CHIEF DIRECTORATE: Maternal, Child and Woman's Health
DIRECTORATE: Child and Youth Health
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EXECUTIVE SUMMARY
These are the first national policy guidelines for South African adolescents and youth (people aged 10 to 24 years). They were developed during a two-year process involving young people themselves, as well as government departments and non-governmental organisations in various sectors. They appear at a time when there is increasing international recognition that dedicating resources to adolescent and youth health is one of the most important cost-effective long-term investments a society can make. The framework on which these guidelines are based was developed by the Adolescent Health and Development Programme of the World Health Organisation, in collaboration with the United Nations Population Fund and the United Nations Children's Fund.

There are two strands that weave through these policy guidelines: first, preventing and responding to specific health problems in adolescents and youth, such as unsafe sexual behaviour; and second, promoting the healthy development of all adolescents and youth. Healthy development includes the development of capacities, attributes and opportunities that promote the health of young people. The focus is on the positive potential of young people as opposed to the "problems" they manifest.

There are six guiding principles for adolescent and youth health that underlie these policy guidelines. First, adolescent development underlies the prevention of health problems. The interventions that are most successful in preventing specific health problems invariably do so by addressing developmental needs. The challenge for people developing programmes in adolescent and youth health is to move beyond the impulse to respond to immediate problems and to put in place interventions that promote adolescent and youth development.

Second, problems are interrelated. It is a common finding from studies in several parts of the world that problems tend to cluster together. Thus, those that engage in sexual risk behaviour, for example, are also more likely to abuse alcohol, smoke cigarettes, perpetrate acts of violence, behave in an unsafe manner on the roads, and make suicide attempts. One should thus aim to develop interventions that address the common roots of this cluster of behaviours.

Third, adolescence and youth are times of opportunity and risk. Much of the risk is related to the development of a sense of identity. Thus, many of the decisions taken in adolescence and youth have an influence throughout the life span. Interventions during this phase can yield amplified benefits since their effects can be manifest throughout the life span. Also, a certain amount of risk taking is essential for healthy development. The challenge for policy development is to help young people to find ways in which such risk taking will positive consequences.

Fourth, the social environment influences behaviour. Aspects of the social environment that can have this effect include relationships with friends, parents and other family members, and other key adults such as school teachers and sports coaches; social attitudes and norms; and policies. In South Africa, the social environment is to a large extent determined by apartheid policies of the pre-1994 government.

Fourth, not all young people are equally vulnerable. In particular, specific intervention strategies are necessary for those who are "homeless", with disabilities, in places of safety and children's homes, in conflict with the law, who are abandoned, abused and neglected, living with HIV/AIDS, returned-from exile, and young women and single mothers, and orphans (including "AIDS orphans").

Fifth, gender considerations are fundamental for adolescent and youth health, mainly because they are important determinants of access to economic resources, social services and other opportunities. There are five general intervention strategies for adolescent and youth health: promoting a safe and supportive environment, which includes relationships with families, social norms and cultural practises, mass media, accessibility of key opportunities and commodities, and policies (including legislation); providing information; building skills; counselling; and access to health services.

These general strategies can be utilised to address the common roots of a range of problems. One of the strategies, for example, is building skills. On a general level, communication, for example, is a general life skill that enhances capacity to make healthy choices in a variety of domains. However, the specific life skills required vary between situations.

Each of these general intervention strategies can be applied in various settings, such as the: home, school, health facilities, workplace, street,
community-based organisation and residential centre.
The settings differ according to the type of general strategy for which they are best suited, the populations of young people they are likely to reach and the spheres of a young person's life on which they are likely to impact. Not all general strategies are necessarily appropriate for each setting. However, in principle one can consider a matrix, with general strategies on one axis and settings on another. The more comprehensive an adolescent and youth policy, the more general strategies would exist for each of the settings.
Also, for each particular health problem, such a matrix can be created. However, the main thrust of adolescent and youth policy guidelines should be on an integrated, horizontal programming as opposed to problem-specific, vertical intervention efforts. Nonetheless, each health priority is characterised by unique considerations, which are addressed in the final section of the policy guidelines. The following eight health priorities are included:
sexual and reproductive health;
mental health;
substance abuse;
vioence;
unintentional injuries;
birth defects and inherited disorders;
nutrition; and
oral health.
For each health priority, a brief situation analysis is provided, followed by remarks about the impact of the health priority on the health of adolescents and youth. The core of each health priority consists of a list of intervention strategies for this priority. These strategies are listed as examples of the general intervention strategies that were listed above. Finally, examples of indicators are provided.
The responsibility for the implementation of national health policy lies with the provincial departments of health. Partly for this reason, an attempt has been made to avoid being too specific or detailed in programme recommendations. It is hoped that the framework that is presented in these policy guidelines can be used by provincial health departments to develop policies that address their specific health priorities, policies and fiscal restraints.

ABBREVIATIONS
AIDS: Acquired Immuno-Deficiency Syndrome
ATICC: Aids Training, Information and Counselling Centre
CBO: Community Based Organization
CBR: Community Based Rehabilitation
CLIG: Child Labour Inter-Sectoral Group
CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women
CEDPA: Centre for Development and Population Centre
CRC: Convention on the Rights of the Child
CToP: Choice on Termination of Pregnancy
DoH: Department of Health
GEAR: Growth Economic and Restribution
HIV: Human Immuno-Deficiency Virus
IEC: Information, education and communication
ICPD: International Conference on Population and Development
IUPHC: Institute for Urban Primary Health Care
INP: Integrated Nutrition Programme
NASHI: National Adolescent Sexual Health Initiatives
NCESS: National Committee on Education and Support services
NCSNET: National Commission on Special Needs in Education and Training
MCWH: Maternal Child and Women's Health
MEDICOS: Medical Institute of Community Services
MRC: Medical Research Council
NGO: Non-governmental organisation
PHC: Primary health care
RHRU: Reproductive Health Research Unit
PREAMBLE

According to the 1996 census, there are 8 834 816 million adolescents (people aged 10 to 19 years) and 8 173 069 youth (people aged 15 to 24 years) in South Africa. These groups comprised 21.77% and 20.14% of the total population respectively. The 17 007 885 adolescents and youth together (or young people) comprise 41.91% of the population. (The South Africa Population Census, 1996 Report No: 03-01-11 [11996]

This is a very diverse group of people. At the one extreme, they are not yet sexually mature and would generally be regarded as children. At the other extreme, most are fully integrated into adult society and many have children of their own. There is also variation between individuals of the same age, depending on factors such as gender, level of physical, psychological and social development, and environmental and cultural factors.

Despite this wide variation in the lives of young people, it is commonly believed that all their subgroups are characterised by relatively good health. It is indeed the case that mortality rates are relatively low in these age groups. However, a large proportion of deaths of adolescents and youth are preventable. In South Africa, for example, it has been documented that approximately two thirds of all deaths of adolescents aged 15 to 19 years are due to external causes such as assault and traffic "accidents", which are preventable.3 Also, there are health problems that are particularly important in adolescence and youth, such as unsafe sexual behaviour, tobacco and other substance use, suicide and road traffic "accidents", all of which will receive further attention below.2 Some of these problems have more serious consequences for adolescents and youth than for older people, such as obstetric complications in very young mothers. Other problems, such as substance abuse and dependence, require different intervention strategies for young people compared to older people. Preventing and responding to specific health problems in adolescents and youth comprises one strand that weaves through these policy guidelines. The other is the promotion of healthy development of all young people, whether they have or are at risk for "problems" or not. Healthy development includes the development of capacities, attributes and opportunities that promote the health of the young person. These may include aspects such as life skills, income generating opportunities, education, respect and being listened to, establishing a sense of self, identity and value, positive role models and assistance in maintaining or re-establishing relationships with families. The focus of the promotion of healthy development is on the positive potential of young people as opposed to the "problems" that they manifest.

Of course, there are a range of fundamental social conditions that are essential for adolescent health, such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, equity. These fundamental conditions are essential for two interrelated reasons. First, they can affect the mental, physical and social well-being of adolescents and youth. Unemployment, for example, can reduce physical well-being (through insufficient income for food) and mental wellbeing (through reduced self esteem). Second, they can have an impact on the effectiveness of interventions. Adolescents, for example, are unlikely to be receptive to information about the importance of safer sex practices if they are homeless and dependent on income derived from commercial sex. Despite their salience for the health of adolescents and youth, such fundamental conditions will not be addressed in these policy guidelines. They constitute components of national reconstruction and development, and are being addressed by other sectors. The involvement of other sectors is also necessary to address the specifically health needs of adolescents and youth. This is reflected in the team that has developed these policy guidelines, who are listed in Appendix A.
Young people have been involved in the development of these policy guidelines, for example through the participation of the National and some provincial Youth Commissions. Adolescent and youth involvement is crucial not only for the development of adolescent and youth policy, but also for its implementation. Indeed, young people have traditionally tended to help their families, which can provide a natural starting point for involvement in health promotion. They often display an enthusiasm, idealism, creativity and imagination that can add impetus and substance to projects. Active endorsement by adolescents and youth, which is facilitated by involvement in all stages of policy development and implementation, increases the chances of successful dissemination of policy and perfusion of programmes. Finally, such involvement can enhance psychosocial development through factors such as contributing to the well being of the community, working alongside older people and achieving social recognition.

The process of developing these national policy guidelines commenced in October 1997, when a list of health priorities was identified by the Youth and Adolescent Health Task Team (Appendix A). This list was sent to all the provinces for them to provide contributions, which were discussed by the Task Team before they finalised the list of health priorities. Compilation of the first draft of the policy guidelines then started through a consultative process involving all relevant role players. These role players provided the Sub-directorate: Adolescent and Youth Health with information, opinions and referrals to relevant research. In addition, a series of tri-provincial workshops were organised, each of which lasted two days, at which further input was provided. These processes comprised the basis of the second draft of the policy guidelines, which was sent to all the provinces and to other role players for their comments, inputs and recommendations. These were presented at the first national workshop, which took place in September 1998. The third draft was produced after the national workshop. A consultant, Professor Alan Flisher, was appointed in February 1999. He was requested to refine and restructure the policy guidelines in consultation with the Sub-directorate and the Task Team. A second national workshop was held in June 1999, at which suggestions were made for further improvements.

These are the first national policy guidelines for adolescent and youth health in South Africa. Adolescent and youth health was not a government priority prior to 1994:

In the past, the apartheid state violated not only the rights and opportunities of young people through its repressive and discriminatory policies. It also ignored the special needs and concerns of youth. Young people were left to find their own way in a divided and volatile society - to varying degrees brutalised as master and servant alike.

- President Nelson Mandela, 1997

These policy guidelines appear at a time when there is increasing international recognition that dedicating resources to adolescent and youth health is one of the most important cost-effective long-term investments a society can make. The Adolescent Health and Development Programme of the World Health Organisation, in collaboration with other United Nations (UN) agencies such as the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), have played a major role in providing leadership and intellectual and technical support in promoting the health of adolescents. Indeed, the framework on which these policy guidelines is based was derived at a Study Group convened by these three agencies.8'9

The principle aim of this framework is to inform efforts aimed at either preventing and responding to health problems or the promotion of healthy development. The guidelines recognise that many programmes that impact on adolescent and youth health are based in other sectors such as education, welfare and correctional services. Such programmes should be actively supported by the health sector. However, the framework presented in these policy guidelines may suggest ways in which such programmes should be complemented or improved.

The guidelines also recognise that responsibility for the implementation of national health policy lies with the provincial health departments and not the national Department of Health. Partly for this reason, an attempt has been made to avoid becoming too specific or detailed in programme recommendations. It will be necessary for the provincial health departments to use the general framework to develop their own policies in a manner that recognises their specific health priorities, policies and fiscal constraints.

This document has a further four sections. Section 2 summarises key existing policy, legislative and treaty commitments that have a direct bearing on adolescent and youth health. This is necessary since policy,
legislation and treaties can contribute to the creation of an enabling environment, or have the opposite effect. It is necessary to situate these adolescent and youth health policy guidelines in the context of existing commitments. It is, for example, superfluous to develop new policy in a specific area if policy, already exists in this regard. Also, the present policy guidelines should be consistent with and support existing commitments. Section 2 will not include any material that is specific for a content area. Such specific material will be included where relevant below, when specific health priorities are addressed. Also, relevant legislation and policy documents for each health priority are listed in Appendix B.

Section 3 briefly reviews the six key guiding concepts for adolescent and youth health. One of these guiding concepts is that problems have common roots and are interrelated. This obviously has implications for the present policy guidelines. Thus, if one accepts the validity of this guiding principle, one would be disinclined to focus exclusively on specific health problems. One would rather aim to develop general strategies that address the common roots of a range of problems. By so doing, positive outcomes for a range of problems would be demonstrated.

Section 4 presents five such general strategies. Clearly, the specifics of these strategies would vary according to the problems being addressed. One of these strategies, for example, is building skills. On a general level, communication is a general life skill that enhances a young person's capacity to make healthy choices in a variety of domains.

However, the specific communication skills required to make such healthy choices differ somewhat between, say, those necessary to persuade an unwilling partner to use a condom and those necessary to refuse an unwanted cigarette. Section 4 will not address the problem-specific dimensions of the general strategies, which will receive attention below dealing with selected health priorities.

Section 5 introduces the important settings in which the general strategies presented in Section 4 can be applied. The settings differ according to the type of general strategy for which they are best suited, the populations of young people they are likely to reach and the spheres of a young person's life upon which they impact. Not all general strategies are appropriate for each setting. However, in principle one can consider a matrix, with general strategies on the one axis and settings on the other. The more comprehensive an adolescent and youth health policy, the more general strategies would exist for each of the settings.

