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The emergence of the adolescent subject in global health: Prioritizing epistemic justice in research and practice

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ABSTRACT

In 2015, the United Nations integrated adolescents as a unique category into the Sustainable Development Goals, a recognition the World Health Organization expanded in 2017 with the introduction of the Global Accelerated Action for the Health of Adolescents. This paper examines the emergence of the 'adolescent subject' in global health. Adolescence is a modern concept embedded in Western views that is not universally applicable, hence raising issues in global health practice by embodying a colonial legacy in using categories that may not align with all cultural contexts. Moreover, the paper explores a critical gap in global health research: while the majority of the world's adolescents reside in low- and middle-income countries, most adolescent health research is conducted in high-income settings. This disparity is due, in part, to a lack of funding for adolescent research and barriers like parental consent requirements that prevent adolescents from participating in research. This exclusion inadvertently silences some adolescents' voices and restricts their opportunities for research engagement, perpetuating an epistemic injustice in global health data production. The paper calls for a concerted effort to develop measures to inclusively engage adolescents in global health research, aiming for a fair and representative inclusion of adolescent perspectives.

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SUSTAINABLE DEVELOPMENT GOALS
SDG 3: Good health and well-being; SDG 10: Reduced Inequalities

Introduction

In 2015, the United Nations launched the *Global Strategy for Women's, Children's and Adolescents' Health*, delineating a comprehensive roadmap for achieving specific health-related *Sustainable Development Goals* (SDG) to be accomplished by 2030 (WHO, 2015). This initiative marked a pivotal moment in global health. The strategy acknowledged adolescents as a distinct demographic cohort, different from children and adults, thus underscoring their unique health exigencies and challenges (*ibid*, p. 11). In tandem with the Global Strategy's overarching objectives, the World Health Organisation (WHO) introduced in 2017 the *Global Accelerated Action for the Health of Adolescents* (AA-HA!), providing guidance to facilitate the strategy's effective implementation at national levels (WHO, 2017). Echoing the tenets of the Global Strategy, AA-HA! firmly asserts the mistake of characterising adolescents as 'older children' or 'young adults', emphasising the imperative to formally recognise adolescents as a unique category within public health and medicine.

This shift in global health perspective, described by the WHO in 2023 as the 'coming of age' of adolescent health (WHO, 2023), warrants an examination of the evolution of this new focus. Concern for adolescent health has long intersected with major global health challenges like the HIV/AIDS pandemic. For instance, in 1993, Dr. Karen Hain, serving as the president of the *Society of Adolescent Medicine*, drew attention to the alarming observation that 'the new face of AIDS worldwide is the face of teenaged girls' (Goldsmith, 1993). However, despite recognising the importance of addressing adolescents' health needs, global health disparity persists. Most research endeavours on adolescents are conducted within high-income nations, even though a staggering 90% of the global adolescent population resides in low- and

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middle-income countries (Blum & Boyden, 2018; United Nations Population Fund, 2014; Vandermorris & Bhutta, 2017). Furthermore, while adolescents constitute a quarter of the population from developing countries, they receive less than 2% of all global health funding (Li et al., 2018).

This disparity in research attention exemplifies a form of epistemic oppression (Dotson, 2014), wherein systemic structures in global health, such as research funding priorities, marginalise groups like adolescents from developing countries by excluding them from contributing to knowledge production. This exclusion perpetuates an epistemic injustice, as it routinely overlooks or dismisses the voices and experiences of adolescents in resource-constrained settings. Compared to their peers in high-income countries, these adolescents face systemic neglect that sustains inequalities in whose knowledge and experiences are prioritised (Bhakuni & Abimbola, 2021). These dynamics, rooted in epistemic oppression, highlight structural barriers that limit adolescent inclusion in knowledge production processes in global health.

This oversight is further reflected in the current SDG framework, which inadequately monitors adolescent health, as only 6% of SDG indicators precisely capture information related to the health of adolescents (Kagesten et al., 2023). However, it is crucial to underscore that adolescents from marginalised groups in high-income settings, like gender-diverse and racialized youth, are similarly neglected in research (Newman et al., 2022). As a result, the prevailing research on adolescent health tends to overrepresent the issues and experiences of adolescents from more affluent socio-economic backgrounds. This systemic bias presents significant epistemic justice problems: it not only obscures our understanding of the varied health needs among diverse adolescent populations but also, from a democratic standpoint, silences the voices of certain (often marginalised) youth regarding matters that concern them. Furthermore, this bias affects the field of implementation science, since it limits the generalisability and applicability of research findings across cultural contexts (Passmore & Kisicki, 2022). Ultimately, these research deficiencies obstruct the creation of effective, culturally relevant interventions and policies crucial for enhancing adolescent health outcomes worldwide, especially in regions where the needs are most acute yet data are most lacking (Nagata et al., 2016).

This paper addresses epistemic injustice issues in relation to adolescents in global health through three key objectives: 1) present the genealogy of the 'adolescent subject' and explore its emergence in the field of global health, 2) examine the epistemic justice issues stemming from the insufficient involvement of adolescents in global health research, highlighting the consequential impact on the production of global health data, and 3) propose strategic measures to enhance the inclusion of adolescents as active contributors in global health research. These objectives call on global health researchers to reflect on their positionality and the power asymmetries shaping their engagement with adolescents. By addressing these power imbalances and prioritising the inclusion of marginalised adolescent voices, this paper advances an approach that seeks to rectify epistemic injustices in global health. Such an approach not only amplifies the voices of adolescents but also ensures that research outcomes are more valid, inclusive, and reflective of the lived realities and diverse needs of adolescents globally, thereby contributing to more just and equitable health policies and programs.

Theoretical approaches: Genealogical subjectivity and epistemic injustice

This paper adopts a Foucauldian genealogical approach to analyse the concept of 'the adolescent subject' within global health. Philosopher Michel Foucault emphasised the importance of critically examining knowledge systems that position individuals within specific discursive formations (Chambon et al., 1999, p.52). Foucault highlighted the significance of tracing the historical development of mechanisms through which individuals become subjects (Foucault, 1982, p.777). An illustrative example of Foucault's method is his examination of the perception of homosexuality. He charted how the 'homosexual subject' transitioned from being considered a 'criminalized subject' through legal language to a 'pathologized subject' through medical discourses. This genealogical method demonstrates how changes in discourse and power dynamics shape subjectivities (i.e., subjects), prompting inquiries into who has the authority to define subjects and societal norms (Foucault, 1976).

