

Adolescent and Youth Health Policy 2012



Draft 10th December 2012

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FOREWORD

TO BE ADDED

As pointed out in the Second National Youth Risk Behaviour Survey (2008) youth is both a time of opportunity and of risk. The metaphor *umthente uhlaba usamila* – the grass prickles sharp as it grows – was employed by the authors to illustrate the disproportionate impact that behaviours learned or initiated during adolescence and youth have on their lifetime health outcomes.

This policy, which replaces the Policy Guidelines for Youth and Adolescent Health developed in 2001, represents an important milestone for young people. There is increasing international recognition of dedicating resources to adolescent and youth health, as an important and effective long-term investment strategy.

I wish to thank the team that spent many days, weeks and months working on this document. I would also like to thank the people who supported them to make this project a success. I hope the implementation of this policy will provide young people with services that are accessible, appropriate and friendly. I trust that it will improve the quality of care experienced by young people, and promote healthy lifestyles among adolescents and youth in our country.

ACKNOWLEDGMENTS

The Child, Youth and School Health Chief Directorate of the Department of Health would like to thank the individuals and organisations who contributed to the review of the Adolescent and Youth Health Policy. A special thank you goes to the Task Team members who dedicated their time and effort into making sure that the revised policy is aligned with the latest evidence and best practice in the field.

The task team members are as follows:

Department of Health

- Provincial Youth Coordinators
- National Department of Health: Intra-Departmental Committee on Youth Affairs (IDC)
- National Youth Health Forum

National Departments

- Department of Education
- Department of Social Development
- South African Police Services
- Department of Correctional Services

Academic Institutions

- Prof Alan Flisher (University of Cape Town)
- Prof Land (University of Cape Town)

Faith-Based Organisations

- Youth for Christ
- South African Council of Churches
- Religious Aids Programme

Developmental and Implementation Partners

- The Centres for Disease Control (CDC)
- World Health Organization (WHO)
- United Nations Population Fund (UNFPA)
- United Nations Children's Fund (UNICEF)
- USAID
- Love life
- IBIS Reproductive Health

A special thanks to CDC, UNICEF and WHO for the generous financial and technical support provided during the review.

EXECUTIVE SUMMARY

TO BE ADDED

ABBREVIATIONS - NEED TO BE UPDATED

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community based organisation
CHW	Community Health Workers/Community Care Workers
CRC	Convention on the Rights of the Child
CaCx	Cervical Cancer
CTOP	Choice on Termination of Pregnancy
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
HPV	Human Papilloma Virus
ISHP	Integrated School Health Programme
LGBTI	Lesbian Gay Bisexual Transgender Intersex
MCWH	Maternal, Child and Women's Health
MDR	Multi-drug Resistant
MRC	Medical Research Council (South Africa)
MMC	Medical Male Circumcision
MTOP	Medical Termination of Pregnancy
NGO	Non-governmental organisation
NDBE	National Department of Basic Education
NDOH	National Department of Health
NSDA	Negotiated Service Delivery Agreement
NYP	National Youth Policy
NYDA	National Youth Development Agency
NYRBS	National Youth Risk Behaviour Survey
NHS	National Health System
NIMSS	National Injury Mortality Surveillance System
PHC	Primary health care
PWP	Prevention with Positives
SACENDU	South African Community Epidemiology Network on Drug Use
SANCA	South African National Council on Alcohol and Drug Dependence
SAPS	South African Police Service
STI	Sexually Transmitted Infection
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
UN	United Nations
UNCRC	United Nations Convention on the Rights of Children
USAID	United States Agency for International Development
WHO	World Health Organisation
XDR	Extremely Drug Resistant
AYFS	Adolescents and Youth Friendly Services

INTRODUCTION

The mandate of the Department of Health is to ensure a long and healthy life for all South Africans. Young people account for a significant proportion of the total population, and 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 Youth and Adolescent Health Policy, which has been designed through a collaborative process involving partners in government and civil society, is therefore intended to improve the long-term health outcomes of the nation through targeting the youth as an especially strategic sector of the population. Thus, the principal aim of this policy is to strengthen and provide guidance to efforts aimed at both preventing and responding to health problems through the promotion of healthy development amongst adolescents and youth.

The first National Policy Guidelines for Youth & Adolescent Health were launched in 2001, and are therefore more than a decade old. This revised policy builds on the 2001 guideline, but has been reviewed and updated in order to ensure that it reflects current developments. Particularly attention was placed on ensuring that the revised policy:

- Provides guidance regarding implementation of plans and programmes at sub-district, district and provincial levels;
- Is aligned with relevant national plans such as the National Youth Strategy and the NSP 2012-16;
- Is aligned with Department of Health strategies and plans including the Annual Performance Plans, NSDA outcomes, primary healthcare re-engineering, and the teenage pregnancy strategy 2010;
- Responds to research findings such as the National Youth Risk Behaviour Surveys (NYRBS) undertaken in 2002 and 2008, and the survey of out-of-school youth undertaken in 2011.

The purpose of this policy is to give guidance to all departmental officials in all levels of government, as well as healthcare professionals and other staff in clinics, community health centres, youth centres and hospitals, who play a key role in promoting youth empowerment and development and in preventing and responding to specific health problems experienced by young people.

This policy was developed following a review of literature, and extensive consultation with young people, government departments, and non-governmental organizations working with young people in various sectors. The process of developing this policy has thus been consultative, involving young people, the National Youth Development Agency (NYDA), the National and Provincial Health Departments, other National Departments, as well as non-governmental and community-based organisations.

Adolescents and youth are a very diverse group of people. Whilst this age group experiences less of a burden of disease than other age groups, it should be noted that a large proportion of deaths among young people are preventable. As was pointed out in the Second National Youth Risk Behaviour Survey (2008) youth is both a time of opportunity and of risk. The metaphor *umthente uhlaba usamila* – the grass prickles sharp as it grows – was employed by the authors to illustrate the disproportionate impact that behaviours learned or initiated during adolescence and youth have on their lifetime health outcomes.

