# Youth health and well-being: Why it matters

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Over half of the South African population are under the age of 25. This "youth bulge" has the potential to provide a future "demographic dividend" to South Africa in the form of increased economic productivity. However, such a boon is dependent on a number of factors, key of which is that young people are healthy. Currently, the burden of disease among youth is high, with tuberculosis (TB) and HIV emerging as the leading causes of death among all youth in the country, along with violence and traffic accidents for young men.[1]

Improving the health and well-being of adolescents and youth is crucial for their well-being *today*, and for their *future* economic productivity, because behaviour and health developed during these stages of life are key predictors of the *adult* burden of disease, and because health – like education – is a key factor in the intergenerational transmission of poverty.[2]

Better youth health is dependent on the provision of high-quality health services, but is also much intertwined with factors falling outside the realm of the health sector.[3] Poverty, in all its dimensions,[i] undermines health and well-being through a variety of pathways. Poor nutrition, for example, impacts negatively on a young person's capacity to learn, progress through school and earning potential. Poor living conditions and physical inactivity lead to a higher burden of chronic respiratory and/or heart disease. Exposure to domestic violence and harsh discipline increases the risk of young people becoming either victims or perpetrators of violence.

Individual factors such as delinquency and substance abuse impact on young people's well-being and are predictors of future ill health. Family level factors such as the absence of warm, positive parenting, as well as community level elements such as gang violence, for instance, impact on the emotional health of youth and may, in turn, undermine educational outcomes and employment chances.

Against this backdrop, this essay provides an overview of the current state of youth health and well-being in South Africa and identifies opportunities to improve outcomes by focusing on the following key questions:

- What do we know about youth health?
- What is being done to improve youth health?
- What can strengthen initiatives to improve youth health?

## What do we know about youth health?

> *Together, adolescence and young adulthood represent a period of experimentation and identity formation, and also a time when lifelong behaviour patterns are typically initiated or established. WHO estimates that 70 percent of premature deaths in adults worldwide are the result of behaviors begun in adolescence.*[4]

Adolescence and young adulthood are times of rapid physical and psychosocial change and development. They are stages in which parental influence decreases and the influence of peers and media increases.[5] As a result, these stages are often associated with a rise in experimentation and exploration, a search for identity, and a consequent increase in risky behaviour, alcohol and substance use and abuse, possible sexual and reproductive health (SRH) problems, violence and mental illness.[6] In addition, growing up in poverty creates specific challenges for a large proportion of the country's youth.

In South Africa, the leading causes of death among young people differ by gender, race and income status. Statistics South Africa reports that the leading causes of death among young men aged 15 – 29 in 2013 were "external causes", with a peak among 20 – 24-year-olds. This reflects the risk of violence, injuries and traffic accidents. Among young women of the same age group, communicable diseases[ii] were the leading cause of death, in particular TB and HIV.[7]

This section outlines some of the leading health issues affecting South Africa's youth, including sexual and reproductive health (SRH) and violence. It further elaborates on substance abuse and mental health, both of which are intricately related to the drivers and consequences of ill health. The essay further highlights how young people's lifestyle choices are shaped by a complex interplay of social norms, economic, gender and spatial inequalities, poor physical environmental conditions and inadequate access to services.

### Sexual and reproductive health

Exploring sexuality and intimate relationships are key components of youth SRH and well-being. However various social factors – such as peer pressure, intimate partner violence, rape, a lack of knowledge

i The essay on p. 22 and the *Children Count – The Numbers* section on p. 100 outline multiple dimensions of deprivation for children and young people in South Africa.
ii Communicable diseases "are those diseases that are infectious and include, among others, diseases such as tuberculosis, intestinal infectious diseases and influenza and pneumonia." (See no. 1 in references)

about SRH and barriers to contraception – also contribute to high rates of unprotected sex.[8] This places a substantial proportion of South Africa's youth at risk of unwanted pregnancies, sexually-transmitted infections (STIs), and HIV infection. Young women bear a disproportionately high burden of sexual and reproductive ill health.

