulted for this review argues that even when formal health and social service infrastructures exist, adolescents (as do adults) generally prefer to rely on family and friends first and only subsequently turn to formal services, health or otherwise (Boldero-Fallon, 1995). Other studies in developing countries suggest a progression from home treatment, in the case of illness, to the use of traditional healers to the use of modern or public health facilities as a last resort. Other studies suggest that one kind of help or health service does not preclude use of another and that both adults and adolescents may use multiple kinds of health services and other help.

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In several industrialized countries, research has sought to measure social support or adolescent connections to family and other social supports (Blum & Rinehart, 1997). However, in many developing country settings, the concepts of family and religion as sources of support are so ubiquitous that they have seldom been directly studied as being "social supports." In many cultural settings, connectedness or reliance on family and the local community setting, including religion, have been taken for granted or are such an integral part of the social context and social interactions that there have been relatively few studies examining how they influence adolescent development. A few exceptions to this trend include a forthcoming study by Talukder (personal correspondence) to study the risk and protective factors of adolescent behaviour, with moral and spiritual status and family connectedness being the two main independent protective variables. Similarly, in low income settings in Brazil, Rizzini & Barker (2001) have sought to map informal sources of support for adolescents – including extended family, religion and others – which are often considered less important than formal supports. While public health research has begun to pay attention to the roles of traditional healers and informal sources of health care, the role of informal social supports for adolescent development overall (with the exception of the role of families) have not received as much attention in research and programme development.

Distance to sources of help

With rural to urban migration in many developing countries, adolescents may be physically further from traditional sources of help. In Thailand, one programme reported that young people are moving (without their parents) to urban areas, becoming free from traditional mechanisms of control over their sexual behaviour. In rural areas, distances to public health clinics and other institutional sources of help may be considerable and transportation costs high. For example, a study in Bangladesh found that low use of government health facilities by adolescents was related to distance (62%) followed by lack of trust of the treatment available at the centre (34.7%) (Islam, 1995). Recognizing the distances and difficulties for young people to seek help outside their communities, a number of adolescent health initiatives

promote integrating health services through the school setting, as reported in the programme consultation and various key informants. In some cases this has meant attempting to create more caring and supportive school environments or offering health services in the school setting.

Availability of services, service infrastructure, case loads, costs of services and costs associated with referrals

The existence of an accessible and affordable service infrastructure for adolescents is also a major factor in help-seeking behaviour. For example, with increased reliance on private health care in some countries and settings, the costs of some kinds of help have increased in some settings; for young people, who generally have less disposable income than adults, these costs are even more onerous.

In terms of availability of services, mismatches between the kinds of help adolescents want or need and the kinds of services offered can occur. For example, most existing ASRH services address the unhealthy consequences of unprotected sexual activity. However, in terms of sexuality and reproductive health, some researchers have argued that the majority of adolescents in most parts of the world need mainly information and counselling (Hughes & McCauley, 1998).

Other studies suggest tremendous variation in the availability of adolescent health services by country and region. As previously mentioned, in many industrialized countries, there is a substantial formal infrastructure of health and social services for adolescents, which is often underused. To give just one example, research from Canada on the mental health needs of adolescents finds that most teens report that they are coping well and report having someone or some place to turn to when they have mental health needs (Ward et al., 1996). On the other hand, in many developing countries, formal public health and other social services for adolescents (and the general population) may be lacking and those formal supports that do exist are often stressed with the number of patients they already support. In the former setting, promoting help-seeking has often focused on promoting use of the existing services, while in the latter, the health and social service infrastructure itself needs to be expanded. Indeed, in some regions and countries, a focus on adolescent health, or on adolescents as an age group with special needs, is relatively new or nearly non-existent. In the Western Pacific region, for example, many key informants and programmes consulted reported that there are few specific adolescent health initiatives or programmes, and those that exist often focus on punitive measures for adolescent "deviance," including substance use, truancy and violence.

How long adolescents have to wait for a service, and the size of case loads is also a factor associated with help-seeking behaviour. As we describe later in the section on efforts to promote help-seeking, many initiatives to promote adolescent help-seeking behaviour have focused on reducing waiting times and reducing case loads. For example, in the case of in-school counselling for students in Malaysia, as reported by one key informant, seeking help is hampered by the fact that "counselling" teachers often had case loads of more than 1,000 students, while also having full-time teaching responsibilities.

Examining issues of access, some researchers have suggested the need to understand health-seeking behaviour (of adolescents and others) from the point of view of "clients", that is seeking to understand how adolescent (and other) clients choose from among varying products and what characteristics of a service or product attracts them to the service. There seems to be little research on how adolescents make decisions about which source of help or social support they use for given needs, including decisions about where they seek formal health care.

Staff receptivity to adolescent needs and staff competence to work with adolescents

Overlapping with the issue of trust that we previously discussed, the lack of staff who understand adolescents, are sensitive to their needs and realities, and know how to listen to and talk to adolescents has been widely cited as a barrier to attracting adolescents to use existing health services (Newton, 2000).

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Some adolescent health clinics and initiatives designate one or more individuals to act as advocates or point persons for welcoming and receiving adolescents in spaces that are not adolescent-exclusive, for example primary health care (PHC) clinics, hospitals and SRH clinics that offer services for adults and adolescents.

Several key informants and programmes consulted mentioned the issue of staff training and the fact that public health staff in particular are generally trained to deal with "illness and not with promoting health," as one said. Other key informants and programmes consulted said that adolescent health staff are not trained to deal with a wide range of adolescent development needs. Other programmes consulted cited the stressed nature of the public health system, saying that staff saw themselves as overworked and thus were reluctant to make the clinic more receptive or welcoming for adolescents. These findings suggest that promoting help-seeking by adolescents, at least within the public health system, requires training staff in a broader range of adolescent needs and creating or expanding services, or creating appropriate linkages with other service providers. While emphasis is often given to staff attitudes in dealing with adolescents, training staff about adolescence and increasing both their skills and knowledge for working with adolescents are crucial.

Local values about adult-adolescent interaction and the nature of adult-adolescent relationships

Local norms about adolescent-adult communication influence adolescent help-seeking in a variety of ways. Some societies have an implicit belief in the importance of adolescent autonomy, particularly in many western settings, where adolescents are often segregated from adults and spend most of their time in adolescent-only institutions. In other settings, authoritarian styles of adult-adolescent interactions are the norm, with adults dictating rules and closely monitoring the behaviour of young people. In such settings, adults often directly control access to social supports by young people. Many programmes consulted in Asia said that families had to be consulted in all decisions of providing formal help to young people; otherwise they would not allow their adolescent daughters or sons to use the service.

Looking specifically at the issue of ASRH, various studies find that adult attitudes about adolescent sexuality constitute a major barrier to adolescents feeling comfortable in seeking information and services. In many settings, in spite of overwhelming evidence to the contrary, adults believe that helping adolescents deal with sexual and reproductive health matters will encourage greater sexual activity (Newton, 2000). Norms against family-child communication about sexuality are widespread in sub-Saharan Africa and other parts of the world (WHO, 1997).

As mentioned in the introduction, in many settings, adolescents rely first or largely on their families for support. However, while families can be sources of support and bridges to other forms of help, they can also be barriers to receiving help; and some families may be sources and barriers simultaneously. In some settings, families may inhibit adolescent access to some kinds of information or help (e.g. related to sexuality); in cases of domestic violence or sexual abuse, families may discourage adolescents from seeking outside help. In other cases, adolescents may attempt to "spare" their parents from information that they believe will make them uncomfortable, thus adolescents may turn to other family members. For example, in a study in Bangladesh, sisters-in-law were frequently mentioned as the preferred source of reproductive health information for both males and females (Barkat et al., 1999). In the same study, young men said they got information from friends and grandparents while young women turned to neighbours, elderly people and other people who have experienced the same health problem. For married adolescents, spouses are sometimes the main sources of information and other help, but other studies suggest that husband-wife communication about family planning is less pronounced among adolescents than adult couples (BDHS, 1995; Barkat et al., 1999).

Beyond the issue of ASRH, however, there seems to be much less research on the nature of adult-adolescent relationships in terms of how these relationships encourage or discourage help-seeking. Indeed, consulting and interviewing family members about how they perceive adult-adolescent interactions and their perceptions of adolescent needs must be central in efforts to promote help-seeking.

Legal and policy context

The legal and policy context has direct implications for which services can be provided to adolescents with or without parental (or in some cases spousal) consent and is therefore also a factor in help-seeking behaviour. In addition, whether national policies promote service availability and integration of services are also important considerations related to adolescent help-seeking. Later in this section we present a few examples of policy initiatives in the adolescent health field that have sought, at least indirectly or implicitly, to influence adolescent help-seeking behaviour.

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Some conclusions on exogenous factors related to help-seeking

This limited review, and comments from key informants and programmes consulted, suggest a number of important issues to consider when assessing the array of existing social support. First, provider or staff attitudes toward adolescents, and the training of these staff, are paramount concerns. Second, norms about adult-adolescent interaction are also crucial. In some western settings, adolescents are often seen as autonomous – and perhaps therefore not seen as needing much help. In other settings, adolescents may be treated in authoritarian ways, with sometimes rigid control of their actions. Both cases suggest the importance of listening to family members and other adults about their perceptions of adolescents and their needs.