It is only in Section 6, the final section of these policy guidelines, that specific health priorities are addressed. As implied above, the main thrust of an adolescent and youth health policy should be on integrated, horizontal programming as opposed to problem specific, vertical intervention efforts. Nonetheless, each health priority is characterised by unique considerations, which are addressed in this section. There is inevitably a tension between the need to consider adolescent and youth health in a holistic manner and the existence of pressing public health problems (such as high rates of HIV infection) that beg for solutions. These policy guidelines do not aim to abolish such tension, but rather to ensure that both aspects receive sufficient policy attention. For each health priority, where appropriate, there will be four sections: situation analysis; impact; intervention strategies (presented in terms of the five general strategies mentioned in Section 4); and examples of indicators.

It is necessary to emphasise that the list of indicators provided for each health priority represents examples of the kinds of indicators that might be appropriate to assess the impact of intervention strategies. Clearly, the precise indicators selected will flow from the objectives of intervention activities. Ideally, they will be feasible to collect, valid across cultures, repeatable, and simple and inexpensive. The examples of indicators are derived mainly from the work of Solum Donas and the WHO. In most cases, the indicators should be made more specific depending on the particular rationale for their use. For example, an indicator could be provided for a particular age group, gender, socio-economic level, province or district.

In addition to the indicators provided, there are a number of other important indicators that are not associated with specific health priorities, such as health service utilisation rates and proportions of health facilities that are "youth friendly". Clearly, a comprehensive monitoring system should not overlook these more generic indicators.

Finally, in several places in these policy guidelines, data are disaggregated by racial categories as defined in the Population Registration Act promulgated by the apartheid government. Clearly, such racial categories were created and used for purposes of political and socio-economic oppression. Use of these racial categories in these guidelines does not imply acceptance of their scientific or anthropological validity. They are used either to draw attention to groups that are particularly at risk on the basis of historical inequities, or because data are available only for specific subgroups of the population. In the latter cases, it was thought to be
preferable to present such limited data rather than no data at all.

2. CURRENT LEGAL, POLICY & TREATY FRAMEWORK


On 16 June 1995, the South African Government ratified the UN Convention on the Rights of the Child (CRC), which is an internationally endorsed set of fundamental rights for all children. This is relevant for these guidelines since "children" includes all those aged 18 years and less.

The National Programme of Action for Children in South Africa (NPA) is the instrument by which South Africa's commitments to children in terms of the CRC. It is a mechanism for identifying all plans for children developed by government departments, NGO's and other child-related structures, and for ensuring that all these plans converge in the framework provided by the CRC, the goals of the 1990 World Summit on Children and the Reconstruction and Development Programme.” The NPA is thus not a separate plan; it is rather an integration of existing policies and plans. The NPA has identified several policy priorities for children, one of which is child and maternal health. All of the goals for this priority either address issues that predominantly affect infants or young children, or maternal morbidity or mortality. The health needs of adolescents and youth do not receive the specific attention they deserve. However, the development of programmes to deal with adolescent health is offered as one of several national strategies. In addition, other such programmes potentially have obvious relevance for adolescents and youth, such as HIV/AIDS, injury prevention and mental health services. Also, in the Initial Country Report for the CRC, 12 youth health receives attention. One aspect that is explicitly mentioned is the Task Team for Youth and Adolescent Health that is centrally involved in the development of these policy guidelines. These guidelines thus give concrete expression to South Africa's obligations in terms of the CRC.

2.2 The constitution of the Republic of South Africa

The constitution sets the broad policy context for these policy guidelines. The Bill of rights, for example, has a section dealing specifically with the rights of children. Since children are defined in the Constitution as people under the age of 18 years, these rights would be applicable to many adolescents as defined in these policy guidelines (i.e. those aged 10 to 19 years). Among the rights of children are the rights to: family or parental care; basic nutrition; basic health care services and social services; and to be protected from maltreatment, neglect, abuse or degradation. Clearly, many of these rights are particularly pertinent to the health of young people. These policy guidelines could be regarded as giving expression to some of the rights of children that are included in the Bill of Rights.

Another aspect of the broad policy context for these national policy guidelines is the powers, responsibilities and functions allocated to each level of government, viz. the national, provincial and local levels. These constitutional arrangements bear on the process of and responsibility for the implementation of these policy guidelines.

2.3 The White Paper for the Transformation of the Health System in South Africa

This wide-ranging white paper has the objective of presenting a set of policy objectives and principles upon which the Unified National Health System of South Africa will be based. A number of chapters deal with specific health priorities that receive attention in this document, such as nutrition, HIV/AIDS and sexually transmitted diseases, mental health and substance abuse, oral health, and occupational health. However, the chapter that is most relevant for these guidelines as a whole is that dealing with maternal, child and woman's health (MCWH). Although adolescents and youth are not included in the title of this chapter (nor that of the corresponding national directorate), it is clear from the text of the White Paper that the health needs of adolescents and youth are indeed regarded as part of the scope of maternal, child and woman's health. It is however unfortunate that adolescents and youth are not in the foreground in this respect in the same way as, for example, children are.

The White Paper provides six principles for MCWH

MCWH services should be accessible to mothers, children, adolescents and women of all ages, the focus being on the rural and urban poor and farm workers;
MCWH services should be comprehensive and integrated;
clear objectives and targets should be set at the national, provincial, district and community levels in accordance with the goals of the RDP, the health sector and the United Nations Convention on the Rights of the Child;
individuals, households and communities should have adequate knowledge and skills to promote positive behaviour related to maternal, child and reproductive health;
MCWH services should be efficient, cost-effective and of a good quality; and
women and men will be provided with services which will enable them to achieve optimal reproductive and sexual health.
The current policy guidelines give expression to all of these principles. Indeed, many of the specific implementation strategies correspond directly to those identified for the six principles listed above.

2.4 Vision and mission of the Sub-directorate: Youth and Adolescent Health
The Sub-directorate: Youth and Adolescent Health is a component of the Directorate: Child and Youth Health in the Department of Health, RSA. Clearly, the Directorate and Department have developed visions and missions. However, only the vision and mission of the Sub-directorate is presented here since it is most proximal to these policy guidelines.
The vision of the Sub-Directorate: Youth and Adolescent Health is to facilitate the development of South African youth and adolescents to become healthy and responsible adults.
The mission of this sub-directorate is to:
be effective in addressing the needs of the youth and adolescents;
build a network of quality youth and adolescent health services in collaboration with non governmental and community organisations, the private sector, youth brigades of various political organisations, the South African Police Services, and the Departments of Education, Labour, Trade and Industry, Health, Economics, Social Welfare and Population Development, Safety and Security, Justice, Agriculture, Sport and Recreation, and Correctional Services;
monitor and evaluate the provision of youth services in order to encourage accessibility, equity, appropriateness, affordability and youth-friendly health care services;
promote the grooming of youth and adolescents into responsible adulthood; and
to collaborate with international, continental and regional youth services.
These policy guidelines give direct expression to this vision and mission. Specifically, in terms of the vision, they attempt to provide guidelines as to how the development of South African youth and adolescents to become healthy and responsible adults will be facilitated. All the elements of the mission can be detected in the strategies that are sprinkled through the guidelines.

2.5 National Youth Policy
This policy was developed by the National Youth Commission to provide a framework for youth development across the country. It is obviously necessary that the present policy guidelines are consistent with the National Youth Policy. This is one of the reasons that some provincial and the National Youth Commission was involved from the outset in the development of these policy guidelines.
The National Youth Policy identifies eight "priority target groups":
young women;
unemployed young men and women;
out-of-school young women and men;
rural young men and women;
young men and women at risk through socio-economic factors or participation in risk behaviours;
young men and women with a disability;
young people living and working on the street; and
young men and women with HIV/AIDS.

In the development of the Policy Guidelines for Adolescent and Youth Health, every effort was made to ensure that the health needs of these groups are recognised.
Health comprises one of nine "strategy areas" in the National Youth Policy. Within the health strategy area, there are three specific health strategies. The first is a "National Youth Health Action Plan", being developed by the Department of Health. This refers to the current policy guidelines. A number of issues that should be addressed in the plan are listed. Although the bulk of these issues are indeed addressed in these policy guidelines, there are some omissions. The most significant omission is "the identification of well-defined,
gender-dis-aggregated and quantifiable data and research on a wide range of youth health matters". This was not considered an appropriate component of policy guidelines. In any case, many of these data are available from other sources.

The second strategy is the development of a South African AIDS Youth Programme by the Department of Health. Although the present guidelines cannot be construed as fulfilling this strategy, most of the issues listed are in fact addressed in these policy guidelines. Any future attempts to develop a National Youth HIV and AIDS Strategy should build on these policy guidelines as well as the National AIDS Plan.

The third strategy refers to teenage pregnancy and school attendance. While the health aspects of teenage pregnancy are addressed in the policy guidelines, the educational aspects should be addressed primarily by the education sector.

Finally, the National Youth Policy proposed the establishment of a Youth Law Team that will review a range of laws that have a bearing on youth health. These laws address aspects such as the ages at which young women and men can consent to sexual intercourse, purchase alcohol and tobacco, and enter into marriage. In the light of the proposed establishment of this team, the legal aspect will receive minimal attention in these guidelines.

GUIDING CONCEPTS

3.1 Adolescent development underlies the prevention of health problems

In the USA, an analysis of over 100 school-based programmes that aimed to prevent specific problems such as drug use, school drop-out, pregnancy and delinquency found that successful programmes were characterised by, for example, skills building, participation, membership of groups, commitments to school and community, and the fostering of adult-youth relationships. These activities promote healthy adolescent and youth development as opposed to focus on the specific problems at hand. Closer to home, a programme to reduce cigarette smoking among black South African school students, for example, did so by improving their social skills.15 Also, life skills comprise an important facet of the intervention programmes offered, for example, by the Planned Parenthood Association in South Africa and the National AIDS Plan of the Department of Health in collaboration with the Departments of Education and Welfare.

It was mentioned in the preamble above that the two strands that weave through these guidelines are the prevention and response to problems and the promotion of healthy adolescent development. Of course, these strands are not separate but rather are interwoven with each other. Indeed, those programmes that are most successful in preventing a health problem invariably do so by addressing developmental needs. The challenge facing people developing policy guidelines and programmes for adolescent and youth health is to move beyond the impulse to respond to immediate health problems and put in place interventions that promote adolescent development. Ironically, this is in fact the optimal way of alleviating the specific health problems as well.

3.2 Problems are interrelated

It is a consistent finding from studies in several parts of the world that problems tend to cluster together. 16 In a Cape Town study among 7,340 high-school students, for example, it was found that engaging in any of the following risk behaviours increased the likelihood of engaging in any of the remaining behaviours: alcohol bingeing, cannabis use, cigarette smoking, participation in sexual intercourse, suicide attempts, unsafe road-related behaviour and violent behaviour.

One possible reason for this covariation is that the different behaviours have common causes. Poor social skills or sensation seeking, for example, may both contribute to both alcohol bingeing and sexual activity. 17 One might thus expect that interventions that aim to improve social skills would thus reduce the prevalence rates of both these risk behaviours. Another possible reason for the covariation is that engaging in one risk behaviour could increase the chances of another risk behaviour taking place. 18 Alcohol binging, for example, might reduce inhibitions resulting in unsafe sexual behaviour, risky road-related behaviour and violence. Interventions that prevent one risk behaviour may thus have a collateral effect on other risk behaviours.

3.3 Adolescence and youth are times of opportunity and risk

Adolescence and youth are characterised by substantial physical, social and psychological changes. Physically, there are changes in body size and stamina, and the reproductive system matures to enable so that pregnancy and childbirth to take place; socially, new relationships develop, especially outside the family; and psychologically, the capacity for empathy and abstract thinking become manifest These changes are accompanied by new opportunities. Decisions affecting their well-being are increasingly taken by the
young people themselves, many of which are related to developing a sense of identity. There are two key implications in terms of adolescent and youth health policy development. First, many of the decisions and choices made in adolescence have an influence throughout the life span. There is evidence from international studies, for example, that almost all adults who smoke cigarettes commenced doing so in adolescence. An unwanted adolescent pregnancy clearly can alter the life course of a young woman, especially if it results in her dropping out of school.20 The WHO has estimated that 70% of premature deaths of adults are largely due to behaviour initiated during adolescence.2 Interventions offered to young people can thus yield amplified benefits since their effects may be manifest throughout the life span. Second, a certain amount of risk taking is necessary for optimal development - risk taking has even been described as "a vital tool that adolescents can use to shape their lives".21 The challenge for policy development is thus to help young people find healthy ways in which this "vital tool" can be used, which would reduce the need to use this tool to take risks that result in adverse health outcomes.

3.4 The social environment influences behaviour
Risk taking and other personal attributes of adolescents and youth that influence their health do not exist in a vacuum. Rather, the social environment can have an impact on the thoughts and behaviours of adolescents. This includes: (a) relationships with friends, parents and other family members, and other key adults such as school teachers and sports coaches; (b) social attitudes and norms, much of which is transmitted through the media, educational institutions and organised religion; and (c) policies. In South Africa, the social environment of young people today is to a substantial extent determined by the apartheid policies of the pre-1994 era. Some of the effects of these policies were to separate family members from each other, limit access to education, and distribute economic resources such that black people (especially those living in rural areas) were systematically disadvantaged. A lack of economic resources reduces opportunities for positive social influences to exert themselves, for example through sports and other leisure activities. Also, influx control legislation prevented the development of an orderly and "natural" urbanisation process. The adverse social environment characterising urbanisation is illustrated by a study which showed that, for black high-school students, increasing duration of residence in an urban areas was associated with several adverse health outcomes such as cigarette smoking, alcohol bingeing, suicidal ideation and behaviour, and being a victim and perpetrator of violence. Related to this is that previous systems for assisting young people in making the transition to adulthood have been eroded in recent decades. Various factors have contributed to this, including the migrant labour system, economic conditions that have transformed male and female roles, the breakdown of traditional extended families, single woman-headed households and exposure to media that idolises Western values and customs. Modern South Africa, while changing rapidly in the social, political and economic domains, is unable to fill the social gaps that have arisen. However, the values associated with the previous systems are frequently maintained in concert with new adaptations to a rapidly changing socio-cultural environment. In such a transitional state, adolescents and youth frequently find themselves caught between conflicting socio-cultural pressures, for example concerning sexuality and childbearing. Thus, for example, young people may feel social pressure to establish sexual relationships. However, they may simultaneously carry traditional beliefs about sexual behaviour (such as a fear of infertility and hence a reluctance to use contraception). This contradiction predisposes them to sexual and reproductive problems.