### *Youth pregnancy*

Youth pregnancy is associated with significant health risks and socio-economic costs. While South Africa's teenage childbearing declined from 30% to 23% from 1984 to 2008,[9] it remains a serious concern. Teen mothers have poorer educational outcomes than non-teen mothers, which has negative implications for their future chances economically.[10] Studies consistently find that pregnancy and childbearing contribute significantly to falling behind and dropping out of school,[11] as well as discrimination and exclusion from school[12].

Pregnant teenagers are at greater risk of maternal health problems, accounting for 33% of all maternal deaths in South Africa.[13] Early access to antenatal care is critical for safer pregnancies and birth, yet youth attendance is particularly poor. Pregnant girls and young women cite the lack of privacy, confidentiality, and the fear of coerced HIV testing, as some of the obstacles to attending health care services.[14] Furthermore, children born to teen mothers are at risk of poorer health and educational outcomes – feeding the intergenerational cycle of poverty.

Kuthala's story (case 6) illustrates the interplay of various factors that shape young adolescents' decisions around sexual behaviour – the inaccessibility of youth-friendly health services and a lack of support and information after birth – which have a cumulative impact on young girls' education and emotional health.

### HIV

Globally, young people aged 15 – 24 comprise 41% of new HIV infections in those older than 15 years.[16] In South Africa, young women aged 15 – 19 are at highest risk of HIV and eight times more likely to be HIV positive than similar aged young men (5.6% vs 0.7%).[17] Furthermore, HIV is related to a range of other illnesses such as TB, listed by Statistics South Africa as the leading cause of death among young women.[18]

The drivers of the HIV and AIDS pandemic are complex and multi-faceted. Women have a higher biological susceptibility to HIV, but "a host of sociocultural and economic factors rooted in gender power inequities [further] exacerbate women's vulnerability to infection".[19] Gender inequality, coerced sexual relations and economic insecurity that leads to transactional sex make it significantly more difficult for young women to negotiate condom use: Between 2008 and 2012, reported condom use by males at last sex declined from 85% to 68% while reported condom use by females declined from 67% to 50%.[20]

Research consistently indicates the negative economic and psychosocial impact of HIV infection on families and individuals, especially adolescents and youth.[21] The expansion of antiretroviral treatment also means that babies infected in the perinatal period are living healthy lives, thus entering adolescence and young adulthood. While they have SRH needs common to other youth, they also have needs specific to living with HIV. Many recount insecurity in approaching intimate relationships due to their HIV status and rarely have their SRH needs adequately met in HIV care.[22]

### Violence

Most young people in South Africa are exposed to violence in their homes, schools and broader neighbourhoods – this includes

**Case 6: Khutala – The health complexities of a young mother's life in a South African township**

Khuthala (not her real name) was 18 at the time of our first interview, and mother of a one-year-old boy. She lived in Gugulethu with her mother, father, brother and baby. As a child, her father drank, abused her mother, and left no money for school fees, uniforms or food. Her grandparents therefore asked her to come and live with them in the Eastern Cape but when they died, she moved back to Cape Town. Khuthala still resented her father, but reported that she had a stable relationship with her mother, who supported her during her pregnancy.

Khuthala loved school but her unplanned pregnancy led to her dropping out in grade 11. Her story reflects how the institutions that are expected to provide guidance and support fail today's youth: Her family home was not a place of safety and when Khuthala went to the clinic to ask for the contraceptive pill, the nurses told her they only gave injections. This echoes other research which describes how medical staff can be unsupportive of teens, scolding them for sexual activity and being reluctant to provide them with contraceptives.[15] Khuthala was left alone to make a decision about contraception within a relationship she considered stable and mature enough not to use condoms any more. She had unprotected sex with her boyfriend of over a year and fell pregnant.

