

# 3. GUIDING CONCEPTS

## 3.1 Adolescent development underlies the prevention of health problems

A review of international experience suggests that effective adolescent and youth health interventions place emphasis on 'whole lifestyles' and the building of positive capacities and competencies rather than on negative prohibitions and disconnected

aspect of behaviour.<sup>11</sup> Indeed, 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 features such as skills building, meaningful participation in safe and supportive peer groups, schools and communities, together with the fostering of positive 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.<sup>13</sup> For these reasons, life skills comprise an important facet of the intervention programmes offered, for example, by the Planned Parenthood Association 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 who develop policies and programmes for adolescents and youth is to

move beyond the imperative simply to respond to immediate (though pressing) health problems. Rather, it is necessary to put in place interventions that promote enduring impact and the ongoing development of South Africa's young people.



## 3.2 Problems are interrelated

It is a consistent finding from studies in several parts of the world that adolescent and youth problems tend to cluster.<sup>14</sup> In a Cape Town study among 7,340 high-school students, for example, it was found that engaging in any one of the following risk behaviours increased the likelihood of engaging in one or more of the others: alcohol bingeing, cannabis use, cigarette smoking, participation in sexual intercourse, suicide attempts, unsafe road-related behaviour and violent behaviour.<sup>15,16</sup>

One possible reason for this covariation is that the different behaviours have common causes. Poor social skills or sensation seeking, for example, may contribute to both alcohol bingeing and sexual activity.<sup>15</sup> One might thus expect that interventions that aim to improve social skills would reduce the prevalence rates of both these

risk behaviours. Another possible reason for the covariation is that engaging in one risk behaviour can create conditions that are conducive for others.<sup>16</sup> Alcohol bingeing, for example, might reduce inhibitions resulting in unsafe sexual behaviour, risky road-related behaviour and violence.

Consequently, interventions that prevent one risk behaviour may have collateral benefits in reducing others.

### 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 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.<sup>8</sup> 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*.<sup>17</sup>

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 can alter the

life course of a young woman, especially if it results in her dropping out of school.<sup>18</sup>

The WHO has estimated that 70% of premature deaths of adults are due to behaviour initiated during adolescence!<sup>2</sup> 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".<sup>19</sup>

The challenge for policy makers is thus to help young people find ways to use this "vital tool" to promote their health and well-being whilst actively contributing to the collective project of social transformation and development.

### 3.4 The social environment influences behaviour

Risk taking and other personal attributes of adolescents and youth that relate to health do not exist in a vacuum, for young people interact with a social environment that shapes their thoughts and behaviour.<sup>2</sup> The social environment has several interrelated components. These include: (a) the social structural and institutional environment (which can include interpersonal relationships and relations with kith and kin, as well as economic, legal, political and policy-making structures); and (b) the context of shared attitudes, norms, beliefs and values.<sup>8</sup>

In South Africa, the social environment of young people today is substantially 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 opportunities reduced the extent to which positive social influences could prevail, 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 the urban areas was associated with adverse health outcomes such as cigarette smoking, alcohol bingeing, suicidal ideation and behaviour, and being a victim and perpetrator of violence.<sup>20</sup>

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 and transformation of gender roles and family structures. Modern South Africa, while changing rapidly in the social, political and economic domains, is unable to fill the social gaps that have arisen.

Nevertheless, 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, including those relating to sexuality and childbearing.<sup>18</sup> 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 that is associated with a reluctance to use contraception). Contradictions and ambiguities

of this nature can compromise decision-making and predispose young people 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. They face the same dangers and challenges as their peers and, in addition to this, have to deal with their specific problems. 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 visible homeless young people are male. Some have left their homes on a permanent basis and live in the streets. Others operate in the cities raising money by begging or odd jobs by day and returning 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 and poor facilities for personal hygiene. Meanwhile there is evidence to suggest that homeless young people are vulnerable to sexual abuse and exploitation resulting in sexually transmitted infections such as HIV infection. Any interventions for this subgroup should aim to

provide appropriate accommodation and to empower young people so that they take decisions that promote their well-being.

**The following steps can be taken to address the needs of this vulnerable sub-group:**

- ④ co-ordinate and link 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;
- ④ develop data bases and record keeping in NGO's working with street children, in order to obtain statistical data and information on the movements of the street children;
- ④ implement social mobilisation to create an awareness of the services that are available;
- ④ develop community-based support services to address the problems that lead children to run away and live on the streets;
- ④ ensure that follow-up services are in place for children that have become reintegrated into their families; and
- ④ involve adolescents and youth 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 South African Central Statistical Services reported a national disability prevalence rate of approximately 5% and it has been estimated that there are about 4 million South African children who experience different forms of disabilities.<sup>23</sup>

The causes of disability listed in the White Paper on an Integrated National Disability Strategy<sup>24</sup> include violence and war, poverty, lack of information, failure of medical services, unhealthy life styles, environmental factors, accidents and inherited and genetic factors. It is noted that 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 in educational and work institutions.

