

6. PRIORITIES

As mentioned above, the main thrust of adolescent and youth policy guidelines should be on integrated, horizontal programming as opposed to problem-oriented, individual efforts. However, this chapter addresses the unique considerations that characterise selected health priorities. These priorities are sexual and reproductive health, mental health, substance abuse, violence, unintentional injuries, birth defects and inherited disorders, nutrition and oral health.

These priorities were selected after considerable consultation and debate, taking care to ensure that they are consistent with the White Paper for the Transformation of the Health System in South Africa. Despite this, there is a measure of arbitrariness in the selection of these specific priorities. Certainly, there may be health priorities that are specific for certain provinces, such as malaria in KwaZulu/Natal and tuberculosis in the Western Cape.

It is possible to apply the **guiding concepts** enumerated above (Chapter 3) in developing **general strategies** (Chapter 4) in various **intervention settings** (Chapter 5) for *any* specific health priority.

For each health priority, there are four subsections: situation analysis, impact, intervention strategies and examples of indicators.

Indicators are necessary to facilitate monitoring and evaluation. The intervention strategies are presented in terms of the five general strategies. For reasons of space, it has not been possible to apply each of these general strategies in a systematic and complete manner to all of the intervention settings (as would occur when developing a matrix). Rather, the intervention

strategies provided for each health priority should be regarded as *examples* of appropriate strategies.



6.1 Sexual and reproductive health

The programme of action of the International Conference on Population and Development (ICPD) highlights the critical need to address adolescent, sexual and reproductive health issues which have largely been ignored by existing reproductive health services. The ICPD defines

reproductive health as: *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.* The components of sexual and reproductive health care are as follows⁵⁷:

- ☉ safe motherhood: prenatal care, safe delivery, essential obstetric care, perinatal and neonatal care, postnatal care and breast feeding;
- ☉ family planning information and services;
- ☉ prevention and management of infertility and sexual dysfunction in both men and women;
- ☉ prevention and management of complications of abortion;
- ☉ provision of safe abortion services;
- ☉ prevention and management of reproductive tract infections, especially sexually transmitted infections, including HIV infection;
- ☉ promotion of healthy sexual maturation from pre-adolescence, responsible and

safe sex throughout the lifetime and gender equality;

- elimination of harmful practises, such as female genital mutilation, premature marriage, and domestic and sexual violence against women; and
- management of non-infectious conditions of the reproductive system.

In this section, the situation analysis will focus on selected aspects of the knowledge, behaviour and attitudes of young South Africans that are pertinent to sexual and reproductive health. Thereafter, the impact of the situation on three aspects will be briefly reviewed: teenage and unwanted pregnancies, termination of pregnancy and sexually transmitted infections (including HIV infection). Clearly, these policy guidelines will address only those aspects of reproductive health that are considered most pertinent to adolescents and youth .

6.1.1 Situational analysis

A recent report aimed to identify and summarise all South African studies addressing the sexual health of adolescents and youth.⁴⁸ Approximately three dozen studies were included. Some of the main findings from this review are provided below.

- For the majority of young South Africans, sexual activity starts in the mid-teens. Because of differences in the samples included in the studies and the strategies by which they were obtained, it is difficult to arrive at a figure that represents the average age of first intercourse for young South Africans. However, based on the most representative studies,^{58,59} in

the context of the remaining studies, it is reasonable to conclude that the national average age of first intercourse is 15 years for girls and 14 years for boys. There is, however, great variability around these figures. Significant numbers of young people have their sexual debut well before age 14, while many are virgins at age 18. Boys start to have sex significantly earlier than girls do, and in greater numbers.

- While almost all young South Africans have heard of AIDS, there is highly variable knowledge about the illness itself. There is variability both between studies (with some studies showing a good overall level and some studies the converse), and within studies (with large proportions showing both high and low overall levels). Also, levels of knowledge tended to vary across different topics. Thus, the overwhelming majority of respondents are aware of the facts that the disease is sexually transmitted and is eventually fatal for almost all those infected. Knowledge levels are less impressive

about other aspects, such as that HIV can be contracted through blood; that it can be passed from mother to child; and that it has a “dormant” phase; and that it is impossible to contract AIDS from casual contact.