Applying a similar genealogical method, this paper examines the concept of the 'adolescent subject' by exploring the historical and discursive shifts that contribute to the current conceptualisation of adolescents in global health. For instance, we may ask ourselves: What is an adolescent, and who has the authority to

define adolescence? The paper posits that this identity of 'adolescent' is not fixed or inherent, but a relatively modern construct emerging from the interaction of various scientific fields like anthropology, sociology, neuroscience, and medicine (Bedin, 2009) to communicate with alien lifeforms By extension, in global health, the adolescent subject has been shaped through interdisciplinary dialogues, including those in demography, public health, and psychology (O'Donohue et al., 2013). These interdisciplinary exchanges have led to new understandings of adolescence and have prompted increased attention to this population. Consequently, there has been a movement in global health to recognise adolescents as a distinct and independent group, separate from children and adults. However, it is crucial to acknowledge that the concept of adolescence varies across cultures, raising significant epistemological questions, including the existence of adolescence as a universal category. This cultural variability challenges the universal applicability of policies and interventions designed within a predominantly Western framework. Moreover, recognising the constructed nature of the adolescent subject can help identify and address the epistemic injustices that arise when certain voices and experiences are marginalised in the production of global health data.

While Foucault's genealogical method enables us to trace how adolescence has been constituted as a category through historically situated power/knowledge regimes, Miranda Fricker's theory of epistemic injustice offers a complementary normative lens for analysing the consequences of this categorisation. Together, these frameworks allow us to examine not only how the adolescent subject is discursively produced, but also how such constructions shape whose voices are recognised—and whose are excluded—in the domain of global health knowledge production. Fricker's work (1999, 2017) is useful to consider how adolescents are frequently marginalised as knowers, both in terms of their ability to speak about their own experiences and their inclusion in shaping knowledge that affects them. While Foucault prompts critical reflection on the historical contingencies that shape subject positions, Fricker sharpens our attention to the ethical stakes of these processes by foregrounding how certain groups—such as adolescents—are systematically disempowered in their epistemic participation. The following sections introduce and apply Fricker's two key dimensions of epistemic injustice to illustrate how these exclusions manifest in global health.

Testimonial Injustice occurs when a speaker's credibility is unfairly downgraded due to prejudice. Adolescents, often perceived as naive or immature given their age, can face testimonial injustice in global health research. For example, adolescents' insights into the social determinants of their health, such as the impact of unsafe school environments on their mental well-being, can be undervalued or dismissed, reflecting adult-centric assumptions about the validity of their perspectives (Verhoog et al., 2024). Such dismissal of adolescents' perspectives not only excludes them from shaping policies that affect their lives but also reinforces the epistemic authority of adults, like researchers, perpetuating a cycle of exclusion.

Hermeneutical Injustice arises from a structural gap in collective interpretive resources, preventing certain groups from making sense of or articulating their experiences. Adolescents often encounter this injustice when dominant global health frameworks fail to capture the complexities of their lived realities. For instance, adolescents' experiences of navigating fragmented healthcare systems, where they are shuffled between paediatric and adult care, are often inadequately addressed beacuse policy frameworks fail to account for the transitional nature of their developmental stage and healthcare needs (Hardin et al., 2017).

Fricker's framework underscores the importance of critically examining who defines the experiences and challenges of adolescents in global health. Similar to Foucault's analysis of subject formation, this approach reveals how power and knowledge intersect to determine whose voices are recognised as credible or intelligible. By addressing these forms of epistemic injustice, global health researchers can begin to include adolescents as legitimate epistemic agents, fostering more equitable knowledge production and ensuring that global health data more accurately reflects the diverse realities of adolescent populations.

The genealogy of the adolescent subject

The definition of adolescence is inherently complex, marked by its recent emergence in the historical context of human development (Bedin, 2009). The term 'adolescence' finds its linguistic origins in the Latin word *adolescere*, signifying the transition into maturity (Lerner & Steinberg, 2009; Sawyer et al., 2018). Notably, during the 19th century, adolescence began to be recognised as a distinct life stage, initially

among the bourgeois and aristocratic classes, and later extending to the working class in the 20th century (Rozzi, 2014). Young individuals from more privileged backgrounds benefitted from greater economic stability, access to education, and leisure time, which facilitated a period of 'adolescence' that was not as accessible to their peers from lower socio-economic backgrounds, who often had to enter the labour market earlier and assume adult responsibilities (e.g. child-rearing). Before the 19th century, European societies lacked a conceptual framework for adolescence, with individuals transitioning directly from childhood to adulthood (Aries, 1960). In contrast, the United States viewed adolescents as 'inferior adults' rather than a distinct social category (Moran, 2000).

The emergence of adolescence as a separate life stage in the 20th century can be attributed to several factors. Key among these was industrialisation, accompanied by progress in medicine and public health that reduced mortality rates among young people (Sawyer et al., 2012). Most importantly, enhanced wider access to education contributed to differentiating adolescence as a unique phase of human development (Moran, 2000), thereby effectively prolonging the childhood phase (Moraes & Weinmann, 2020). As a result, children became financially dependent on their parents for extended periods compared to previous times in human history (Catalano et al., 2012; Frota, 2007). However, it is essential to highlight that the concept of adolescence, as it emerged, is primarily rooted in a North American and Eurocentric context (Sebaa, 2009), as exemplified by the work of the Hall (1904), considered the father of adolescence in psychology. In contrast, many cultures worldwide lack a well-defined notion of adolescence and often categorise individuals simply as children or adults (Quentel, 2008). For instance, there is no clear concept of adolescence in India, and Indian languages do not have an equivalent term for 'adolescence' (Burra, 2014).

Adolescence is now recognised as a distinct stage of human development. However, its definition varies across disciplines like anthropology, psychology, neurology, and medicine due to the overlapping domains of human maturity, including social, developmental, biological, emotional, and cognitive aspects (Bedin, 2009; Lansford & Banati, 2018). The beginning of adolescence is often agreed to coincide with the onset of puberty, which includes clear biological markers such as menarche in people who can menstruate (Sawyer & Patton, 2018; Worthman & Trang, 2018). Although biological markers, like menarche, offer a seemingly objective criterion for initiating adolescence, it is critical to emphasise that such markers are subject to social influence. For instance, as observed throughout the decades, the more economically developed a country becomes, the earlier the average onset of menarche (Worthman & Trang, 2018). This phenomenon suggests that biological indicators of adolescence are not strictly tied to a fixed chronological age but are instead influenced by socio-economic factors.

Conversely, the determination of when adolescence concludes and adulthood commences is met with less consensus, mainly due to the absence of universally recognised biological or chronological indicators signifying this transition (Arnett & Taber, 1994; Dahl et al., 2018; Feuillet-Liger, 2012). Instead, the end of adolescence and the onset of adulthood are often signalled by social and cultural milestones, such as marriage and parenthood (Ledford, 2018; Sawyer et al., 2018). These indicators can vary substantially across different cultures and often depend upon certain norms (e.g. cisheteronormativity). For example, in Ethiopian and Eritrean societies, a woman's transition from adolescence to adulthood is primarily defined by her marital and parental status, rather than her chronological age, which contrasts with Western norms that prioritise chronological age, such as reaching 18 years old, as the principal determinant of adulthood (Clark-Kazak, 2009; Grabska & de Regt, 2019). Meanwhile, in Hmong culture, the transition from childhood to adulthood occurs around the ages of 12-13, bypassing a distinct adolescent stage like in the West (Patel et al., 2007). In contrast, while the prolongation of education into late adolescence is expected in the Global North, reflecting a tendency to extend the period of childhood, it is not unusual for adolescents in regions, such as Bangladesh, to abandon school and enter the workforce at earlier ages given precarious economic contexts (Heissler, 2011).