3.5 Not all young people are equally vulnerable
There are sub-groups of young people that have specific needs through adverse circumstances, disadvantage, or disability. In striving for equity, special efforts need to be made to ensure that intervention strategies reach such sub-groups. In addition, unique approaches may need to be developed to ensure that these sub-groups have their needs met.

3.5.1 "Homeless" adolescents and youth
The overwhelming majority of homeless young people are male. Some have left their homes on a permanent basis and live in the streets. Others operate in the cities in the day, raising money by begging or odd jobs, and return to their families at night, or on some nights. In both cases, the reasons for being on the streets can be found in abusive or very economically deprived domestic circumstances, or in an attraction to the excitement and independence that characterises street life, or in a combination of these two scenarios. With high
unemployment, jobs previously done by homeless youngsters have become desirable to older people, resulting in abuse and violence. "Homeless" people face a myriad of problems, including a lack of safe and warm accommodation, poor facilities for personal hygiene and sexual abuse and exploitation resulting in sexually transmitted infections such as HIV infection. Clearly, any interventions for this subgroup should aim to provide appropriate accommodation and to induce a sense of responsibility in the young people so that they take decisions that promote their well-being.

The kinds of specific intervention strategies that may be appropriate for this vulnerable sub-group include:

• co-ordinating and linking current efforts of role players such as the Departments of Correctional Services, Education, Health, and Welfare; the National and Provincial Youth Commissions; the South African Youth Council; the South African Police Services; local authorities; universities; organised business; and the Alliance of Street Children;
• a social mobilisation to create an awareness of the services that are available; and
• an involvement of adolescents and youth in general in the development and implementation of programmes.

3.5.2 Adolescents and youth with disabilities

There are no accurate data regarding prevalence rates of disabilities among youngsters. The United Nations Development Programme estimates that, in 1990, 5.2% of the world's population was experiencing moderate to severe disability. This ranged from 7.7% in developed countries to 4.5% in less developed countries. In its 1995 survey, the Central Statistical Services reported a disability prevalence rate of approximately 5% in South Africa. Also, it has been concluded on the basis of unrepresentative samples that there are about 4 million South African children who experience different forms of disabilities.

Causes of disability as listed in the White Paper on an Integrated National Disability Strategy include violence and war, poverty, lack of information, failure of medical services, unhealthy life styles, environmental factors, accidents and inherited and genetic factors. Two groups are especially vulnerable: (a) those who because of a severe intellectual or mental disability are unable to defend their own interests and rights; and (b) those who because of multiple disabilities experience difficulty integrating, both at in educational institutions and at work.

The majority of people with disabilities and in some cases their families in South Africa have been excluded from the mainstream of society and have thus been prevented from accessing fundamental social, political and economic rights. This exclusion is the results of a range of factors, including the political and economic inequalities of the apartheid system; poverty, unemployment and social isolation; social attitudes which have perpetuated stereotypes of disabled people as necessarily dependent and in need of care; and a discriminatory, and weak legislative framework which has sanctioned and reinforced exclusionary barriers.

Disabled young women are subject to additional pressures. They are perceived as reinforcing traditional stereotypes as dependent, passive and needy. Disabled females are more likely to be poor or destitute, malnourished and illiterate than disabled males. Also, women (especially) who bear disabled children sometimes face rejection and even scorn from their partners, families and communities. This is exacerbated by health professionals who may take over decision-making from the parent(s), insisting that they know what is best for the child. The parent (usually the mother) may lose confidence in their parenting ability and hence self-confidence in general.

People with disabilities often encounter obstacles in the physical and social environment, and thus handicapped by the environment. Also, health services do not respond appropriately to the needs of people with disabilities. According to the same white paper mentioned above, the occurrence of disability is increased by the inadequacy of primary health care and genetic counselling services, weak organisational links of between social services, the faulty treatment of the injured when accidents occur and the incorrect use of medication. Other problems that adolescents and youth with disabilities may encounter include reduced access to contraceptives, unauthorised or uninformed sterilisation and a lack of care in performing vaginal examinations of paraplegics because of the perception that pain is not experienced.

Adolescents and youth with disabilities are particularly vulnerable to physical, sexual and emotional abuse in families, institutions and communities. Not only are they frequently unable to defend themselves, but they are often alone and undervalued by those around them. Also, they are less likely than their siblings to attend school, to go on outings, to contribute to household responsibilities and to experience situations where they have to develop solutions to problems of living. They can thus grow up to be disempowered and unskilled,
which in turn contributes to their unemployment. Some facilities for disabled young people are in place. There are, for example, 36 schools for deaf children, 18 for blind children, 19 for children with cerebral palsy, 48 for children with serious behavioural problems, and 149 for children with mental disability. There are also schools for children with epilepsy, pervasive developmental disorders such as autism, and physical disabilities. However, there is a lack of equity in terms of access to these facilities. More than 80% of black children with disabilities live in extreme poverty in inhospitable environments. They have poor access to appropriate health care facilities and early childhood development opportunities, and many are out of school (particularly those in rural and other disadvantaged areas). When born into families in poor socio-economic circumstances, disabled young people may grow up believing that their disabilities are an economic and social curse and burden on their families. They may thus perceive themselves as having limited worth.

Some specific strategies to address the needs of this vulnerable group include:
- preventing the disabilities from arising in the first place, where possible;
- the early identification of impairment/disability;
- develop appropriate intervention programmes using the Community Based Rehabilitation (CBR) approach;
- integrate CBR programmes into primary health care;
- protecting and promoting the rights of the disabled;
- emphasizing educational and vocational integration;
- ensuring that health and other services are barrier-free;
- providing care facilities for those that require it;
- developing skills training for those with disabilities;
- raising public awareness on disabilities;
- developing regional referral mechanisms for people with disabilities requiring more specialised assessment and treatment;
- develop management information systems with appropriate indicators to facilitate follow-up and evaluation of disability prevention and rehabilitation efforts;
- promoting empowerment of young people with disabilities;
- paying fair compensation to people with disabilities;
- integrate developments of appropriate rehabilitation technology into services provision;
- providing increased support and empowerment to families and to community resources that serve people with disabilities;
- involving people with disabilities in the development and implementation of prevention and rehabilitation programmes;
- re-orient, and improve the training of, professionals who work with people with disabilities.

3.5.3 Other vulnerable groups.
These include the following groups of adolescents and youth:
- residents in places of safety and children's homes;
- those who have committed crimes;
- orphans (including AIDS orphans);
- those who have been abandoned, abused or neglected;
- women;
- single mothers;
- sex workers;
- those living with HIV/AIDS; and a those returned from exile.
Clearly, specific strategies need to be developed to address the needs of each of these vulnerable groups.

3.6 Gender considerations are fundamental
Gender considerations are fundamental for adolescent and youth health, mainly because they are important determinants of access to economic resources, social services and other opportunities. Specifically, young women's lives tend to be framed within patriarchal assumptions and practices. Both in the family and in society at large, women generally occupy a terrain that is defined and controlled by men. The girl child is frequently discriminated against from birth onwards. Her life can be bound by traditional, cultural and social gender stereotypes to the extent that she is regarded as perpetually subordinate to males, irrespective of their age.
Socialisation into gender roles is reflected in the division of labour within the family, school and community. Girls and young women tend to be assigned roles of lesser status and with less potential to develop self-confidence and independence. In the family, for example, girls may be allocated cleaning, cooking and child care duties while boys may be more involved in family decision-making processes. In educational institutions, young females may be covertly disempowered, resulting in reduced participation in educational activities and compromised educational outcome. This in turn impacts negatively on access to further educational opportunities and occupational potential.

Young women are particularly disadvantaged in the domain of sexual health. It is, for example, relatively more difficult for them to obtain contraceptives, partly because of pejorative attitudes towards sexually active young women. A lack of economic resources and physical power renders them vulnerable to participation in unwanted sexual activities with the resultant risk of sexually transmitted infections such as HIV infection. In some communities, sexual relations with young girls are desired by some men since they are less likely to be HIV positive and sex with young girls may even be regarded to be a cure for AIDS. Sexual abuse (whether incestuous or not), gender-based violence, coercive sex and gang rapes are more likely to be perpetrated on girls or young women than their male counterparts. Finally, they are particularly vulnerable to commercial sexual exploitation.

The socio-cultural context is crucial in determining sexual behaviour. This includes both social and peer expectations of appropriate sexual behaviour and internalised gender-specific social norms. Examples of this include the social expectations in some cultural contexts that men have multiple sexual partners and that young women are subservient and sexually inviting while simultaneously being monogamous. Moreover, work by Wood and colleagues highlights the "normalcy" of sexual violence, both from the male and female perspective. Finally, peer pressure is a strong motivation for boys and girls not only to become sexually active at a young age but also to have multiple partners, even though many might prefer to abstain from sex. Of course, there are some ways in which males are disadvantaged. In South Africa, young men are vulnerable to sepsis and even death from initiation circumcision procedures performed in unhygienic circumstances. They appear to be more likely to be victims of child labour in rural areas. Finally, the perception that they are tough and strong renders them vulnerable to corporal punishment.

Clearly, the success of any adolescent and youth health policy guidelines is dependent on the extent to which gender discrimination against children, adolescents and youth has been diminished. Indeed, the advancement of gender equality and equity is a crucial strategy for the promotion of the health of young people. This should be achieved through collaboration with relevant governmental and non-governmental structures, especially those that focus on adolescent, youth and gender issues.

Discriminatory practices such as female infanticide and prenatal sex selection should be abolished. Schools, the media and other social institutions should seek to eliminate stereotypes in all types of communication and educational materials that reinforce existing inequities between males and females. Community traditional, religious and other leaders in both urban and rural areas should be sensitised regarding gender issues. Conversely, public awareness of the value of girl children should be increased, which would in turn enhance the self-esteem and status of girls and female adolescents and youth.

In addition to these general issues, there are some specific measures that apply to the health sector. Obviously, policies, planning and interventions themselves need to address the needs of both men and women. All adolescent and youth reproductive health programmes should address gender socialisation in the curriculum. Finally, obligations in terms of international agreements should be scrupulously implemented. Such agreements include the United Nations Convention on the Rights of the Child, the Convention on the Elimination of all Forms of Discrimination Against Women, the Beijing Platform of Action and the International Conference on Population and Development.

4. GENERAL INTERVENTION STRATEGIES

4.1 Promoting a safe and supportive environment

4.1.1 Relationships with families, other adults and friends

Parents remain an important positive force in the lives of adolescents and youth. They can serve as positive behavioural role models; they can provide emotional/psychological support and encouragement; they are promoters of autonomy and independence; and they are brokers for needed services; and transmitters of values and information. However, it should be borne in mind that in many South African cultures parents have played a relatively small role in sexual socialisation and education. In Zulu culture, for example, this was the responsibility of a senior female relative such as an aunt or older sister. This is illustrated by the results
of a study conducted among urban black mothers in Durban: communication with their children about sexuality was poor, and none had spoken to their children about AIDS. This should not be taken to imply that parents do not want their children to know about sexuality - it is just that they do not want to be the ones to provide the information.

The relevance of relationships with teachers for health-related behaviour is illustrated by a study in which good relationships with teachers were associated with lower rates of cigarette smoking. Indeed, the promotion of good student--teacher relationships is an important aspect health promoting schools (see Section 5.2 below).

4.1.2 Social norms and cultural practises

There should be a twin focus in terms of social norms and cultural practises. On the one hand, positive cultural practises such as initiation schools should be encouraged and validated where they contribute to the young person's well-being and social integration. On the other hand, steps should be taken to prevent cultural practises which violate basic human and constitutional rights. Thus, coerced adolescent marriages and female genital mutilation should be prohibited by legislation, and septic male circumcision countered by the introduction of safety regulations. Another important strategy to alter norms and cultural practises is the involvement of high-profile individuals such as political leaders and music and sports stars.

4.1.3 Mass media

Many young people spend substantially more time watching television than they do on their studies (including time spent in school). Other media include radio, movies, flyers, newspapers, puppetry, live theatre, magazines, videos, the internet, dance and photo novellas.

In South Africa, Soul City, a project of the Institute for Urban Primary Health Care, attempts to provide a supportive environment by influencing healthy behaviour choice. So far, some of the health related topics that have been tackled are HIV/AIDS, alcohol and tobacco. A variety of media are used, including television, radio, newspaper, and life skills and education packages. So far, there have been three 13-part episodes broadcast on SABC1, with a fourth due for broadcast later in 1999. The project has been systematically evaluated, and found to be achieving its aims.

Another South African project using mass media is the photo novella entitled "Roxy", produced by the National Progressive Primary Health Care Network and the Medical Research Council. It was developed from the experiences of teenagers with the idea of influencing and altering social norms in relation to HIV/AIDS and general unsafe sexual behaviour. The comic was designed to be a short-term HIV education intervention which could be used in multiple contexts independently of adult facilitators. Roxy aimed to confront teenagers with a range of issues concerning sexual behaviour in the context of the HIV epidemic and to present the choices available to them. Again, well conducted scientific efficacy studies showed that it achieved its purposes.