The components of national reconstruction and development programmes, despite their relevance for the health of adolescents and youth, are not addressed in these policy guidelines. These are being addressed by other sectors and government clusters including:

- Human Development (Social) Cluster
- Justice, crime prevention & security
- Economic sector and employment
- Infrastructure development
- Governance and administration

This policy recognizes that the primary responsibility for the implementation of national health policy lies with the provincial departments of health. The National Department has an important monitoring and oversight role. For this reason, the policy attempts to provide a solid national framework for implementation, which

provides provinces with an excellent guide for what needs to be done. It is imperative that provincial health departments use this policy to guide their strategies in a manner that recognizes their specific health priorities, policies and fiscal constraints.

CHAPTER 1: CURRENT LEGAL, POLICY AND STRATEGIC FRAMEWORK

South Africa has a range of well-established policies and laws that have a bearing on adolescent and youth health. It is essential that this policy is consistent with these provisions, bearing in mind that new legislation and policies may become relevant to this guide as they are developed and enacted.

The following section provides details on local and international provisions that have a bearing on this policy.

1. LEGISLATIVE FRAMEWORK

THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, ACT 108 OF 1996

The Constitution of the Republic of South Africa (1996) underscores the legal framework for all legislation in South Africa. This covers the rights of the child, including adolescents, to equality, education, health, nutrition, social security, a safe environment, water and shelter, and identity, amongst others.

The Constitution provides for the right of access to health care services and for other health related rights:

- Section 24 provides that everyone, including young people, has the right to an environment that is not harmful to their health or wellbeing. The State therefore has an obligation to ensure that its conduct, whether by way of legislation or policies, does not create an environment that is harmful to people's health.
- Section 27 provides that everyone has the right to have access to health care services, including sexual and reproductive health care; sufficient food and water; and social security, including if they are unable to support themselves and their dependants, appropriate social services.
- Section 27 further requires the State to take reasonable legislative and other measures to achieve the progressive realization of the rights referred to above.
- Section 28 provides that every child has the right to basic nutrition, shelter, basic health care services and social services; not to be required or permitted to perform work or provide services that place at risk the child's wellbeing, education, physical or mental health or spiritual, moral or social development.

The adolescent and youth health policy guidelines are one of the measures aimed at achieving the realization of the rights affirmed in these sections insofar as the rights apply to young people.

THE NATIONAL HEALTH ACT, 61 OF 2004

This Act is the foremost health legislation which determines the functioning and service provision of the South African health system. The Health Act stipulates the rights and responsibilities of those who provide care and utilize the health system for medical purposes, this includes youth and adolescents. The National Department of Health, the National Health Council, the Consultative Health Forum, and the Forum of Statutory Health Professions Councils oversee the general functioning of all health activities nationally. The National Department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.

This policy operates within the framework provided by the Act, and to be implemented in accordance with the structures and systems as laid out in the Act.

THE CHILDREN'S ACT, 38 OF 2005 AS AMENDED

The Children's Act seeks to protect all children by;

- Preserving and strengthening of families and giving effect to the following constitutional rights of children, namely:
 - Family care, parental care, or appropriate alternative care when removed from the family
 - Environment and social services;
 - Protection from maltreatment, neglect, abuse or degradation;
- Making provision for structures, services and means for promoting and monitoring the sound physical, psychological, intellectual, emotional and social development of children;
- Strengthening and developing community structures which can assist in providing care and protection for children;
- Recognizing the special needs those children with disabilities and chronic illnesses may have.

The Act lays out provisions intended to protect the health of children. Children may consent to medical treatment and surgical operations from the age of 12. They may also consent to being tested for HIV, may have access to contraception, and should be provided with condoms freely. Medical advice and counselling is identified as an essential prerequisite for the protection of child health.

THE CHOICE ON TERMINATION OF PREGNANCY ACT, 92 OF 1996 AS AMENDED

The Choice on Termination of Pregnancy (CTOP) Act defines a woman as: "any female person of any age". It further states that only the woman's consent is needed for the termination of pregnancy (TOP) and in the case of a minor, only the minor's consent is needed subject to advising such a minor to consult with the parents.

The CTOP Act makes it clear that: "Notwithstanding any other law or the common law... no consent other than that of the pregnant woman (i.e. the female person of any age) shall be required for the termination of a pregnancy". This means that the age limits for medical treatment or surgery without parental assistance (as set out in the Children's Act) do not apply to a girl requiring a TOP by either medical or surgical means.

Thus the Children's Act does not change the provisions in the CTOP Act when it comes to the ages of consent for girls requiring a TOP. This position is confirmed by the Children's Act in section 129(1), which says that section 129 is "Subject to section 5(2) of the Choice on Termination of Pregnancy Act". Thus, even if the child is 10, she would not need parental consent in order to terminate her pregnancy. However, in the *Christian Lawyers case*, where these provisions of the CTOP Act were challenged, it was found that the requirement of informed consent was central to obtaining TOP services, and that the Act did not allow any termination of pregnancy to take place where the woman was unable to give informed consent, irrespective of her age. Under the CTOP Act minors may consent to termination of pregnancy and an adolescent mother may consent to surgical treatment of her own child.

CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007

The Act primarily addresses the creation of statutory sexual offences, special protection measures for children and persons who are mentally disabled, certain transitional arrangements and evidence related matters. The purpose of the Act is to protect children from sexual abuse and exploitation; however some of the provisions effectively criminalise sex between consenting adolescents.