In global health, there are ongoing debates regarding the definition of adolescence. For instance, Sawyer et al. (2018) advocate for extending the age range of adolescence to 10–24 years, arguing that this range more accurately reflects the developmental stages of adolescents today. This extension is particularly relevant considering various global trends. For example, the age at menarche is decreasing; a study in the US showed that among females born between 1950 and 2005, the proportion experiencing early menarche (before age 11) increased from 8.6% to 15.5% (Wang et al., 2024). More young people are prolonging education, leading to extended economic dependence on parents into their twenties, especially in Europe, where education and

living costs are high (Sompolska-Rzechuła & Kurdyś-Kujawska, 2022). Methodologically, expanding the definition of adolescence could enhance our understanding of the transitions from childhood to adolescence and subsequently into adulthood. Additionally, it is essential to recognise that neurological studies have shown that the 'adolescent brain' continues to mature into the twenties (Johnson et al., 2009). However, some, such as the European Training Effective Care and Health Faculty, contend that extending the definition of adolescence may not offer additional benefits (McDonagh et al., 2018). They argue that it could introduce more confusion by complicating the terminology surrounding adolescence. This confusion is especially pertinent in the case of paediatric medicine where it is challenging to define the upper age limit of paediatric services and the start of adult healthcare services (Hardin et al., 2017; White & Greenlee, 2015). Consequently, adolescents find themselves in a grey area, navigating between paediatric and adult medical care, often without access to services that cater specifically to their unique developmental needs (Pettifor & Subramaniam, 2018).

These examples highlight the multifaceted and complex nature of defining adolescence, illustrating the substantial variation in how this life stage is conceptualised across different scientific and cultural contexts. This diversity in conceptualisation raises relevant questions regarding the universal applicability of the adolescent category within the context of global health research and initiatives, challenging the assumption that adolescence is a fixed, universal category and instead emphasising its culturally and historically constructed nature. Specifically, this diversity challenges us to consider the various criteria employed to delineate this transitional period and the knowledge systems that inform our understanding of adolescence.

The emergence of the adolescent subject in global health

In 2000, the United Nations set forth the Millennium Development Goals (MDG) to be achieved by 2015, with one of the eight goals dedicated to improving the health of young children (i.e., those under 5 years old). Significant advancements were made in enhancing health and reducing mortality among young children because of these goals (Sawyer & Patton, 2018). However, it was observed over the MDG era that these health improvements diminished as children transitioned into adolescence (Sheehan et al., 2017; Viner et al., 2012). Simultaneously, research has shown that many health issues and leading causes of mortality in adults have their origins in adolescence, including alcohol and tobacco use, unhealthy dietary habits, and mental health conditions. Consequently, the recognition of the unique health challenges faced by adolescents and their long-term impacts led to their inclusion as a distinct category in the SDG in 2015. This shift underscores a growing awareness of the importance of addressing adolescent health, a group historically overlooked in global health initiatives and international development efforts (WHO, 2017).

The increased global focus on the 'adolescent subject' was further exemplified in 2016 when the United Nations' Committee on the Rights of the Child revised the *Convention on the Rights of the Child*. The Convention advocates for the rights of all people under the age of eighteen while recognising the child's development and evolving capacities. However, the Committee made a significant addition by emphasising the need for distinct approaches to fulfil adolescents' rights compared to those of younger children. This update highlights that policy approaches must be adopted to ensure the realisation of the rights of adolescents while simultaneously recognising that they differ substantially from those adopted for younger children (UN Committee on the Rights of the Child, 2016, p.3). This modification helps shape adolescents' identity in global health discussions, recognising them as individuals entitled to specific rights because of their unique stage of development, distinct from younger children.

The increasing focus on adolescent populations within global health discourses can also be attributed to what could be termed the 'demographization' of adolescence. Today, the world witnesses the largest cohort of young people, with over 1.8 billion individuals aged 10 to 24, constituting nearly a quarter of the global population (United Nations Population Fund, 2014). Global health discourses argue that this adolescent generation's health and human capital are pivotal for the future economic and social development of low- and middle-income countries (Bloom, 2012; Patton, Sawyer, Santelli, et al., 2016). Among various global health challenges tied to the discourses around the demographization of adolescence, the HIV epidemic is particularly alarming. Without significant decreases in HIV transmission rates, the current record-high global youth population—who are starting to become sexually active—could potentially trigger a resurgence of the epidemic (Bekker et al., 2018; Starrs et al., 2018).

The current global health narrative suggests that investing in adolescent health yields a 'triple dividend': it benefits adolescents' health today, enhances their wellbeing as they transition into adulthood, and improves the health of their future children, stemming from their parents' healthier adolescence (Kleinert & Horton, 2016; Patton, Sawyer, et al. 2016; Patton, Sawyer, Santelli, et al., 2016; Sheehan et al., 2017). This approach positions adolescents' health as crucial not only for their immediate wellbeing but also as a foundation for the health of future generations (Mokdad et al., 2016). However, as mentioned above, adolescents are neglected in global health research (Patton, Sawyer, Santelli, et al., 2016), highlighting the need to address the ethical implications and develop strategies to mitigate this oversight.

Charting paths to overcome epistemic injustice in global health research on adolescents

Historically, global health has overlooked adolescents, assuming that youth equates to robust health, thus prioritising other demographic groups (Patton, Sawyer, Santelli, et al., 2016). This neglect reflects a reductionist view of adolescents as a homogenous group. Though generally healthier than older adults or younger children, adolescents have distinct health needs (WHO, 2017). Global health research is essential for designing effective, context-specific adolescent health initiatives. For instance, the strong focus on sexual health—often limited to concerns about sexually transmitted infections and adolescent pregnancies—has overshadowed equally urgent concerns, such as mental health. While sexual health matters, global health metrics like disability-adjusted life years show that mental health issues represent a more prevalent and critical challenge among adolescents (Kieling et al., 2024; Patel et al., 2007; Patton, Sawyer, Santelli, et al., 2016; Piao et al., 2022). Yet adolescents rarely shape these health priorities. Greater epistemic justice would mean not only recognising overlooked issues like mental health, but also including adolescents in identifying them.