After the birth of the baby, Khuthala felt she had "lost herself", as she could no longer go to school and had no time to read or think. She felt "stupid" about having fallen pregnant, but tried to maintain a positive attitude.

She considered finding a part-time job, taking the baby to crèche and studying part-time once the child was two years old. However, a year later she had taken on a full-time job in a clothing shop because "something had happened at home". She was uncertain about her chances of returning to school.

**Source:** De Lannoy A (2008) *Educational Decision-making in an Era of AIDS.* PhD Thesis. Cape Town: University of Cape Town.

homicides, intimate partner violence and rape. Exposure to violence and deviant peer behaviour increases the likelihood of high risk and violent behaviour among youth as they seek stronger connections with peers. Further, structural factors such as poor quality education, high levels of unemployment and economic hardship may lead youth to be attracted to gang-related activities.[23]

Experiences of violence in South Africa are shaped by age, gender, socio-economic status and geographical location. A disproportionate number of young men in the country are both victims and perpetrators of violence,[24] and data on registered deaths in 2013 show that "external causes of death" accounted for approximately 60% of deaths among young men aged 15 – 24[25]. Young men living in poor, urban areas are at greatest risk of interpersonal violence, whereas girls and young women are at highest risk of sexual violence.[26] Dominant constructions of masculinity, including norms that demand toughness and strength and avoiding expressions of emotion and weakness,[27] increase the chances of men becoming both victims and perpetrators of violence and place young women at risk of sexual violence. Violence is particularly prevalent in poor communities where poverty, unemployment, poor quality schooling and a lack of recreational facilities may leave little opportunity for young men to gain a sense of belonging and "respect". Feelings of frustration and marginalisation may find expression in violent encounters with women and other young men.[28]

Sexual and intimate partner violence against girls and women are leading causes of health problems such as unwanted pregnancy and STIs, HIV infection, and mental health problems such as post-traumatic stress disorder.[29] In 2013/2014, 46,253 rapes were reported to the police,[30] and this is estimated as a fraction of actual rapes in South Africa.[31] Girls younger than 20 report high rates of coerced sex, particularly in first sexual encounters.[32]

> *I was still young, I was about 15. This guy would force me to do what he wants me to do at his own time. He would hit me, try to have sex with me, close the door, tie me [up] to have sex with him.* (22-year-old female, Johannesburg)[33]

The Youth Risk Behaviour Survey (YRBS) provides data on experiences of violence among public high school learners in grades 8 – 11.[34] In the month before the survey, a third of learners reported being bullied at school, 17% reported feeling unsafe travelling to school, and 13% reported carrying a weapon. Sexual and intimate partner violence are also prevalent: 11% of learners reported being assaulted by their romantic partner in the six months preceding the survey; and just under 10% of learners had experienced forced sex.

### Substance abuse

Globally, an estimated 70% of premature adult deaths are the result of behaviours begun in adolescence, many of which relate to substance use.[35] Tobacco use, for example, is a leading cause of adult non-communicable diseases such as chronic respiratory diseases, heart diseases and cancer. Excessive alcohol use can create long-term liver and kidney problems, brain changes and can lead to negative social behaviour.[36] In South Africa, alcohol, "tik" (crystal methamphetamine) and mixed drug use are linked to increased physical and sexual violence and crime.[37] Substance misuse is also associated with riskier sexual behaviour, which increases risks of HIV and STIs. Intervening early is therefore key to enhancing young people's well-being today, and to ensuring better health in the future.

South Africa's youth increasingly engage in hazardous drinking and drug abuse, and the treatment demand for youth substance abuse and addiction has increased over the past two decades. Alcohol and cannabis are the main substances of choice, but youth are also experimenting with, and abusing methamphetamines, heroin and mandrax.[38] Overall smoking among South Africa's high school students decreased from 23% to 17% between 1999 and 2011, but increased slightly for girls.[39] Box 5 highlights problems with alcohol and drug misuse amongst South Africa's youth.