Section 15 criminalises acts of sexual penetration by adults with children between the ages of 12 and 16 years, despite their consent. Section 16 is intended to criminalise acts of consensual sexual violation committed by adults with children between the ages of 12 and 16 years. The Act provides, among others, that children who engage in certain acts with each other, such as kissing, cannot be prosecuted for doing so if both agreed to such acts and the age difference between the two children is not more than two years. The Act goes further to ensure that children who innocently engage in certain acts with each other are not prosecuted by affording the Directors of Public Prosecutions with the discretion to decide whether prosecutions should be instituted or not in those cases where there are two children involved. The provisions of section 16, read with sections 56(2)(b)

and 66(2)(a)(vi), of the Act have been carefully drafted so as to avoid the situation that teenage sexual experimentation of a non-penetrative nature attracts criminal prosecution, but, at the same time, ensuring that persons who sexually abuse children do not go unpunished.

THE LIQUOR ACT, 59 OF 2003

The Liquor Act, ratified in August 2004, aims to reduce the socio-economic and broad consequences of alcohol abuse and promote the development of a responsible and sustainable liquor industry. The Act stipulates that a person may not advertise alcohol with the intention to target or attract minors or sell or supply alcohol to a minor.

THE MENTAL HEALTH CARE ACT, 17 OF 2002

The Mental Health Care Act emphasizes human rights, promoting access to care and a community-based approach, which is in line with the constitution and the Bill of Rights. The definition of the mental health care user in the Mental Health Care Act is inclusive of all age groups including youth and adolescents.

THE NATIONAL YOUTH DEVELOPMENT AGENCY ACT, 54 OF 2008

This Act, developed by Parliament in 2008, introduced the National Youth Development Agency as a national public entity in South Africa. The Agency is tasked with developing a national Integrated Youth Development Plan and Strategy, as well as initiating, establishing, co-ordinating, and monitoring and evaluating youth development programmes.

The Act obliges each person involved in the National Youth Development Agency to be a qualified and registered youth development practitioner.

PREVENTION AND TREATMENT OF SUBSTANCE ABUSE ACT, 70 OF 2008

This Act tasks the Department of Health with provision of specific services with regard to responding to substance abuse problems.

THE PROMOTION OF EQUALITY AND PREVENTION OF UNFAIR DISCRIMINATION ACT, 4 OF 2000

The Promotion of Equality and Prevention of Unfair Discrimination Act promotes and prevents unfair discrimination of pregnant learners

2. KEY POLICIES AND PROGRAMMES

THE NATIONAL YOUTH POLICY 2009-2014

The National Youth Policy is a framework for youth development across the country addresses the major concerns and issues critical to young men and women and gives direction to youth programmes and services provided by government and non-government organisations.

The National Youth Policy 2009-2014 identifies teenage pregnancy, maternal mortality, reproductive and sexual health, HIV and AIDS as particular health challenges facing South African youth. The policy recommends that access to youth-friendly health related programmes and services be improved through the following steps:

- Government in partnership with relevant stakeholders should increase youth-friendly clinics and extend their coverage, particularly to rural areas;

- Departments of Health and Social Development and Education should expand school health services, to be accessed by youth in schools for the purposes of accessing services including counselling, contraceptives, antenatal services, mental health services etc;
- The Department of Health should provide information on sexuality, reproductive health and risky behaviour and further provide age-appropriate information packages to the targeted youth;
- Information on disease prevention, especially prevention of HIV, should not only target young people up to the age of 22 and those living in poor areas, but should also target older youths;
- The Department of Education should ensure that education around sexuality forms part of the life skills curriculum from an early age in order to empower youth to prevent risky behaviour that exposes them to HIV infection;
- Government should engage civil society organisations in rendering youth development services with particular reference to sexual and reproductive health and rights;
- The Departments of Health and Social Development should ensure that young people are able to access voluntary counselling and testing (VCT) services through clinics and youth organisations; and
- The Department of Health should develop a comprehensive inter-cluster health plan in consultation with relevant role players in accordance with the plan.

THE NEGOTIATED SERVICE DELIVERY AGREEMENT (NSDA) CHARTER, 2010

The Service Delivery Charter focuses on the health priorities of the country, of which outcome number two - a long and healthy life for all South Africans - seeks to increase life expectancy, decrease maternal and child mortality, combat HIV and AIDS and decrease the burden of disease from TB, and strengthen health system effectiveness.

In line with the ideals of the NSDA, the Youth and Adolescent Health Policy aims to guide the implementation of youth friendly services to respond to the challenges of poor quality health service delivery and to ensure improved access, quality of care and a reduction in inequity.

THE HIV & AIDS AND TB NATIONAL STRATEGIC PLAN, 2012 - 2016

The National Strategic Plan 2012 - 2016 aims to reduce the incidence of new HIV infections by 50% and minimize the impact of HIV and AIDS & TB on individuals, families, communities and society by improving access to suitable treatment, care and support. The plan contains four strategic objectives that will form the basis of the HIV, STI and TB response, namely; Focus on social and structural approaches to HIV and TB prevention, care and impact; Prevention of HIV and TB infections; Sustain Health and Wellness; and Protection of Human Rights and Promotion of Access to Justice.

Young people are prioritized as a high-risk group and are a key focal point for the Plan. Reducing adolescent pregnancy is highlighted as a priority.

MINI DRUG MASTER PLAN FOR THE HEALTH SECTOR: 2011/12 – 2013/14

The Mini Drug Master Plan for the Health Sector outlines the strategic interventions that the Health Sector will implement in responding to substance abuse in accordance with the National Department of Health's 10-point Strategic Plan 2010 – 2013. It also outlines areas in which the Health sector will work with key partners to improve both preventive and curative services and ensure better access to health services.