3. Help-seeking for special needs

As mentioned in the introduction, much of the literature on help-seeking behaviour, for adults and adolescents, focuses on help-seeking for special needs. While the review in this section is not exhaustive, it provides a general overview of the kinds of information that exist on adolescents' use of services for specific needs, including disabled adolescents, chronically ill adolescents, or those needing counselling or other services for suicidal tendencies, substance use, victimization or violence, HIV and sexual orientation.

Sexual and reproductive health

As previously stated, much of the research related to adolescent help-seeking comes from the ASRH field, and there is significant body of research, some of it previously presented, that has described the patterns of use of ASRH services, as well as adolescents' self-reported needs and current use of SRH services. Similarly, there is a fairly extensive body of research on seeking treatment for STIs, including patterns of help-seeking for STIs. As previously mentioned, research in many settings finds that in the case of STIs many adolescents and adults opt first for self-treatment or some non-professional service (local healers, patent medicine sellers, etc.) and only subsequently turn to public health clinics or other professional health providers. For example, research from Bangladesh has found that in the case of STIs, the preferred place of treatment for female adolescents (both married and unmarried) was pharmacies, followed by local healers (Barkat et al., 2000). The most common reasons given for not seeking any treatment for STIs were: "shame", "did not feel necessary", "financial problem" and "heals automatically". Similarly, in India, research with adolescent girls has found that in the case of SRH needs, young women consult their parents first, then doctors, with the most common treatment for SRH-related issues being over-the-counter medication (Devi et al., 1999). Such trends hold across many developing country settings for adolescent women and men. Other studies have found that use of public clinics to treat STIs is affected by an array of factors, including availability of other kinds of care and whether STIs – or specific STIs – are considered taboo in a given setting (Ward et al., 1997).

There is also significant literature on where adolescents would like to receive basic information about sexuality and reproductive health – i.e. their normative needs for information on the topic. Numerous demographic and health surveys, baseline studies and qualitative inquiries have provided information

on where and how adolescents prefer to receive this information. In studies around the world, adolescents typically report that their peers are their main source of information about sexuality. Teachers, adult family members, siblings and television and other media are also reported as sources of information with varying percentages across regions.

We also have insights into the kind of SRH-related information that adolescents would like to have. In Bangladesh, girls aged 10–12 stated a need for information on changes during adolescence, especially menstruation, and suggested that this be provided by mothers, teachers or the media (GOB/ICDDR B, 1999). In the same study, older adolescents expressed a similar desire for information, adding such topics as reproduction, fertility, marriage, family planning and STIs and reproductive tract infections (RTIs). Preferred sources of information were sisters-in-law, elder sisters, cousins, peers and community field workers. They also identified a need for health services, to be delivered in late-opening clinics, by caring, female health providers in an atmosphere of privacy. Such studies exist from various countries and show fairly similar trends.

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These limited examples suggest, however, that while we have tremendous information on where, what kind, when and how adolescents would like to receive information on SRH, research is also clear that deep-seated taboos about adolescent sexuality continue to hinder the adequate provision of this information.

HIV and AIDS

In the area of HIV, offering voluntary counselling and testing (VCT) has been heralded as a key strategy, with the rationale that offering such services would lead to increased help- and health-seeking behaviours among all or segments of the population. Nonetheless, research is mixed as to whether in fact offering VCT leads to increased testing and counselling related to HIV. Some studies suggest that offering VCT does lead to increased health-seeking and help-seeking behaviour, while in other settings it has not (MacGowan et al., 1997). A few studies have also looked specifically at the help-seeking behaviours of HIV-positive individuals, including adolescents, and some initiatives have sought to promote improved help-seeking by HIV-positive adolescents. In the US, the Bay Area Positives initiative gathered evaluation data confirming that offering specific services and support groups to HIV-positive adolescents led to a greater use of support networks, i.e. greater help-seeking, by participating adolescents (Bettencourt et al., 1998).

Mental health needs, including suicide

As previously mentioned, much research that uses the term "help-seeking" has focused on the mental health needs of adolescents. Studies have found, for example, that in cases of mental health needs, as in the case of other health needs, adolescents often rely first on friends or try to cope alone, and subsequently turn to adult and then professional help. A study on young women and suicide in the US found that most depressed or suicidal young women turned to family and friends before turning to professional help (Ward et al., 1996). Another study found that in the case of depression, non-medical professionals (teachers, counsellors, health educators) were key gatekeepers to referring depressed individuals to medical professionals (Chavance et al., 1997). Other studies have found that those youth who are the most suicidal or most depressed are those least likely to use mental health services – that is that those young people who most need mental health services are the least likely to seek them.

Services for parenting adolescents

Several studies have looked at the help-seeking behaviour of pregnant and parenting adolescents, including some studies that have sought to measure increases in help-seeking behaviour as the result of programme interventions. For example, in some impact evaluation studies of services for adolescent

mothers, the provision of sensitive prenatal care, educational talks and follow-up care led to increased use of health facilities (Focus, 1997 and 1999). Other studies have examined patterns of health service usage by adolescent mothers, including prenatal care and birthing services. In some countries, such as Bangladesh, home delivery (with inadequate access to emergency services) continues to be the norm. In Bangladesh, almost all births (96%) to adolescent mothers occur at home with only 7.4% of deliveries by adolescent mothers assisted by medically trained personnel.

Conclusions on help-seeking for special needs

The lessons learned about adolescent help-seeking for special needs are similar to those for help-seeking for other adolescent needs. Trust and familiarity with the service or social support emerge as crucial, as does the degree of taboo or stigma associated with the particular need. Finally, it is important to mention that various adolescent health programmes consulted for this study report that even when services are for a specialized need, health practitioners often find that adolescent clients want to discuss a variety of needs. This finding further confirms the need for integrated services and initiatives that offer both general supports for adolescents and specialized services for acute and specific problems.

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4. Programme efforts and policy initiatives to promote adolescent help-seeking

This section provides a brief overview of efforts to promote adolescent help-seeking. These range from efforts to map and integrate formal and informal supports for adolescents encompassing a range of adolescent needs, to more specific efforts to make public health centres more accessible to adolescents. Following this section, we provide four brief case studies of efforts to promote adolescent help-seeking.

Engaging adolescents in health-related issues via the school setting is widely reported as a fundamental strategy for improving adolescent health and attracting adolescents to existing health services.

In various settings around the world, service providers have been experimenting with making clinics more "adolescent-friendly" by offering more convenient hours, hiring and training peer promoters to engage other youth, training staff in the specific needs of adolescents and developing referral networks, among others. The WHO's Department of Child and Adolescent Health and Development is currently working on a series of recommendations for making public health clinics more adolescent-friendly. As previously suggested, making clinics more adolescent friendly is one way to promote adolescent help-seeking by focusing on the clinic itself. This overview of programme and policy examples is by no means complete but serves to identify categories of interventions. Furthermore, the examples here focus both on the demand side – that is working with adolescents to encourage greater use of services – and on the supply side, i.e. improving the available social supports to make them more accessible and to respond in more appropriate ways to adolescent needs.

Relocating services to reach adolescents

In some settings, programme planners have found it useful to locate or relocate health services in order to attract adolescents; school-based health clinics are perhaps the most well-known and widely used example of this. In the literature as well as the programme consultations, engaging adolescents in health-related issues via the school setting is widely reported as a fundamental strategy for improving adolescent health and attracting adolescents to existing health services. Programmes consulted for this study and several key informants note that creating greater linkages between the public health sector and the school are key to promoting greater help-seeking by adolescents. One of the case studies, the Green Light

Initiative in Brazil, seeks to improve access by adolescents to public health clinics by establishing linkages with the public school system. At the same time, some key informants recognized that the public education system is already overburdened and probably cannot, on its own, be the gateway to adolescents' use of public health clinics.

Use of peer promoters

Training and supervising adolescents or young adults to reach their peers with health-related information has long been used as a way to promote adolescent help-seeking; there is considerable literature and analysis of peer programmes in other WHO and Joint United Nations Programme on HIV/AIDS (UNAIDS) documents. Peer promoter programmes have been used widely in ASRH, both for information dissemination and promoting condom access. Peer promotion has also been used in substance use prevention programmes and to create support groups of peers with specific health needs, such as substance use or violence.

Outreach workers or community health promoters

In addition to peer promoter programmes, in some countries adult outreach or community health promoters have been employed to take health services and information to adolescents. In Bangladesh, community health workers reach a relatively large proportion of married adolescent girls. National data found that 28% of adolescent girls surveyed reported having been visited by a fieldworker in the six months prior to the survey to talk about family planning (GOB, 1998). Some programmes have discussed whether the sex of the health worker is relevant, that is whether young women are more likely to feel comfortable with women health workers, and vice versa.

Information campaigns, hotlines and information centres

Information, education, communication (IEC) or media campaigns have long been carried out to increase awareness and use of existing sources of support for adolescents. Information booths or centres have been started to provide youth with information on existing sources of help, health services, job training and recreational activities in the United Kingdom (UK), to a limited extent in Colombia and in the United States (Barker, 1996). In Zimbabwe, some public health centres have developed "youth corners," spaces within clinics that have information for adolescents on services available in the clinic, on health issues and youth-related activities in the community.