**Box 5: Youth alcohol and drug misuse**

- 49.2% of South Africa's school-going youth have had one or more alcoholic drinks in their lifetime.
- Approximately a third (32.3%) of these youth reported having engaged in binge-drinking on one or more days in the month preceding the survey.
- 12.7% of the youth reported having used cannabis in their lifetime.
- 11.5% of learners reported having used at least one of the following drugs: mandrax, heroin, cocaine or methamphetamine.

**Source:** Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS & Omardien RG (2013) *Umthente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011.* Cape Town: South African Medical Research Council.

Key drivers of drinking include peer pressure, boredom, high youth unemployment and cheap and easy access to alcohol.[40] Research in Durban and Cape Town with 1,468 girls and boys aged between 12 – 17 has highlighted the significant impact of environmental stressors (such as discrimination and violent victimisation), parental child-rearing (the absence of warm, positive parenting), parental drug use, peer drug use, and adolescent personal attributes (especially delinquency) on youth illicit substance abuse.[41] A more recent study with ov er 2,000 youth in South Africa found a strong connection between environmental factors such as violent victimisation and "low well-being", i.e. depression, low self-esteem or ill health. These, in turn, influenced alcohol use and smoking in adolescents.[42] This underlines the need to understand emotional well-being of South Africa's adolescents in more detail.

### Mental health

There is growing evidence that poverty increases the risk of mental illness, and that people with mental illnesses are more likely to drift into or remain in poverty. While the precise mechanisms are unclear, two primary causal pathways have been identified (see figure 15). Poverty is often associated with experiences of social exclusion, heightened stress, violence and trauma, which may

increase the risk and severity of mental illness and substance misuse, and compromise access to care. At the same time people with mental illness are more likely to slide into poverty as a result of increased health expenditure, stigma, loss of employment and income.[43]

In addition, exposure to violence, substance abuse and HIV lead to increased vulnerability to mental health problems among young people.[44] The YRBS found that one in four youth (24.7%) reported feeling sad or hopeless, and just under 18% had made at least one suicide attempt. Only 37.2% of youth who reported feelings of sadness had sought treatment from a counsellor or doctor. Significantly, more young women (20%) than young men (15%) had considered suicide. The report recommended that:

> *More research needs to be conducted to explore the underlying determinants of this serious mental health problem. Intervention development and implementation needs to be accelerated together with evaluation mechanisms for both treatment and prevention of these mental health problems.*[45]

Finally, poor mental health is related to other health and developmental concerns in young people such as lower educational achievement, substance abuse, violence and poorer reproductive and sexual health.[46] Mental health disorders are also accompanied by suffering, stigma and financial strain,[47] which can influence the extent to which mental health disorders are reported and lead to underestimated prevalence data[48].

## What is being done to improve youth health?

Since 1994, government has introduced a range of laws, policies and programmes to promote youth health. However, their impact has been variable due to challenges with policy design and implementation, and due to insufficient attention to the underlying social determinants of youth health.