This neglect highlights epistemic injustices in global health research: excluding adolescents from knowledge production silences their perspectives, producing incomplete data that fails to address their unique health challenges effectively. Such exclusion exemplifies epistemic injustice and perpetuates epistemological violence by framing adolescents as passive recipients rather than active contributors to global health knowledge and policy development (Teo, 2010). Power imbalances shaped by researchers' privilege, institutional authority, and externally driven research agendas can often prioritise global metrics over local needs. For example, a qualitative study with adolescents in American Samoa demonstrated how pervasive stigma and the absence of open dialogue around mental health discourage help-seeking and, critically, silence young people's experiential knowledge (Blas and Mew, 2024). This culture of silence underscores how structural barriers inhibit adolescents from shaping understandings of their own health, reinforcing epistemic exclusion in global health research and perpetuating inequities in whose realities inform policy and intervention design. Addressing these injustices demands research practices that move beyond token participation to genuinely recognise adolescents as co-producers of knowledge, which is an essential step toward more just, contextually grounded global health interventions.

To address these injustices, global health researchers must adopt a multifaceted approach. First, they must recognise and engage with local interpretations of adolescence, acknowledging cultural variability. Second, researchers should critically examine and challenge the systematic exclusion of adolescents from health research. Finally, ethical frameworks must evolve to promote adolescents' active participation in research, ensuring their voices are heard and valued. By integrating these measures into global health practices, researchers can begin to rectify epistemic injustices and foster a more inclusive and equitable approach to adolescent health.

Culturally appropriate conceptualisations of adolescence

Global health practices carry a colonial legacy (Greene et al., 2019), particularly evident in psychiatry and mental health, where Western diagnostic criteria have been applied in culturally incongruent ways (Fernando, 2014; Summerfield, 2008). This imposition often disregards local epistemologies and culturally specific understandings of health and illness, leading to interventions that lack relevance or efficacy. A similar colonial approach is mirrored when the concept of adolescence is employed in cultural contexts that lack a notion of adolescence or where the understanding of adolescence diverges from Western perspectives. In the West, the term 'adolescence' is inherently tied to notions of 'childhood,' where individuals in this category are not yet considered adults, carrying different social implications and symbolic meanings,

such as authority and legal rights. Applying the category of 'adolescent' to individuals who are regarded as adults in their own cultures can be culturally insensitive and inappropriate. Despite the practical benefits of having a standardised definition of adolescence (e.g. ages 10–19 for the World Health Organisation) in data collection for enhancing data comparability across different settings, global health research must adapt to the cultural contexts of the studied populations. This adaptation involves using culturally specific labels and acknowledging that the concept of adolescence may not universally apply when doing global health.

The recommendation to adapt global health frameworks to culturally specific labels acknowledges that adolescence, as a concept, is not universally applicable as a category of people—and that its use as a data category must be approached critically, with cultural reflexivity and ethical care. However, such adaptation does not negate its importance as a category of data in global health. When transparently and cautiously applied, adolescence can offer a practical lens for identifying developmental health transitions—but its application must not override or obscure how individuals or communities understand their own life stages. Using adolescence as a category of data enables the identification of critical health disparities and trends across regions. For instance, while the socio-cultural markers of adolescence may vary widely, data on biological and psychosocial transitions during this phase, such as puberty or mental health vulnerabilities, remain globally relevant. Therefore, the emphasis on cultural sensitivity does not call for the abandonment of the category of adolescence but rather for a dual approach: maintaining adolescence as a flexible category of data while actively respecting and integrating diverse cultural interpretations of this life stage. By balancing these perspectives, global health can better address the needs of adolescents while avoiding the imposition of a one-size-fits-all framework that risks epistemic and cultural insensitivity.

In research ethics, it is recognised as unethical to exclude individuals from participating in research from which they could benefit (Council for International Organisations of Medical Sciences, 2017). A typical example of this ethical issue is the critique of the underrepresentation of women in HIV drug clinical trials, despite women representing half of the people living with HIV, as drugs may have different social and/or biological effects (Curno et al., 2016). This principle is equally applicable to adolescents, who are often systematically excluded from research on health topics that directly impact them and from which they could benefit (Day et al., 2020; Santelli, 2003). However, there is no global consensus on the minimum age at which adolescents can independently consent to participate in research, as countries vary widely in their age thresholds based on local laws and cultural norms (Day et al., 2020). The prevalent practice of setting the minimum age threshold for research participation at 18 prompts ethical questions, such as: what substantive differentiations (biological, social, neurological, etc.) exist between a 16-year-old and an 18-year-old that would justify excluding the former from studies offering potential benefits? While the autonomy of adolescents is frequently restricted in various aspects of their lives, it is crucial to affirm their right to participate in discussions on matters that affect them (Dockett & Perry, 2011; United Nations, 1991). A key ethical principle supporting this inclusion is democracy, which advocates for engaging young people in defining and implementing policies that will shape their futures (Mabaso et al., 2016). Adolescents deserve to participate in research on topics that concern them and need to be able to contribute to producing global health data.

The researcher-participant relationship must be reconceptualized to actively engage adolescents as co-creators of knowledge. Such reconceptualization can be achieved through participatory research methods, such community-based participatory approaches, which centre adolescents' lived experiences and perspectives. These methodologies not only validate adolescents as credible knowers but also democratise the knowledge production process. For example, in Mozambique, a participatory photovoice project with adolescent girls engaged participants in identifying nutrition-related challenges within their communities, demonstrating how youth-driven insights can directly inform and transform intervention design (Bauler et al., 2025). These methodological approaches can amplify adolescents' voices and also challenge existing power dynamics that can marginalise them within global health frameworks (Okoroji et al., 2023; Shier, 2001).

Developing resources for global health researchers

There are several reasons for the exclusion of adolescents from research. A principal reason is the requirement for parental consent (Day et al., 2020; Weir, 2019). This requirement can be seen as an administrative burden, leading researchers to exclude adolescents in order to simplify the research process (Mustanski, 2011). Additionally, some researchers may mistakenly believe that including adolescents in their studies inherently requires parental consent due to unfamiliarity with research ethics policies (Mathews,

2022). This issue is especially problematic in studies on sensitive topics, such as sexuality or mental health, where requiring parental consent may compel adolescents to disclose stigmatised or private aspects of their lives. For instance, gay adolescents may avoid participation if it means disclosing their sexual orientation to parents (Macapagal & Coventry, 2017; Mustanski & Fisher, 2016), and youth with eating disorders may do the same to maintain privacy (Cavazos-Rehg et al., 2020).

Gatekeeping practices further compound these challenges. School administrators, healthcare providers, or community leaders may restrict access to potential participants, particularly when research involves stigmatised or controversial topics (Spellecy, 2023). Although often well-intentioned, such gatekeeping can inadvertently hinder research that aims to amplify adolescents' voices, especially in global health contexts.

Adolescence is a developmental period often marked by a growing detachment from key adult figures, which can complicate the balance between protecting adolescents and respecting their autonomy in research contexts. Adults, operating from the perspective that they 'know better' and are acting in the adolescent's best interest, may unintentionally marginalise adolescent voices by prioritising protection over participation. This attitude not only undermines adolescents' ability to contribute meaningfully to research but also limits opportunities for mutual knowledge sharing. Acknowledging this dynamic is essential, as it highlights the need for research frameworks that safeguard adolescents' wellbeing while empowering them as active participants in knowledge production. This balance is especially crucial given the evolving capacities of adolescents to provide valuable insights into their lived experiences (UN Committee on the Rights of the Child, 2016; United Nations, 1991).