In some settings, young people say they prefer to receive information anonymously, via brochures, the internet or telephone hotlines. Telephone hotlines have been useful for reaching adolescents with information (although evaluation data is lacking as to whether hotlines lead to greater use of services apart from the telephone counselling). In Kenya, a radio call-in show was "swamped" with callers and visitors. A hotline on ASRH in Mexico reports receiving an average of 4600 calls per month, and a South African AIDS helpline received 30 000 calls in 1997. The Dial-a-Friend hotline for adolescents in the Philippines, received 150 000 calls during the first 7 months of operation. A hotline in Uganda found that adolescents preferred calling after 9 pm when their parents were asleep. Many of these hotlines provide referrals to other services, but generally do not have data on the use of these referrals. Successful hotline programmes have often used IEC campaigns to promote their existence (Focus, 1999).

Other examples of the use of media to inform adolescents include Talking About Reproductive and Sexual Health Issues (TARSHI) Delhi, India, which operates a telephone help-line, offering free and confidential information, counselling and referrals on sexuality and reproductive issues to adolescents. Basic sex information, conception and contraception are among some of the main concerns of adolescent callers.

More recently websites and the internet are gaining attention as a way to reach adolescents with health-related information or to form virtual, "help" communities for adolescents. One health information website in Brazil reported 60 new visitors a day to the site (Infoviva: www.infoviva.hpg.ig.com.br). This same site offered internet consulting (allowing users to ask questions that are responded to by on-line specialists). This service received about 8–12 users per week, 50–60% of whom were young people, the majority girls.

In addition to those examples cited in the literature, key informants and survey respondents described several IEC or media campaigns that have been carried out with adolescents to increase awareness about and use of existing sources of support. In Asia, survey respondents reported using information booths and IEC materials, often focusing on promoting contraceptive use and birth spacing. In other settings in Asia, in-school debates and essay contests have been used to raise awareness about reproductive health in schools and universities and to promote use of existing services. Other IEC strategies for promoting help-seeking by adolescents have included radio and television messages, picture stories, folk songs, cartoon serials and other audio-visual materials, including videos.

Service integration

As previously mentioned, in several countries, the creation of networks among existing services – both formal and informal – has often been employed as a strategy to promote help-seeking by adolescents, with the goal of creating multiple entry points for young people and creating wider networks working in collaboration to assist adolescents.[3] This integration may take place within the same institution or community, or may involve creating referral mechanisms. A 1996 World Bank document highlighted a number of key characteristics of these efforts including: (1) modifying existing services by increasing access, changing location or hours and enhancing content and activities for youth; (2) creating new primary and/or specialized services; (3) enhancing staff through staff training and creating new staff positions; and (4) improving connections between specialized and primary services (Barker, 1996). Such initiatives have been carried out in Brazil, Colombia, Sri Lanka, the United Kingdom, the United States and elsewhere. Such service integration efforts are often based on the premise that in most communities there is at least some infrastructure or potential infrastructure of formal and informal social supports that can be integrated to increase access to and supply of social supports. The theory behind such integration is that through collaboration these social supports can become "much larger than the sum of the parts and in theory more efficient and effective" (Costello, Pickens & Fenton, 2001).

… the creation of networks among existing services – both formal and informal – has often been employed as a strategy to promote help-seeking by adolescents, with the goal of creating multiple entry points for young people …

Parent and community education programmes

The potential role of families and communities in encouraging adolescent help-seeking has led a number of programmes to involve family members and other adult community members. The Bangladesh Rural Advancement Committee (BRAC) implemented an Adolescent Family Life Education Programme that includes informal schools and family life education(FLE) to out-of-school, rural based youth ages 10–15. As part of the programme, meetings with parents, teachers and community leaders are used to inform or sensitize parents about adolescent health, development and ASRH. This strategy has also been implemented in Belize, the Dominican Republic, Mexico and Sierra Leone. An ASRH initiative to attract adolescents to clinics in Zambia created dialogue sessions between health centre staff, parents and youth (Newton, 2000). In Thailand, an adolescent health project sought to build a new community of adolescents, recognizing that many are cut off from their families who continue to live in rural areas. The initiative builds support networks for young people at risk because of their sexual behaviour and links existing organizations. The project engages local leaders, including teachers, and reaches youth via places of work and entertainment, creating spaces for youth to discuss their needs among themselves and seeking to create positive youth peer groups (Fongkaew & Bond, undated).

[3]As in the case of help-seeking and social support, there are few common definitions of service integration. Nonetheless, as previously mentioned, we are using the term to refer to deliberate efforts to create linkages among services, and to offer multiple health and social services for adolescents.

Outreach and recruiting efforts and refitting existing services to be more adolescent-friendly

In several settings, programme staff have sought to make existing health services more adolescent- or youth-friendly, have sought to recruit youth or reach them where they are, or have otherwise refitted or altered services to be more attractive to young people. Some clinics have established links or clinics within schools, as previously mentioned. The multipurpose youth centre model, offering some combination of health services along with recreational, vocational training and/or other activities interesting to youth has a long history in Colombia, Mexico and the United States, Western Europe and elsewhere. In some settings, these multipurpose centres have not been cost-effective, attracting only small numbers of youth or attracting the easiest-to-reach youth. Other settings report more success with the model (Senderowitz, 1999).

In South Africa, the National Adolescent-Friendly Clinic Initiative funded by the Kaiser Foundation is certifying clinics as being adolescent-friendly. Indicators for certification include: (1) attention to processes that support adolescents rights; (2) a physical environment conducive to adolescents; (3) psychosocial and physical assessments of youth; (4) operating hours; (5) location and privacy; (6) confidentiality and adequate time for interaction; and (6) adequate administrative procedures (fees, drop-in clients) (Finger/FHI, 2000). Clinic staff rank their clinics on these indicators and devise their own plans for making the clinics more adolescent-friendly. In Zambia, Lusaka Urban Youth-Friendly Health Services used a participatory needs assessment process involving parents, community leaders and youth, which led to more non-pregnant youth seeking services (Finger, 2000).

Senderowitz (1999) identified the following characteristics as being youth-friendly in terms of ASRH services:

- specially trained staff;
- respect for young people;
- privacy and confidentiality honoured;
- adequate time for consultation;
- peer counsellors available;
- separate space and time for adolescents;
- convenient hours and location;
- space and privacy;
- comfortable surroundings;
- youth involvement in service design;
- drop-in clients welcomed;
- no overcrowding/short waiting times;
- affordable fees;
- publicity and recruitment that inform and reassure youth;
- using young people to recruit other young people;
- boys and young men welcomed and served;
- a wide range of services available;
- necessary referrals available;
- educational material available;
- alternatives to accessing information;
- counselling and services provided; and
- pelvic examination and blood tests delayed (so as not to discourage some youth who may be nervous about these kinds of medical procedures).

Offering new services for adolescents

In some settings, there may be a need for new health services or other social support for adolescents, either within existing organizations or by creating new ones. Some research suggests that with the decline in reliance on traditional sources of information related to puberty and sexuality, that adolescents in fact do require new services. Youth migration to urban areas, previously cited, illustrates the need for offering new sources of help for adolescents in some settings.

Offering assertiveness training

Using social learning theory as its base, some evaluated initiatives in the United States have measured an increase in use of reproductive health services by adolescents using a combination of presenting factual information, teaching assertiveness and discussing problem situations via role plays or case studies (King, 1999).

Multiple-pronged approaches

Several efforts or initiatives to promote adolescent help-seeking behaviour have incorporated more than one of the previously mentioned strategies. In the United States, the Kellogg Foundation has supported a number of initiatives that have sought to promote adolescent help-seeking behaviour, including:

- engaging juvenile court judges and parents to increase referrals to formal health and social services;
- taking advantage of indigenous values (in Native American areas of the United States);
- promoting case management to provide multiple, integrated services among various adolescent health and social service providers;
- providing home visits by staff from adolescent health and social services;
- supporting intergenerational programmes linking youth with elderly members of communities; and supporting school-based initiatives to engage families to a greater extent in the educational process.

Among the lessons learned, they cite: (1) the need to identify service barriers; (2) the need for written agreements and detailed plans to link services; (3) the need to recognize the value of culturally available models of support; and (4) the need to work with existing community resources. As in the case of nearly all the examples cited in this section, evaluation of these United States-based initiatives has been mostly process rather than impact (Kellogg Foundation, 1998).

Policy-level initiatives to create more adolescent-friendly services and safe and supportive communities

In a few countries, there have been initiatives at the policy level to either promote adolescent-friendly services at a broader level and/or create safe and supportive communities for adolescents. In South Africa, Zambia and Zimbabwe some of the examples cited have been supported by national or regional level policy changes. A number of new policy initiatives in various countries (Brazil, Colombia, Israel, the United Kingdom, the United States and others) have started with the premise that all communities have at least some sources of help, services, activities and programmes for young people (Barker, 1996).

In a few countries, there have been initiatives at the policy level to either promote adolescent friendly services at a broader level and/or create safe and supportive communities for adolescents.

A few of these initiatives also take into account the community context as a place for promoting behaviour change. In the HIV prevention field, for example, behavioural change models were traditionally based on individual psychology, as many adolescent health initiatives have been. However, a wide body of research suggests that sustained and significant changes in health behaviour generally require macro-

level changes (including policy level changes) as well as individual behaviour change (Sweat & Denison, 1995; Mane, 1996).