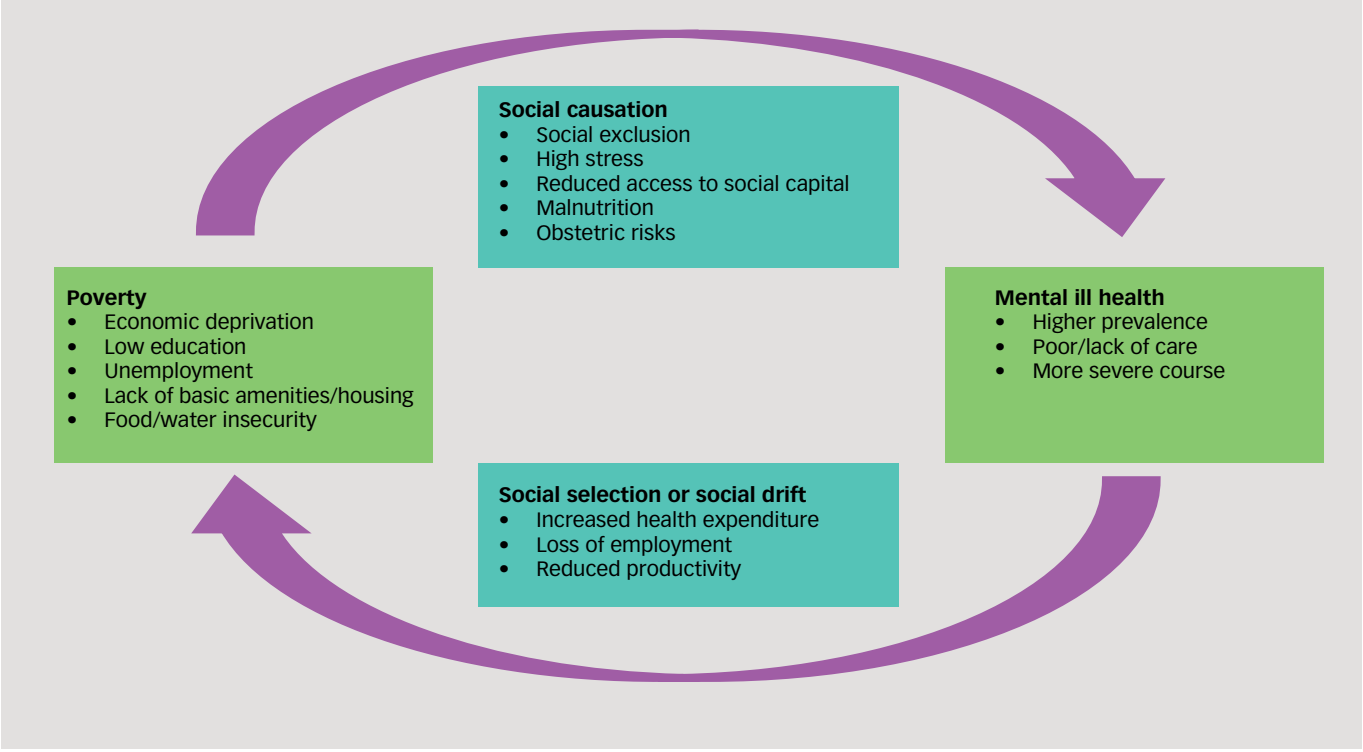
Non-governmental youth health programmes focus primarily on the prevention of violence and promotion of sexual and reproductive health. These include national media campaigns promoting HIV awareness among youth such as Soul City and loveLife, and peer education programmes to prevent HIV and gender-based violence such as Stepping Stones.

Evaluation of these type of programmes shows varying measures of success.[49] Shortcomings identified in several programmes highlight the limitations of attempting to change individual health behaviours without adequately addressing broader social determinants of health.

### Adolescent and youth-friendly clinics

Despite a legal entitlement to sexual and reproductive health care, including contraception on request from age 12, and abortion in terms of the law without an age restriction, youth experience numerous barriers in accessing health care. These include transport costs, clinic hours clashing with school timetables, a lack of privacy and confidentiality, and negative attitudes of health care workers.[50]

**Figure 15: A vicious cycle of poverty and mental ill health**




**Source:** Lund C, de Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Knapp M & Patel V (2012) *Poverty and Mental disorders: Breaking the Cycle in Low-income and Middle-income Countries.* Prime Policy Brief 1. Cape Town: Programme for Improving Mental Health Care, UCT.

**Case 7: Assessing school, facility and community-based sexual and reproductive health services**

After extensive community consultation, the Centre for AIDS Programme of Research in South Africa piloted a youth SRH intervention programme in the Vulindlela area of KwaZulu-Natal in 2011/12 to assess adolescents' preferences for different forms of SRH interventions. Students in 14 schools were rotated through three SRH interventions. In one intervention arm, students were provided with school-based services including group information and awareness sessions led by school nurses and a mobile clinic service.