INTEGRATED NATIONAL DISABILITY STRATEGY, 1998

The strategy outlines three main policy objectives namely:

- Healthy lifestyle promotion (in the home, at school, in the workplace and on the sports field);
- Protective measures (immunisation, protection against accidents, and protection against occupational hazards); and

- Secondary prevention (early identification of impairments and disabilities followed by prompt treatment (or early intervention), which may result in a cure, slow progression, or the prevention of complications).

Young people with disabilities are identified specifically as a vulnerable group.

3. GLOBAL INSTRUMENTS

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD, 2003

The Convention on the Rights of the Child (CRC) 10 prescribes that relevant countries “develop and implement, in a manner consistent with adolescents’ evolving capacities, legislation, policies and programmes to promote the health and development of adolescents. T

The convention also provides for “adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behaviour and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent’s rights (art. 27 (3);” (CRC/GC/2003/4, paragraph 16)

The convention further states that “Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity.” (CRC/GC/2003/4, paragraph 26) 10 UN. 2003.

AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF CHILDREN, 1990

In 1990, the adoption of the African Charter introduced the first regional mandatory instrument to legally recognize the child as a holder of inherent rights. Viewed as a pioneering and potentially powerful instrument in the enhancement of children’s rights, the Charter emphasizes the incorporation of African cultural values and experiences in all matters pertaining to the rights of children in Africa. The principles upon which the Charter is based include non-discrimination; best interests of the child; right to life, survival and development; and the views of the child. The core of the Charter, non-discrimination, insists on equality of opportunity for every child regardless of gender, race, language, national or social origin, disability, religion, fortune and beliefs.

THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, 1994 AND THE MAPUTO PLAN OF ACTION (2006)

The Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010 reflects the outcome of a special session of the African Union Conference of Ministers of Health, who met in Maputo, Mozambique in September 2006. The goal of the Maputo Plan of Action is “universal access to comprehensive sexual and reproductive health services in Africa by 2015”.

The Maputo Plan of Action is premised on sexual and reproductive health in its fullest context as defined at the landmark International Conference on Population and Development a UN meeting held in Cairo, Egypt in 1994. The links between women’s status, reproductive health, and social and economic development which were first recognised by the global community at the 1994 conference, are reinforced in the Maputo Plan of Action.

UNITED NATIONS DECLARATION ON THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES 2011

This declaration acknowledges that the global burden and threat of non-communicable diseases (NCDs) constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world, and threatens the achievement of internationally agreed development goals.

The declaration reaffirms the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and recognizes the importance of strengthening local, provincial, national and regional capacities to address and effectively combat non-communicable diseases, particularly in developing countries, and that this may entail increased and sustained human, financial and technical resources;

The declaration encourages the development of multi-sectoral public policies that create equitable health promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives; fosters partnerships between government and civil society, building on the contribution of health-related NGOs and patients organizations, to support, as appropriate, the provision of services for the prevention and control, treatment, care, including palliative care, of NCDs. Finally the declaration calls for promotion of research and development and strengthening of monitoring and evaluation.

CHAPTER 2: CURRENT SITUATION

Young people (ages 10 - 24 years) comprise just less 30% of the total population of South Africa. The 2011 census indicated that out of a total population of 51 770 560, 4 594 886 (8.9%) were aged between 10 and 14 years; 5 003 477 (9.76%) between 14 and 19 years and 5 374 542 (10.4%) between 20 and 24 years old¹. This phenomenon is often referred to as a “youth bubble”.

Young people, like other South Africans, face a quadruple burden of disease. Young people are most adversely affected by the HIV/AIDS and TB epidemics, as well as the high prevalence of violence, trauma and injuries. Although non-communicable disease are relatively uncommon in adolescents, the high prevalence of risk factors such as over-nutrition and a sedentary lifestyle in young South Africans is set to fuel the ongoing increase in prevalence of the diseases of lifestyle, particular hypertension and diabetes. The high teenage pregnancy rate means that high maternal mortality rates adversely affect many adolescents.

Mental health conditions are also prevalent in adolescents. These are often linked with abuse of alcohol, tobacco and drugs.

As a group adolescents are less likely to recognize their symptoms, and are more likely to under-estimate their importance and delay seeking assistance. Fear of the outcome, worries about stigma and concerns that they may not be treated well at a clinic all contribute to late presentation. In many clinics there is insufficient space to guarantee privacy and some healthcare professionals do not treat adolescents with dignity and respect. The lack of access to health services especially with regard to contraception, safe termination of pregnancy and health promotion represent an important barrier to better health outcomes for adolescents.

The current situation regarding the most important health problems faced by young people and adolescents are outlined below.

HIV/AIDS AND OTHER STIS

The HIV epidemic is currently being fuelled by new infections in young people between 15 and 24 years. More than half of STI's occur among adolescents and young adults. Although most are curable, many infections are left untreated. Studies also indicate that up to half of patients presenting with symptomatic STIs may be co-infected with HIV, and HIV co-infection may be as high as 80% in some communities. There are many reasons why young people are particularly vulnerable to sexually transmitted infections. Apart from physiological vulnerability, they are susceptible to peer pressure, have a tendency to engage in risk-taking behaviour, are less able to negotiate safe sex practices, and have difficulties accessing easily understandable information on signs and symptoms of STIs and youth friendly services.

Unprotected sex during adolescence generally occurs without prior planning or consideration to the consequences. In many cases, early sexual experience is unwanted and is the result of coercion or pressure. Early sexual maturation generally results in multiple sexual relationships, thereby increasing risk of acquiring HIV and other sexually-transmitted infections.

Significant opportunity rests in the fact that the prevalence of HIV among 15 year olds is only 3.2% which is low in the context of a generalized epidemic of this magnitude. Adolescents are also more likely to adopt and maintain safe behaviours and a sustained reduction in new infection rates among teenagers over the next five to ten years could substantially change medium-to-long-term prevalence rates and its related impact.