At the national policy level, in Latin America, both Bolivia and the Dominican Republic have implemented comprehensive national youth policies which – while not using the term "help-seeking" – have clear goals of establishing networks among existing services, training health-care providers, engaging youth in planning and providing comprehensive health and social services. Experience from those two countries so far suggests that while such national policies are important, programme implementation – and hence improvements in adolescent health and well-being – have not matched the progress in the policy arena (Rosen, 2000).

Similarly, in some Asian countries, national policies have sought to promote comprehensive services and network-building that in turn may promote adolescent help-seeking. In Bangladesh, the Health and Population Sector Programme includes a range of comprehensive provisions for adolescents, including school-based health education, special services for pregnant adolescents, increased access to STI treatment, engagement of NGOs and intersectorial coordination among various government sectors working on youth-related issues. Similarly, in Thailand, the 8th National Economic and Social Development Plan (NESDP, 1997–2001) included various provisions related to intersectorial collaboration that may promote help-seeking behaviour (National Youth Bureau, 1996; Department of Health, 1996). And in the Philippines, the Population Commission implemented a comprehensive Adolescent Development Programme in 1995 that seeks to develop a favourable policy and social environment supportive of youth activities, including counselling services for Filipino youth.

Initial conclusions about efforts to promote help-seeking

This initial overview, while incomplete, nonetheless suggests that whether or not they use the terms "help-seeking" or "social supports", there have been numerous efforts around the world to encourage adolescents to make greater use of existing health and social services. If we have numerous examples, however, this review also suggests that evaluation of these efforts is largely lacking, and has focused mostly on process indicators.

5. Case Studies of Efforts to Promote Adolescent Help-Seeking

As an additional input to this project, information was collected, either by direct interviews or from existing literature, of interesting approaches to promoting adolescent help-seeking. Rather than being in-depth case studies, the examples here are illustrative. Much more information, including direct site visits and multiple interviews, as well as evaluation information, would be required for more in-depth case studies. Four case studies are included that provide useful insights to the challenges in promoting adolescent help-seeking, one from sub-Saharan Africa, one from Asia and two from Latin America.

Case Study 1

The "Green Light" Initiative, City Health Programme, Rio de Janeiro, Brazil

The Adolescent Health Programme of the Municipal Health Secretariat of the City of Rio de Janeiro (called PROSAD) has the chief goal of training public health practitioners to work with adolescents and attracting adolescents in greater numbers within the municipal health posts. As in many parts of the world, convincing adolescents to use health posts within a large, overburdened, urban public health system brings numerous challenges. In some public health clinics in Rio de Janeiro, specific services for adolescents exist, while in most, there is no special attention given to adolescents.

As a way to increase adolescent use of the public health system, PROSAD started an initiative called the Green Light Programme, which involves both the public education and health sectors.

Through this initiative, adolescents are given preferential treatment in public health posts. With specially designated staff at the health clinics, adolescents are able to see these practitioners directly and to obtain information, obtain condoms, and set up a time for an appointment – sometimes even to see a health professional (nurse or doctor) without waiting.

While no evaluation of the programme has been carried out, and the programme itself is still being implemented and tested in many communities, project coordinators say they have already seen a change in terms of a greater number of professionals taking an interest in working with adolescents. In terms of remaining challenges, programme coordinators cite the lack of real youth participation in the public health system and the continuing fear by many health professionals that attracting adolescents or facilitating their access will lead the clinics to be overrun with demand. At other times, youth continue to be received so poorly by guards or receptionists at local clinics that they do not return. Other adolescents report a lack of privacy when they seek public health services. For the future, PROSAD plans to focus on staff training and maintaining the political and organizational will to work with adolescents.

Source: Interview with Viviane Castelo Branco, Coordinator, PROSAD

Case Study 2

Women's Health and Action Research Centre, Benin City, Nigeria

One of the few studies found on help-seeking that sought to measure impact of intervention on help-seeking behaviour is from Benin City, Nigeria. The study found that Nigerian adolescents often do not use formal health services for STI treatment. The most common source of treatment was over-the-counter treatment, with 22% of adolescents reporting having received treatment from patent medicine dealers. Factors associated with low or delayed use of STI clinics are: perceived high cost of clinic services, lack of confidentiality, negative provider attitudes and perceived poor treatment at public health facilities. In addition the strong social stigma attached to STIs means that most adolescents would prefer not to receive services in the same place as adults.

With this baseline information, the Women's Health and Action Research Centre developed an intervention to promote use of STI clinics. The intervention consisted of peer- and school-based information about STIs, with messages about the need to treat STIs and inform partners. Physicians and pharmacists were also trained as part of the project. A group of peer counsellors offered adolescents a list of trained private providers who were "adolescent-friendly". In evaluation research, compared to control group schools without the intervention, adolescents in the intervention schools showed an increased use of private physicians for STIs. The study suggests that the help-seeking behaviour of adolescents related specifically to STIs can be changed with targeted interventions promoting use of existing services.

Source: Ogunsakin, 2001, personal correspondence

Case Study 3

Improving Health Care for Adolescent Girls in Urban Slums in Madhya Pradesh, India

A situation analysis of Jabalpur city in Madhya Pradesh, India, revealed that adolescent girls living in the urban slums had limited knowledge of bodily changes associated with puberty, about family planning and about the identification, prevention and treatment of RTIs. Furthermore, the use of reproductive health services was limited, due to various social and institutional barriers, and the young women faced a large number of health problems, as well as being vulnerable to sexual exploitation, unwanted pregnancy and abortion.

Established in 1997, the objectives of the project "Improving health care for adolescent girls in urban slums in Madhya Pradesh" were to:

- reach at least half of adolescent girls in participating communities who had reproductive health problems with medical care and appropriate treatment;
- improve maternal care;
- increase the use of family planning; and
- provide a range of high quality reproductive health services and information for them.

The chief strategy of the help-seeking intervention was to train a cadre of adolescent girls as health guides to provide continuing education about SRH and refer other young women to the existing services. At the same time, the service network was expanded and special training was provided to reproductive health providers about the special needs of adolescents. In this way, the intervention sought both to promote increased help-seeking and to improve the supply of services available to young women

Among the activities of the project were: a needs assessment study of the target group in the selected slum areas; identification and training of community health workers from the slum areas; orientation of parents and teachers; development of strategies to reach both in-school and out-of-school adolescents; education in SRH issues; development of a referral system to meet the needs of the those with SRH problems; counselling services; and creation of a depot for stocking and distribution of birth-spacing contraceptives. (No impact evaluation results were reported).

Case Study 4

Bases of Support: An Action-Research Project to Build a Community-Wide Network Support for Adolescents, Rio de Janeiro, Brazil

Bangu is a large neighbourhood of about 600,000 residents at the westernmost city limits of Rio de Janeiro. As part of a process to start a community-wide network of services for adolescents, Instituto PROMUNDO (an NGO) and the Centre for Study on Childhood (part of a private university) carried out research with adolescents aged 12–18 on their use of, awareness of, and opinions on existing community and family supports, including public health services. As a first step in this process, the researchers carried out focus group discussions with youth, asking them to take the researchers to existing youth programmes and other public infrastructure (parks, etc.) and interviewing staff or adults affiliated with youth programmes in the community. Based on this initial assessment, the researchers created a survey instrument to use with adolescents. Because they wanted to understand youth culture, and because they wanted to offer young people opportunities for leadership and community involvement, the research team opted to involve youth in all aspects of the survey process. The project recruited, hired, trained and supervised young people who worked on the study. The young people helped design and pre-test the questionnaire, and helped plan the process for selecting a sample – that is; where, when and how to approach young people.

Results of the study include:

- Several youth programmes exist in the community but the number of youth who participate in them is limited, and youth have low awareness of existing programmes.
- Participation in informal youth groups is higher than participation in structured youth programmes. In total, more than 38% of young people surveyed said they belong to some kind of informal youth group. Nearly 40% had used informal tutors for help with their school work, the most widely used social support in the community.
- For many young people, religious groups are an important source of formal and informal supports. More than half of young people say they regularly practice some form of religion.

- Nearly 20% of adolescents surveyed said they had used a health service in the last month, but in the qualitative aspect of the study young people complained about long waits and difficulties of receiving the health services they wanted. Initial observations and contacts with the clinic suggest that adolescents generally find clinic staff to be friendly, but complain that the demand for health services at the clinic is so large and that there is no specific attention for adolescents.
- As in other low income areas in Rio de Janeiro, the presence of armed drug trafficking groups has an impact on nearly all youth-related programmes and on young people themselves, and their help-seeking behaviour. Some public spaces in the community are taken over by young people involved in the drug trafficking groups, which limits access to services for young people.

This information has since been discussed with staff at existing youth programmes. Dialogue with these staff, and with young people and their parents, is serving to define the next steps for building a community-wide network of support for young people. This baseline data will also be used to create pre- and post-test instruments to measure increases in use of existing services by young people in the community over the course of a three-year intervention.