To address these structural and ethical challenges, institutional research ethics boards (REBs) can play a critical role in supporting the ethical inclusion of adolescents. REBs should provide clear, accessible guidance—for instance, outlining when and how adolescents may participate without parental consent, based on local legal thresholds for 'mature minor' status (Sanci et al., 2004). REBs can also support researchers by offering risk-based consent frameworks (Kopelman, 2004), community consent models (Weijer, 1999), and tools such as referral lists for free emotional and social services.

In some jurisdictions, legal frameworks dictate policies around parental consent requirements for adolescent participation in research, making the context more difficult for global health researchers to change. However, it is crucial to recognise that while parental consent policies aim to protect the wellbeing of adolescents, these policies can lead to epistemic injustices. These injustices prevent adolescents from participating in data production on topics that concern them, ultimately undermining them by silencing their voices and leading to the implementation of health interventions that do not meet their needs (Flicker & Guta, 2008).

Ethical reflection for global health practice

This paper raises critical questions about epistemic justice for the field of global health. A main question is whether adolescence truly exists as an objective universal stage of life or is a cultural construct. Building on this, we must consider how adolescence is defined and understood: should it be based on scientific definitions, or can societies independently define or reject the concept? This reflection leads to questions of authority and power: who holds the legitimacy to define adolescence? Is it grounded in biological processes such as puberty, or through neuroscientific models that map out adolescence in the brain? Alternatively, should adolescence be primarily defined through social and cultural practices, for example, such as *quinceañera* in some Latin American cultures, which mark a girl's entry into womanhood at 15 years old?

Despite these epistemological reflections, the most critical issue for the field of global health is recognising that adolescents (or young people) from the Global South are often ignored in global health research. Addressing this epistemic justice issue is essential for ensuring that global health initiatives adequately represent and address their unique health needs and perspectives. Standardised data collection for young people aged 10–24 is pertinent as it allows for meaningful comparisons of young people between different contexts around the world. In global health, there is insufficient disaggregation of data on adolescents, suboptimal measurement, a lack of well-defined indicators, and limited evidence on the differential impacts of social policies and programs for adolescents (Bhutta & Yount, 2020). Addressing these gaps requires greater governance at the country level and a multisectoral approach to adolescent health that goes beyond the health sector to include education, transportation, communication, and safety

(George and Jacobs, 2021). Ultimately, there must be greater involvement of adolescents and more opportunities for them to be heard on diverse topics that concern them. Exclusion from opportunities to share and create knowledge undermines adolescents' confidence as epistemic agents and reinforces narratives that devalue their experiences. In global health, this lack of recognition perpetuates inequality and weakens the inclusivity and effectiveness of interventions. Meaningful adolescent participation requires creating opportunities, supporting engagement, and embedding participatory practices as a core institutional value, recognising it as both a right and a necessity for decision-making (Shier, 2001). Promoting epistemic justice among adolescents requires culturally sensitive frameworks that address power dynamics and support mechanisms enabling young people to see themselves as 'knowers', such as participatory research practices and co-creation of knowledge within their socio-cultural contexts.

The current gap in research participation for adolescents in global health leads to epistemic injustice, where the voices and experiences of adolescents from marginalised communities and resource-constrained settings are sidelined or omitted, resulting in an incomplete representation of the global adolescent population. This epistemic injustice not only poses a fairness issue but also has real-world consequences for policy and practice. Without comprehensive data and insights from diverse cultural contexts, global health initiatives may fail to effectively address the unique health challenges adolescents worldwide face.

Conclusion

This paper examined the emergence and evolution of the adolescent subject within global health discourses, revealing a persistent epistemic injustice: the marginalisation of voices of adolescents in global health, particularly those from low- and middle-income countries. Addressing this injustice requires an inclusive, equitable, and representative engagement of adolescents as active participants in global health research. Such engagement is not just an ethical necessity but is essential for developing effective, culturally relevant health interventions that resonate with the diverse experiences of adolescents worldwide. Historically, adolescents have been denied meaningful participation in decisions affecting their lives due to various barriers (e.g. societal norms and stereotypes undermining their capabilities, insufficient platforms for youth voices to be heard). Recognising and removing these barriers in global health is crucial to respecting, protecting, and fulfilling adolescents' right to participation in society (Lansdown, 2018). This step is vital for addressing epistemic injustice and ensuring adolescents have a voice in global health discourse (Fricker, 1999, 2017).

Author contributions

JB: conceptualisation and writing.

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The author reports that there are no competing interests to declare.

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Data availability statement

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References

Aries, P. (1960). *L'Enfant et la Vie Familiale sous l'Ancien Régime*. Librairie Plon.

Arnett, J. J., & Taber, S. (1994). Adolescence terminable and interminable: When does adolescence end? *Journal of Youth and Adolescence*, *23*(5), 517–537. https://doi.org/10.1007/BF01537734

Bekker, L. -G., Alleyne, G., Baral, S., Cepeda, J., Daskalakis, D., Dowdy, D., Dybul, M., Eholie, S., Esom, K., Garnett, G., Grimsrud, A., Hakim, J., Havlir, D., Isbell, M. T., Johnson, L., Kamarulzaman, A., Kasaie, P., Kazatchkine, M., Kilonzo, N., …

Weir, B. (2018). Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: The International AIDS Society—Lancet Commission. *The Lancet*, *392*(10144), 312–358. https://doi.org/10.1016/S0140-6736(18)31070-5

Bauler, S., Tse, C., Dos Santos, A., Moises, L., Mbouemboue, N., Young, M., Gittelsohn, J., George, C. M., & Leontsini, E. (2025). Applying photovoice and human-centered design to contextualize an adolescent micronutrient supplementation intervention in Mozambique. *Tropical Medicine and Health*, *53*(1), 85. https://doi.org/10.1186/s41182-025-00768-8

Bedin, V. (2009). *Qu'est-ce que l'adolescence?* Sciences Humaines Éditions.

Bhakuni, H., & Abimbola, S. (2021). Epistemic injustice in academic global health. *The Lancet Global Health*, *9*(10), e1465–e1470. https://doi.org/10.1016/S2214-109X(21)00301-6

Bhutta, Z. A., Yount, K. M., Bassat, Q., & Arikainen, A. A. (2020). Revisiting child and adolescent health in the context of the Sustainable Development Goals. *PLOS Medicine*, *17*(10), e1003449. https://doi.org/10.1371/journal.pmed.1003449

Blas, V., Mew, E. J., Winschel, J., Hunt, L., Soliai Lemusu, S., Lowe, S. R., Naseri, J., Toelupe, R. L. M., Hawley, N. L., & McCutchan-Tofaeono, J. (2024). Community perspectives on adolescent mental health stigma in American Samoa. *PLOS Mental Health*, *1*(5), e0000080. https://doi.org/10.1371/journal.pmen.0000080

Bloom, D. (2012). Youth in the Balance. *Finance & Development*, *49*(1), 6–11.