- The prevalence of contraceptive use varies across the reported studies from 25% to 75%, with an average of about 60% of sexually active youth. Even assuming that some might be hoping for a pregnancy, this still leaves a large segment of young people running the risk of unwanted pregnancy. Men report using condoms more than do women, while women report using oral or injectable contraceptives. Up to 15% of the youth use unreliable methods such as withdrawal or the rhythm method.



- ☉ As regards condom use specifically, which is of relevance both for the prevention of both unwanted pregnancy and sexually transmitted infections such as HIV infection, it was found that significant numbers of young people have never used a condom during sexual intercourse. In some studies, over 90% of the girls or young women surveyed had never used one. Of those who have ever used a condom, a minority report always using one. Studies which asked respondents whether they used a condom in their last sexual encounter, report equally low rates.
- ☉ Most non-virgin school students have had one or two partners. The studies with older youth show that the majority of young people had either not been sexually active, or had engaged in sexual intercourse with only one person in the preceding four to twelve months. A minority (less than 30%) engage in sexual intercourse with numerous partners. Males report more sexual partners than females.

In Section 5.3 above dealing with health facilities as a site for programmes, it was reported that there are several factors that prevent public health facilities from achieving their potential as sites for health service provision. These include their inaccessibility, the fear that problems will not be kept confidential, poor relationships between young people and clinic staff, and large numbers of missed opportunities for intervention.

Although these points are valid for all the health priorities included in these policy guidelines, they are particularly pertinent for sexual and

reproductive health.

Indeed, many of the studies cited above were specifically addressing sexual, and reproductive health issues. In addition, there are some specific issues that pertain to sexual health. A good example in this regard is the denial of access to contraceptives by sexually active adolescents under the age of 14 years if they do not have permission from their parents.

6.1.2 Impact

(a) *Unwanted teenage pregnancy*

In 1995 it was estimated that the pregnancy rate was 330 per 1000 women under the age of 19 years, and 40% of all pregnancies were estimated to be to teenage girls.⁶⁰ In 1993, teenagers accounted for 15% of births in South Africa, and 22% of those aged 15 to 19 years had ever been pregnant.⁶¹ Data from studies conducted in parts of the country are consistent with these statistics. Among rural school girls in the Transkei, 23% had previously been pregnant.⁶² Of women delivering at Butterworth Hospital, also in Transkei, 28% were aged 19 years and younger.⁶³

In 1991, maternal mortality was almost double for women under 20 years of age compared with those over that age.⁶¹ The under five-mortality rate (U5MR) is 50% higher for children born to young teenagers than for mothers aged 20-34 years. From the social perspective, pregnancy of young people can be accompanied by reduced self esteem, financial costs such as medical care and social support, school drop

out, reduced income generating potential and hence poverty.⁴⁸ The adolescent mother and her baby can be economically dependent on family and society in general. Other consequences of unwanted teenage pregnancy include ill-timed marriages, child abuse and abandoned children.

(b) *Termination of pregnancy*

It has been shown both internationally and in South Africa that unsafe abortions result in significant morbidity and mortality.⁶⁵ Prior to the recent amendment of legislation governing the termination of pregnancy, it was suggested that between 6,000 and 120,000 illegal abortions were undertaken per annum in South Africa, most of which were on young women.⁶⁵ Even after the legislative amendment, the prevailing problem is that those who most need access to safe abortions (i.e. impoverished, disadvantage and disempowered women) are those who are least likely to reach present services.⁶⁶ According to the Department of Health, within the first 3 months of the implementation of the Choice of Termination of Pregnancy Act, 60% of the nearly 7,300 terminations took place in Gauteng.

(c) *Sexually transmitted diseases (including HIV infection)*

Adolescents and young people are particularly vulnerable to sexually transmitted infections because biological factors, susceptibility to peer pressure, a tendency to engage in risk-taking behaviour, inexperience with alcohol and other substances resulting in a failure to predict their disinhibitory effects and relative inaccessibility of health facilities.

