

5. INTERVENTION SETTINGS¹

5.1 Home

The home is a suitable setting for the development of a safe and supportive environment. Specifically, improving the relationships and communication between parents and other adults in the home and young people would promote adolescent health and reduce risk behaviour. In the US, home-based interventions have been shown to be effective reducing anti-social behaviour in young people who have been convicted of serious offences.

The Planned Parenthood Association has produced a booklet that aims to help parents discuss sexuality with their children. A school-based intervention aims to penetrate the home setting through teaching children to take health messages home using the "child-to-child" approach.

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

Interventions at the home should aim to: (a) educate parents and other adults in the home regarding family health, including aspects that are specifically relevant for children with special needs; (b) empower adolescents, youth and communities in general to take responsibility for programmes geared towards effective parenting; and (c) provide counseling services for parents and other adults in the home so that relationships and communication can be improved.⁸

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

- ☉ select and train appropriate personnel to provide the educational and counselling programmes, and to train others to do so;
- ☉ promote and enable caregivers such as family and community workers to provide effective home-based care for adolescents and youth with chronic mental and physical health problems;
- ☉ liaise with families, religious organizations, schools, and NGO's to establish structures in the community to address parenting challenges;
- ☉ motivate and encourage parents and youth workers to form peer support groups;
- ☉ include elements in the school curriculum involving parenting skills; and
- ☉ facilitate linkages and communication between homes, schools, religious organisations and other community structures.

5.2 School

Schools provide a site that has the potential to reach large numbers of adolescents. The overwhelming majority of South African adolescents attend school; 97% of those aged 10 to 14 years and 83% of those aged 15 to 19 years attend school. This widespread access to schools stands in contrast to limited access to health facilities for many South Africans. The Central Statistical Service, for example, estimated that 56% of the rural population live more than 5 kilometres from a health facility.⁴²

There are other advantages that schools have over health facilities as sites of health promotion efforts. First, there is the potential to reach large groups of adolescents in an efficient manner. Second, the students attending a school are to a large extent constant from day to day. In health

facilities, this is not the case. Thus, one is able to offer interventions at schools over several sessions whereas at health facilities the focus is generally on "one-off" interventions.

An improved health status enables students to make better use of their learning opportunities⁴³ and prevents drop-out.⁴⁴ Conversely, improved educational attainment enhances health. Thus, there is a correlation between the educational level of mothers and the health of their children.⁴⁵ 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.⁴³

There has been considerable progress since 1994 in the provision of health services at schools.

Approximately half of all provincial departments of health and education have developed policy documents regarding school health; in most provinces there is collaboration between departments of health and education in developing programmes for school-aged young people in their province; and in almost all the provinces school health programmes are currently being implemented in secondary schools.⁴⁶ Such programmes include counselling and other mental health interventions, feeding programmes, and education regarding the environment, sexuality and life skills. However, insufficient attention has been given to the evaluation of such programmes, and in some cases they are not sufficiently comprehensive and integrated. The provincial and national departments of health aim to support initiatives aimed at developing health promoting schools. In doing so, they should foreground the tasks that Vergnani et al.⁴⁷ have listed with respect to the continued development of school based health promotion services:



- ☉ advocacy for the development of a national commitment to these services;
- ☉ inter-sectoral collaboration, both between disciplines and departments, to combat fragmentation, territoriality and duplication;
- ☉ the optimal utilisation of all existing services, both from inside and outside the schools;
- ☉ basing interventions on a holistic approach to health, which would include the developmental aspects emphasised above;
- ☉ the involvement of all stakeholders in the school in a "whole school approach";
- ☉ the incorporation of health education into the curriculum;
- ☉ changing the attitudes and practice of teachers so that they are consistent with a holistic approach to health;
- ☉ moving from a top-down approach to a more bottom-up, participatory approach to curriculum development and the delivery of services, with particular emphasis on including adolescents and youth, teachers, parents and the community;
- ☉ the initiation of research to develop optimal methods and content of health promotion through schools; and the development of pilot projects.