Blum, R., & Boyden, J. (2018). Understand the lives of youth in low-income countries. *Nature*, *554*(7693), 435–437. https://doi.org/10.1038/d41586-018-02107-w

Burra, N. (2014). 16. Indian Adolescence and Its Discontents: Transformational Solutions Through Education, Skill Development, and Employment. In Bhabha, In J (Ed.), *Human Rights and Adolescence*. 309–325. University of Pennsylvania Press. https://doi.org/10.9783/9780812290110.309

Catalano, R. F., Fagan, A. A., Gavin, L. E., Greenberg, M. T., Irwin, C. E., Ross, D. A., & Shek, D. T. (2012). Worldwide application of prevention science in adolescent health. *The Lancet*, *379*(9826), 1653–1664. https://doi.org/10.1016/S0140-6736(12)60238-4

Cavazos-Rehg, P., Min, C., Fitzsimmons-Craft, E. E., Savoy, B., Kaiser, N., Riordan, R., Krauss, M., Costello, S., & Wilfley, D. (2020). Parental consent: A potential barrier for underage teens' participation in an mHealth mental health intervention. *Internet Interventions*, *21*, 100328. https://doi.org/10.1016/j.invent.2020.100328

Chambon, A. S., Irving, A., Epstein, L. (Eds.). (1999). *Reading Foucault for social work*. Columbia University Press.

Clark-Kazak, C. R. (2009). Towards a Working Definition and Application of Social Age in International Development Studies. *Journal of Development Studies*, *45*(8), 1307–1324. https://doi.org/10.1080/00220380902862952

Council for International Organizations of Medical Sciences. (2017). *International ethical guidelines for health-related research involving humans*. CIOMS.

Curno, M. J., Rossi, S., Hodges-Mameletzis, I., Johnston, R., Price, M. A., & Heidari, S. (2016). A Systematic Review of the Inclusion (or Exclusion) of Women in HIV Research: From Clinical Studies of Antiretrovirals and Vaccines to Cure Strategies. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *71*(2), 181–188. https://doi.org/10.1097/QAI.0000000000000842

Dahl, R. E., Allen, N. B., Wilbrecht, L., & Suleiman, A. B. (2018). Importance of investing in adolescence from a developmental science perspective. *Nature*, *554*(7693), 441–450. https://doi.org/10.1038/nature25770

Day, S., Kapogiannis, B. G., Shah, S. K., Wilson, E. C., Ruel, T. D., Conserve, D. F., Strode, A., Donenberg, G. R., Kohler, P., Slack, C., Ezechi, O., & Tucker, J. D. (2020). Adolescent participation in HIV research: Consortium experience in low and middle-income countries and scoping review. *The Lancet HIV*, *7*(12), e844–e852. https://doi.org/10.1016/S2352-3018(20)30269-1

Dockett, S., & Perry, B. (2011). Researching with Young Children: Seeking Assent. *Child Indicators Research*, *4*(2), 231–247. https://doi.org/10.1007/s12187-010-9084-0

Dotson, K. (2014). Conceptualizing epistemic oppression. *Social Epistemology*, *28*(2), 115–138. https://doi.org/10.1080/02691728.2013.782585

Fernando, S. (2014). *Mental Health Worldwide*. Palgrave Macmillan UK. https://doi.org/10.1057/9781137329608

Feuillet-Liger, B. (2012). Adolescents and medical treatment: a common Reality? In In B Feuillet-Liger, I. Ryuichi, & T. Callus (Eds.), *Adolescents, Autonomy and Medical Treatment: Divergence and Convergence Across the Glob* (pp. 323–341). Édition Bruylant.

Flicker, S., & Guta, A. (2008). Ethical approaches to adolescent participation in sexual health research. *Journal of Adolescent Health*, *42*(1), 3–10. https://doi.org/10.1016/j.jadohealth.2007.07.017

Foucault, M. (1976). *Histoire de la sexualité vol.1: La volonté de savoir*. Éditions Gallimard.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, *8*(4), 777–795. https://doi.org/10.1086/448181

Fricker, M. (1999). Epistemic oppression and epistemic privilege. *Canadian Journal of Philosophy Supplementary Volume*, *25*, 191–210. https://doi.org/10.1080/00455091.1999.10716836

Fricker, M. (2017). Evolving concepts of epistemic injustice. In Kidd, In IJ, Medina, J., Pohlhaus, G. Jr. ((Eds.), *The Routledge handbook of epistemic injustice*. 53–60. Routledge. https://doi.org/10.4324/9781315212043-5

Frota, A. M. M. C. (2007). Diferentes concepções da infância e adolescência: A importância da historicidade para sua construção. *Estudos e Pesquisas En Psicologia*, *7*(1), 144–157.

George, A., Jacobs, T., Ved, R., Jacobs, T., Rasanathan, K., & Zaidi, S. A. (2021). Adolescent health in the Sustainable Development Goal era: Are we aligned for multisectoral action? *BMJ Global Health*, *6*(3), e004448. https://doi.org/10.1136/bmjgh-2020-004448

Goldsmith, M. F. (1993). Invisible" epidemic now becoming visible as HIV/AIDS pandemic reaches adolescents. *JAMA: The Journal of the American Medical Association*, *270*(1), 16. https://doi.org/10.1001/jama.1993.03510010018004

Grabska, K., de Regt, M., & Del Franco, N. (2019). *Adolescent Girls' migration in the global south: Transitions into adulthood* (Vol. *2019*, 1st ed.). Springer International Publishing: Imprint: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-00093-6

Greene, J., Thorp Basilico, M., Kim, H., & Farmer, P. (2019). 3. Colonial medicine and its legacies. In Farmer, In P, Kleinman, A., Kim, J., Basilico, M. (Eds.), *Reimagining Global Health*. 33–73. University of California Press. https://doi.org/10.1525/9780520954632-005

Hall, G. S. (1904). *Adolescence: Its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion and education* (Vol. 1–2). D. Appleton and Company.