SEXUAL AND REPRODUCTIVE HEALTH

Research shows that that 52% of young people have had full penetrative sex by age 17, and yet 35% of teenagers who have sex say they only sometimes wear a condom, while 32% who have sex say they never wear a condom

Many adolescents seldom have an opportunity to discuss issues of sexual and reproductive health with a caring, knowledgeable adult and are often confronted with unresponsive health services. Abstaining from sex, delaying the onset of first sexual experience, reducing the number of sexual partners and increasing levels of dual-protection contraception are all ways to reduce pregnancies and sexually transmitted infections. Without access to support, many young people are left with unnecessary fears about the effects of contraception or misconceptions about how to prevent STIs. Furthermore, even if young people have a general understanding about contraceptives, such as condoms or pills, they often do not know where to get them, how to use them correctly or how to negotiate their use with a sexual partner.

TEENAGE PREGNANCY

Although fertility rates have been declining steadily over the last fifteen years, the birth rate for adolescents in the country still remains unacceptably high. By age 19, roughly a third of girls in South Africa have been pregnant or had a child. Early pregnancy and child birth increases the health risk for the mother since girls who become pregnant under the age of 18 are between two to five times more likely to die during childbirth than older women. In South Africa, approximately one in eight adolescent deliveries is by caesarean section. This indicates complicated births, and highlights the risk that adolescents place themselves at by becoming pregnant at such an early age. First pregnancies also carry higher risk of developing hypertensive disorders, preeclampsia leading to haemorrhage with severe consequences. Furthermore, young mothers have a higher incidence of premature labour, miscarriage and stillbirth. Their infants generally weigh less at birth and experience higher rates of mortality and morbidity, even after socioeconomic and demographic factors are taken into account. The socio-economic consequences of adolescent pregnancy are also enormous as schooling is interrupted and early parenthood is likely to adversely affect educational achievement with significant employment and socio-economic ramifications.

TERMINATION OF PREGNANCY

Prior to the amendment to the legislation governing the termination of pregnancy, approximately 100 000 illegal abortions were conducted each year in South Africa – most of which were on young women under the age of 24.

Although there are currently efforts to ensure that safe pregnancy termination services are both accessible and affordable for young women across South Africa, many continue to self-induce or opt to have the procedure performed by an unskilled or non-medical provider. For a number of reasons, young women are also more likely to postpone the termination of their pregnancy until after the first trimester, which makes the procedure more risky and young women with abortion-related complications also often delay getting treatment, which can worsen their condition: three out of five women hospitalized for abortion complications are under 20 years of age.

Young women who undergo termination of pregnancy may also feel remorse or guilt, or they may encounter negative reactions from peers, family, providers or society.

GENDER-BASED VIOLENCE AND SEXUAL ABUSE

Young people are especially vulnerable to sexual violence, to force or threats and to psychological pressure to have sex. Underscoring the problem are issues of patriarch and gender. The resultant power imbalance between boys and girls often manifests itself in coercive sex where girls are generally more vulnerable. Sexual abuse often takes place in the home, with the homeless, orphaned and the displaced without being reported. Young people are especially vulnerable when they are unprotected by their families. Many young people, but mainly young girls are more vulnerable to sexual exploitation and abuse. Some opt to trade sex and thus increasing the risk of HIV infection. Also significant is that in many communities across South Africa, young women are conditioned to be submissive to men, and find sexual coercion and/or sexual violence a routine part of a relationship. Sexual abuse can result in physical injury, unintended pregnancy, STIs and psychological trauma. Victims of abuse are often prone to low self-esteem, earlier consequential sexual activity and high-risk sexual behaviours. Rape is common among adolescents as the South African police statistics for 1996-1999 indicate. Of the crime of rape and attempted rape, 40% of survivors were under the age of 18. The role of

peers in the coercive nature of sexual relationships is also a significant influential factor which results in lifelong health and social consequences.

VIOLENCE, TRAUMA AND INJURIES

Unintentional injury is the leading cause of death among young people in South Africa, with road traffic accidents being a key contributor. Deaths and injuries from accidents are more likely at this age than any other, accounting for 78% and 41% of deaths among adolescent males and females respectively. Boys and young men are particularly vulnerable to injury from accidents and are vulnerable - both as victims and perpetrators – of violence. Violence within the home is also not fully acknowledged and young people may be at risk from violent parents well into their adolescence with young women being vulnerable to physical abuse by their boyfriends. In many communities, these types of ‘domestic’ violence are not treated seriously by police and courts.

CHRONIC DISEASES

As outlined above, although chronic diseases, especially the diseases of lifestyle, are relatively uncommon in young people, many of the behaviours that place individuals at increased risk of developing these conditions in later life, are adopted during adolescence. Development of healthy behaviours, especially with regards to diet and physical activity, needs to be strongly encouraged (see below).

At the same time it is important to ensure that adolescents with chronic diseases receive the care that they require. Chronic conditions such as diabetes require a multifaceted response throughout the life course and adolescence is often a challenging time as it coincides with hormonal and emotional imbalances. Resultantly there are health implications which often impact on social, educational and life skills abilities. Thus equal access to youth friendly services is key consideration in the treatment and care of this group.

NUTRITION

Where socio-economic challenges exist, nutritional deficiencies persist throughout the life course. Notwithstanding this, adolescents require extra nutrition to support their rapid growth. Furthermore an inadequate diet can delay or impair healthy development, and in girls, poor nutrition can delay the onset of puberty and/or lead to the underdevelopment of sexual and reproductive organs that could result in the birth of low weight babies and birth complications in young girls. Maternal mortality is also higher in anaemic girls.

Similarly the problem of overweight and obesity poses a challenge for public health programming in the country. The early detection, preventative screening to detect pre-obesity and diabetes together with the promotion of increased fruit and vegetable intake must take precedence at school and primary health level. Eating disorders are common occurrences particularly for young girls in certain communities and are normally linked to poor body image, peer pressure and lack of information on healthy eating habits.