A survey of over 100 organisations throughout South Africa with a focus on HIV/AIDS, sexual health and young people revealed that pamphlets were the most popular media material used (used by 86% of respondents), followed by posters (84%), videos (67%), plays (54%), magazines (52%), newspapers (42%) and comic strips (38%). Of the respondents, 92% affirmed the need for a national multi-media campaign targeting young people. It was felt that a campaign should use messages that reinforce positive life styles and images; there is a need to use language that youth find meaningful; messages need to consider different categories and experiences of youth; and messages need to avoid clichés, rhetoric and moralising. The National Adolescent Sexual Health Initiative (NASHI) is in the process of developing such a multi-media campaign.

4.1.4 Accessibility of key opportunities and commodities

This refers to a wide range of things, including recreational facilities, educational opportunities, tutoring and condoms. Clearly, factors such as economic disadvantage reduces accessibility of these opportunities and commodities, resulting in sub-optimal health and development outcomes. Gender can have the same effect, as occurs when a young woman drops out of school to find work so that her brother can pursue educational opportunities.

4.1.5 Policies including legislation

All the specific health priorities dealt with in Section 6 below are amenable to legislative efforts. Some of
these legislative efforts occur in the health sector (such as legislation to outlaw tobacco advertising) while others will occur outside the health sector (such as legislation making schooling compulsory up to a certain age). Advocating for legislative improvements that promote a safe and supportive environment is an important intervention for health workers in the field of adolescent and youth health.

4.2 Providing information
This strategy is necessary for the remaining strategies to be discussed below to have any impact. Adolescents and youth need information in a variety of domains, such as:
- growth and development;
- gender-specific needs and roles;
- specific areas of health, for example, oral care, nutrition and mental health;
- risks to health; and
- opportunities and available services, both health-related and general.

In South Africa, a number of health promotion efforts have focused exclusively or predominantly on providing information. The area that has received the most attention is sexuality. However, knowledge in key areas is still deficient. As regards HIV infection, for example, a review of 27 South African studies concluded that almost all young people had heard about AIDS, but their knowledge about the disease itself was very variable. The facts that AIDS is sexually transmitted and almost always fatal is widely known, but further knowledge is generally lacking. If this is the case for HIV infection, it is probable that knowledge regarding other topics (which have received less attention) is also scanty. Although knowledge about a health risk is insufficient for behaviour change, it is certainly necessary. There are thus still enormous challenges in providing information to young South Africans.

4.3 Building skills
This refers to the process of teaching competencies to influence behaviour through a set of structured activities. The structured activities can include brainstorming, rehearsal, role play, games and debates. Key elements in teaching a new skill include demonstration, having the learners try it out, requesting self-assessment, providing feedback in a supportive, constructive manner and then having the learner try it out again.

There are many different types of skills, such as practical self care skills, livelihood skills, skills to deal with specific situations (such as how to say no to drugs) and life skills. Life skills refer to adaptive and positive proficiencies that enable one to deal with the challenges in everyday life. They include:
- decision making;
- problem solving;
- creative thinking;
- critical thinking;
- effective communication;
- interpersonal relating;
- self-awareness;
- ability to communicate empathy;
- coping with emotions;
- stress management;
- the ability to act assertively in changing one's environment in response to a problem;
- the capacity to pursue goal-directed behaviour;
- the capacity to withstand pressure from others; and
- the ability to evaluate the effectiveness of one's actions and pursue alternative solutions if necessary.

Of course, there are specific skills that are required for specific situations. There are specific skills required, for example, to persuade an unwilling partner to use a condom. However, if there is a high level of proficiency in the generic life skills listed above, it would not be a major step to apply them to the situation at hand. Thus, generic skills to act assertively, pursue goal-directed behaviour, communicate effectively and communicate empathy may be relevant to this scenario. This is consistent with the guiding principle that problems have common roots and are interrelated.

In South Africa, life skills comprise one of the eight learning areas in Curriculum 2000. The outcomes based approach to assessment implies that students will be required to demonstrate that they have indeed acquired life skills. Life skills training for teachers and educational support staff is in progress under the auspices of
the Departments of Health and Education. Life skills also comprise an important component of the programmes run by the Planned Parenthood Association of South Africa. Certain community organisations are also involved in skills training, such as the youth clubs. However, building skills does not appear to be a priority in other sites such as health facilities, workplaces and the street. Adolescents and youth that are out of school, for example, are thus are not potentially exposed to this strategy.

Priority objectives in implementing further this general strategy are thus to:

- support existing policies and programmes regarding life skills located in the provincial and national departments of education;
- improve co-ordination and collaboration between government and NGO's;
- introduce skills development initiatives into other sites;
- investigate the employment of adolescents and youth themselves as trainers in skills development;
- develop a system to monitor skills development programmes in all sites and for all priority health problems, with a view to preventing duplication and facilitating collaboration so that available resources are optimally used.

4.4 Counselling

The term 'counselling' is used to include a wide range of activities in diverse settings. However, all these activities are characterised by one person assisting another person (or group of people) to gain understanding of themselves and their situation, thus facilitating making and implementing appropriate decisions. The counsellor is generally a professional person such as a teacher, health worker or religious leader. However, in situations characterised by resource shortages, peers or other lay people can be effective. In one Cape Town study, for example, a brief training programme in rape crisis intervention produced an increase in the ability of young lay counsellors to offer therapeutic conditions necessary for positive change in rape survivors.

The guiding concept that problems are interrelated and have common roots implies that an episode of counselling should not be confined to the presenting problem. Rather, an attempt should be made to deal with other related problems. In addition, this should be done in such a way as to promote the development of the adolescent or youth, so that they are better equipped to deal with similar scenarios that might arise in the future. The existence of a "presenting problem" implies that the person's normal way of dealing with a situation has been sub optimal. If this were not the case, there would be no need to present for counselling. There is thus the potential to develop new capacities or acquire new skills. It is the counsellor's duty to assist the client to do so, thus resulting in a higher state of development than existed before the onset of the "presenting problem". This is an example of how the dual threads of preventing and responding to problems and promoting healthy development are inextricably interwoven.

4.5 Access to health services

Health services are generally perceived to serve the function of responding to health problems as they arise. However, they also have important roles to play in terms of preventing health problems. This can be achieved by, inter alia, monitoring, provision of advice and information, and maintaining an open attitude so that young people will feel free to ask questions. Finally, they can promote healthy development by engaging other sectors to contribute to programming, advocating and providing interventions outside health facilities. The Access to health services, including the important aspect of youth friendly clinics, received more detailed attention in Section 5.3 below.

5. INTERVENTION SETTINGS

5.1 Home

The WHO also includes media/entertainment and political/legislative systems as settings where interventions can be provided. They are not included here since they are not places, as for the other settings discussed here. Also, the key issues for these two settings have been presented in Section 4 above.

The home is a suitable setting for the development of a safe and supportive environment. Specifically, improving the relationships and communication between parents and other adults in the home and young people would promote adolescent health and reduce risk behaviour. In the US, home-based interventions have been shown to be effective reducing anti-social behaviour in young people who have been convicted of serious offences. In South Africa, the Planned Parenthood Association has produced a booklet that aims to help parents discuss sexuality with their children. A school-based intervention aims to penetrate the home
setting through teaching children to take health messages home using the "child-to-child" approach.

However, in South Africa, in general, the home has not been prioritised as a site for adolescent and youth health interventions. There is a general lack of knowledge, guidance and support regarding effective parenting skills. Parents and other adults in the home are not helped to counteract negative media influences on adolescents and youth. On the contrary, there are widespread negative role models for parenting and family relationship issues. There are, insufficient links between the family on the one hand and educational and religious institutions on the other. There is a widespread resistance on the part of health workers to facilitate the provision of sexuality education in the home setting.

Interventions for this site should aim to: (a) educate parents and other adults in the home regarding family health, including aspects that are specifically relevant for children with special needs; (b) empower adolescents, youth and communities in general to take responsibility for programmes geared towards effective parenting; and (c) provide counseling services for parents and other adults in the home so that relationships and communication can be improved.

To achieve these aims, a number of strategies are necessary, including:

- the selection and training of appropriate personnel to provide the educational and counseling programmes, and to train others to do so;
- promoting and enabling carers such as family and community workers to provide effective home-based care for adolescents and youth with chronic mental and physical health problems;
- liaison with families, religious organizations, schools, and NGO's to establish structures in the community to address parenting challenges;
- motivate and encourage parents and youth workers to form peer support groups;
- including elements in the school curriculum involving parenting skills; and
- facilitating linkages and communication between homes, schools and religious organisations.

5.2 School

Schools provide a site that has the potential to reach large numbers of adolescents. The overwhelming majority of South African adolescents attend school; 97% of those aged 10 to 14 years and 83% of those aged 15 to 19 years attend school.44 This widespread access to schools stands in contrast to limited access to health facilities for many South Africans. The Central Statistical Service, for example, estimated that 56% of the rural population live more than 5 kilometers from a health facility.

An improved health status enables students to make better use of their learning opportunities and prevents drop-out. Conversely, improved educational attainment enhances health. Thus, there is a correlation between the educational level of mothers and the health of their children. Also, the longer a young women stays in school the more likely she is to delay child rearing, which results in better obstetric and child health outcomes.

In South Africa, there has been considerable progress since 1994 in the provision of health services at schools. Approximately half of all provincial departments of health and education have developed policy documents regarding school health; in most provinces there is collaboration between departments of health and education in developing programmes for school-aged young people in their province; and in almost all the provinces school health programmes are currently being implemented in secondary schools. Such programmes include counseling and other mental health interventions, feeding programmes, and education regarding the environment, sexuality and life skills.

So far as the provincial and national departments of health are concerned, the principle aim should be to support these initiatives. In doing so, they should foreground the tasks that Vergnani et al. have listed that need to be pursued in the continued development of school-based health promotion services:
- advocacy for the development of a national commitment to these services;
- inter-sectoral collaboration, both between disciplines and departments, to combat fragmentation, territoriality and duplication;
- the optimal utilisation of all existing services, both from inside and outside the schools;
- basing interventions on a holistic approach to health, which would include the developmental aspects emphasised above;
- the involvement of all stakeholders in the school in a "whole school approach";
- the incorporation of health education into the curriculum;
- changing the attitudes and practice of teachers so that they are consistent with a holistic approach to health;
- moving from a top-down approach to a more bottom-up, participative approach to curriculum development and the delivery of services, with particular emphasis on including adolescents and youth, teachers, parents and the community;
the initiation of research to develop optimal methods and content of health promotion through schools; and the development of pilot projects.

5.3 Health facilities
There are several important factors that prevent South African public health facilities from achieving their potential as sites of health service provision. First, health services are relatively inaccessible to many young people, especially the poor and those living in rural areas. Second, many adolescents and young adults fear that their problems will not be kept confidential. A Northern Province study found that in many clinics there is insufficient space to guarantee privacy, resulting in consultations being easily overheard by other patients.52 A Durban study found that although private rooms were available in most clinics, they were usually not used for students requesting condoms.53 This study also found that male students felt uncomfortable waiting with female students, both at the counters where condoms were distributed and in the waiting rooms.

Third, there is often a poor relationship between the young person and nursing personnel. In another Northern Province study, it was found that the most important barrier to seeking contraception was the attitudes of health personnel, who were described as harassing, rude, short-tempered, and arrogant.54 Young people were frequently asked intrusive and irrelevant questions, such as whether they had a boyfriend, why they had sex at such a young age, and whether they had told their mothers. This adversarial style of relating is not conducive to the transmission of accurate and timely information on which adolescents and youth can make informed decisions. Young people are unlikely to provide truthful feedback if this is solicited in these circumstances. Finally, these factors result in young people being fearful of approaching health workers with sexuality issues.

Many of these problems could arise because health care workers are inclined to regard moral guidance of young people and discouraging sexual activity as part of their social role. They thus fail to put their professional obligations above their moral commitments. Another cause of these problems could be that very few health personnel have received sufficient training in adolescent and youth health. Clearly, any attempts to maximise the potential of health facilities as sites of service provision should aim to address these barriers to service utilisation. By so doing, health facilities would be made more accessible and transformed into "youth friendly" clinics. Important strategies to achieve this may include:

- increasing the number of facilities such that they are accessible to a greater proportion of the population;
- making structural changes to the facilities to promote privacy and confidentiality;
- allocating certain days or sessions for adolescents and youth alone;
- re-training and re-orientation of health workers, with an emphasis on the development of interpersonal skills to promote good provider-recipient communication and respect for young people;
- involvement of adolescents and youth in the development of "youth friendly" clinics;
- developing a set of adolescent and youth health service standards to facilitate monitoring and evaluation; and co-ordination and liaison with NGO's, and community based organisations (CBO's) and the private sector to strengthen and sustain youth friendly services.

In addition, there is evidence from two Cape Town studies that there are missed opportunities for intervention among youth attending primary care facilities. In one study, it was found that 43% of youth attending primary health facilities did not receive any intervention regarding contraception at that visit to the clinic yet would have liked to receive such information. Another study reported similar results for use of cigarettes, alcohol and other substances. This suggests that a more integrated and comprehensive approach would be welcomed by youth. Thus, in addition to the presenting complaint being attended to, the health services should aim to provide a comprehensive array of other services to the young person.

5.4 Workplace
Large numbers of young South Africans are employed; one estimate is that 200,000 children between the ages of 10 and 14 years alone are engaged in remunerative employment. One of the most common forms of work is domestic service. This is a relatively hidden form of work in that it is difficult to obtain estimates of how many young people are involved. However, there is evidence that rural adolescents and youth are recruited by city dwellers to work as domestic workers, but are then subject to strenuous labour for exploitative wages. Another common form of work among adolescents and youth is street trading. This can take on various forms, such as roadside vending of fruit, vegetables, newspapers and other commodities in both urban and rural areas. The taxi industry employs adolescents and youth as cleaners, "conductors", and drivers
(often without licenses). Likewise, other businesses employ young people as packers, building labourers, petrol attendants, contractors, brickyard hands, and entertainers and models. Finally, young women and men may earn money as commercial sex workers.