Hardin, A. P., Hackell, J. M., Simon, G. R., Boudreau, A. D. A., Meade, K. E., Baker, C. N., Barden, G. A., Moore, S. B., & Richerson, J. Committee on practice and ambulatory medicine. (2017). Age Limit of Pediatrics. *Pediatrics*, *140*(3, e20172151. https://doi.org/10.1542/peds.2017-2151

Heissler, K. (2011). We are poor people so what is the use of education?' tensions and contradictions in girls' and boys' transitions from school to work in rural bangladesh. *The European Journal of Development Research*, *23*(5), 729–744. https://doi.org/10.1057/ejdr.2011.40

Johnson, S. B., Blum, R. W., & Giedd, J. N. (2009). Adolescent maturity and the brain: The promise and pitfalls of neuroscience research in adolescent health policy. *Journal of Adolescent Health*, *45*(3), 216–221. https://doi.org/10.1016/j.jadohealth.2009.05.016

Kagesten, A. E., Wallengren, E., Newby, H., Moller, A. -B., Marsh, A. D., & Regina, G. (2023). 81. How well do the Sustainable Development Goals (SDGs) capture adolescent health? A systematic mapping of age disaggregation, relevance and gaps across the SDG indiCators. *Journal of Adolescent Health*, *72*(3), S48. https://doi.org/10.1016/j.jadohealth.2022.11.102

Kieling, C., Buchweitz, C., Caye, A., Silvani, J., Ameis, S. H., Brunoni, A. R., Cost, K. T., Courtney, D. B., Georgiades, K., Merikangas, K. R., Henderson, J. L., Polanczyk, G. V., Rohde, L. A., Salum, G. A., & Szatmari, P. (2024). Worldwide prevalence and disability from mental disorders across childhood and adolescence: evidence from the global burden of disease study. *JAMA Psychiatry*, *81*(4), 347. https://doi.org/10.1001/jamapsychiatry.2023.5051

Kleinert, S., & Horton, R. (2016). Adolescent health and wellbeing: A key to a sustainable future. *The Lancet*, *387*(10036), 2355–2356. https://doi.org/10.1016/S0140-6736(16)30297-5

Kopelman, L. M. (2004). Minimal risk as an international ethical standard in research. *The Journal of Medicine and Philosophy*, *29*(3), 351–378. https://doi.org/10.1080/03605310490500545

Lansdown, G. (2018). *Conceptual framework for measuring outcomes of adolescent participation*. UNICEF.

Lansford, J. E., & Banati, P. (2018). *Conclusions* (Vol. *1*). Oxford University Press. https://doi.org/10.1093/oso/9780190847128.003.0023

Ledford, H. (2018). Who exactly counts as an adolescent?. *Nature*, *554*(7693), 429–431. https://doi.org/10.1038/d41586-018-02169-w

Lerner, R. M., Steinberg, L. D. (Eds.). (2009). *Handbook of adolescent psychology*. Wiley.

Li, Z., Li, M., Patton, G. C., & Lu, C. (2018). Global development assistance for adolescent health from 2003 to 2015. *JAMA Network Open*, *1*(4), e181072. https://doi.org/10.1001/jamanetworkopen.2018.1072

Mabaso, Z., Erogbogbo, T., & Toure, K. (2016). Young people's contribution to the *Global strategy for women's, children's and adolescents' health (2016–2030)*. *Bulletin of the World Health Organization*, *94*(5), 312–312. https://doi.org/10.2471/BLT.16.174714

Macapagal, K., Coventry, R., Arbeit, M. R., Fisher, C. B., & Mustanski, B. (2017). I Won't Out Myself Just to Do a Survey": Sexual and Gender Minority Adolescents' Perspectives on the Risks and Benefits of Sex Research. *Archives of Sexual Behavior*, *46*(5), 1393–1409. https://doi.org/10.1007/s10508-016-0784-5

Mathews, B. (2022). Adolescent Capacity to Consent to Participate in Research: A Review and Analysis Informed by Law, Human Rights, Ethics, and Developmental Science. *Laws*, *12*(1), 2. https://doi.org/10.3390/laws12010002

McDonagh, J. E., Ambresin, A. -E., Boisen, K. A., Fonseca, H., Jakobsson Kruse, P., Meynard, A., Stronski, S., Michaud, P. -A., & Takeuchi, Y. L. (2018). The age of adolescence and young adulthood. *The Lancet Child & Adolescent Health*, *2*(4), e6. https://doi.org/10.1016/S2352-4642(18)30079-8

Mokdad, A. H., Forouzanfar, M. H., Daoud, F., Mokdad, A. A., El Bcheraoui, C., Moradi-Lakeh, M., Kyu, H. H., Barber, R. M., Wagner, J., Cercy, K., Kravitz, H., Coggeshall, M., Chew, A., O'Rourke, K. F., Steiner, C., Tuffaha, M., Charara, R., Al-Ghamdi, E. A., Adi, Y., … Patton, G. C. (2016). Global burden of diseases, injuries, and risk factors for young people's health during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, *387*(10036), 2383–2401. https://doi.org/10.1016/S0140-6736(16)00648-6

Moraes, B. R. D., & Weinmann, A. D. O. (2020). Notas sobre a história da adolescência. *Estilos Da Clinica*, *25*(2), 280–296. https://doi.org/10.11606/issn.1981-1624.v25i2p280-296

Moran, J. P. (2000). *Teaching sex: The shaping of adolescence in the 20th century*. Harvard Univ. Press.

Mustanski, B. (2011). Ethical and regulatory issues with conducting sexuality research with LGBT adolescents: a call to action for a scientifically informed approach. *Archives of Sexual Behavior*, *40*(4), 673–686. https://doi.org/10.1007/s10508-011-9745-1

Mustanski, B., & Fisher, C. B. (2016). HIV Rates Are Increasing in Gay/Bisexual Teens. *American Journal of Preventive Medicine*, *51*(2), 249–252. https://doi.org/10.1016/j.amepre.2016.02.026

Nagata, J. M., Ferguson, B. J., & Ross, D. A. (2016). Research priorities for eight areas of adolescent health in low- and middle-income countries. *Journal of Adolescent Health*, *59*(1), 50–60. https://doi.org/10.1016/j.jadohealth.2016.03.016

Newman, P. A., Reid, L., Lacombe-Duncan, A., Tepjan, S., & Ramsundarsingh, S. (2022). A methodological scoping review of qualitative research on LGBTQ + bullying victimization: Implications for diversity, equity, and inclusion. *Journal of Gay & Lesbian Social Services*, *34*(4), 521–555. https://doi.org/10.1080/10538720.2022.2044424

O'Donohue, W. T., Benuto, L. T., Tolle, L. W. (Eds.). (2013). *Handbook of adolescent health psychology*. Springer.

Okoroji, C., Mackay, T., Robotham, D., Beckford, D., & Pinfold, V. (2023). Epistemic injustice and mental health research: A pragmatic approach to working with lived experience expertise. *Frontiers in Psychiatry*, *14*, 1114725. https://doi.org/10.3389/fpsyt.2023.1114725

Passmore, S. R., Kisicki, A., Gilmore-Bykovskyi, A., Green-Harris, G., & Edwards, D. F. (2022). There's not much we can do…" researcher-level barriers to the inclusion of underrepresented participants in translational research. *Journal of Clinical and Translational Science*, *6*(1), e4. https://doi.org/10.1017/cts.2021.876

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*(9569), 1302–1313. https://doi.org/10.1016/S0140-6736(07)60368-7

Patton, G. C., Sawyer, S. M., Ross, D. A., Viner, R. M., & Santelli, J. S. (2016). From advocacy to action in global adolescent health. *Journal of Adolescent Health*, *59*(4), 375–377. https://doi.org/10.1016/j.jadohealth.2016.08.002

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., … Ssewamala, F. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet*, *387*(10036), 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Pettifor, A., & Subramaniam, H. (2018). *HIV Prevention Among Adolescents* (Vol. *1*). Oxford University Press. https://doi.org/10.1093/oso/9780190847128.003.0019

Piao, J., Huang, Y., Han, C., Li, Y., Xu, Y., Liu, Y., & He, X. (2022). Alarming changes in the global burden of mental disorders in children and adolescents from 1990 to 2019: A systematic analysis for the Global Burden of Disease study. *European Child & Adolescent Psychiatry*, *31*(11), 1827–1845. https://doi.org/10.1007/s00787-022-02040-4

Quentel, J.-C. (2008). L'adolescence: Une nouvelle place à défnir. L'école Des Parents, Fédération. *Nationale Des Ecoles de Parents et Des Educateurs*, 5–8.