Among South Africans that are sexually active, those in the youngest age groups are most at risk; 60% of all HIV infections occur in the 15 to 24 year age group. Some of the reasons that young females are more vulnerable than males are provided below:

- They are often involved in sexual relationships with older men who may have been exposed to a greater number of partners. This situation is exacerbated by the belief held by some men that having coitus with a virgin will cure them of HIV disease.
- Young girls are sometimes physically forced to have intercourse, resulting in genito-urinary trauma with lacerations and hence risk of infection
- STD's in females are more likely to be asymptomatic and hence not treated.
- Women are more likely to be involved in commercial sex work, which is characterised by a very high risk of contracting STD's.

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

The STD with the most ominous implications for the health of young South Africans is HIV infection. In 1998, the proportions of women attending antenatal clinics who were HIV positive were 21% and 26% for those aged less than 20 years and 20 to 24 years respectively.⁶⁷ The age group 20 to 24 years had the highest annual HIV infection rate between 1990 and 1997.⁴⁸ However, in 1998, women aged 25 to 29 years had the highest rate (26.9%).⁶⁷ Of particular concern is the increasing percentage of women under 20 years that are HIV positive; there was a dramatic increase for this age group from 12.7% in 1997 to 21.0% in 1998.⁴⁸

Assuming an incubation period of 8 - 9 years,

these youth will not live to their 30th birthday. The Department of Health estimates that at these levels, around 1 in 5 South African women currently aged 20-24 will die of AIDS.⁶⁷ It is estimated 2,226 people aged 15 to 19 years and 10,438 people aged 20 to 24 years died (or will die) from AIDS in the 12 months beginning 1 November 1998.⁶⁸ There are twice as many females among these deaths than males.⁶⁸

6.1.3 Intervention strategies

(a) *Creating a safe and supportive environment*

- ☉ promote positive family values
- ☉ promote delayed childbearing
- ☉ promote marriage preparedness
- ☉ expand access to education and training, especially for girls and women
- ☉ provide income-earning opportunities, especially for young women and those offering sex on a commercial basis
- ☉ attempt to alter social norms that tend to stigmatise religious and cultural groups, single mothers and those living with the HIV/AIDS
- ☉ encourage public debate on sexual and reproductive health
- ☉ facilitate easy, cheap and private access to all forms of contraception (including "emergency contraception"); in the case of condoms, such access should exist at all times of day or night, especially at venues at which adolescents and youth congregate such as:
 - shebeens
 - taverns
 - sports and recreation facilities
 - cloak rooms
 - shopping complexes

- restaurants
- sites of learning and
- filling stations.

- ☉ facilitate effective communication between parents or caregivers and their children in general and about sexuality in general

(b) *Providing information*

- ☉ use multi-media methods to provide information to adolescents and youth and their families about all matters pertaining to sexual health, taking into account the results of studies that aim to document current gaps in knowledge, on matters such as:
 - the personal risk faced by young people
 - abstinence;
 - the advantages of postponing the onset of sexual activity;
 - safer sex, including monogamy and condom use;
 - sexually transmitted infections;
 - emergency contraception (the "morning after pill" or "postcoital contraception"); and how to
 - access termination of pregnancy
- ☉ emphasise that the safest way of avoiding disease and pregnancy is abstention from penetrative sexual activity
- ☉ emphasise the necessity of "dual protection", i.e. protection against both pregnancy and disease increase the amount of sexuality information in school curricula, using the "spiral curriculum" concept whereby developmentally appropriate material is conveyed from Grade 1 onwards
- ☉ young people should be encouraged to respect one another self determination

and to share responsibility in matters of sexuality and reproduction and raise awareness among political, government, religious and other community leaders about sexual health, including aspects such as:

- the right to make informed choices about termination of pregnancy;
- the need for sexuality education from an early age;
- the necessity of taking steps to reduce stigma attached to groups of people such as single mothers and people with HIV/AIDS

- ☉ sensitise parents and adults in general on the importance of talking to their children about sexuality

(c) *Building skills*

- ☉ support existing efforts to provide life skills training to adolescents and youth and institute such programmes at sites where they do not exist yet
- ☉ include skills specifically relevant for sexual health in life skills programmes, such as :
 - decision making;
 - negotiating contraceptive use;
 - saying “no” to unwanted sexual advances or activities

(d) *Counselling*

- ☉ establish or strengthen peer counselling programmes for both in and out of school adolescents
- ☉ provide training in sexuality counselling for adults who have contact with adolescents and youth, especially educators and health workers provide counselling to pregnant teenagers on

parenting skills.