Work experiences can be either positive or negative. Besides providing funds, work can promote health and development. Newspaper vendors, for example, who are school-going and deliver newspapers door-to-door for extra pocket money may learn about the importance of consistency, responsibility and punctuality. In addition, they may use the money for development-enhancing hobbies or sports participation. This is in contrast to their impoverished counterparts, who may be fetched from townships as early as 3:00 am to sell newspapers on street corners, for much longer hours and in unprotected conditions. It is difficult to remain in school in these circumstances, and their family may depend on the money to fulfill their basic needs such as food and shelter. Domestic workers, especially those who are very young, are vulnerable to physical, emotional, sexual and economic exploitation. Farm workers may be at risk for insecticide poisoning and injury from farm machinery. Commercial sex workers are at very high risk for assault, sexually transmitted infections and substance abuse.

It is important to have a full understanding of the work circumstances of young people in a specific work situation before developing intervention strategies. Indeed, the aims of the strategies vary according to the conclusions flowing from such an understanding. Thus, if exploitation is taking place, it may be necessary to abolish certain work by people under a certain age. However, this should be accompanied by the twin aim of creating other sources of income for the affected young people, otherwise more harm than good may result. Another aim may be to improve working conditions. The Sex Workers Education and Advocacy Taskforce (SWEAT), for example, has as one of its main aims to reduce the incidence of sexually transmitted infections (STIs) such as HIV infection among sex workers. Finally, an aim could be to offer health promotion programmes in the work setting. Certain subgroups of young people may be optimally reached at work, such as out-of-school adolescents.

There are a number of strategies that are necessary to achieve one or more of these aims, such as: liaison with relevant role players to develop a programme of action in addressing the child labour problem in South Africa; promoting ongoing awareness campaigns around child labour issues; encouraging provincial and local structures to play a leading role in the elimination of child labour especially through awareness raising campaigns; increasing awareness regarding safety and homes, public places, industries, schools and other educational institutions; increasing awareness regarding the importance of occupational safety measures, e.g. street lights for sex workers, safety precautions (such as goggles) for factory workers; promoting and encouraging research pertaining to child labour; enforcing legislation for effective elimination of child labour; enforcing legislation (acts and regulation) regarding safety in public places, industries, schools and other educational facilities; forming an inclusive national forum under the auspices of the Department of Labour called the Child Labour Inter-Sectoral Group (CLIG) ; and establishing and maintaining a comprehensive national data system on the extent and nature of work by adolescents and youth.

5.5. Street
Issues around the street as a site of intervention for adolescents and youth have been dealt with above in Section 3.5.

5.6 Community-based organisations
Involvement in community-based organisations is often primarily motivated by a desire to participate in sport, recreation or community service. However, such involvement can have substantial health benefits. In terms of preventing and responding to health problems, many community-based organisations provide information and guidance about topics such as drugs or sexuality. However, their main contribution in terms of health is by promoting healthy development. Thus, the organisations may provide young people with social support, skills training, constructive alternatives to risk behaviour such as sexual activity and substance misuse, a sense of belonging, responsibility to others, and increased self esteem through
achievement and the consequent personal satisfaction and public recognition. South Africa is fortunate in having a large number of and wide diversity in community-based organisations. They include religious groups, the youth wings of political parties, business groups, woman's groups, the Boy Scouts and Girl Guides, as well as a number of independent youth groups. These groups are almost invariably NGO's. The main aim of the provincial and national departments of health should be to lend support and encouragement to these groups. In addition, health departments should assist either with preventing or responding to health problems or promoting healthy development.

5.7 Residential centres
This term is used to refer to a range of facilities such as shelters, drop-in centres, in-patient psychiatric units, orphanages, children's homes and prisons. The wide range of centres makes it difficult to be too specific about what interventions may be indicated. Also, the characteristics of the adolescents and youth in the centres can mitigate against successful health interventions. Young people in prisons, for example, may be antisocial and aggressive. Psychiatric patients may be too impaired by their symptoms to respond to health interventions (other than their psychiatric treatment). Finally, in many centres there are very unfavourable staff–young person ratios, relatively unskilled staff and few resources.
However, despite these challenges, the health services should aim to grasp every opportunity to prevent or respond to health problems or promote health. These opportunities may arise for any of the general strategies mentioned above, and include improving the social environment by enhancing relationships with adults, providing information, building skills and providing health services.

6. PRIORITIES
As mentioned above, the main thrust of adolescent and youth policy guidelines should be on integrated, horizontal programming as opposed to problem-oriented, individual efforts. However, this chapter addresses the unique considerations that characterise selected health priorities. These priorities are sexual and reproductive health, mental health, substance abuse, violence, unintentional injuries, birth defects and inherited disorders, nutrition and oral health.
These priorities were selected after considerable consultation and debate, taking care to ensure that they are consistent with the White Paper for the Transformation of the Health System in South Africa. Despite this, there is a measure of arbitrariness in the selection of these specific priorities. Certainly, there may be health priorities that are specific for certain provinces, such as malaria in KwaZulu/Natal and tuberculosis in the Western Cape.
However, it is possible to apply the guiding concepts enumerated above (Chapter 3) in developing general strategies (Chapter 4) in various intervention settings (Chapter 5) for any specific health priority. This can be operationalised in the form of a matrix, with general strategies on one axis and settings on the other. For each health priority, there are four subsections: situation analysis, impact, intervention strategies and examples of indicators. The intervention strategies are presented in terms of the five general strategies. For reasons of space, it has not been possible to apply each of these general strategies in a systematic and complete manner to all of the intervention settings (as would occur when developing a matrix). Rather, the intervention strategies provided for each health priority should be regarded as examples of appropriate strategies.

6.1 Sexual and reproductive health
The programme of action of the International Conference on Population and Development (ICPD) highlights the critical need to address adolescent, sexual and reproductive health issues which have largely been ignored by existing reproductive health services. The ICPD defines reproductive health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. The components of sexual and reproductive health care are as follows:
• safe motherhood: prenatal care, safe delivery, essential obstetric care, perinatal and neonatal care, postnatal care and breast feeding;
• family planning information and services;
• prevention and management of infertility and sexual dysfunction in both men and women;
• prevention and management of complications of abortion; a provision of safe abortion services; prevention and management of reproductive tract infections, especially sexually transmitted infections,
including HIV infection;
promotion of healthy sexual maturation form pre-adolescence, responsible and safe sex throughout the
lifetime and gender equality;
elimination of harmful practices, such as female genital mutilation, premature marriage, and domestic and
sexual violence against women; and
management of non-infectious conditions of the reproductive system.
In this section, the situation analysis will focus on selected aspects of the knowledge, behaviour and attitudes
of young South Africans that are pertinent to sexual and reproductive health. Thereafter, the impact of the
situation on three aspects will be briefly reviewed: teenage and unwanted pregnancies, termination of
pregnancy and sexually transmitted infections (including HIV infection). Clearly, these policy guidelines will
address only those aspects of reproductive health that are considered most pertinent to adolescents and
youth.

6.1.1 Situational analysis
A recent report aimed to identify and summarise all South African studies addressing the sexual health of
adolescents and youth. Approximately three dozen studies were included. Some of the main findings from
this review are provided below.
For the majority of young South Africans, sexual activity starts in the mid-teens. Because of differences in
the samples included in the studies and the strategies by which they were obtained, it is difficult to arrive at a
figure that represents the average age of first intercourse for young South Africans. However, based on the
most representative studies, in the context of the remaining studies, it is reasonable to conclude that the
national average age of first intercourse is 15 years for girls and 14 years for boys. There is, however, great
variability around these figures. Significant numbers of young people have their sexual debut well before age
14, while many are virgins at age 18. Boys start to have sex significantly earlier than girls do, and in greater
numbers.
While almost all young South Africans have heard of AIDS, there is highly variable knowledge about the
illness itself. There is variability both between studies (with some studies showing a good overall level and
some studies the converse), and within studies (with large proportions showing both high and low overall
levels). Also, levels of knowledge tended to vary across different topics. Thus, the overwhelming majority of
respondents are aware of the facts that the disease is sexually transmitted and is eventually fatal for almost
all those infected. Knowledge levels are less impressive about other aspects, such as that HIV can be
contracted through blood; that it can be passed from mother to child; and that it has a "dormant" phase; and
that it is impossible to contract AIDS from casual contact.
The prevalence of contraceptive use varies across the reported studies from 25% to 75%, with an average of
about 60% of sexually active youth. Even assuming that some might be hoping for a pregnancy, this still
leaves a large segment of young people running the risk of unwanted pregnancy. Men report using condoms
more than do women, while women report using oral or injectable contraceptives. Up to 15% of the youth
use unreliable methods such as withdrawal or the rhythm method.
As regards condom use specifically, which is of relevance both for the prevention of both unwanted
pregnancy and sexually transmitted infections such as HIV infection, it was found that significant numbers of
young people have never used a condom during sexual intercourse. In some studies, over 90% of the girls or
young women surveyed had never used one. Of those who have ever used a condom, a minority report
always using one. Studies which asked respondents whether they used a condom in their last sexual
encounter, report equally low rates.
Most non-virgin school students have had one or two partners. The studies with older youth show that the
majority of young people had either not been sexually active, or had engaged in sexual intercourse with only
one person in the preceding four to twelve months. A minority (less than 30%) engage in sexual intercourse
with numerous partners. Males report more sexual partners than females.
In Section 5.3 above dealing with health facilities as a site for programmes, it was reported that there are
several factors that prevent public health facilities from achieving their potential as sites for health service
provision. These include their inaccessibility, the fear that problems will not be kept confidential, poor
relationships between young people and clinic staff, and large numbers of missed opportunities for
intervention. Although these points are valid for all the health priorities included in these policy guidelines,
they are particularly pertinent for sexual and reproductive health. Indeed, many of the studies cited above
were specifically addressing sexual; and reproductive health issues. In addition, there are some specific issues
that pertain to sexual health. A good example in this regard is the denial of contraceptives to sexually active adolescents under the age of 14 years if they do not have permission from their parents.

6.1.2 Impact

(a) Unwanted teenage pregnancy

In 1995 it was estimated that the pregnancy rate was 330 per 1000 women under the age of 19 years, and 40% of all pregnancies were estimated to be to teenage girls. In 1993, teenagers accounted for 15% of births in South Africa, and 22% of those aged 15 to 19 years had ever been pregnant. Data from studies conducted in parts of the country are consistent with these statistics. Among rural school girls in the Transkei, 23% had previously been pregnant. Of women delivering at Butterworth Hospital, also in Transkei, 28% were aged 19 years and younger.

Teenagers who get pregnant are at increased risk of perinatal loss and obstetric complications. Babies born to teenage mothers are likely to be of low birth weight and are at increased risk of fetal distress. In 1991, maternal mortality was almost double for women under 20 years of age compared with those over that age. The under-five-mortality rate (U5MR) is 50% higher for children born to young teenagers than for mothers aged 20-34 years. From the social perspective, pregnancy of young people can be accompanied by reduced self-esteem, financial costs such as medical care and social support, school drop out, reduced income generating potential and hence poverty. The adolescent mother and her baby can be economically dependent on family and society in general.

(b) Termination of pregnancy

It has been shown both internationally and in South Africa that unsafe abortions result in significant morbidity and mortality. Prior to the recent amendment of legislation governing the termination of pregnancy, it was suggested that between 6,000 and 120,000 illegal abortions were undertaken per annum in South Africa, most of which were on young women. Even after the legislative amendment, the prevailing problem is that those who most need access to safe abortions (i.e. impoverished, disadvantage and disempowered women) are those who are least likely to reach present services. According to the Department of Health, within the first 3 months of the implementation of the Choice of Termination of Pregnancy Act, 60% of the nearly 7,300 terminations took place in Gauteng.

(c) Sexually transmitted diseases (including HIV infection)

Adolescents and young people are particularly vulnerable to sexually transmitted infections because biological factors, susceptibility to peer pressure, a tendency to engage in risk-taking behaviour, inexperience with alcohol and other substances resulting in a failure to predict their disinhibitory effects and relative inaccessibility of health facilities. Among those that are sexually active, those in the youngest age groups are most at risk; in South Africa, 60% of all HIV infections occur in the 15 to 24 year age group. Some of the reasons that young females are more vulnerable than males are provided below:

They are often involved in sexual relationships with older men who may have been exposed to a greater number of partners. This situation is exacerbated by the belief held by some men that having coitus with a virgin will cure them of HIV disease.

Young girls are sometimes physically forced to have intercourse, resulting in genito-urinary trauma with lacerations and hence risk of infection

STD's in females are more likely to be asymptomatic and hence not treated.

Women are more likely to be involved in commercial sex work, which is characterised by a very high risk of contracting STD's.

Complications of STD's include infertility, pelvic inflammatory disease, ectopic pregnancy, sepsis, premature birth, perinatal problems and malignancy (especially cervical carcinoma).

The STD with the most ominous implications for the health of young South Africans is HIV infection. In 1998, the proportions of women attending antenatal clinics who were HIV positive were 21% and 26% for those aged less than 20 years and 20 to 24 years respectively. The age group 20 to 24 years had the highest annual HIV infection rate between 1990 and 1997. However, in 1998, women aged 25 to 29 years had the highest rate (26.9%). Of particular concern is the increasing percentage of women under 20 years that are HIV positive; there was a dramatic increase for this age group from 12.7% in 1997 to 21.0% in 1998.