Rozzi, E. (2014). Transitions to adulthood in contemporary italy: balancing sociocultural differences and universal rights, *Human Rights and Adolescence* (pp. 39–58). University of Pennsylvania Press.

Sanci, L. A., Sawyer, S. M., Weller, P. J., Bond, L. M., & Patton, G. C. (2004). Youth health research ethics: Time for a mature-minor clause? *Medical Journal of Australia*, *180*(7), 336–338. https://doi.org/10.5694/j.1326-5377.2004.tb05969.x

Santelli, J. (2003). Guidelines for adolescent health research, a position paper of the society for adolescent medicine. *Journal of Adolescent Health*, *33*(5), 396–409. https://doi.org/10.1016/j.jadohealth.2003.06.009

Sawyer, S. M., & Patton, G. C. (2018). *Health and well-being in adolescence* (Vol. *1*). Oxford University Press. https://doi.org/10.1093/oso/9780190847128.003.0002

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The Lancet Child & Adolescent Health*, *2*(3), 223–228. https://doi.org/10.1016/S2352-4642(18)30022-1

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S. -J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: A foundation for future health. *The Lancet*, *379*(9826), 1630–1640. https://doi.org/10.1016/S0140-6736(12)60072-5

Sebaa, F. Z. (2009). L'adolescence en question(s). *Insaniyat*, *46*, 33–44. https://doi.org/10.4000/insaniyat.357

Sheehan, P., Sweeny, K., Rasmussen, B., Wils, A., Friedman, H. S., Mahon, J., Patton, G. C., Sawyer, S. M., Howard, E., Symons, J., Stenberg, K., Chalasani, S., Maharaj, N., Reavley, N., Shi, H., Fridman, M., Welsh, A., Nsofor, E., & Laski, L. (2017). Building the foundations for sustainable development: A case for global investment in the capabilities of adolescents. *The Lancet*, *390*(10104), 1792–1806. https://doi.org/10.1016/S0140-6736(17)30872-3

Shier, H. (2001). Pathways to participation: Openings, opportunities and obligations. *Children & Society*, *15*(2), 107–117. https://doi.org/10.1002/chi.617

Sompolska-Rzechuła, A., & Kurdyś-Kujawska, A. (2022). Generation of young adults living with their parents in European Union Countries. *Sustainability*, *14*(7), 4272. https://doi.org/10.3390/su14074272

Spellecy, R. (2023). Representing and protecting: Gatekeepers in community-engaged research. In In EE Anderson (Ed.), *Ethical Issues in Community and Patient Stakeholder–Engaged Health Research. Philosophy and medicine* (Vol. *146*, pp. 171–180). Springer International Publishing. https://doi.org/10.1007/978-3-031-40379-8_13

Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., Coll-Seck, A. M., Grover, A., Laski, L., Roa, M., Sathar, Z. A., Say, L., Serour, G. I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers, C., & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher– Lancet Commission. *The Lancet*, *391*(10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *BMJ*, *336*(7651), 992–994. https://doi.org/10.1136/bmj.39513.441030.AD

Teo, T. (2010). What is epistemological violence in the empirical social sciences? What is epistemological violence in the empirical social sciences? *Social and Personality Psychology Compass*, *4*(5), 295–303. https://doi.org/10.1111/j.1751-9004.2010.00265.x

UN Committee on the Rights of the Child. (2016). General comment No. 20 (2016) on the implementation of the rights of the child during adolescence. https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-20-2016-implementation-rights

United Nations Population Fund. (2014). *The power of 1.8 billion: Adolescents, youth and the transformation of the future.* United Nations Population Fund.

United Nations. (1991). Convention on the Rights of the Child. United Nations.

Vandermorris, A., & Bhutta, Z. A. (2017). How Canada can help global adolescent health mature. *Reproductive Health*, *14*(1), 94. https://doi.org/10.1186/s12978-017-0353-y

Verhoog, S., Eijgermans, D. G. M., Fang, Y., Bramer, W. M., Raat, H., & Jansen, W. (2024). Contextual determinants associated with children's and adolescents' mental health care utilization: A systematic review. *European Child & Adolescent Psychiatry*, *33*(7), 2051–2065. https://doi.org/10.1007/s00787-022-02077-5

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet*, *379*(9826), 1641–1652. https://doi.org/10.1016/S0140-6736(12)60149-4

Wang, Z., Asokan, G., Onnela, J. -P., Baird, D. D., Jukic, A. M. Z., Wilcox, A. J., Curry, C. L., Fischer-Colbrie, T., Williams, M. A., Hauser, R., Coull, B. A., & Mahalingaiah, S. (2024). Menarche and time to cycle regularity among individuals born between 1950 and 2005 in the US. *JAMA Network Open*, *7*(5), e2412854. https://doi.org/10.1001/jamanetworkopen.2024.12854

Weijer, C. (1999). Protecting communities in research: Philosophical and pragmatic challenges. *Cambridge Quarterly of Healthcare Ethics*, *8*(4), 501–513. https://doi.org/10.1017/S0963180199004120

Weir, K. (2019). Studying adolescents without parents' consent: A new APA resolution supports mature minors' participation in research without parental permission. *American Psychological Association*, *50*(2), 1–20.

White, P. H., Greenlee, C., & Cooley, W. C. (2015). Differing opinions on upper age limit for pediatrics. *Pediatrics*, *136*(6), e1682. https://doi.org/10.1542/peds.2015-3204A

WHO. (2015). Every woman, every child, every adolescent: Achievements and prospects: the final report of the independent Expert Review Group on Information and Accountability for Women's and Children's health. World Health Organization. https://iris.who.int/handle/10665/183585

WHO. (2017). Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation. World Health Organization. https://iris.who.int/handle/10665/255415

WHO. (2023). Coming of age: Adolescent health. https://www.who.int/news-room/spotlight/coming-of-age-adolescent-health

Worthman, C. M., & Trang, K. (2018). Dynamics of body time, social time and life history at adolescence. *Nature*, *554*(7693), 451–457. https://doi.org/10.1038/nature25750