It seems that the majority of people with disabilities - and in some cases their families - 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 result 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 because traditional gender stereotypes already depict them as dependent, passive and needy. Indeed, disabled females are more likely to be poor or destitute, malnourished and illiterate than disabled males. Also, women who bear disabled children sometimes face rejection and even scorn from their partners, families and communities.

This is exacerbated by health professionals who may appropriate the decision-making of the parent(s), and insist that they know what is best for the child. As a consequence, the parent (usually the mother) may lose confidence in her parenting ability and this can, in turn, undermine her self confidence.

People with disabilities often encounter obstacles in the physical and social environment, and are thus further handicapped by the environment. Also, health services do not respond appropriately to the needs of people with disabilities. According to the White Paper on an Integrated National Disability Strategy,<sup>24</sup> the occurrence of disability is increased by the inadequacy of primary health care and genetic counselling services, weak organisational links 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 lack of care in performing vaginal examinations on paraplegics because of a 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 also tend to be left alone and/or are undervalued by those around them. Moreover, disabled adolescents and youth 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, and this in turn contributes to their unemployment.

Nevertheless, 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.<sup>23</sup> 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 broad approaches to address the needs of this vulnerable group are provided below:

- ⑤ prevent the disabilities from arising in the first place, where possible;

- ④ identify impairment/disability as soon as possible;
- ④ develop appropriate intervention programmes using the Community Based Rehabilitation (CBR) approach;
- ④ integrate CBR programmes into the primary health care system;
- ④ protect and promote the rights of the disabled;
- ④ emphasize educational and vocational integration;
- ④ ensure that health and other services are barrier-free;
- ④ provide care facilities for those that require it;
- ④ develop skills training programmes for those with disabilities;
- ④ raise public awareness on disabilities;
- ④ develop regional referral mechanisms for people with disabilities requiring more specialised assessment and treatment;
- ④ develop management information systems with appropriate indicators to facilitate follow-up and evaluation of disability prevention and rehabilitation efforts;
- ④ promote empowerment of young people with disabilities;
- ④ pay fair compensation to people with disabilities;
- ④ integrate developments of appropriate rehabilitation technology into services provision;
- ④ providing increased support and empowerment to families and to community resources that serve people with disabilities;
- ④ involving people with disabilities in the development and implementation of prevention and rehabilitation programmes;
- ④ re-orient, and improve the training of,

professionals who work with people with disabilities.

It is necessary for provincial and other authorities to develop specific policies and strategies that can give expression to these approaches.

### **3.5.3 Adolescents and youth living with HIV/AIDS**

In 1999, the prevalence of HIV infection among women presenting to public ante-natal clinics was 16.5% for those aged 15-19 years and 25.6% for those aged 20 - 24 years.<sup>67</sup> Conditions that facilitate living positively with the virus include:

- ④ a non-discriminatory environment;
- ④ adequate shelter and nutrition;
- ④ timeous treatment of opportunistic infections; and
- ④ support from family, friends, schools, teachers, employers and co-workers.

Safe sex remains an important priority for those living with HIV/AIDS.

### **3.5.4 Other vulnerable groups.**

These include the following groups of adolescents and youth:

- ④ residents in residential facilities such as places of safety, children's homes, reform schools and adult prisons;
- ④ those who have committed crimes; orphans (including AIDS orphans);
- ④ those who have been abandoned, abused or neglected;
- ④ women;
- ④ single mothers;
- ④ sex workers;
- ④ those living with HIV/AIDS;
- ④ "illegal" immigrants;

- ☉ refugees;
- ☉ those returned from exile; and
- ☉ those with chronic diseases.

Again, provincial and other authorities need to develop policies and strategies to address the needs of these vulnerable groups. Such policies and strategies should include: (a) forming partnerships with, and strengthening and supporting existing organisations working with these groups; and (b) collaborating with relevant other departments.

### 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 outcomes. 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.<sup>49</sup> A lack of economic resources and physical power renders them vulnerable to sexual exploitation and increased 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, young women 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.<sup>25,26,27,28</sup> 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.

There are some ways in which males are disadvantaged. 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. The perception that they are tough and strong renders them vulnerable to corporal punishment. Peer pressure can increase the likelihood that they will participate in gang violence, criminal activity, unprotected sex and substance use.