(e) *Access to health services*

- ☉ work towards the integration of sexual and reproductive health services (including termination of pregnancy services) at the primary, secondary and tertiary levels of health care
- ☉ establish transport and communication facilities for effective referrals between health facilities
- ☉ establish national standards and mechanisms for monitoring standards of care for reproductive health services
- ☉ improve training of doctors, nurses, social workers and other staff involved in sexual and reproductive health service provision, including as regards
 - responding to adolescents and youth with empathy and respect; and
 - maintain confidentiality
- ☉ establish an audit system on sexual and reproductive health services at all levels of health care
- ☉ ensure that sexual and reproductive health services constitute a central component of youth-friendly health facilities
- ☉ improve screening for sexually transmitted infections
- ☉ promote the syndromic approach to the treatment of sexually transmitted infections
- ☉ make HIV voluntary counselling and testing services accessible
- ☉ with regard to termination of pregnancies:
 - they should be accessible to even the poorest and most rural women
 - infrastructure and referral pathways should be strengthened to prevent

- patients who are referred for termination not arriving at the relevant facility
- women should be counselled and empowered to make the choice about whether to terminate pregnancy that is appropriate for them in terms of their values, religious convictions and social circumstances
- the aim should be to reduce the demand for terminations through improved contraceptive coverage (including emergency contraception)
- management protocols should be both provider - and recipient-friendly
- women undergoing termination should be provided with information and counselling that would prevent future pregnancies
- the right of health care providers not to participate in terminations should be scrupulously respected

6.1.4 Examples of indicators

- percentage of pregnancies among young women < 20 years ending in abortion
- percentage of women with first birth < 20 years
- percentages of young people living with HIV/AIDS
- percentages of young people with STDs (excluding HIV infection)
- age at first pregnancy
- age of coital debut
- characteristics of male progenitors (age, educational level, type of employment)
- existing legislation on reproductive health
- existing standards for reproductive health care
- fertility rates

- levels of satisfaction of adolescents and youth with reproductive health services
- maternal mortality ratio (<17 years)
- number and percentage of young people sexually active
- number and percentage of young people who use each type of contraception, if they are sexually active
- number and percentages of pregnant young people according to educational level
- number and percentages of young people who receive some formal type of sexual education
- organisations, associations or services providing each type of contraception
- percentage of births attended by fathers
- percentage of pregnant young people initiating antenatal care by each trimester of pregnancy
- violence incidence and prevalence against young people, including sexual abuse
- source of sex education
- young people's knowledge about sexuality, contraception, STD's

6.2 Mental Health

Note that mental health issues receive attention in other sections. Alcohol, tobacco and other substances are dealt with in Section 6.3; mental health issues in relation to violence in Section 6.8; and mental disability in Section 6.4. Suicide has been included here since it is sensibly regarded as a manifestation of mental health problems.

The Directorate: Mental Health and Substance Abuse of the Department of Health is developing policy guidelines to address the mental health needs of adolescents and youth. The current

policy guidelines should be read in conjunction with those being developed by the Directorate: Mental Health and Substance Abuse.

6.2.1 Situational analysis

South Africa has a number of characteristics that place its adolescents and youth at risk of mental health problems, such as widespread poverty and familial disruption. However, there are very few studies that attempt to provide prevalence rates for psychiatric disorder in adolescents and youth, and these studies are of variable quality, use different assessment methods, generally do not address the cultural aspects of psychopathology in the relevant communities, and tend to be clinic-based. There are certainly no national studies. However, based on existing estimates and international data, it would be reasonable to assume that approximately 15% of young people in South Africa suffer from mental health problems warranting a psychiatric diagnosis.⁶⁹ The overwhelming majority of these would benefit from mental health services.