5.3 Health facilities

There are several important factors that prevent South African public health facilities from achieving their potential as sites of health service provision for adolescents and youth:

Health services are relatively inaccessible to many young people, especially the poor and those living in rural areas.⁴² Few facilities cater for young people; rather, they tend to cater for babies, adults or the elderly.

Many adolescents and young adults fear that their problems will not be kept confidential. A Northern Province study found that in many clinics there is insufficient space to guarantee privacy, resulting in consultations being easily overheard by other patients. A Durban study found that although private rooms were available in most clinics, they were usually not used for students requesting condoms. This study also found that male students felt uncomfortable waiting with female students, both at the counters where condoms were distributed and in the waiting rooms.

There is often a poor relationship between the young person and nursing personnel. In another Northern Province study, it was found that the most important barrier to seeking contraception was the attitudes of health personnel, who were described as harassing, rude, short-tempered and arrogant. Young people were frequently asked intrusive and irrelevant questions, such as whether they had a boyfriend, why they had sex at such a young age, and whether they had told their mothers.

This adversarial style of relating is not conducive to the transmission of accurate and timely information on which adolescents and youth can make informed decisions. Young people are unlikely to provide truthful feedback if this is solicited in these circumstances. Finally, these factors result in young people being fearful of approaching health workers with sexuality issues.

Many of these problems could arise because health care workers are inclined to regard moral guidance of young people and discouraging sexual activity as part of their social role. They thus fail to put their professional obligations above their moral convictions. Another cause of these

problems could be that very few health personnel have received sufficient training in adolescent and youth health.

Any attempts to maximise the potential of health facilities as sites of service provision should aim to address these barriers to service utilisation. By so doing, health facilities would be made more accessible and transformed into "youth friendly" clinics. Important strategies to achieve this may include:

- ④ increase the number of facilities such that they are accessible to a greater proportion of the population;
- ④ make structural changes to the facilities to promote privacy and confidentiality;
- ④ allocate certain days or sessions for adolescents and youth alone;
- ④ convenient opening hours;
- ④ re-train and re-orientate health workers, with an emphasis on values clarification and the development of interpersonal skills to promote good provider/recipient communication and respect for young people;
- ④ facilitate and enable 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;
- ④ involve adolescents and youth in the development of "youth friendly" clinics;
- ④ develop a set of adolescent and youth health service standards to facilitate monitoring and evaluation; and
- ④ co-ordinate and liaise with NGOs, and community based organisations (CBOs) and the private sector to strengthen and sustain youth friendly services.

In addition, there is evidence from two Cape Town studies that there are missed opportunities for intervention among youth attending primary care facilities. In one study, it was found that 43% of youth attending primary health facilities

did not receive any intervention regarding contraception at that visit to the clinic yet would have liked to receive such information.⁵³ Another study reported similar results for use of cigarettes, alcohol and other substances.⁵⁴ This suggests that a more *integrated* and *comprehensive* approach would be welcomed by youth. Thus, in addition to the presenting complaint being attended to, the health services should aim to provide a comprehensive array of other services to the young person. Where appropriate, such services could be included in the core "package" of primary care services.

5.4 Workplace

Large numbers of young South Africans are employed; one estimate is that 200,000 children between the ages of 10 and 14 years alone are engaged in remunerative employment.⁵⁵ One of the most common forms of work is domestic service. This is a relatively hidden form of work in that it is difficult to obtain estimates of how many young people are involved. However, there is evidence that rural adolescents and youth are recruited by city dwellers to work as domestic workers, but are then subject to strenuous labour for exploitative wages.⁵⁵ Another common form of work among adolescents and youth is street trading. This can take on various forms, such as roadside vending of fruit, vegetables, newspapers and other commodities in both urban and rural areas. The taxi industry employs adolescents and youth as cleaners, "conductors", and drivers. Other businesses employ young people as packers, building labourers, petrol attendants, contractors, brickyard hands, and entertainers and models. Young women and men may earn money as



commercial sex workers.