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. The following strategies and approaches can contribute to this:

- ④ collaborate with relevant governmental and non-governmental structures, especially those that focus on adolescent, youth and gender issues;
- ④ obtain data on female infanticide, prenatal sex selection, forced marriages and female genital mutilation, with a view to abolishing these practises;
- ④ eliminate stereotypes in all types of communication and educational materials that reinforce existing inequities between males and females;
- ④ sensitise community, traditional, religious and other leaders in both urban and rural areas regarding gender issues;
- ④ increase public awareness of the value of girl children, which would in turn enhance the self-esteem and status of

girls and female adolescents and youth;

- ④ ensure that policies, planning and interventions themselves address the needs of both men and women;
- ④ address gender socialisation in the curriculum of all adolescent and youth reproductive health programmes;
- ④ scrupulously implement obligations in terms of international agreements such as 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

Many of the general intervention strategies discussed in this section do not constitute part of the mandate of the Department of Health. They are frequently of an intersectoral nature. However, even where the strategies do not constitute part of the mandate of the Department of Health, it would be a responsibility of this department to motivate or advocate for such strategies.

## 4.1 Promoting a safe and supportive environment

### 4.1.1 Relationships with families, other adults and friends

Parents and members of the extended family can be an important positive force in the lives of adolescents and youth. They can also 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.<sup>8</sup>

It should be borne in mind that in many South African cultures parents have played a relatively small role in the sexual socialisation and education of their children. 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.<sup>30</sup> Parents do want their children to know about sexuality, but they often do not want to be the ones providing the information.<sup>29</sup> Their own background may not have given them the language and skills to talk



openly and confidently about such matters with young people.

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.<sup>31</sup> Indeed, the promotion of good student-teacher relationships is an important aspect of health promoting schools (see Section 5.2 below). Other important adults that are important for the development of a safe and supportive environment are religious and community leaders.

### 4.1.2 Social norms and cultural practises

There should be a twin focus in terms of social norms and cultural practises. Positive cultural practices such as initiation schools should be encouraged and validated where they contribute to the young persons wellbeing and social integration. However, 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. An important strategy to alter norms and cultural practices 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).<sup>8</sup> Other media include radio, movies, flyers, newspapers,

puppetry, live theatre, magazines, videos, the internet, dance and photonovellas.

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.<sup>32</sup>

Another South African project using mass media is the photonovella 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.<sup>33</sup> 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. Scientific efficacy studies have shown that it achieved its purposes.<sup>33</sup>

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.<sup>34</sup>

#### **4.1.4 Accessibility of key opportunities and commodities**

This refers to a wide range of things, such as:

- ☉ educational opportunities,
- ☉ tutoring,
- ☉ condoms,
- ☉ access to affordable and quality health care services, and
- ☉ facilities for sport, physical exercise and recreation.

Factors such as economic disadvantage reduce accessibility of these opportunities and commodities, and thereby result in sub-optimal health and development outcomes. Gender discrimination 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. One of the important means by which this strategy can be achieved is by the provision of information, education and communication (IEC) materials. Adolescents and youth need information in a variety of domains, such as:

- ④ growth and development;
- ④ gender-specific needs and roles;
- ④ how to defend oneself if assaulted;
- ④ specific areas of health, for example, sexual and reproductive health;
- ④ risks to health; and
- ④ opportunities and available services, both health-related and general.

A number of health promotion efforts have focussed 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.<sup>48</sup> The fact 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 health topics (which have received less attention) is also scanty.<sup>48</sup> Knowledge about a health risk is necessary for behaviour change. 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.<sup>8</sup>

There are many different types of skills, such as practical self care skills, livelihood skills, 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 and effective communication.

There are specific skills that are required for specific situations. The skills required, for example, to persuade an unwilling partner to use a condom are specific. 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. 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.

Life skills comprise one of the eight learning areas in Curriculum 2005. 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 such as youth clubs are also involved in skills training. 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 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;
- ☉ employ adolescents and youth themselves as trainers in skills development;
- ☉ providing opportunities for work in the community that has the potential to offer opportunities for experiential learning;
- ☉ encourage and support participation in sport and physical exercise;
- ☉ 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.<sup>8</sup>

The counsellor is generally a professional person such as a teacher, health worker or religious leader.<sup>8</sup> 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.<sup>36</sup>

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, health services can promote healthy development by engaging other sectors to contribute to programming, advocating and providing interventions outside health facilities. Access to health services, including the important aspect of youth friendly clinics, will receive more detailed attention in Section 5.3 below.