One particularly conspicuous and tragic manifestation of mental health problems is suicide. There are wide racial discrepancies in the extent of suicide, with the proportions of deaths of 15 to 24 year-olds being between 9 and 12% for Asians and whites of each gender, and below 3% for others.⁷⁰ Although there is concern that suicide may be increasing among young South Africans, this is supported by empirical evidence in the case of young white males only.⁷¹ Deaths from suicide account for only one aspect of the problem of suicidality; it is estimated that the ratio of completed suicides to non-fatal attempts varies between 50 and 120 to 1.⁷²

Among Cape Town high-school students, 19% had thought about committing suicide in the past year, while 8% had made an actual attempt in this time period. The relevance of this for

mental health is that the overwhelming majority of young people who commit suicide are suffering from a treatable mental disorder at the time of their death, and those with non-fatal suicidality are at substantially increased risk for such disorder.^{73,74}

In the context of these large service needs, there are very few mental health services for adolescents and youth. There are only six provincially supported child and family units, and a handful of specialist adolescent units that are linked to academic complexes.⁶⁹ These services are relatively inaccessible to many young people, especially those in disadvantaged and rural communities. Primary and secondary level mental health services are particularly underdeveloped. Young people with severe psychiatric conditions requiring hospitalisation generally receive custodial care, followed by attendance at outpatient or community clinics where interventions other than pharmacological therapy receive low priority.⁷⁵ Mental health services (like health services in general) are fragmented and ill-equipped to intervene effectively. There is poor inter-sectoral liaison and co-ordination of services, resulting in duplication and fragmentation. There is limited expertise to deal with adolescent and youth mental health issues, especially at the primary level. Graduates of training programmes are frequently not equipped to respond to the public mental health needs of the majority of South African young people.

6.2.2 Impact

There are other consequences of mental health problems in adolescents and youth besides immediate and obvious impacts of suffering (both for the person with mental health problems and their significant others), family disruption and poor educational progress or dropout. First, if not treated appropriately, people with mental health problems when young are at increased risk for such problems in adulthood.

Second, there are immense economic consequences of poor mental health, both for the family and society at large. Societal costs accrue from factors such as the costs of treatment, welfare benefits, and a reduced ability to contribute to society.

6.2.3 Intervention strategies

(a) *Creating a safe and supportive environment*

- ☉ improve the safety of the environments of children (to prevent head and other injuries that can directly cause impairment of mental health)
- ☉ provide adequate recreational facilities at convenient places for adolescents and youth
- ☉ support parents to prevent negative family conflict, which predisposes to and precipitates mental health problems and suicidality
- ☉ facilitate the formation of youth and adolescent mental health fora to identify community-specific causative factors for poor mental health
- ☉ work with the media to ensure that suicide is reported in a responsible manner, which would include not glamourising or giving excessive coverage to suicides of famous people
- ☉ limit access to means of suicide, such as weapons and (in certain rural communities) pesticides

(b) *Providing information*

- ☉ engage in public education about mental health, with a view to: (a) promoting mental health; (b) destigmatising mental health problems; (c) assisting young

people and the members of their support systems to recognise mental health problems and obtain the necessary assistance

- ☉ educate and raise awareness of young people, parents, family and the community in general about suicide, emphasizing the fact that suicidality is a potent signal of unmet mental health needs

(c) *Building skills*

- ☉ include in existing life skills programmes measures that may promote mental health or prevent suicide, such as how and where to request assistance with mental health problems

(d) *Counselling*

- ☉ increase access of young people to counseling services, including telephone hot lines, crisis centres and counseling services at primary health care level
- ☉ educate adults already in positions where young people approach them for assistance regarding mental health issues, including the warning signs of suicide and the necessity of taking suicide threats and other signs indicating the possible presence of mental health problems seriously