Assuming an incubation period of 8 - 9 years, these youth will not live to their 30th birthday. The Department of Health estimates that at these levels, around 1 in 5 South African women currently aged 20-24
will die of AIDS. It is estimated 2,226 people aged 15 to 19 years and 10,438 people aged 20 to 24 years died (or will die) from AIDS in the 12 months beginning 1 November 1998. There are twice as many females among these deaths than males.

6.1.3 Intervention strategies
(a) Creating a safe and supportive environment
   promote delayed childbearing
   promote marriage preparedness
   expand access to education and training, especially for girls and women
   provide income-earning opportunities, especially for young women and those offering sex on a commercial basis
   attempt to alter social norms that tend to stigmatise religious and cultural groups, single mothers and those living with the HIV/AIDS
   encourage public debate on sexual and reproductive health
   facilitate easy, cheap and private access to all forms of contraception (including "emergency contraception"); in the case of condoms, such access should exist at all times of day or night, especially at venues at which adolescents and youth congregate such as: shebeens; taverns; sports and recreation facilities; cloak rooms; shopping complexes; restaurants; sites of learning; and filling stations.
   facilitate effective communication between parents or caregivers and their children in general and about sexuality in general
(b) Providing information
   use multi-media methods to provide information to adolescents and youth and their families about all matters pertaining to sexual health, taking into account the results of studies that aim to document current gaps in knowledge, on matters such as: the personal risk faced by young people abstinance; the advantages of postponing the onset of sexual activity safer sex, including monogamy and condom use; sexually transmitted infections; post coital contraception (the "morning after pill" or "emergency contraception"); and how to access termination of pregnancy
   emphasise the necessity of "dual protection", i.e. protection against both pregnancy and disease
   increase the amount of sexuality information in school curricula, using the "spiral curriculum" concept whereby developmentally appropriate material is conveyed from Grade 1 onwards
   young people should be encouraged to respect each other's self determination and to share responsibility in matters of sexuality and reproduction
   raise awareness among political, government, religious and other community, leaders about sexual health, including aspects such as: the right to make informed choices about abortion; the need for sexuality education from an early age; the necessity of taking steps to reduce stigma attached to groups of people such as single mothers and people with AIDS
   sensitize parents and adults in general on the importance of talking to their children about sexuality
(c) Building skills
   support existing efforts to provide life skills training to adolescents and youth and institute such programmes at sites where they do not exist yet
   include skills specifically relevant for sexual health in life skills programmes, such as: decision making;
negotiating contraceptive use;
saying "no" to unwanted sexual advances or activities

(d) Counselling
establish or strengthen peer counselling programmes for both in and out of school adolescents
provide training in sexuality counselling for adults who have contact with adolescents and youth, especially
educators and health workers
provide counselling to pregnant teenagers on parenting skills.

(e) Access to health services
work towards the integration of sexual and reproductive health services (including termination of pregnancy
services) at the primary, secondary and tertiary levels of health care
a establish transport and communication facilities for effective referrals between health facilities
a establish national standards and mechanisms for monitoring standards of care for reproductive health
services
improve training of doctors, nurses, social workers and other staff involved in sexual and reproductive health
service provision, including as regards
responding to adolescents and youth with empathy and respect; and
maintain confidentiality
a establish an audit system on sexual and reproductive health services at all levels of health care
ensure that sexual and reproductive health services constitute a central component of youth-friendly health
facilities
a improve screening for sexually transmitted infections
promote the syndromic approach to the treatment of sexually transmitted infections
with regard to termination of pregnancies:
they should be accessible to even the poorest and most rural women
infrastructure and referral pathways should be strengthened to prevent patients who are referred for
termination not arriving at the relevant facility
women should be counselled and empowered to make the choice about whether to terminate pregnancy that
is appropriate for them in terms of their values, religious convictions and social circumstances
the aim should be to reduce the demand for terminations through improved contraceptive coverage (including
post-coital contraception)
management protocols should be both provider- and recipient-friendly
women undergoing termination should be provided with information and counselling that would prevent
future pregnancies
the right of health care providers not to participate in terminations should be scrupulously respected

6.1.4 Examples of indicators
%age of pregnancies among young women < 20 years ending in abortion
%age of women with first birth < 20 years
%ages of young people living with HIV/AIDS
%ages of young people with STD's (excluding HIV infection)
age at first pregnancy
age of coital debut
average menarche age
average spermache age
characteristics of male progenitors (age, educational level, type of employment)
divorce rates
existing legislation on reproductive health
existing standards for reproductive health care
fertility rates
levels of satisfaction of adolescents and youth with reproductive health services
marriage rates
maternal mortality ratio (<17 years)
number and percentage of young people sexually active
number and percentage of young people who use each type of contraception, if they are sexually active
number and percentages of pregnant young people according to educational level
number and percentages of young people who receive some formal type of sexual education
organisations, associations or services providing each type of contraception
percentage of births attended by fathers
percentage of pregnant young people initiating antenatal care by each trimester of pregnancy
population of young people as percentage of the total population
total population of young people
violence incidence and prevalence against young people, including sexual abuse
who they receive sex education from
young people's knowledge about sexuality, contraception, STD's

6.2 Mental Health
Note that mental health issues receive attention in other sections. Alcohol, tobacco and other substances is
dealt with in Section 6.3; mental health issues in relation to violence in Sections 6.8; and mental handicap in
Section 6.4. However, suicide has been included here since it is most sensibly regarded as a manifestation of
mental health problems.
The Directorate: Mental Health and Substance Abuse of the Department of Health is developing policy
guidelines to address the mental health needs of adolescents and youth. The current policy guidelines should
be read in conjunction with those being developed by the Directorate: Mental Health and Substance Abuse.

6.2.1 Situational analysis
South Africa has a number of characteristics that place its adolescents and youth at risk for mental health
problems, such as widespread poverty and familial disruption. However, there are very few studies that
attempt to provide prevalence rates for psychiatric disorder in adolescents and youth, and these studies are
of variable quality, use different assessment methods, generally do not address the cultural aspects of
psychopathology in the relevant communities, and tend to be clinic-based. There are certainly no national
studies. However, based on existing estimates and international data, it would be reasonable to assume that
approximately 15% of young people in South Africa suffer from mental health problems warranting a
psychiatric diagnosis. The overwhelming majority of these would benefit from mental health services.
One particularly conspicuous and tragic manifestation of mental health problems is suicide. There are wide
racial discrepancies in the extent of suicide, with the proportions of deaths of 15- to 24-year-olds being
between 9 and 12% for Asians and whites of each gender, and below 3% for others. Although there is
concern that suicide may be increasing among young South Africans, this is supported by empirical evidence
in the case of young white males only. Deaths from suicide account for only one aspect of the problem of
suicidality; it is estimated that the ratio between completed suicides and non-fatal attempts varies between
50 and 120 to 1. Among Cape Town high-school students, 19% had thought about committing suicide in the
past year, while 8% had made an actual attempt in this time period. The relevance of this for mental health is
that the overwhelming of young people who commit suicide are suffering from a treatable mental disorder at
the time of their death, and those with non-fatal suicidality are at substantially increased risk for such
disorder.
In the context of these large service needs, there are very few mental health services for adolescents and
youth. There are only six provincially supported child and family units, and a handful of specialist
adolescent units that are linked to academic complexes. These services are relatively inaccessible to many
young people, especially those in disadvantaged and rural communities. Primary and secondary level mental
health services are particularly underdeveloped. Young people with severe psychiatric conditions requiring
hospitalisation generally receive custodial care, followed by attendance at out-patient or community clinics
where interventions other than pharmacological therapy receive low priority. Mental health services (like
health services in general) are fragmented and ill-equipped to intervene effectively. There is poor
inter-sectoral liaison and co-ordination of services, resulting in duplication and fragmentation. There is limited
expertise to deal with adolescent and youth mental health issues, especially at the primary level. Graduates
of training programmes are frequently not equipped to respond to the public mental health needs of the
majority of South African young people.

6.2.2 Impact
There are other consequences of mental health problems in adolescents and youth besides immediate and
obvious impacts of suffering (both for the person with mental health problems and their significant others),
family disruption and poor educational progress or dropout. First, if not treated appropriately, people with
mental health problems when young are at increased risk for such problems in adulthood. Second, there are immense economic consequences of poor mental health, both for the family and society at large. Societal costs accrue from factors such as the costs of treatment, welfare benefits, and a reduced ability to contribute to society.

6.2.3 Intervention strategies
(a) Creating a safe and supportive environment
improve the safety of the environments of children (to prevent head and other injuries that can directly cause impairment of mental health)
(a) provide adequate recreational facilities at convenient places for adolescents and youth
support parents to prevent negative family conflict, which predisposes to and precipitates mental health problems and suicidality
facilitate the formation of youth and adolescent mental health fora to identify community-specific causative factors for poor mental health
work with the media to ensure that suicide is reported in a responsible manner, which would include not glamorising or giving excessive coverage to suicides of famous people
limit access to means of suicide, such as weapons and (in certain rural communities) pesticides
(b) Providing information
engage in public education about mental health, with a view to: (a) promoting mental health; (b) destigmatising mental health problems; (c) assisting young people and the members of their support systems to recognise mental health problems and obtain the necessary assistance
educate and raise awareness of young people, parents, family and the community in general about suicide, emphasizing the fact that suicidality is a potent signal of unmet mental health needs
(c) Building skills
include in existing life skills programmes measures that may promote mental health or prevent suicide, such as how and where to request assistance with mental health problems
(d) Counselling
increase access of young people to counseling services, including telephone hot lines, crisis centres and counseling services at primary health care level
educate adults already in positions where young people approach them for assistance regarding mental health issues, including the warning signs of suicide and the necessity of taking suicide threats and other signs indicating the possible presence of mental health problems seriously
(e) Access to health services
mobilise additional resources to improve mental health services for adolescents and youth
conduct research in which the magnitude and nature of mental health needs of adolescents and youth in South Africa are documented
improve national statistics regarding the prevalence of completed suicide and suicide attempts
develop mental health services for adolescents and youth at primary, secondary and tertiary levels (Table 1)

Table 1. Levels of adolescent and youth mental health services (adapted from Dawes et al)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Level</th>
<th>Site</th>
<th>Personnel</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>District</td>
<td>Clinics, Schools, District hospitals, Maternity services, Courts, Penal system, Children's homes, Families, Private practises, NGO's</td>
<td>Generally not mental health specialists</td>
<td>Parental and youth education about mental health issues, Screening for mental disorder (including suicidality), Identification of young people at risk for abuse, Short-term counselling services for young people and their families</td>
</tr>
<tr>
<td>Secondary</td>
<td>Region</td>
<td>Regional hospitals</td>
<td>Child Guidance Clinics</td>
<td>Child abuse units</td>
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<td>-----------</td>
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<td>-----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Tertiary</td>
<td>Province/nation</td>
<td>Academic health complexes, including child and family units, eating disorder units, adolescent units, abuse units</td>
<td>NGO's</td>
<td>Private sector</td>
</tr>
</tbody>
</table>

- develop human resources particularly at primary and secondary level to provide the services listed in Table 1
- develop an appropriate mental health information system for evaluation, auditing and monitoring of mental health programmes for adolescents and youth, including the development of indicators
- ensure that mental health programmes for adolescents and youth at all levels address key priorities, such as violence, abuse, suicide, and severe psychiatric conditions, including the detection of these conditions
- take steps to ensure that medication required for the management of psychiatric problems in adolescents and youth are available at all levels
- ensure that comprehensive integration of youth and adolescent mental health services with other services takes place
- where appropriate, involve communities (including disadvantaged and rural communities) in the planning and implementation of adolescent and youth mental health care services at all tiers
- increase the number of people responsible for adolescent and youth mental health services at national and provincial levels, and improve their managerial capacity
- include a mental health component in the health promotion efforts at schools
6.2.4 Examples of indicators
- Percentage of young people attending health facilities with "psychosomatic" complaints
- Attempted suicide rates
- Autonomy
- Incidence and prevalence of selected psychiatric disorders
- Self-esteem
- Suicide rates

6.3 Substance abuse

6.3.1 Situational analysis

Alcohol is the substance most frequently abused by young South Africans. A representative national study of black youth aged 10 - 21 years reported that 80% had used alcohol at some time, while 34% were current drinkers (i.e. had used alcohol in the last twelve months prior to the study). Of more concern is levels of risky drinking, defined as consuming the equivalent of about 3.5 x 340 ml cans of beer per day. Using this definition, it was found that 4.4 and 7.8% of urban and rural black youth respectively were risky drinkers, with the corresponding figures for females being 1.9% and 1.8% respectively. Equivalent statistics are not available for other (non-Black) youth.

Among Cape Peninsula high-school students, 27% and 15% of males and females had engaged in binge drinking in the fortnight preceding the study. Among those who had dropped out, there was a trend for the rates of binge drinking to be somewhat higher. There is some evidence that the rates of risky drinking among high-school students in the Cape Peninsula may have increased between 1990 and 1997.

Another drug that is frequently abused is tobacco. Among Cape Peninsula high school students, 18% are regular smokers, i.e. smoke at least one cigarette per day. Among males in Grade 12, the proportion is 28%!

Data for the last two decades from other provinces are not available yet, but there is no reason to suspect that there may be substantial differences between the provinces.

Illicit drugs constitute another important group. Among Cape Peninsula high school students, 7.5% had ever used cannabis, and 2.4% had done so in the previous seven days. Of the total sample, 1.6% had ever used methaqualone (Mandrax). Use of other illicit drugs appears to be very low among school students, at least in Cape Town. The study among black youth aged 10 to 21 years mentioned above found that cannabis use was confined to urban males, among whom 5.5% had used cannabis. The same study found low rates of other illicit substances in the past 12 months: 1.5% for LSD, 1.7% for Mandrax, 0.8% for cocaine, 0.9% for heroin and 2.9% for steroids. However, with South Africa's increasing exposure to international drug traffic, it is likely that these prevalence rates will increase. Other possible substances that can be abused are prescription drugs (especially minor tranquillisers), over the counter sedatives and weight-reducing agents, and solvents. In general, rates of substance misuse are higher among males, and increase with increasing age or school grade.

