Defining adolescence: priorities from a global health perspective

A recent Viewpoint[1] in *The Lancet Child & Adolescent Health* proposed extending the definition of adolescence from 10–19 years to 10–24 years, noting delays in the transition age to adult roles (eg, marriage and parenthood) in many societies as the main motivation.

The Evidence for HIV Prevention in Southern Africa research programme specifically reviewed definitions of child, adolescent, youth, and adult used in research and health programming in eastern and southern Africa.[2] This review supports defining adolescence as 10–24 years, on the basis of realities of adolescence and youth in substantially different, resource-limited contexts. Young people still adopt adult roles early in life, yet face diverse and changing epidemiological, social, and economic threats to health different from those of children and adults. While 20–24 year olds are substantially different to 10–19 year olds, their health challenges are also part of a continuum of risks and intervention opportunities that starts in the younger group. The review, like Janet McDonagh and colleagues,[3] also reiterated the need for a unified approach to categorising the 10–24 year age group to reduce confusing comparisons or extrapolations across settings.

However, the review emphasised more prominently the pressing need for disaggregated data within adolescence, which Susan Sawyer and colleagues,[4] also now highlight. To support evidence-based interventions and policies that meet the health needs of adolescents and young people, we propose adolescence be categorised into three age groups and descriptors—young (10–14 years), middle (15–19 years), and late (20–24 years) adolescence—rather than just a single, very broad age band.

Disaggregation is particularly relevant from a global health perspective. If we take HIV for example, in eastern and southern Africa, incident HIV infections occur predominantly among young people aged 15–24 years. However, a persistent scarcity of data prevents increased disaggregation by age and other factors.[5] Therefore, understanding of the growth of a range of public health problems (including HIV, teen pregnancies, and mental ill health) in specific subpopulations is remarkably poor, as highlighted in the WHO Global Accelerated Action for the Health of Adolescents report. As a result, programmatic responses might be inadequately focused and targeted.

We acknowledge that the 5-year bands we propose can also restrict analysis, but this approach remains practical for routine reporting and comparisons. Further disaggregation is clearly desirable.

Future research and programmatic investments should prioritise: revisiting existing datasets to produce further disaggregated analyses; including additional age-ranges with adequate sample sizes in new qualitative and quantitative studies; enhancing the abilities of researchers, ethics review committees, and funders to undertake age-sensitive formative research, intervention design, and evaluation; and supporting policy making and programming that are based on rigorous evidence of what is age-appropriate and stage-appropriate.

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1 Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. *Lancet Child Adolesc Health* 2018; **2:** 223–28.
2 MannionDaniels. Adolescents and HIV: definitions and disaggregation. 2018. http://www.ehpsa.org/critical-reviews/age-disaggregation (accessed Feb 12, 2018)
3 McDonagh JE. The age of adolescence…and young adulthood. *Lancet Child Adolesc Health* 2018; **4:** e6.
4 Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence…and young adulthood – Authors' reply. *Lancet Child Adolesc Health* 2018; **4:** e7.
5 Idele P, Gillespie A, Porth T, et al. Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. *J Acquir Immune Defic Syndr* 2014; **66** (suppl 2)**:** S144–53.

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For the **WHO Global Accelerated Action for the Health of Adolescents report** see http://apps.who.int/iris/bitstream/10665/255418/1/WHO-FWC-MCA-17.05-eng.pdf