Source: Rizzini I & Barker G, 2001

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Conclusions and final recommendations

Based on these various inputs, we offer the following conclusions and recommendations:

- *There is considerable interest among programmes consulted in the theme of adolescent help-seeking and how to promote it.* Nonetheless, programme staff recognize that there is much work needed to form a consensus about what "help-seeking" is, how to measure and evaluate it, how to promote it and how to promote positive use of both informal and formal sources of support.
- *Interviews with key informants and programme consultants confirmed that our proposed definition of help-seeking, which goes beyond use of health services, to include three levels of adolescent needs and to include informal and formal supports is more appropriate than one that narrowly focuses on health-seeking behaviour.* In sum, initial lessons learned and programmes consulted argue that promoting greater use of existing services and meeting the unmet needs of adolescents requires focusing on their broad range of expressed needs, including, but not limited to, health-care needs.
- *Given the relative lack of research on the issue of adolescent help-seeking, the WHO should develop a related research framework and research guidelines.* Specifically, we recommend that the WHO develop and field-test "Rapid Assessment Guidelines" for mapping and identifying formal and informal supports for adolescents in a given setting, using as a partial base the "Rapid Assessment Guidelines" for health-seeking behaviour. Limited experience in studying or mapping sources of support for adolescents has found that simply carrying out a community assessment of support for adolescents can lead to improvements in adolescent help-seeking and help availability. As mentioned, there is a lack of research on adolescent decision-making, that is how adolescents decide when, where and how to seek help. Furthermore, understanding why young people seek help, and which help they seek, requires an understanding of how adolescents define their needs, in addition to understanding the perceptions and biases of parents, service providers, policy-makers and other adults. All of these issues should be included in these research guidelines. A suggested outline for these guidelines is included as Appendix 2.
- *In terms of recommendations for research, there are a number of interesting research approaches that deserve special attention.* The concept of "therapeutic narratives", that is listening to the stories or narratives that patients tell of the history of a specific health problem, the progression of the need and the history of seeking help for the need, may be applicable to adolescent help-seeking behaviour. This methodology underscores the potential utility of qualitative research methods for listening to adolescents and the meanings, beliefs and self-reported behaviours related to their perceived need for help and their perceptions of available social support, formal and informal (Ward et al., 1997). As another potential research approach, the application of strategies from social marketing, that is approaching adolescents as consumers of social support and seeking to understand where and which services they use and why may also be useful for studying help-seeking (Partnering for Social Change, 2001).
- *Efforts to map or study social supports and adolescent help-seeking behaviours should include the meaningful participation of adolescents.* In particular, working with adolescents as junior researchers who can interview other adolescents and can help frame a research agenda about social supports and help-seeking is an extremely useful approach. Given the reported difficulties that adults in some settings have in understanding and being sensitive to the needs of adolescents, this underscores the need to promote youth participation in research about adolescent help-seeking. As reported in one of the case studies, in Brazil two research organizations trained a group of young people to carry out a survey of adolescents, and to develop and test a questionnaire on where young people turn for various kinds of needs.

Summing up, seeking help and finding help are fundamental to adolescent health, development and well-being. While many adolescent health initiatives have focused on services provided in the health sector, among programmes consulted there is a growing belief in the need for more integrated services that take into account normative adolescent needs and specific health problems.

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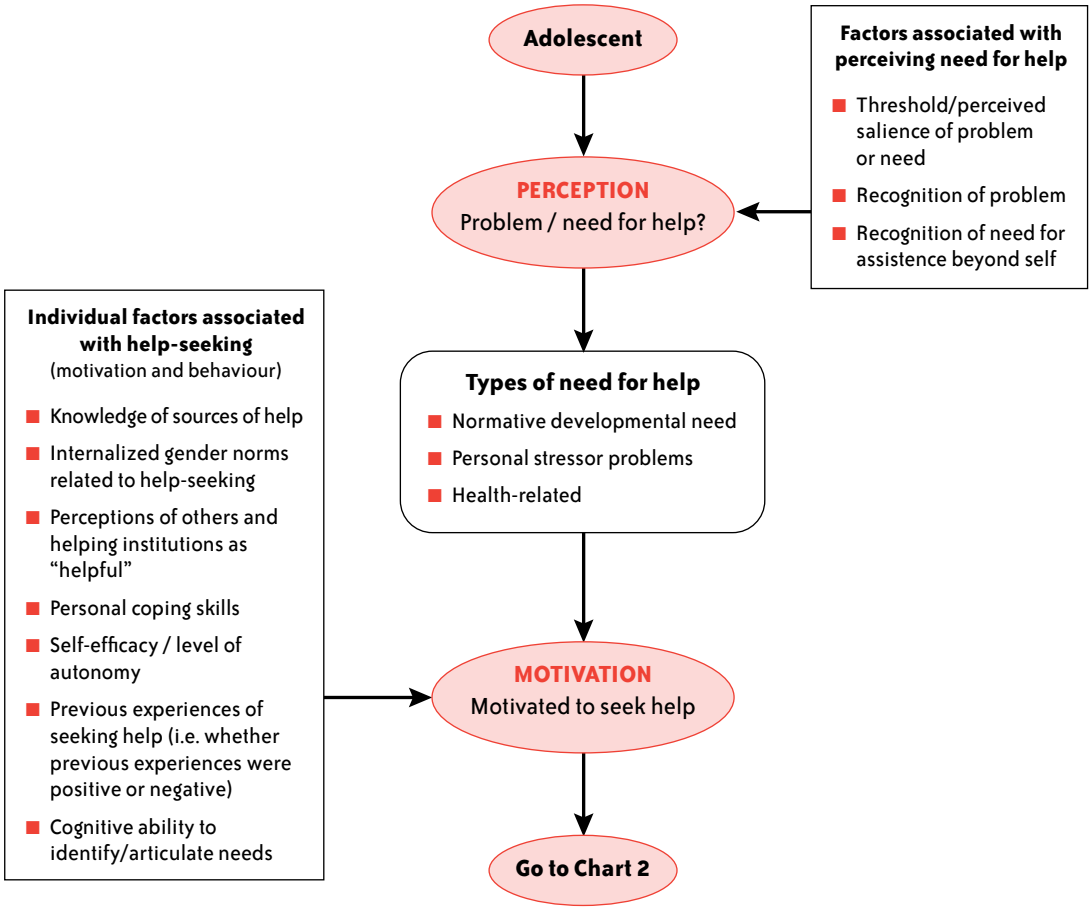
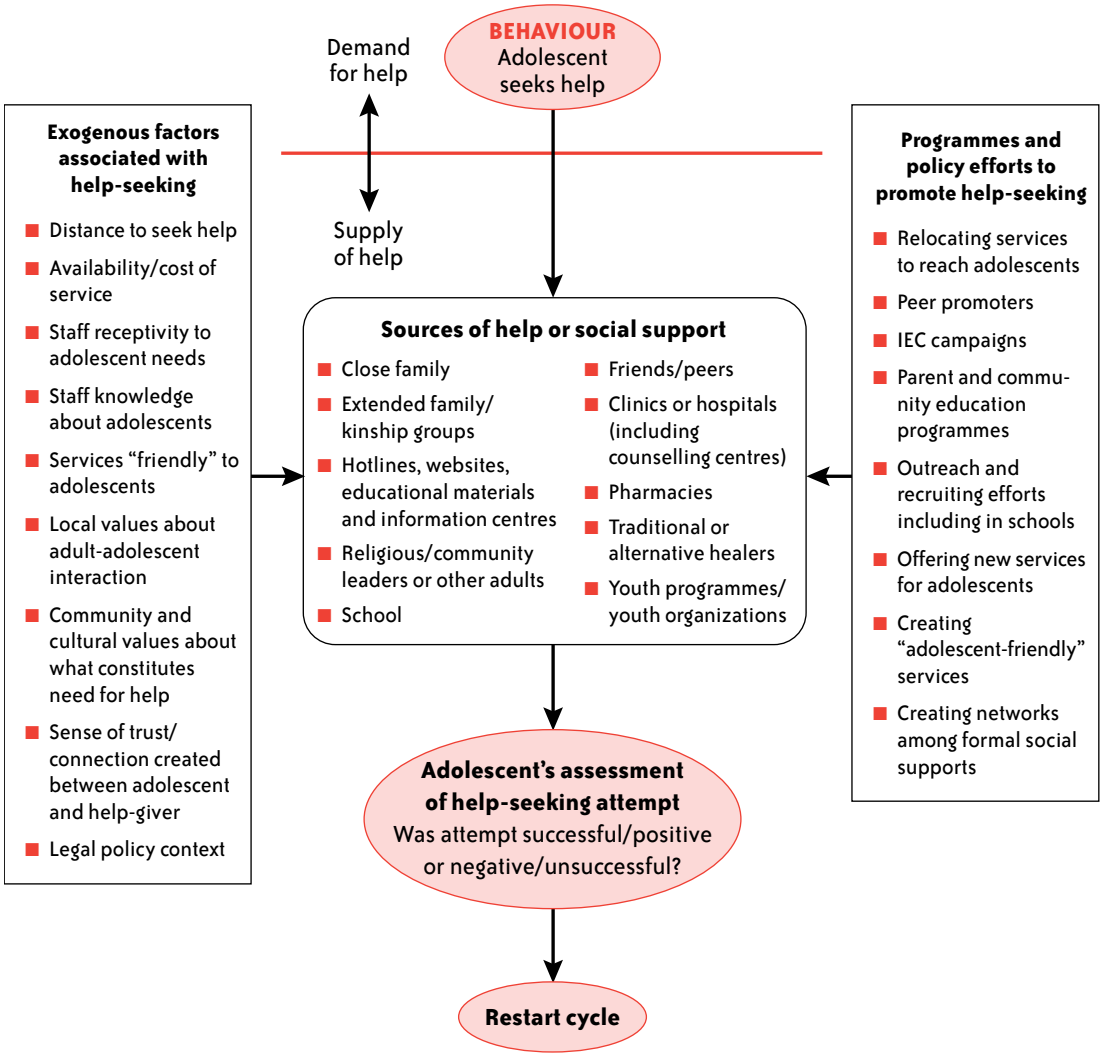
Proposed schema for adolescent help-seeking

Chart 1



Proposed schema for adolescent help-seeking

Chart 2



APPENDIX 1

Results from the programme consultations

To gather information and insights directly from adolescent health programmes, a questionnaire was developed and sent to 67 adolescent health programmes in Latin America, Asia, the Western Pacific and the Middle East. The questionnaire was based in part on the initial literature review, and was reviewed by staff at the WHO and the Pan American Health Organization (PAHO). In total, 35 programmes responded to the questionnaire: Asia (20), the Pacific region (4), Latin America (10) and Lebanon (1).