6.3.2 Impact

Young people, especially young adolescents, are particularly vulnerable to the short-term adverse impact of substances such as alcohol and illicit drugs, for two reasons: they may have lower tolerance due to relatively smaller body size; and they may lack experience with the effects of the substance. The short-term adverse outcomes include injury and death from traffic accidents and assault, overdoses, suicidality and poor scholastic performance or drop-out. In addition, inhibitions may be lowered, increasing the likelihood of participation in unsafe sex with the attendant risks of unwanted pregnancy and STIs. Intravenous drug use is a risk factor for HIV infection through using "second-hand" needles. Partly for economic reasons, a minority of young people become involved in drug dealing/trafficking. Besides having repercussions for those whom they supply with drugs, they area at risk for sexual exploitation and spiralling involvement in other crimes and gang involvement.

The long-term impact of substance use tends to become evident when the abusers are in their thirties or older. However, the patterns of substance use that lead to these outcomes has invariably been laid down in adolescence. This is part of the reason that tobacco and alcohol companies target adolescents in their advertising campaigns. Important fatal outcomes of alcohol and tobacco use include heart disease and malignancies (especially lung cancer for tobacco). Alcohol can also cause foetal alcohol syndrome; 26% of the young women attending routine antenatal classes in selected poorer Western Cape communities consume sufficient alcohol to place their babies at risk for this syndrome. There are also substantial economic
consequences of substance use from factors such as absenteeism, increased use of medical benefits, increased workers compensation claims, poor productivity, high job turnover, interpersonal conflict, injuries and damage to property. These economic consequences will adversely affect the ability of the country to achieve economic targets, such as those included in the Growth, Economic and Redistribution Policy.

6.3.3 Intervention strategies
Many of these intervention strategies are derived from the work of Adolescent Health and Development Programme of the WHO, the Framework for a National Drug Master Plan and the work of Charles Parry and Anna Bennett.

(a) Creating a safe and supportive environment
decrease availability by:
increased collaboration with international drug control agencies in pursuing drug syndicates and addressing drug production
bilateral and sub-regional agreements
improved co-ordination of different agencies involved in enforcing drug laws (e.g. SA Police Services, SA National Defence Force)
enforcing existing legislation regarding the minimum age of drinking, the "dop" system and public drunkenness
improved training of and equipment for customs officials increased rewards and witness protection for people reporting illegal substance-related activities
supporting cannabis crop eradication and substitution
decrease the social desirability of substance use (thus altering social norms and cultural practises) by rigorous enforcement of the Tobacco Products Control Amendment Bill, which outlaws advertising or promoting any tobacco product and prohibits smoking in public places
advocating for legislation to increase restrictions on alcohol advertising, including sports sponsorship and the times of day when alcohol can be advertised
declaring certain areas to be drug-free (including alcohol, tobacco and other drugs) such as schools, workplaces, sports facilities
make blood and urine testing mandatory for all drivers involved in motor vehicle accidents
introduce random "spot" breath, blood and/or urine testing checks for drivers
increase taxation on alcohol and tobacco products
license all liquor outlets, including shebeens, to increase control over aspects such as under-age drinking
provide free needles or arrange needle exchange programmes for young people addicted to intravenous drugs (to prevent HIV transmission)
build pedestrian bridges or tunnels for busy roads
foster positive role models, such as sport and entertainment stars, to speak out against substance misuse

(b) Providing information
institute vigorous multi-media campaigns to educate young people about substance use, taking care to include young people in the planning and implementation of such efforts
require warning labels on alcohol products referring to aspects such as drinking and driving and drinking in pregnancy
use counter-advertising to challenge some of the myths propagated by advertisers and others, such as that certain products increase stamina, energy or potency
include a focus on drinking and driving in education programmes
educate parents, teachers and other adults close to young people of the importance of not explicitly or implicitly condoning cigarette smoking, illicit drug use and inappropriate alcohol use
prioritise young people at particular risk in education programmes, such as:
pregnant adolescents and youth
sex workers
homeless adolescents and youth
children of people who have substance-related problems
support the work done by religious organisations, NGO's and CEO's in educating young people about substance abuse

(c) Building skills
• ensure that the social skills that are particularly relevant for substance use are included in existing life
skills programmes, such as:
• assertiveness
• withstanding peer pressure
• delaying gratification
• reducing vulnerability to advertisements
(d) Counselling
• improve the substance-related component in the training of people who are already counselling young people in this regard, such as
• educators
• religious leaders
• health workers
• hotline counsellors
improve availability of substance-related counselling services at key sites (e.g. schools, health facilities, prisons, streets)
increase the availability of telephone hotlines in all official languages
support self help groups and families of young people with substance use problems
(e) Access to health services
improve training of health personnel (especially nursing staff) in the detection, diagnosis and management of patients suffering from substance abuse, both in their or specialised professional training and their continuing professional development
ensure that the management of young people with substance-related problems is integrated into primary health care services
improve the consultation and liaison support in the field of substance abuse and dependence available to health workers at primary level
improve the capacity of the health services to offer detoxification and out-patient treatment services
increase the number of day and in-patient programmes for young people with substance-related problems
ensure that health services with the above characteristics are available in key sites such as prisons and health services at tertiary educational institutions
improve the detection rate for alcohol and other drug abuse at antenatal clinics, and provide the appropriate services to reduce the incidence of foetal alcohol syndrome

6.3.4 Examples of indicators
%age of young people who have ever used selected substances
%age of young people who are regular users of selected substances
%age of young people who use selected substances in a week, month and year
age of commencement of use of selected substances
attitudes and knowledge pertaining to use of selected substances

6.4 Violence
6.4.1 Situational analysis
Violence is an important cause of morbidity and mortality among the youth. Assault is the leading cause of death among coloured and black adolescents aged 15 - 19 years, accounting for 47% and 44% respectively of deaths in this age group. Among Asians and whites the proportions were 6% and 14% respectively. Mortality data underestimate the full extent of the problem. Less than 1 % of adolescents who present at health facilities for the treatment of assault die from their injuries. Among Cape Peninsula high-school students, 13% and 10% had been injured by another person at home and school respectively. In another Cape Town study conducted among 60 children in a children's home and a part of Khayalitsha, Cape Town, characterised by high levels of community violence, 95% had witnessed violence and 56% had been victims of violence themselves.
Gender violence, including various kinds of domestic violence, rapes and other forms of sexual assault and sexual molestation, are recognised as a major problem in South Africa. In a study conducted in Khayalitsha, Cape Town, the majority of adolescents reported that coercive and violent intercourse is a consistent feature of their sexual lives. All but two of the 24 informants reported having been beaten by their partners on multiple occasions. In another study, it was found that the first sexual encounter was generally coercive and
occurred with a male partner that was about 5 years older. The participants reported threats, violent practices including forcing legs apart, tearing off clothes, punching with fists and locking the door. Another study found that forced sex occurred among nearly a third of urban black youth. Ncayiyana and Haar (1989), reported that a quarter of pregnant rural Transkei girls in their study experienced their first coitus under duress. Again, there is a dearth of data regarding other (non-Black) young people.

People who are known to be HIV-positive are at risk for assault. Such was the case of a woman who was ruthlessly murdered by neighbours in KwaZulu Natal, soon after revealing her HIV-positivity.

The causes of violence can be conceptualised in three domains: the victim, the agent and the environment. Victim-related factors include:

- age;
- gender;
- physical strength;
- low self esteem;
- peer pressure;
- poor communication skills;
- substance abuse;
- and lack of information;

Agent-related factors include ease of access to weapons such as knives and firearms. Environment-related factors include:

- political intolerance;
- unresolved political issues such as provincial border disputes;
- gender and racial discrimination;
- media, e.g. access to violent films and television programmes;
- unsafe sports and other recreational activities;
- insufficient opportunities for adolescents and youth to participate in decision making;
- inadequate educational systems resulting in a lack of academic fulfillment, high drop-out rates and a failure to re-integrate dropouts into the educational system; and
- adverse social circumstances, e.g. the disintegration of the family, unemployment, and migrant labour.

6.4.2 Impact

Violence and violent crimes have immediate impact on the physical and psychological well being of the youth. Physical effects can include permanent disability. Short-term effects can include sleep disturbance, inattention, poor concentration, social withdrawal, physical complaints such as headaches and stomach aches, and behavioural problems. More serious reactions persist as post-traumatic stress disorder, which reflects intense fear, horror and helplessness associated with the violent trauma. Typical symptoms are: recurring flashbacks of the event, in which the trauma is re-experienced (e.g. in bad dreams), deliberate efforts to avoid thoughts and feelings about the trauma, and persistent hyper arousal (manifest, for example, by jumpiness and disturbed sleep). Continuing symptoms of this nature interfere with the development of the adolescent or young person.

6.4.3 Strategies

(a) Creating a safe and supportive environment

- design low cost housing to maximise defensible space and mutual visibility
- maximise use of electronic monitoring devices in public and private spaces
- encourage the media to be responsible in their programming, for example limiting the extent to which adolescents and youth are exposed to violence in television programmes
- improve access to telephones for reporting incidents
- ensure strict application of existing firearm limitation legislation and work towards increasing the restrictiveness of legislation
- restrict ammunition sales
- encourage safe weapon storage at home
- smash illegal gun markets
- restrict availability of dangerous knives
institute post-release rehabilitation programmes for perpetrators of violent crimes
prevent presence of weapons at public places
increase use of metal detectors and body searches at public events or particularly vulnerable places to which
the public have access (such as police stations)
outlaw all corporal punishment
reduce alcohol and drug abuse (see above)
provide shelter for abused adolescents and youth, especially females

(b) Providing information
institute vigorous multi-media education campaigns that convey the importance of:
resolving conflicts in non-violent ways;
walking away from situations that are potentially violent;
safe storage of weapons and other objects that could be used as weapons;
the negative consequences of violence both for the victim and perpetrator (to reduce the social desirability or "culture" of violence)
educate parents about non-violent disciplinary techniques to reduce their dependence on corporal
punishment and other forms of violence
provide the public with information derived from analyses of violent crimes regarding factors such as places and times where crimes were committed
disseminate information about successful crime prevention efforts

(c) Building skills
develop programmes to enhance skills that are relevant for violence prevention, such as:
resolving conflict in non-violent ways;
how to leave potentially violent situations; and
how to make one's needs known in a way that is assertive yet non—violent
jobs skills training
how to maximise general health and fitness
how to use alcohol responsibly and reduce or cease intake of other mind-altering substances
ensuring that the above social skills that are incorporated in existing life skills programmes

(d) Counselling
train members of the SA Police Services, the health services and other people that come into contact victims
of violence in their work to respond to victims in an empathic and constructive manner

(e) Access to health services
give particular attention to mothers that are at risk to abuse their infants, for example by more frequent clinic
visits or home visits both before the birth and after
train health care professionals in the identification, management and referral of victims, both from the physical and psychological points of view

6.4.4 Examples of indicators
%ages of health care professionals who are trained in the identification, management and referral of victims
mortality rates for homicide
number and nature of programmes to enhance skills that are relevant for violence prevention
numbers and %ages of young people involved in gangs
numbers and %ages of young people receiving treatment for injuries
numbers of young people seeking shelter following violence
prevalence rates for violence in boyfriend/girlfriend relationships

6.5 Unintentional injuries

6.5.1 Situational analysis
Unintentional injury is one of the leading causes of mortality and morbidity among youth in both developed and developing countries. Socio-economic changes taking place in South Africa, and rapid urbanisation, increasingly expose the youth to hazards such as road accidents. Road accidents were the most common external cause of death among South African adolescents aged 10 to 14 years in 1984-1986. It was also the most common external cause of death among white and Asian adolescents aged 15 to 19 years, and the second
most common cause for the remainder. (Although these studies were conducted some time ago, more contemporaneous data are not available)

Of course, as for violent deaths, mortality data are 'only a tip of the iceberg' so far as the consequences of unintentional injuries are concerned. Among high school students in the Cape Peninsula, for example, 9% had been involved in an accident while traveling in a motor vehicle during the previous twelve months, and 7% had been injured as pedestrians by a motor vehicle, motorcycle or a bicycle. Risk behaviour can be implicated in these accidents. Only 63% had worn a safety belt on the last occasion they had traveled in the front seat of a motor vehicle. Of those who had driven a vehicle during the previous year, 8% had done so under the influence of alcohol or cannabis, while 63% had done so without a license. Although data are not available for other sites and age groups, there is no reason to suspect that the same overall trends would prevail. In particular, it would be difficult to underestimate the effect of alcohol and other substance use on the incidence of road-traffic "accidents".

There are several other types of unintentional injury for which data are lacking, such as burns in the home and unintentional poisonings.

6.5.2 Impact
The physical and psychological impact of unintentional injuries are similar to those of injuries caused by violence.

6.5.3 Intervention strategies
Clearly, the intervention strategies vary according to the cause of the unintentional injury. By way of example, the strategies that are appropriate for road-related injuries are provided below. Clearly, similar sets of strategies would need to be developed for the other causes of unintentional injuries.