MENTAL HEALTH

South Africa has a number of characteristics that place young people at risk of mental health problems, such as widespread poverty, familial disruptions, high levels of violent crime, and death in the family as a result of AIDS. The economic challenges faced by families in poor conditions are often barriers that persist throughout early adulthood and are influential in eroding potential that prevents full adulthood. Single parent families are an all too common phenomenon in South Africa with an estimate of approximately 11 million single parent families in the country. This has the potential to impact enormously in terms of social, emotional and economic on young people’s lives.

A young person experiencing anxiety, depression or another mental health problem often has no frame of reference for his other condition and may not recognize this as an illness or seek treatment. Depression is also commonplace in young people who have low self-esteem or little hope for their future. This can significantly reduce the quality of a young person’s life at a time when he or she should be full of optimism. A young person who feels as though they have no future is also much more likely to take risks with his or her health, or to commit suicide.

TOBACCO, ALCOHOL AND SUBSTANCE ABUSE

Many of the most significant threats to the health and well-being of young people ensue from behaviours they adopt during their adolescent years. These behaviours are often referred to as 'risk behaviours' linked to lifestyle choices. The risks associated with alcohol and drug use has the potential to predispose the user to other risks, including unprotected sex, violence and car accidents. Risky activities are usually initiated through experimentation and peer pressure and unfortunately for many results in addition and life-long complications.

Research shows that a young person who adopts one risky practice is more likely to adopt another. Poor school performance is typically an indicator of adolescents in trouble. Young people from poor socio-economic circumstances are more at risk of early school drop-out, have poor access to health information, experience more environmental risk and feel more unsafe in their communities. These risk factors impact their health and social protection and minimize the chances of optimizing their potential. Under these conditions that the health system response is tested for effectiveness in reducing the gap of unmet needs for adolescents and young people.

Harmful drinking among young people is an increasing concern in many countries. It reduces self-control and increases risky behaviours. Harmful drinking is a primary cause of injuries (including those due to road traffic accidents), violence (especially domestic violence), and premature deaths. Regulating access to alcohol is an effective strategy to reduce harmful use by young people. Bans on alcohol advertising can lessen peer pressure on adolescents to drink.

Adolescents with lower–socio economic stature are more exposed and vulnerable to the risk factors associated with substance abuse. Adolescents of parents with alcohol problems or who have several family members who abuse alcohol are at greater risk for alcohol problems and they often start drinking at a younger age, and progress towards problems quickly.ⁱⁱ They are between four to ten times more likely to develop problems with alcohol themselves than adolescents who have no close relatives with alcohol problems. Money for alcohol takes precedence over the welfare of the children, thus there is high absenteeism from school and later '*drop-out*'ⁱⁱⁱ.

CHAPTER 3: POLICY

The purpose of this policy is to provide guidance to departments and organisations working with the Department of Health on how to respond to the health needs of young people. Responding to the multifaceted changes of the youth and adolescent health requires an integrated approach that are not just problem-oriented but provides for the mitigation of risk factors and puts in place 'safety nets' for early detection and prevention.

1. TARGET POPULATION

Although the constitution of South Africa defines youth as 14 – 35 years, the Department of Health's definition of 'youth' is aligned with that of the World Health Organization. This policy therefore targets all young people and adolescents between the ages of ten and 24.

This policy further identifies particular vulnerable and/or target groups within this category to ensure a health safety net for those that fall outside of the mainstream health sector. These include youth who are considered particularly vulnerable, namely the disabled, street children, sex workers and youth who are in conflict with the law. Similarly emphasis is placed on youth living in rural and peri-urban areas, those that are out of school and not in the formal employment sector, as well as orphans and child headed households and abandoned abused or neglected young people which include "illegal" immigrants, asylum seekers and refugees and those with special needs such as lesbian, gay, bisexual, transgender and Intersex (LGBTI) groups and youth living with chronic conditions including HIV/AIDS, diabetes, and mental health disorders or living in places of safety and in residential facilities and prisons.

2. VISION

"A long and healthy life for all South African youth and adolescents"

The capacity of each young South African to achieve their full potential is enhanced through the provision of a set of health care, prevention, promotion, treatment, management and rehabilitation services that are accessible, responsive and caring, high-quality, comprehensive, efficient and effective.

3. MISSION

To improve the health status of young people through the prevention of illness, the promotion of healthy lifestyles, and the improvement of health care delivery system by focussing on the accessibility, efficiency, quality, and sustainability of youth and adolescent friendly health services.

4. VALUES

- Advocating for health that is holistic and defensible throughout the lifecycle
- Encouraging empowerment of young people to optimize health seeking practices and behaviours
- Ensuring equity in enhancing access to appropriate health services
- Promoting health and development throughout the life course
- Protecting and supporting vulnerable groups through gender and disability sensitive programmes provision and minimization of risks thereby enhancing human rights for all
- Respecting autonomy of young people through recognition and respect to the progressive realization of rights

5. GUIDING PRINCIPLES

The policy takes cognizance of the social, environmental and economic conditions in communities; thus efforts to improve adolescent and youth health are contextualized within a multi-sectoral approach that addresses all sectors and government levels.

There are six **guiding principles** for adolescents 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.

Second: problems are interrelated. It is a common finding from studies in several parts of the world that problems tend to cluster. 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, including the adoption of value systems. 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.

Fourth, behaviour is influenced by the social environment. 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.

Fifth, 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 and AIDS, returned from exile, "illegal" immigrants, and young women and single mothers, and orphans (including children orphaned by AIDS).