(e) *Access to health services*

- ☉ mobilise additional resources to improve mental health services for adolescents and youth
- ☉ conduct research in which the magnitude and nature of mental health needs of adolescents and youth in South Africa are documented

- ④ improve national statistics regarding the prevalence of completed suicide and suicide attempts
- ④ develop mental health services for adolescents and youth at primary, secondary and tertiary levels (Table 1 on page 46)
- ④ develop human resources particularly at primary and secondary level to provide the services listed in Table 1
- ④ develop an appropriate mental health information system for evaluation, auditing and monitoring of mental health programmes for adolescents and youth, including the development of indicators
- ④ ensure that mental health programmes for adolescents and youth at all levels address key priorities, such as violence, abuse, suicide, and severe psychiatric conditions, including the detection of these conditions
- ④ take steps to ensure that medication required for the management of psychiatric problems in adolescents and youth are available at all levels
- ④ ensure that comprehensive integration of youth and adolescent mental health services with other services takes place
- ④ where appropriate, involve communities (including disadvantaged and rural communities) in the planning and implementation of adolescent and youth mental health care services at all tiers
- ④ increase the number of people responsible for adolescent and youth mental health services at national and provincial levels, and improve their managerial capacity
- ④ include a mental health component in the health promotion efforts at schools

6.2.4 Examples of indicators

- ④ percentage of young people attending health facilities with “psychosomatic” complaints
- ④ attempted suicide rates
- ④ completed suicide rates
- ④ incidence and prevalence of selected psychiatric disorders

Table 1. Levels of adolescent and youth mental health services (adapted from Dawes et al.⁶⁹)

Tier	Level	Site	Personnel	Services
Primary	District	Clinics Schools District hospitals Maternity services Courts Penal system Children's homes Families Private practises NGO's	Generally not mental health specialists Lay counsellors Trained volun- teers	Parental and youth educa- tion about mental health issues Screening for mental disorder (including suicidality) Identification of young people at risk for abuse Short-term counselling ser- vices for young people and their families Basic management of behavioural disorders maintenance Management of young people with chronic conditions
Secondary	Region	Regional hospitals Child Guidance Clinics Child abuse units Educational support services	General mental health special- ists, e.g. psychi- atrists, psycholo- gists, nurses, social workers Multidisciplinary teams with addi- tional training in adolescent and youth mental health	Investigation and treat- ment of severe problems referred from Tier 1 Consultation, supervision and training to Tier 1 personnel Link with other local and provincial sectors and NGO's in cross-sectoral prevention and promotion initiatives
Tertiary	Province/ nation	Academic health complexes, including child and family units, eating disorder units, adolescent units, abuse units NGO's Private sector	Adolescent and youth mental health specialists	Super-specialist diagnos- tic and treatment services Support, consultation and training to all levels of service Rehabilitation services for subgroups such as autistic adolescents and youth and those with psychotic disorders

6.3 Substance abuse

6.3.1 Situational analysis

Alcohol is the substance most frequently abused by young South Africans. A representative national study of black youth aged 10 - 21 years reported that 80% had used alcohol at some time, while 34% were current drinkers (i.e. had used alcohol in the last twelve months prior to the study).⁷⁶ Of more concern is levels of risky drinking, defined as consuming the equivalent of about 3.5 x 340 ml cans of beer per day. Using this definition, it was found that 4.4 and 7.8% of urban and rural black youth respectively were risky drinkers, with the corresponding figures for females being 1.9% and 1.8% respectively. Equivalent statistics are not available for other (non-Black) youth.

Among grade 6 and 7 learners in four primary schools in a historically disadvantaged area in the Pretoria Metropolitan Area, 14% had drunk alcohol in the past 30 days to get drunk.⁷⁷ Among Cape Peninsula high-school students, 27% and 15% of males and females respectively had engaged in binge drinking in the fortnight preceding the study.⁷⁸ Among those who had dropped out, there was a trend for the rates of binge drinking to be somewhat higher.⁴⁴ There is some evidence that the rates of risky drinking among high-school students in the Cape Peninsula may have increased between 1990 and 1997.⁷⁹

Another drug that is frequently abused is *tobacco*. Among Cape Peninsula high-school students, 18% are regular smokers, i.e. smoke at least one cigarette per day.⁸⁰ Among males in Grade 12, the proportion is 28%!