(a) Creating a safe and supportive environment
improve street lighting
where possible, build sidewalks
build bridges or subways at places where large numbers of people cross busy roads
compel motor vehicle manufacturers to install air bags in all new cars
enforce existing legislation regarding aspects such as seat belt use, driving under the influence of alcohol, reckless driving, and helmet use
introduce legislation requiring wearing a helmet when riding a bicycle
promote a "culture" of care and consideration on the roads

(b) Providing information
provide multi-media education campaigns, involving a wide variety of organisations (e.g. NGO's, schools), to convey the dangers of unsafe road-related behaviour
educate policy makers in all relevant sectors about steps that can be taken to reduce the incidence of unintentional injuries

(c) Providing skills
where appropriate, offer training in driving skills to young people
assist adolescents and youth to acquire skills in first aid

(d) Counselling
improve the ability of health service providers to offer counselling to victims of unintentional injury

(e) Access to health services
improve the emergency management of injured people, both within the health system and NGO's

6.5.4 Examples of indicators (for road-related injuries only)
• %age of vehicles with air bags installed
%age of young people using a helmet when driving a motorbike and bicycle
%age of young people with a knowledge of basic first aid
%ages of young people driving while under the influence of alcohol
%ages of young people using seat belts
nature and extent of campaigns to convey the dangers of unsafe road-related behaviour
proportion of streets with street lighting and sidewalks
proportional mortality and mortality rates for road-related injuries

6.6 Birth defects and inherited disorders
6.6.1 Situational analysis
There is limited data available in the prevalence of birth defects and inherited conditions amongst the youth and adolescents in South Africa. It is estimated that 1/40 people are born with birth defect and 1/10 people are affected by genetic conditions at some stage of their lives. Some genetic conditions are visible at birth whilst others manifest themselves later in life. Conditions which have a major impact on the lives of teenagers include neural tube defects, albinism, down syndrome, muscular dystrophy, haemophilia and cystic fibrosis.

6.6.2 Impact
Myths that certain genetic conditions do not exist within the Black population has contributed to their under-diagnosis. The reason perhaps that these conditions are thought not exist within the black population is because most of these children are vulnerable and die at an early age due to childhood illnesses like diarrhoeal diseases and upper respiratory tract infections.

The impact of having someone with a genetic condition in the family is mainly on the provision of care for this young person. Often the caregivers are mothers and this means that they are unable to get full time employment to support their families. In the rural areas, this contributes greatly to the continued cycle of poverty.

The lack of genetic counselling often means that the mother may have a second child with a similar condition. It is therefore essential that young people as future parents, are aware of the health services that they should seek out.

A condition such as albinism although not life threatening, impacts on the teenagers' ability to socialise with his/her peers. The mental handicap associated with down syndrome may also affect the young person's ability to interact socially. The limited mobility resulting form neural tube defects and muscular dystrophy as well as the quality of lives of these affected individuals greatly impacts on their social lives as young people and as potential employees. Haemophilia and cystic fibrosis may limit the young person's involvement in physical activities.

6.6.3 Intervention strategies
Creating a safe and supportive environment
• increase access to medical treatment for birth defects and inherited conditions
• no discrimination in access to schools, the workplace, medical insurance and in social activities
(b) Providing Information
create awareness on specific birth defects and inherited conditions common in South Africa
educate that anyone can be a carrier of a genetic condition
educate on the primary prevention of conditions like neural tube defects and Fetal Alcohol Syndrome. This may involve caution against consequences of binge drinking and unprotected sex, information, on the risk of having a child with albinism and the encouraging folate supplementation three months prior to conception
educate young people on the available services in the health sector

(b) Building skills
Involve young people in creating awareness on genetic conditions

(c) Provision of health services
prospective parents to be made aware of available tests on genetic counselling
provide pre-test counselling - "what the test may mean"
provide post test counselling - "what the results mean"
it is important that health providers be aware of the psychological impact of providing some of the genetic tests on both those who test positive and negative, and to respect the individual's right (within the extended family) not to want to know.

6.7 Nutrition
6.7.1 Situational analysis and impact
Malnutrition contributes more than any other factor to disease and injury worldwide. It contributes to iron deficiency anaemia, which is the third leading cause of disease for women between the ages 15 - 44 in developing countries. Malnutrition and anaemia contribute to many of the diseases found in pregnancy and delivery and play a part in many maternal deaths. Iron deficiency anaemia is also one of the causes of morbidity, especially for pregnant and lactating women in South Africa. Among pregnant adolescents in KwaZulu-Natal, anaemia was found to be related to low birth weight and pre-term delivery.

There is a significant body of research on the nutritional status of South African children. An anthropometric survey conducted on 97,790 primary school entrants selected from 3,300 schools across the country showed that 13% of the pupils were stunted, 9% were underweight and 3% were wasted. Also, it has been estimated that 20% of primary school children in South Africa are stunted and suffer from chronic malnutrition.

Whilst there is literature on the nutrition status of children in South Africa, much less research has been done on youth. From the little information available, it appears that folate and iron deficiencies are common amongst adolescents across all ethnic groups. Although sufficient in energy, carbohydrate, fat and protein intakes, pregnant adolescents in KwaZulu/Natal were found to be below recommendations in 14 nutrients. Children who are malnourished and have various macro-nutrient deficiencies do not usually have normal growth, and this may have implications for their growth even well into their youth. Research shows that pregnant and poor teenagers, who are malnourished as children, tend to have malnourished babies and often the cycle of malnutrition continues. Where a teenage mother has to return to school, her baby may be undernourished, as s/he is left with an often overburdened grandmother.

While inadequate energy intake is the major macro nutritional problem in sub-Saharan Africa, there is also the prevalence of excess energy intake or obesity. This is partly attributable to a proclivity towards "fast foods". The decline of infectious and communicable diseases and increased life expectancy can be expected to increase the prevalence of non-communicable diseases in the near future. South Africa exhibits both problems of inadequate dietary intake, and obesity and associated diseases of lifestyle such as high blood pressure, unfavourable lipid profiles and diabetes mellitus.

At present there are no specific nutrition intervention strategies targeted for youth and adolescents. However, the broad goal of the Integrated Nutrition Programme (INP) is to facilitate a coordinated inter-sectoral approach to solving nutrition problems in the country. The emphasis is on building long term capacity of communities to be self-sufficient in terms of their food and nutrition needs, and at the same time on protecting and improving the health of the most vulnerable groups of the population (children and pregnant and lactating women).

6.7.2 Intervention strategies
(a) Providing a safe and supportive environment
   • streamline and monitor Integrated Nutrition Programme activities to focus on adolescents and youth provide adequate nutrition for young people in institutions such as prisons, places of safety, hostels, and care institutions.
   fortify staple foods where appropriate
   implement school feeding in schools serving children from poor households
   provide food supplementation to:
      malnourished children;
      at-risk pregnant and lactating women;
      those suffering from chronic diseases of lifestyle or communicable diseases; and
      the at-risk elderly
(b) Providing information
   • ensure that nutrition education comprises an aspect of the curriculum in secondary schools, with a particular emphasis on aspects of importance for adolescents such as:
      • skin problems;
      • body weight;
      • muscle development;
      • pregnancy;
      • breast feeding; and
      • food-specific cultural differences
(c) Providing skills
build capacity of the youth and adolescents to make informed decisions regarding their nutritional well-being through properly targeted nutrition programmes and/or activities

d)  Counselling

develop specific nutrition counselling/education programmes targeted at adolescents and youth suffering from nutrition-related diseases (including obesity)

(e)  Health services

develop nutrition surveillance directed at adolescents and youth and adolescents to increase the available information on the nutritional needs of these age groups
provide primary and secondary nutrition interventions at health facilities, especially for those that are underweight and have micro-nutrient deficiencies
ensure that growth monitoring takes place, especially for adolescents and youth that have a chronic disease or are underweight or have micro-nutrient deficiencies

6.7.4  Examples of indicators

%age of institutions of various kinds that provide an adequate diet
%age of schools in poor areas with school feeding schemes
%age of young people who experience hunger
%age of young people who go to school without having had breakfast
food consumption patterns
growth and pubertal development patterns of young people
mean levels of cholesterol and triglycerides in serum
nutritional status of young people using the body-mass index
prevalence of iron deficiency anaemia
the extent to which staple foods are fortified

Oral health

6.8.1  Situational analysis

The oral health of South Africans is poor. About 90% of the population are affected by oral disease, in particular dental caries and periodontal disease. (National Oral Health Survey, South Africa 1988/1989) A survey of farm workers in the Boland, Western Cape, found that only 3% of six-year-olds were caries free, and only 15% of 18-year-olds still had all their teeth. The current oral health problems are likely to worsen as a result of rapid urbanisation and lifestyle changes, which usually result in increased sugar consumption—hence increase in dental caries (Department of Health, 1997).

Oral health status is affected by factors such as:
lack of fluoridated water and running water;
a lack of information and awareness of the importance of good oral hygiene;
inaccessible and unaffordable oral health services - of all the facilities available in the public sector, only 15% have oral health facilities;
uneven distribution of oral health curative services between the public and the private sectors, with the 10% of oral health professionals that are employed in the public sector having to attend to the oral health needs of more than 80% of the total population;
a failure to fully integrate oral health programs into existing primary health care services and a low priority at primary health care level;
an inadequate coverage of oral health services in schools, especially in rural areas where these services are not available at all;
demands for tooth extractions and modification for cosmetic purposes, due to lack of oral health knowledge by the majority of the population.

6.8.2  Intervention strategies

(a)  Providing a safe and supportive environment

fluoridation of the drinking water supply (in collaboration with the Department of Water Affairs and Forestry)

promote community (especially adolescent and youth) involvement during national, local and public campaigns, especially on national health days and national dental health week.

(b)  Providing information

Aim to increase knowledge about factors such as:
the use of fluorides;
the importance of good oral hygiene practices from an early age; and
the necessity of maintaining healthy eating practices, including a reduction in sugar intake
where necessary, alternative sources of fluoride administration, such as tablets and mouth rinses
include oral health education in the education curriculum

(c) Providing skills
imparting tooth brushing skills at pre-school and primary school level through organised tooth brushing programmes

(d) Counselling
train oral health workers to use opportunities present when providing curative services to counsel adolescents and youth about aspects such as oral hygiene and cosmetic practices
educate youth and adolescents to counsel their peers on oral health

(e) Health services
integrate oral health services into all levels of the health care delivery system
increase the number and accessibility of public oral health facilities and personnel
formulate strategies to make optimum use of the available human resources

6.8.4 Examples of indicators
numbers of caries and lost teeth
%ages brushing their teeth daily
%age of young people using fluoride
%age of water supplies that are fluoridated
of those who brush their teeth daily, %age using correct technique
%ages using dental floss or an equivalent method daily
numbers of oral health facilities
%ages of primary health care facilities with oral health services

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8. APPENDICES

8.1 Individuals and organisations who contributed to the development of the policy guidelines

8.1.1 Task team members

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8.1.2 Organisations which attended the tri-provincial workshops and/or one or both national workshops.

NATIONAL & PROVINCIAL DEPARTMENTS
Health
Welfare
Education
Agriculture
Correctional Services
Sports and Recreation National
Population Unit Public service Commission
NON GOVERNMENTAL ORGANISATIONS
PPASA
ATICC
NPPHCN
MEDICOS
HSDU
YDT
Youth Council
Border Institute of PHC
SAPLER Population Trust
Winterveldt Aids Trust
Youth Academy
Health Academy
Health Care Trust
Family and Marriage society of South Africa (FAMSA)
Azanian Youth Organisation (AZAYO)
Women's Health Project(WHP)
Reproductive Health Research Unit(RHRU)

EDUCATIONAL INSTITUTIONS
Wits Community Health
University of Cape Town

RELIGIOUS ORGANISATIONS
Apostolic Faith Mission Worship Centre
Council of Churches Religious AIDS Programme
South African Association of Youth Clubs
Young Men's Christian Association

OTHERS
Children's Rights School Guidance Dramaide
Children's Home

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8.2 Legislation and policy documents
This appendix consists of a list of legislation and policy documents that pertain to each priority area.

8.2.1 Sexual and reproductive health
Beijing Platform of Action
Child Care Amendment Act, 1991
Choice on Termination of Pregnancy Act 92 of 1996
Constant Curriculum change
Convention on the Elimination of all forms of Discrimination Against Women
Marriage Act 25 of 1961
8.2.2 Mental health
Arms and Ammunition Act 75 of 1969
Child Care Amendment Act, 1991
Convention on the Elimination of all forms of Discrimination against Women.
Criminal Procedure Act and Amendment Act 51 of 1977
Mental Health Act 18 of 1973
Films and Publication Act 65 of 1996
National Commission on Special Needs in Education and Training
National Committee on Education and Support Services
National Education Policy Act 27 of 1996
South African Schools Act, 1996
Sterilization Bill 78 of 1998
White Paper on National Disability Strategy and Bill of Rights

8.2.3 Substance abuse
Child Care Amendment Act, 1991
Cigarette Tobacco Bill
Criminal Procedure Act, 1977
Mental Health Act 18 of 1973
Liquor Bill 115 of 1998
Drug Master Plan
Drugs and Drug Trafficking Act (Act 140 of 1992)
Prevention and Treatment of Drug Dependence Act, 1992

8.2.4 Violence
Child Care Amendment Act, 1991
Basic Conditions of Employment Act, 1997
Criminal Procedure Act, 1977
Inter Ministerial Committee - Youth at Risk Policy
National Youth Policy
National Crime Prevention Strategy.
Correational Service Act., no 111 of 1996
International standard minimum rules. "Safe custody of young people".
Beijing Rules for institutionalization of young people.
Family Violence Act
Convention on the elimination of all forms of discrimination against women (CEDAW).

8.2.5 Unintentional injuries
- Road Traffic Act 29 of 1989
- Liquor Act 27 of 1987
Third party license

8.2.6 Birth defects and inherited disorders
Policy Document on Affirmative Action
Equity Bill
White paper on National Disability Strategy
Skill Employment Bill
Draft Mental Health Guidelines

8.2.7 Nutrition
Foodstuff, Cosmetics and Disinfectants Act 54 of 1972
Hazardous Substance Act Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies Act 36 of 1947

8.2.8 Oral health
Child Care Amendment Act, 1991.
Occupational Health and Safety Act, 1993
Medical, Dental and Supplementary Health Service Professions, 1997.