In this appendix we present the aggregate results from these questionnaires. The limited and uneven number of responses from each region means that these results must be taken as general indications or illustrative examples rather than being statistically representative of adolescent health programmes in each region. The sample was not randomly selected, nor can the responses received be considered representative. Because of these limitations, we did not calculate percentages for any of the responses.

Nonetheless, many of the responses are consistent with international data on adolescent health, and findings from other WHO surveys. Programmes were selected largely on the basis of convenience. Specifically, the questionnaires were sent to public and private sector organizations working in adolescent health that were identified by the regional consultants in consultation with the WHO (and in the case of Latin America, with PAHO input). A list of countries that responded to the questionnaires is found in Appendix 3. The questionnaire is found in Appendix 4.

In addition to the questionnaires, nine key informant interviews were also carried out with individuals working in research, policy and direct service to adolescents. In the following analysis, we combine the conclusions of the key informants with the programmes consultation.

1. Type of organization

From all three regions, the kinds of organizations that responded to the questionnaire included university-based adolescent health centres or research centres, governmental programmes and NGOs.

2. General services and activities offered

In all three regions, the organizations consulted offered a range of services generally found in adolescent health programmes, including:

- general clinic services
- specialized health services (for pregnant teens, STI treatment and diagnosis, HIV counselling and testing, substance use services, etc.)
- outreach and linkages to schools
- health education and promotion
- leisure or sports activities
- training of trainers
- research.

3. Research on the needs of adolescents

More than half of the organizations had carried out some research on the needs and realities of adolescents. In the case of Latin America, eight out of ten organizations had carried out research of this nature, as had two of the four organizations in the Western Pacific.

4. Description of adolescents with whom organization works

In the case of all three regions, most programmes serve lower income adolescents with limited educational attainment. In the case of Latin America, the programmes reach mainly urban-based youth, while in the case of the Western Pacific they reach both rural and urban youth. Programmes serve adolescents and young adults aged 10–25, and most of the patients or participants are either un- or under-employed. In the case of Latin America, as regional data would suggest, most of the adolescents are unmarried, while in the case of Asia more adolescents are married.

5. Main health needs of adolescents

In the case of health needs of adolescents, a wide range of concerns and needs were mentioned. These health needs are fairly consistent with international data on adolescent morbidity:

- puberty/information on the body/SRH needs
- emotional, psychosocial or mental health needs
- accidents/violence
- general or primary health care needs and problems (e.g. anemia, skin infections)
- family-related problems
- substance use concerns
- HIV-related needs.

6. Where adolescents go for health needs

In the case of Latin America, adolescents seek health services (in order of importance) at: (1) public health clinics; (2) hospitals; (3) schools; (4) pharmacies; (5) families; (6) friends; and (7) private clinics and NGOs. In the case of the Western Pacific, adolescents were said to seek health services and information from: friends, teachers, pharmacies, parents and health clinics.

7. Main personal problems

Apart from basic health needs, the following were the main personal problems of adolescents cited:

- sexuality and sexual relations are the most frequent area of concern in all three regions
- employment (Latin America)
- school issues (Latin America, Pacific)
- family violence or crises (Pacific, Asia)
- sexual abuse (Asia)
- substance use (Pacific, Asia)
- normative adolescent concerns and life transitions (Latin America, Pacific)
- homelessness (Pacific)
- marriage, dowry concerns, intimate relationships (Pacific, Asia).

8. Where adolescents go for personal problems/special needs

In the case of Latin America, adolescents usually seek help for these personal needs in the same places they seek general health services, that is from public health clinics first, then hospitals, schools, pharmacies, family, and friends. In the Pacific region, adolescents seek help for personal problems and special needs from teachers and counsellors, NGOs, peers and parents. Some key informants suggested that adolescents rarely seek formal help, and generally only in times of crisis or emergencies. And even when adolescents seek help, several key informants said, health professionals are not prepared to assist them, or are not trained to assist the specific needs of adolescents. At the same time, according to one key informant, adolescents often have a sense of omnipotence that hinders their help-seeking. In many cases, a Latin American key informant argued, an adolescent will have a specific problem that leads to pressure from school, family and/or the justice system for the young person to participate in a project or programme or otherwise seek help. In general though, in the experience of key informants from Latin America, families, the school and the community are not receptive to youth needs.

Some key informants suggested that for the majority of adolescent needs, problem-related and otherwise, adolescents seek informal help via family and friends. The difficulty noted, however, is that family and friends are often not open to helping adolescents when they come with problems.

9. Normative or common adolescent development needs

Normative adolescent development needs are reported to be:

- school-related (Asia, Pacific, Latin America)
- employment-related (Asia, Pacific, Latin America)
- family conflict (Pacific, Latin America)
- sexual orientation (Pacific)
- early marriage, early pregnancy (Asia)
- identity issues (Latin America)
- depression (Latin America)
- puberty, physical changes, belonging to a group, communication/assertiveness (Latin America)
- intimate relationship issues, sexuality (Latin America).

10. Main sources of help for normative or common adolescent development needs

The main sources of help for these normative development needs are:

- peer group, friends, boyfriend/girlfriend (Pacific, Latin America)
- counsellors, teachers (Pacific, Latin America)
- family, parents (Pacific, Latin America)
- hotlines (Pacific)
- youth centres, youth group, NGOs (Latin America)
- churches (Latin America)
- other adults (Latin America)
- health centres (Latin America).

11. Adolescents' awareness of sources of support

Across the three regions, the reported awareness by adolescents of sources of support was from low to medium, with very few ranking awareness by adolescents as high. The consensus that emerged is that adolescents are not highly aware of services and supports that exist, even when services and supports exist.

12. Barriers to help-seeking

In terms of barriers to seeking help, the following were cited:

- how they were received/treated when accessing services (Latin America)
- poor information or misinformation about existing services (Latin America, Pacific, Asia)
- institutional bureaucracy (Latin America)
- belief/perception that seeking help is a sign of weakness (Pacific)
- belief that can resolve problem without help (Pacific)
- cost issues, including transportation costs (Pacific, Asia)
- restriction of mobility by family or community (Asia).

In the case of Asia, several programmes said that services must involve families; if not, families often will not allow the young person to use the service. Key informants from the Pacific said that another barrier to help-seeking is the fear that adolescents may have of certain authority figures. Another barrier, some said, is the lack of awareness of adults and others of their roles as actual or potential helpers.

Yet another barrier to help-seeking and to help provided, cited by key informants, is that most health professionals are trained to respond to illness and not to help per se. One key informant noted that most adolescent health professionals respond to problems and do not use these "problems" as opportunities for health promotion: "The crucial point in attending adolescents is preventing new health risks… and this does not happen. There is not any emergency health service [in our area] that intervenes in this way [with adolescents]".

In addition, another barrier, as previously cited, is that staff in public health systems in some countries are reluctant to encourage adolescents seeking help, firstly because the staff are not prepared, and secondly because they feel overworked with the current volume of clients.

One key informant in Latin America suggested that another barrier to help-seeking, at least in the public health setting, is that clinics are not prepared to serve male youth. Particularly with regard to teenage pregnancy and SRH, there is a focus on adolescent girls and almost no attention paid to fathers.

13. Informal supports

Informal supports used by adolescents were:

- family, extended family (Latin America, Pacific, Asia)
- friends (Latin America, Pacific, Asia)
- teachers, counsellors, social workers (Asia, Pacific)
- religious leaders, churches (Latin America, Pacific, Asia)
- community groups (Latin America)
- neighbours, other adults (Latin America)
- youth organizations (Latin America).

14. Importance of informal supports to adolescents

Among Latin American organizations, the consensus was that in general society does not place value on seeking informal supports; talking to a friend for help is not valued in the same way as talking to a doctor. Among these informal supports, several Latin American respondents criticized religious leaders or churches as taking moralistic positions which thus discredited them as sources of adequate or objective support for adolescents. Among groups in Argentina, however, the church and religious leaders were cited as being particularly important. In the Pacific region, the consensus among the programmes was that informal supports are in fact more important than formal supports and even more important than in the past.