Sixth, gender (& disability & other vulnerabilities e.g. child headed homes considerations are fundamental for adolescent and youth health, mainly because they are important determinants of access to economic resources, social services and other opportunities. The health system should be oriented towards reducing risk factors for young people with poor health, mental health issues, and disabilities and enhancing their protective factors.

Seventh, adolescents and youth should participate in the development of services and programmes and decisions relating to their health status, treatment, care and rehabilitation.

6. OBJECTIVES

The programme's cornerstones are focused on enhancing the social, mental, emotional and physical well-being of adolescents and youth at all levels of service delivery.

- To provide quality, accessible, available and "youth-friendly" health facilities and services
- To strengthen health-promotion programmes targeting young people.
- To promote and enhance the concept of "youth friendly services" at health facility and community level to benefit both in and out of school youth
- To prevent, rehabilitate and manage the health care of our young people, with particular emphasis on the provision of effective responsive services for vulnerable groups.
- To promote multi-sectoral collaboration on critical aspects of youth and adolescent health
- To strengthen monitoring mechanisms that augment adolescent and youth health matters

7. HEALTH PRIORITIES

These priority areas are imperative for the well-being of adolescents and youth and will focus on, Sexual and reproductive health and rights, HIV and AIDS and tuberculosis, chronic disease, disability, Drug and substance abuse, mental health, Violence and unintentional injuries, Nutrition, Oral health and fitness & physical activities. In this policy these areas are addressed under the intervention strategies.

Ten health priorities for Adolescents and Youth:

- Sexual and Reproductive Health and Rights

- HIV, AIDS & TB
- Mental Health
- Drug and Substance Abuse & Alcohol
- Violence, trauma and Injuries
- Chronic Diseases
- Disability
- Nutrition and physical activity

8. INTERVENTION SETTINGS

Health services that target youth and adolescents need to be implemented in various settings, such as:

- Homes
- Health facilities
- Schools and other educational facilities
- Workplaces
- Streets
- Community-based organisations
- Residential centres
- Sports Recreational facilities
- Social clubs
- High transmission areas

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 general strategies on one axis and settings on another. The more comprehensive an adolescent and youth health policy, the more specific would be the strategies that exist for each setting. For each particular health problem, a matrix of settings and strategies can thus be created.

9. INTERVENTION STRATEGIES

Six key strategies for addressing youth and adolescent health are outlined below.

PROMOTE AND SUPPORT YOUTH EMPOWERMENT AND DEVELOPMENT

Young people have a strong sense of themselves and their entitlements. It would be a mistake to describe them in terms that rob them of their agency. Young people need to be engaged as co-implementers, problem-solvers, and potential leaders of the solutions to the health challenges they face. Young people should be encouraged to work for a better society and to become role models in society, who can show both their elders and their younger peers how to live healthy and responsible lives.

Aspects of youth development may include activities such as enhancing life skills, providing income generating opportunities, promoting education and civic participation, establishing a sense of self, identity and value, providing positive role models and assisting in maintaining or re-establishing relationships with families. Youth

The focus of the promotion of healthy development is on the positive potential of young people as opposed to the "problems" that they manifest as health promotion aims to empower young people to increase control over the determinants of health. Peer educators often play a key role in promoting youth development.

PROMOTE A SAFE AND SECURE ENVIRONMENT

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.

Engaging communities in the creation and promotion of social norms that support the health of adolescents and youth should be a key part of this intervention.

PROMOTE AND SUPPORT YOUTH TO ADOPT HEALTH LIFESTYLES

The mass media plays a prominent role in the lives of youth and adolescents in modern society. The role of the media will be maximized to improve access to information:

- Create active transmission opportunities for health information to these target groups
- Advocate, promote and market the available health services for youth and adolescents through TV, newspapers
- Develop capacity of the media for positive reporting on youth and adolescents
- Utilize social media mechanisms for health messaging

The National Communications Survey (2009) found a strong positive correlation between exposure to various multimedia campaigns, and condom use, in the context of South Africa's national response to HIV and AIDS. It has been proven through other studies that mass media can affect health outcomes, though usually this effect is clearest when combined with interpersonal communication and access to services.

Departments of Health also need to ensure that programmes which advocate for increased facilities for sport, physical exercise and recreation are in place. These programmes can also be linked to comprehensive life skills programmes which develop an holistic approach to health for young people and encourage young people to value and manage their own health.

ENSURE THAT ALL POLICIES AND PROGRAMMES ADDRESS YOUTH ISSUES

All policies and programmes developed and implemented by the National Department of Health must specifically identify and address the health needs of young people and adolescents. This is of particular importance with regard to programmes which aim to address the main health problems facing adolescents as outlined above.

INCREASE ACCESS TO AND QUALITY OF YOUTH-FRIENDLY HEALTH SERVICES

As outlined above, many adolescents face barriers in accessing health services, and improving access to health services for youth and adolescents through is an important priority. The Youth-Friendly Health Services initiative aims to ensure that all health services are accessible to youth and adolescents through supporting a more relaxed atmosphere of delivering health care. The initiative includes:

- Identifying and address obstacles in the health care delivery of youth and adolescents
- Developing the capacity of key groups to deliver an effective service
- Establishing strong referral systems for young people to hospitals and other community support systems
- Mobilizing support from partners for implementation
- Increasing the number of facilities that they are accessible to a greater proportion of the population;
- Addressing management and institutional shortcomings
- Facilitating and enabling the development of youth action groups which will take responsibility for their involvement in all stages of planning, implementing and monitoring services in a community;
- Implementing a set of adolescent and youth health service standards to facilitate monitoring and evaluation; and
- Co-ordinating and liaising with NGOs, and community based organizations (CBOs) and the private sector to strengthen and sustain youth friendly services.