In a second arm, individual SRH counselling was provided at school in collaboration with an NGO focusing on relationships, negotiating sex, assertive behaviour and high-risk sexual practices. In a third arm, students could either access school-based SRH counselling and services, or SRH services at primary health clinics. Services were offered both during and out of school hours.

The evaluation of the pilot showed that brief in-class information sessions facilitated student uptake of individual SRH and HIV counselling and testing. In general, youth preferred in-school and mobile services that offered a variety of SRH information, counselling and care rather than those based at health care facilities.

**Source:** Frohlich JA, Mkhize N, Dellar RC, Mahlase GB, Montague CT & Abdool Karim Q (2014) Meeting the sexual and reproductive health needs of high-school students in South Africa: Experiences from rural KwaZulu-Natal. *South African Medical Journal*, 104(10): 687-690.

In 1999 the government introduced the National Adolescent Friendly Clinic Initiative (NAFCI) to improve delivery of facility-based SRH services to youth. A recent analysis of NAFCI's impact indicates that:

> *[A] youth-targeted reproductive health initiative has the potential to substantially and significantly reduce the likelihood of early teen childbearing … [The] preliminary results suggest an increase in educational attainment related to delaying age at first birth.* [51]

Further analysis is needed, however, to disentangle exactly how the different components of NAFCI – education and increased access to clinical care – impact on teen fertility.

## School-based programmes and services

School-based health services are widely considered an effective strategy for providing comprehensive primary health care to school-going youth.[52] South Africa is introducing school health teams as part of its primary health care re-engineering programme.[53] Its new Integrated School Health Policy aims to strengthen existing services and will offer: screening for sight, hearing and oral hygiene; treatment of minor conditions; SRH counselling and either provision of, or referral for, contraceptive services.[54] (While making condoms available in schools is under review, current policies do not allow for provision of condoms or contraception at school.)

The policy also provides for health education in schools to address hygiene, nutrition, abuse, sexual and reproductive health, menstruation, contraception, STIs and HIV, male circumcision, pregnancy and termination of pregnancy, drug and substance abuse and suicide.[55] While these new initiatives are important,[56] school health services are unlikely to be able to meet all youth health needs. Expansion of initiatives offering sport, recreation and community-based services for in- and out-of-school youth are also of key importance.[57]

## Efforts to address violence

Physical and sexual violence is criminalised in South Africa, falling within the ambit of either the Children's Act, Domestic Violence Act or the Sexual Offences Act. Family violence, child abuse and sexual offences police units and special sexual offences courts were established in 1999, disbanded in 2011, and reintroduced following pressure from civil society in 2013. Government has also established Thuthuzela Care Centres in communities where rates of rape are particularly high. These centres bring together specially trained health professionals, social workers, police investigators and prosecutors to reduce secondary trauma, improve conviction rates and enhance coordination across different services.

Non-governmental organisations such as Mosaic and Rape Crisis provide valuable models of counselling and care for survivors of sexual violence. The Tswaranang Legal Advocacy Centre to End Violence Against Women gives legal assistance and advice on access to health services for women survivors of sexual violence. The Shukumisa Campaign promotes action by government and civil society organisations against sexual violence, while the Sexual Violence Research Initiative at the South African Medical Research Council is building a research evidence base and feeding into government policy. In addition, Sonke Gender Justice works with men and boys, and its peer education programmes engage them in activities to challenge attitudes, values and behaviours that compromise their own health and safety and that of women.[58]

While a number of local campaigns against sexual violence have been implemented successfully across rural and urban South African communities, there is a need for more rigorous evaluation to establish the strengths and limitations of these campaigns.[59]

## Substance abuse initiatives

Since the mid-1990s the government has implemented comprehensive tobacco control measures – banning advertising of tobacco products, classifying nicotine as an addictive drug, restricting smoking in public places, increasing excise duties, and prohibiting the sale of cigarettes to children under 18. School-based education programmes discourage smoking. School-going youths' decreased smoking prevalence is important, particularly given increased smoking rates among adolescents globally. However, girls' increased smoking rates need attention.