15. Recommendations for strengthening informal supports

In Latin America, several programmes mentioned efforts to build networks of formal and informal supports, bringing together community organizations along with religious groups, and others, to assist young people. Other organizations in Latin America said that the focus should be on strengthening formal institutions rather than informal supports. In the Pacific, programmes suggested the following as ways to strengthen informal supports for adolescents: (1) imparting skills to the existing informal sector to address adolescent health needs; (2) getting adolescents involved in youth organizations in schools and communities; (3) using the internet; and (4) involving youth role models (musicians, sports figures) in such efforts.

16. Sources of information/referral

In terms of where adolescents learn about specific programmes, they cite:

- peers and friends (Latin America, Pacific)
- NGOs (Pacific)
- teachers, school (Latin America, Pacific)
- family doctors (Pacific)
- health campaigns (Pacific)
- community TV (Latin America).

17. Other sources of support beyond your organization

In terms of the young people who use their service or programme, other sources of support these young people use include:

- private practitioners, private health services (Latin America, Pacific)
- NGOs working in the area of HIV (Pacific)
- pharmacies (Latin America)
- hospitals (Latin America)
- internet (Pacific)
- alternative healers (Latin America)
- friends (Latin America)
- books and magazines (Pacific)
- hotlines (Pacific).

18. Differences between adolescent clinic users and non-clinic users

In all three regions there was a clear consensus that clinic users are different from non-clinic users. In Latin America, programmes said that those who use their clinic services are more attentive to their health needs, and are in general physically and emotionally healthier. Only one programme in Latin America said that there was no difference between clinic users and non clinic-users. In the Pacific region, there was also a general consensus that help-seeking youth were different from non-clinic users, primarily having higher educational attainment and being at lower risk. Non-clinic-using adolescents were reported to face higher probabilities of contracting an STI or facing an early pregnancy.

The implications from this finding, which is also suggested in the literature review, is that those adolescents who do not use clinic-based services are in fact those who perhaps most need the service, i.e. that low help-seeking behaviour correlates with other health and personal risks.

19. Barriers to access to your programme

The following were cited as barriers to access for their specific adolescent health programmes:

- cost, transportation issues and time (Pacific, Latin America)
- stigma of seeking help (Pacific)
- lack of awareness or visibility of service (Pacific, Latin America)
- perception of health clinic as unfriendly (Pacific, Latin America)
- limited space, waiting time, overcrowded (Pacific, Latin America)
- lack of professional staff development, i.e. staff trained to work with adolescents (Latin America).

20. Special efforts to recruit or attract adolescents

The following were mentioned as specific activities that the programmes had carried out to recruit or attract more adolescents into their programme:

- TV and radio coverage (Latin America, Pacific, Asia)
- peer counselling, peer outreach (Latin America, Pacific, Asia)
- publications/IEC materials (Latin America, Pacific, Asia)
- outreach via NGOs, collaborating organizations (Latin America, Pacific, Asia)
- networking with schools (Latin America, Pacific)
- meetings with parents, community members, community leaders (Asia)
- making clinics more adolescent-friendly (Asia).

21. Skills or attributes that adolescents need to seek help

The following were cited as the skills or attributes that adolescents need to seek help:

- self awareness, recognizing the need to seek help (Pacific, Latin America)
- motivation to seek help (Pacific, Latin America)
- ability to engage with adults (Pacific, Latin America)
- ability to communicate in an assertive manner (Latin America)
- intellectual development (Latin America)
- future-oriented attitude (Latin America)
- ability to access the internet (Latin America).

22. Recommendations for promoting help-seeking by adolescents in public health sector

The following were the recommendations for increasing adolescent use of public health centres:

- create linkages between public health clinics and other agencies, including hospitals (Pacific, Asia)
- make health clinics more friendly, create separate spaces for youth (Pacific, Asia)
- organize staff training to identify and help adolescents more effectively (Pacific)
- institute aggressive public health education (Pacific, Asia)
- provide health services within schools/partner with schools (Pacific, Latin America)
- promote youth participation in service development (Latin America, Asia)
- be attentive to diversity of youth (Latin America).

Increasing adolescent help-seeking within the public health sector will also require, one key informant said, greater respect by health professionals for adolescents: "If health professionals do not share information with the youth, nothing will change." Another key informant said that at first glance, many adolescents view the public health system (as do many adults) as a place where one will be badly treated. The challenge in many cases is to get adolescents to overcome this first impression; in most cases, once they actually meet with and interact with clinic staff, they are pleased with the services received.

23. Recommendations for promoting help-seeking by adolescents in school

The following were cited as strategies to increase help-seeking via the school setting:

- offer health services directly in schools (Pacific)
- train school-based counsellors (Pacific)
- engage, train teachers (Latin America, Pacific, Asia)
- train peer counsellors, youth leaders (Pacific, Latin America)
- promote workshops and discussions in schools on themes that interest youth (Latin America)
- include health education in school curriculum (Asia)
- create linkages between school, family, community (Latin America, Asia).

Several key informants noted that creating greater linkages between the public health sector and schools is key to promoting greater help-seeking behaviour. At the same time, at least some key informants recognized that the public education system is already overburdened and will face difficulty taking on the role by itself as the gateway to adolescents' use of public health clinics.

24. Recommendations for promoting help-seeking by adolescents in communities

At the community level, respondents suggested the following strategies for increasing help-seeking by adolescents:

- form adolescent self-help groups in the communities (Pacific);
- facilitate networking (Pacific, Asia);
- develop IEC materials for youth, publicity (Pacific, Asia);
- create networks with sports and recreational activities, parents, local leaders and others (Latin America, Asia);
- workshops, awareness-raising events (Latin America);
- identify youth in situations of risk (Latin America);
- empower youth leaders (Latin America);
- organize advocacy workshops for parents, local leaders (Asia).

25. Recommendations for promoting help-seeking by adolescents at the policy level

At the policy level, respondents suggested the following strategies for increasing help-seeking by adolescents:

- raise awareness through media (Pacific);
- forge linkages between education and health sector, intersectorial networks (Pacific, Latin America);
- promote participation of youth in fora (Latin America);
- recognize cultural differences in health needs (Latin America);
- use existing legislation for child/adolescent rights (Latin America);
- sustain existing programmes (Latin America).

26. Collaborations to promote help-seeking

Respondents suggested the following in terms of building coalitions to enhance help-seeking:

- engage public sector (Latin America)
- engage or form networks with youth organizations, other NGOs (Latin America, Asia)
- engage universities (Latin America)
- engage national and international agencies (Latin America)
- form consortium to train staff (Asia)
- engage media, internet (Asia).

27. Research priorities

Respondents affirmed the following as their research priorities:

- mental health issues (Pacific)
- low-cost ways to provide youth-friendly services (Pacific)
- prevalence studies on adolescent health needs and problems (Pacific)
- research on high risk behaviour of adolescents (Pacific)
- research on youth employment (Latin America)
- youth participation (Latin America)
- research on youth and education, drop out, etc. (Latin America)
- research on engaging male youth (Latin America).

Appendix 2

Proposed outline for "Guidelines for the rapid assessment of social supports to promote the help-seeking of adolescents"

1. **Justification** – Why carry out a rapid assessment on social support. Connect to asset mapping and research on important connections for adolescents. Highlight some of the main findings from the literature review and programme consultation.

2. **Definitions** – Definitions of help-seeking behaviour, social supports.

3. **Framework for rapid assessment**
   - qualitative methods
   - quantitative methods
   - identifying both informal and formal supports
   - examples of possible social supports to be studied
   - adolescent and community participation in the rapid assessment.

4. **Case Examples**
   - 2–3 examples of studies that have sought to assess social support for adolescents.

5. **Analyzing the data** – Suggestions for analyzing the data. Connecting the data to programme and policy.

6. **References**

7. **Appendices** with examples of interview protocols.

Appendix 3

List of organizations consulted

1. Region: South Asia

1. *Key informant:*
   - Essential Services Package and Reproductive Health, Directorate of Family Planning, Government of Bangladesh
   - BRAC Education Programme, Bangladesh.

2. Region: Latin America

1. *Questionnaires:*
   - Centro de Salud y Acción Comunitaria (CESAC), Buenos Aires, Argentina
   - Departamento de Medicina Preventiva da Faculdade de Medicina da Universidade de São Paulo, São Paulo, Brazil
   - Núcleo de Estudos da Saúde do Adolescente (NESA) da Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil
   - Departamento de Pediatria de la Facultad de Medicina de la Pontificia Universidad Catolica de Chile, Santiago, Chile
   - PROFAMILIA, Bogota, Colombia
   - Corporación El Parche, Cali, Colombia
   - Programa JOVIAL of Universidad del Valle, Bogota, Colombia
   - De Adolescentes a Adolescentes, Santo Domingo, Dominican Republic
   - Ministry of Health, Kingston, Jamaica
   - Instituto Peruano de Paternidad Responsable, Lima, Peru.
2. *Key informants and Case Study:*
   - Núcleo de Estudos da Saúde do Adolescente (NESA) da Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil
   - Programa de Saúde do Adolescente, Secretaria Municipal de Saúde, Rio de Janeiro, Brazil
   - Núcleo de Estudos da População (NEPO) da Universidade de Campinas, Campinas, São Paulo.

3. Region: South-East Asia

1. *Questionnaires:*
   - Family Health Development Division, Ministry of Health, Malaysia
   - Child Guidance Clinic, Institute of Health Building, Singapore
   - Centre for Child Mental Health, Cambodia
   - Queen Mary Hospital, China, Hong Kong SAR.
2. *Key informants:*
   - Ungku Omar Polytechnik, Malaysia
   - Odhir Christian Counselling Centre, Malaysia.