Work experiences can be either positive or negative. Besides providing funds, work can promote health and development. Newspaper vendors, for example, who are school-going and deliver newspapers door-to-door for extra pocket money may learn about the importance of consistency, responsibility and punctuality. In addition, they may use the money for development enhancing hobbies or sports participation. This is in contrast to their impover-

ished counterparts, who may be fetched from townships as early as 3:00 am to sell newspapers on street corners, for much longer hours and in unprotected conditions. It is difficult to remain in school in these circumstances, and their families may depend on the money to fulfil basic needs such as food and shelter. Domestic workers, especially those who are very young, are vulnerable to physical, emotional, sexual and economic exploitation. Farm workers may be at risk from insecticide poisoning and injury

from farm machinery.⁵⁶ Commercial sex workers are at very high risk from assault, sexually transmitted infections and substance abuse.

It is important to have a full understanding of the work circumstances of young people in a specific work situation before developing intervention strategies. Indeed, the aims of the strategies vary according to the conclusions flowing from such an understanding. Thus, if exploitation is taking place, it may be necessary to abolish certain work by people under a certain age. However, this should be accompanied by the twin aim of creating other sources of income

for the affected young people, otherwise more harm than good may result. Another aim may be to improve working conditions. The Sex Workers Education and Advocacy Taskforce (SWEAT), for example, has as one of its main aims to reduce the incidence of sexually transmitted infections (STIs) such as HIV infection among sex workers. Finally, an aim could be to offer health promotion programmes in the work setting. Certain subgroups of young people may be optimally reached at work, such as out-of-school adolescents.

There are a number of strategies that are necessary to achieve one or more of these aims, such as:

- ④ liaise with relevant role players to develop a programme of action in addressing the child labour problem;
- ④ promote ongoing awareness campaigns around child labour issues;
- ④ encourage provincial and local structures to play a leading role in the elimination of child labour especially through awareness raising campaigns;
- ④ increase awareness regarding safety and homes, public places, industries, schools and other educational institutions;
- ④ increase awareness regarding the importance of occupational safety measures, e.g. street lights for sex workers, safety precautions (such as goggles) for factory workers;
- ④ promote and encourage research



pertaining to child labour;

- ④ enforce legislation for effective elimination of child labour;
- ④ enforce legislation (acts and regulation) regarding safety in public places, industries, schools and other educational facilities; and
- ④ establish and maintain a comprehensive national data system on the extent and nature of work by adolescents and youth, disaggregated by gender .

Many of these strategies are being implemented under the auspices of the Child Labour Inter-Sectoral Group (CLIG). This is an inclusive national forum with the Department of Labour as lead agency. Its mandate is the elimination of child labour in South Africa. Membership comprises business, government departments, trade unions and non-governmental agencies.

5.5 Street

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

5.6 Community-based organisations

Involvement in community-based organisations is often primarily motivated by a desire to participate in sport, recreation or community service. However, such involvement can have substantial health benefits.⁵ In terms of preventing and responding to health problems, many community-based organisations provide information and guidance about topics such as drugs or sexuality. However, their main contribution in terms of health is by promoting

healthy development. Thus, the organisations may provide young people with social support, skills training, constructive alternatives to risk behaviour such as sexual activity and substance misuse, a sense of belonging, responsibility to others, and increased self esteem through achievement and the consequent personal satisfaction and public recognition.

South Africa is fortunate in having a large number of and wide diversity in community-based organisations. They include religious groups, the youth wings of political parties, business groups, woman's groups, as well as a number of independent youth groups. These groups are almost invariably NGO's. The main aim of the provincial and national departments of health should be to lend support and encouragement to these groups. In addition, health departments should assist either with preventing or responding to health problems or promoting healthy development.

5.7 Residential centres

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

social environment by enhancing relationships with adults, providing information, building skills and providing health services. Also, there needs to be stricter monitoring of residential facilities to ensure that they meet the emotional, physical and psychological needs of the young people under their care.

Finally, there should be a lack of ambiguity as to which national and provincial departments are responsible for the provision of health services in residential centres. If this is not the case, services will not be provided and adolescents and youth will suffer.