Similarly, the government has introduced a number of mechanisms to reduce alcohol availability to minors through increased taxation and restricting liquor outlets,[60] but alcohol remains easily accessible to youth.

**Case 8: Disability and the perpetuation of poverty – A need for inclusive youth development**

*Theresa Lorenzo and Roshan Galvaan*

The UN Convention of the Rights of Persons with Disabilities defines disability as including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[61] Recognising that disabled youth represent 7.5% of the total population of youth in South Africa,[62] the National Youth Policy calls for inclusive policies that promote equal opportunities for disabled youth. Groce[63] supports this call, pointing out that the needs of both disabled and non-disabled youth are similar. Yet many programmes miss the opportunity to address the specific needs of youth with disability. Basic infrastructure developments should address the inaccessibility of toilets, housing and transport as physical assets.[64] While disability grants significantly improve general living conditions, financial resources and material possessions, persons with disabilities are excluded from equal access to employment and education.[65]

A cross-sectional survey of youth with and without disabilities across South Africa[66] found there was a large difference in school attendance and/or completion between non-disabled and disabled youth (99.3% v. 82.4%). There is poor retention of disabled youth from the primary to the secondary level of schooling. Key barriers in accessing education included inadequate support to equip teachers and parents with the knowledge and skills to implement inclusive education; and an absence of information on bursaries and other sources of funding. While the National Youth Policy advocates for inclusive education at all levels and accelerated implementation of the White Paper on Special Needs education, further attention should be given to mechanisms to accelerate such implementation. Mechanisms should attend to the multiple interpretations of and misconceptions related to disability and inclusive education and the way that professional roles, for example of therapists, are changing and influenced in response to inclusive education.[67]

Disabled youth identified poor health and skills development as the main barriers to securing employment opportunities.[68] Further analysis of a snowball sample of 523 disabled youth aged 18 – 35 years identified how the presence of community rehabilitation workers was associated with significant improvements in disabled youth's access to health care and education, which should improve their participation in economic development.[69] Better dissemination of information at community level could enable youth with disabilities to engage in social activities. Recreational facilities also need to be made accessible.[70]

Untreated mental disorders in youth have a negative impact on adjustment to and productive participation in adulthood.[71] For example, stigma and limited access to services may affect their ability to deal with mental illnesses and to participate fully in opportunities and may serve to further perpetuate poverty. Health promotion, violence and substance abuse prevention programmes contribute to reduced risks of suicides.

Awareness of their rights should enable disabled youth to advocate for their needs at local government level to create an inclusive environment in which they are able to participate in mainstream youth development opportunities. Such collaborative learning would help address the social injustices experienced by disabled youth.[72] Empowerment of disabled youth who live in impoverished contexts would create enabling environments, inclusive attitudes, access to information and affordable public transport, which are some of the critical factors that facilitate equal participation.[73]

The citizenship of disabled youth can further be promoted through more data describing and monitoring possible mechanisms for promoting inclusion of disabled youth. Such inclusive research could contribute to achieving this aspirational goal of the National Development Plan and active citizenship by all.

Government has allocated increased resources to "the delivery of substance abuse treatment, expanding the number of state-funded treatment slots and training additional health and social workers to deliver these services".[74] It is, however, important to ensure high quality of services – a priority captured in the country's National Drug Master Plan[75] – which will require routine monitoring and evaluation.