Appendix 4

Questionnaire

WHO Consultation of Programmes on the Help-Seeking Behaviour of Adolescents

Introduction

The World Health Organization's Adolescent Health and Development Programme is carrying out research to develop strategies for influencing adolescent help-seeking, specifically to promote greater help-seeking behaviour by adolescents and improve access to help and health services by adolescents in diverse contexts worldwide.

We are defining **adolescent help-seeking behaviour** as:

> Any action or activity carried out by a young person who perceives herself/himself as having a need for personal, psychological, affective or health-related assistance or services, with the purpose of relieving or addressing this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of an actual service (e.g. a medical consultation or counselling session), a referral for a service provided elsewhere or might simply be talking to another person about the need in question. We emphasize addressing the need in a *positive* way to distinguish help-seeking behaviour from behaviours such as association with anti-social peers, or substance use in a group setting, which a young person might define as help-seeking, but which would not be considered positive from a health and well-being perspective.

We propose defining three somewhat overlapping categories of help-seeking behaviour:

1. Help-seeking for **specific health needs,** including health services (in the formal health care system or via traditional healers and pharmacists), as well as seeking health information. This is generally called "health-seeking" behaviour.
2. Help-seeking behaviour in times of **personal stress or problems,** such as in the case of family crises; family violence or victimization by abuse; relationship issues (friends, boyfriend/girlfriend); or acute financial needs or homelessness, among others.
3. Help-seeking for **normative developmental needs,** including help in completing school, or help related to vocational orientation/training, or employment seeking; relationship issues, sexuality or puberty; and/or other concerns that are frequently associated with adolescence.

You and your organization were identified via the Pan American Health Organization, WHO or via colleague organizations as carrying out activities in the area of adolescent health promotion. This consultation of programmes is being administered among a select number of programmes in Latin America, North America and the Caribbean; Asia; Sub-Saharan Africa and the Middle East; and Oceania. Information collected will be analyzed and published by the WHO and consultants working on this project and provide background information for planning WHO-sponsored initiatives to promote and improve the help-seeking behaviour of adolescents.

We thank you in advance for taking the time to respond to this questionnaire. The information you provide will be extremely important as we seek to design new initiatives and strategies for promoting the health of adolescents.

FOR PROGRAMMES IN LATIN AMERICA, NORTH AMERICA AND THE CARIBBEAN, PLEASE RETURN THIS SURVEY BY MARCH 5, 2001, TO:

Instituto PROMUNDO
Rua Francisco Serrador, 2/702
Rio de Janeiro, Brazil
20031-060
Tel. + 55 21 544-3113, 3115
Fax + 55 21 220-3511
e-mail: g.barker@promundo.org.br

A. ORGANIZATIONAL INFORMATION

1. NAME AND ADDRESS OF ORGANIZATION:

Name: _____

Address: _____

_____

_____

_____

_____

Telephone: _____

Telefax: _____

E-mail: _____

Contact person for work with adolescents: _____

Name and title of person filling out this survey: _____

_____

2. TYPE OF ORGANIZATION: Briefly describe your organization (NGO, governmental, youth serving organization, reproductive/sexual health clinic, community-based NGO, etc.).

3. GENERAL SERVICES AND ACTIVITIES OFFERED: Briefly describe the range of services and activities you offer for adolescents.

B. GENERAL BACKGROUND AND NEEDS OF ADOLESCENTS

4. RESEARCH ON THE NEEDS OF ADOLESCENTS: Has your organization carried out specific research on the health-related needs of adolescents?

YES ☐

NO ☐

If **YES,** briefly describe the main findings from this research. (In addition, if this material is available, please attach or send a copy of the research report, or reports, with this survey.)

5. DESCRIPTION OF ADOLESCENTS WITH WHOM ORGANIZATION WORKS: Briefly describe the adolescents with whom you work (educational status, socioeconomic status, urban/rural, employment status, ages, marital status).

C. HELP-SEEKING BEHAVIOUR OF ADOLESCENTS IN YOUR COMMUNITY OR SETTING

6. HEALTH NEEDS: What are the three main health issues that adolescents in your community or setting seek help for?

a. _____

b. _____

c. _____

6A. WHERE ADOLESCENTS GO FOR HEALTH NEEDS: When faced with one of these three health needs, what are three main places they go to seek help?

a. _____

b. _____

c. _____

7. PERSONAL PROBLEMS/STRESS/SPECIAL NEEDS: Many adolescents have special needs or crises that require special help. This might include family violence; drug addiction or problem; being a victim of abuse, other family crisis, homelessness.

Thinking about the adolescents you work with, what are three main personal problems or special needs for which they seek help?

a. _____

b. _____

c. _____

7A. WHERE ADOLESCENTS GO FOR PERSONAL PROBLEMS/SPECIAL NEEDS: When faced with one of these personal problems, what are the three places where adolescents usually go for help?

a. _____

b. _____

c. _____

8. HELP-SEEKING FOR NORMATIVE OR COMMON ADOLESCENT DEVELOPMENT NEEDS: Nearly all adolescents have what are often called "normative" developmental needs, or common issues in their development, such as completing school, getting training or skills to find a job, and information about puberty and the physical changes associated with being an adolescent.

Thinking about the adolescents you work with, what are the three most common (normative) adolescent development needs for which they seek help?

a. _____

b. _____

c. _____

8A. WHERE ADOLESCENTS GO FOR NORMATIVE OR COMMON ADOLESCENT DEVELOPMENT NEEDS: When faced with these common, or normative, adolescent development needs, where do adolescents in your community usually seek this help?

a. _____

b. _____

c. _____

9. ADOLESCENTS' AWARENESS OF SOURCES OF SUPPORT: How would you rate the awareness on the part of adolescents about existing sources of support and services in your community?

High ☐

Medium ☐

Low ☐

Comment:

10. BARRIERS TO HELP-SEEKING: What would you say are the three main barriers to adolescents seeking more help for their needs in your communities?

a. _____

b. _____

c. _____

11. INFORMAL SUPPORTS: In many communities, "informal" or traditional sources of support, including elders, extended family members, family friends, religious leaders or other adults in the community are the main sources of support for young people. These are sometimes also called social networks. What informal supports or social networks exist that adolescents use in your community?

12. IMPORTANCE OF INFORMAL SUPPORTS: How important are these informal supports or social networks to adolescents? Are they as important as they once were?

13. STRENGTHENING INFORMAL SUPPORTS: Is there some way that adolescents could be encouraged to use informal supports or social networks more, or that informal sources of help for adolescents could be strengthened? How?

D. PROMOTING HELP-SEEKING IN YOUR ORGANIZATION

14. SOURCES OF INFORMATION/REFERRAL: How do adolescents generally know about or hear of your organization or services?

15. OTHER SOURCES OF SUPPORT: In addition to your organization or services, where else do young people go for health services or information?

16. CLINIC USERS VERSUS NON-CLINIC USERS: Would you say that young people who use clinical services at your organization are different from young people who do not use clinical services at your organization? If so, in what ways?

17. BARRIERS TO ACCESS TO YOUR PROGRAMME: What would you identify as the three main barriers or obstacles for young people becoming involved in, using or hearing about your service or organization?

a. _____

b. _____

c. _____

18. SPECIAL EFFORTS TO RECRUIT OR ATTRACT ADOLESCENTS: Has your organization undertaken any special initiatives or efforts to recruit or encourage adolescents to make greater use of the programme or service?

YES ☐

NO ☐

If, **YES,** please describe this initiative or effort.

E. CONCLUSIONS

19. SKILLS FOR HELP-SEEKING: What skills or attributes do adolescents need in order to seek help appropriately?

20. PROMOTING HELP-SEEKING BY ADOLESCENTS IN THE PUBLIC HEALTH SECTOR: What do you think could be done by public health service providers in your community to encourage improved help-seeking behaviour by adolescents, including greater use of existing public health clinics?

21. PROMOTING HELP-SEEKING BY ADOLESCENTS IN SCHOOLS: What do you think could be done in schools in your community to encourage improved help-seeking behaviour by adolescents?

22. PROMOTING HELP-SEEKING BY ADOLESCENTS IN COMMUNITIES: What do you think could be done by community leaders or at the community level to encourage improved help-seeking behaviour by adolescents?

23. PROMOTING HELP-SEEKING BY ADOLESCENTS AT THE POLICY LEVEL: What do you think could be done by policymakers at the local and national level to encourage improved help-seeking behaviour by adolescents?

24. COLLABORATIONS TO PROMOTE HELP-SEEKING: Has your organization established partnerships or collaborative arrangements with other organizations to promote greater help-seeking by adolescents? If so, with which organizations?

25. DESIRE FOR ADDITIONAL COLLABORATIONS: What kind of partnerships or collaborations would enable you to promote more help-seeking?

26. RESEARCH PRIORITIES: What kind of additional research on adolescents and help-seeking would be useful for your work?

27. OTHER COMMENTS: If you have any suggestions, questions or other comments, or issues you think were left out of this survey, please describe those.

Thank you again for taking the time to fill out this programme consultation. Your organization will receive a final copy of the report of the programme consultation and will be included in the list to receive future information on WHO activities related to adolescents and help-seeking behaviour.

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