Illicit drugs constitute another important group. Among Cape Peninsula high-school students, 7.5% had ever used cannabis, and 2.4% had done so in the previous seven days.⁸¹ Of the

total sample, 1.6% had ever used methaqualone (Mandrax). Use of other illicit drugs appears to be very low among school students, at least in Cape Town.⁷⁹ Among the sample of Pretoria primary school students mentioned above, 6.7% had ever used cannabis, and 3.7% had done so in the previous 30 days.⁷⁷ The study among black youth aged 10 to 21 years mentioned above found that cannabis use was confined to urban males, among whom 5.5% had used cannabis.⁷⁶

The same study found low rates of other illicit substances in the past 12 months: 1.5% for LSD, 1.7% for Mandrax, 0.8% for cocaine, 0.9% for heroin and 2.9% for steroids. However, with South Africa's increasing exposure to international drug traffic, it is likely that these prevalence rates will increase.^{76,82,83} Other possible substances that can be abused are prescription drugs (especially minor tranquillisers), over the counter sedatives and weight-reducing agents, and sol-vents.

In general, rates of substance misuse are higher among males, and increase with increasing age or school grade.⁸⁴

6.3.2 Impact

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

involved in drug dealing/trafficking. Besides having repercussions for those whom they supply with drugs, they are at risk for sexual exploitation and spiralling involvement in other crimes and gang involvement.

The long-term impact of substance use tends to become evident when the abusers are in their thirties or older. However, the patterns of substance use that lead to these outcomes has invariably been laid down in adolescence. This is part of the reason that tobacco and alcohol companies target adolescents in their advertising campaigns. Important fatal outcomes of alcohol and tobacco use include heart disease and malignancies (especially lung cancer for tobacco). Alcohol can also cause foetal alcohol syndrome; 26% of the young women attending routine antenatal classes in selected poorer Western Cape communities consume sufficient alcohol to place their babies at risk for this syndrome.⁸⁵ There are also substantial economic consequences of substance use from factors such as absenteeism, increased use of medical benefits, increased workers' compensation claims, poor productivity, high job turnover, interpersonal conflict, injuries and damage to property. These economic consequences will adversely affect the ability of the country to achieve economic targets, such as those included in the Growth, Economic and Redistribution Policy.

6.3.3 Intervention strategies

Many of these intervention strategies are derived from the work of Adolescent Health and Development Programme of the WHO,² the Framework for a National Drug Master Plan⁸³ and the work of Charles Parry and Anna Bennetts.^{82, 84}

(a) *Creating a safe and supportive environment*

- ☉ decrease availability by:
 - increased collaboration with

international drug control agencies in pursuing drug syndicates and addressing drug production

- bilateral and sub-regional agreements
- improved co-ordination of different agencies involved in enforcing drug laws (e.g. SA Police Services, SA National Defence Force)
- enforcing existing legislation regarding the minimum age of drinking, the "dop" system and public drunkenness
- improved training of and equipment for customs officials
- increased rewards and witness protection for people reporting illegal substance-related activities
- supporting cannabis crop eradication and substitution

- ☉ decrease the social desirability of substance use (thus altering social norms and cultural practises) by
 - rigorous enforcement of the Tobacco Products Control Amendment Bill, which outlaws advertising or promoting any tobacco product and prohibits smoking in public places
 - advocating for legislation to increase restrictions on alcohol advertising, including sports sponsorship and the times of day when alcohol can be advertised
 - declaring certain areas to be drug-free (including alcohol, tobacco and other drugs) such as schools, workplaces, sports facilities
- ☉ make blood and urine testing mandatory for all drivers involved in motor vehicle accidents
- ☉ introduce random "spot" breath, blood and/or urine testing checks for drivers
- ☉ increase taxation on alcohol and tobacco products
- ☉ licence all liquor outlets, including shebeens, to increase control over