Efforts to make health services more youth-friendly should be linked to community-based youth development interventions. These include:

- Promotion of increased access to comprehensive sexual and reproductive health and rights;
- Promotion of health prevention strategies at community level
- Development of capacity of health workers, youth through integrative training initiatives
- Strengthen linkages with school health programmes to promote youth and adolescent health
- Promote the peer counsellor/ training programme
- Strengthen collaborative partnerships to promote health and development interventions

The National Department of Health Strategic Plan 2010-2013 has set a target for 70% of PHC facilities implementing youth friendly services by 2014/15, to increase accessibility, availability and utilisation of Health Services by young people. Adolescent and Youth services are rendered within the essential service package of the PHC services and re-engineering of the PHC model including sexual and reproductive health and rights.

STRENGTHEN SCHOOL HEALTH SERVICES

In addition to making health facilities more accessible to young people, the Department of Health also has an obligation to reach more young people through working in other settings especially schools.

Schools provide a site that has the potential to reach large numbers of adolescents, as well as a number of youth. 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. It is thus an advantage to establish a viable school health response to this group at schools where prevention, early intervention and referral services can be delivered to learners. The benefit compounds improved health status that enables learners to make better use of their learning opportunities and prevents drop-out. Conversely, improved educational attainment enhances health as there is a positive correlation between the educational level of mothers and the health of their children. Also, the longer a young woman stays in school the more likely she is to delay child bearing, which results in better obstetric and child health outcomes.

The revised school health policy aims to develop ensure that all learners, especially those in disadvantaged schools, receive a package of preventive, promotive and curative health services including sexual and reproductive health services. The programme is being jointly implemented with the Department of Basic Education.

While the ISHP is an important step forward for young people's health, other educational settings, such as further education and training sites could also be utilized. Programmes to improve the health outcomes of young people in these settings should also be promoted and supported.

CHAPTER 4: IMPLEMENTATION PLAN

Management, coordination and monitoring of the implementation of the policy should take place at different levels. At national level, strategic guidance and direction will be provided. Province-level plans should be developed based on the province-specific health priorities. At the district and sub district/ ward level actual implementation will be coordinated and managed.

CO- ORDINATION AND LEADERSHIP

The National Department of Health will provide strategic guidance and an oversight with regard to the implementation and monitoring of the Adolescent and Youth Health Policy.

Provincial Level

The provincial Department of Health has the mandate to adapt and implement the National Adolescent and Youth Health Policy according to its legislative requirements.

District and sub-district Level

The adolescent and youth health services package will be implemented in line with Adolescent and Youth Friendly Services (AYFS) norms and standards including the youth friendly services charter. The package of services offered should include clinical services that address specific the Ten Priorities as outlined in Chapter 6.

ADOLESCENT AND YOUTH FRIENDLY SERVICES (AYFS)

The delivery of the YFS Package will be in line with the Primary Health Care Essential Services Package including specific services addressing reproduction health and rights of young people. The clinic and youth centre teams will work collaboratively with the outreach teams. PHC teams including the school health teams will strive to include local NGO's and FBO's. Lines of communication and referral systems between the key stakeholders should be clearly defined and approved by all health providers at every level of care.

Adolescent and youth health teams will comprise the following:

Provincial Level:	IDC ¹ under the leadership of the provincial youth and school health coordinator / manager
District Level:	IDC under the leadership of the district youth and school health coordinator / manager
Sub-district Level:	IDC under the leadership of the Sub-district youth and school health coordinators/ Manager
Facility Level (Clinic):	Youth and school health focal person in collaboration with the PHC outreach teams
Youth Centre:	

Youth Centre manager in collaboration with the clinic youth focal person and PHC outreach leader or the school health nurse within the catchment area.

All levels (Provincial, District, Sub-district, Clinic and Youth Centres) should have a specific communication strategy to address specific health issues in their jurisdiction.

Human Resource and Capacity Building:

Clear defined roles & responsibilities, staffing norms, training needs analysis, capacity building plans and partnership agreements need to be in place at all levels.

Financing

A specific budget should be allocated for implementation of adolescent and youth health programmes in line with recommendation of this policy, the AYFS strategy and provincial -specific operational plans.

¹Intra-departmental Committee on Adolescent and Youth Health Affairs for Service Delivery

Costing

All operational plans for implementation should be costed and submitted for approval to the respective accounting officers.

e.g.	National:	Director-General
	Province:	Head of Department
	District:	District Health Manager
	Sub-district:	Sub-district Health Manager
	PHC Clinic:	PHC or Clinic Manager
	Youth Centre:	Youth Centre Manager

ROUTINE MONITORING

Routine monitoring should focus on monitoring the implementation of youth friendly services and provision of school health services in secondary schools. All levels should have a standardised system for data management. Key indicators should include:

- Number of health facilities implementing AYFS per Sub district / Municipality ward
- Number of health facilities assessed / recognized as AYFS per Sub district / Municipality ward
- Number of young people accessing AYFS services per facility in the Sub district / Municipality ward
- Number of health care providers trained and orientated in Adolescent and Youth health services per sub-district/ Municipality ward
- Proportion of Grade 8 and Grade 10 learners receiving services as outlined in the ISHP service package.

The Adolescent and youth friendly service (AYFS) implementation targets to be achieved by 2016:

INDICATOR	2011/12	2012/13	2013/14	2014/15	2015/16
Number of health facilities implementing AYFS per Sub district / Municipality ward	47%	60%	70%	80%	100%

MONITORING OF HEALTH OUTCOMES

A set of health outcome indicators for youth and adolescents should be monitored on a regular basis. These indicators should include:

- HIV prevalence (in the population and amongst ANC attendees)
- Teenage pregnancy rate
- Prevalence of mental health problems
- Prevalence of drug and alcohol abuse
- Cause of death data in young people
- Nutritional status

The national and provincial Departments of Health should work with partner and research organizations in conducting surveys and research studies on key priorities to address specific needs.

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