### Mental health

South Africa's mental health policies aim to promote information, provide culturally sensitive, safe and supportive mental health environments and counselling, and improve access to mental health services with a focus on community-based models of care.[76] However, there are no implementation guidelines to give effect to these policies.[77] Mental health services in South Africa remain poorly resourced, with a limited focus on youth, and curatively oriented rather than focusing on preventive and promotive health.[78]

Despite the strong association between substance misuse and mental health problems, integration of drug and mental health treatment is lacking,[79] as are initiatives to address the strong connections between youth mental health problems, poverty and violence.[80]

## What can strengthen initiatives to improve youth health?

There is no doubt that youth health and well-being need to be approached on multiple fronts, given the complex relationships between alcohol use, violence, and unsafe sexual behaviours.[81]

Programmes fostering warm and caring relationships and communication between caregivers and adolescents on sexual and other life issues can be a major protective factor for youth health.[82] Initiatives that promote equitable intimate relationships, rather than male dominance, are another key protective factor for the health of both young women and men, as positive intimate relationships during youth entrench long-term, positive sexual relationships.[83]

The Integrated School Health Policy promises, if well implemented, to provide a comprehensive, intersectoral package of health care counselling services for school-going youth. In addition, schools should create a safe social environment that supports good physical and mental health, and provides care and support for teaching and learning.

Facility-based health services with improved youth accessibility, staff attitudes and confidentiality are also required,[84] as are initiatives offering recreation and community-based services[85]. Greater linkages between clinics and non-governmental programmes are needed, and innovative forms of health service delivery tailored to youth needs should be implemented and evaluated.

Integration of health care and social support services and stronger mechanisms for transitioning adolescents between school and adult public health services could improve youth health outcomes. Establishing out-of-facility health services such as those in case 7 should be a priority.

Effective initiatives to prevent violence amongst youth that also address risk factors at both individual and community level are needed. For example, the Violence Prevention Through Urban Upgrading programme in Khayelitsha, Cape Town, while its impact remains to be assessed, has adopted an integrated approach by: addressing the underlying causes of violence (and crime) through socio-economic development; re-arranging the physical environment to decrease the likelihood of violence and crime, and providing support to victims of violence.[86]

Greater political action is needed to implement policies and plans and put in place the resources needed to address gender-based violence in particular. While government established an Inter-Ministerial Committee on Violence Against Women and Children in 2012 and a Programme of Action[87] was published in 2014, concrete implementation of the proposed actions and monitoring and evaluation of its impact are required to assess its effectiveness.

Improved prevention strategies are also needed to discourage under-age drinking. This includes challenging current drinking norms and practices, and ensuring the buy-in and support of high school and community leaders.[88]

Better access to drug rehabilitation services, as well as stronger linkages between alcohol and drug rehabilitation and mental health sector programmes, are also needed. Mental health screening among youth should be prioritised, tailored for different female and male needs, and aligned with government plans for expanded school-based health services.[89]

The National Youth Policy 2015 – 2020[90] includes a strong focus on heath care and combating substance abuse, and recognises the need for a holistic approach. Key recommendations include:

- strengthening the district health system to ensure more equitable access to health care services and address barriers that inhibit young peoples' access to SRH services;
- a holistic approach to youth with a strong focus on physical exercise and provision of recreational facilities and the promotion of interpersonal and coping skills through the life orientation curriculum;
- a similar emphasis on building self-esteem and mutual respect to prevent violence and unsafe sex; and
- stricter enforcement of municipal by-laws to restrict access to alcohol.

Global recommendations to improve youth health similarly highlight the importance of engaging sectors beyond health in order to create safe schools and communities. The World Health Organization highlights the value of collecting strategic information on core youth health indicators to measure determinants, coverage and the impact of policies, programmes and services.[91] In addition, the following key principles should inform the design and delivery of youth health initiatives:

- recognise the underlying social determinants of youth health including gender, economic status and geographic location;
- avoid conceptualising youth sexuality as only associated with risk and enhance youth's agency to choose healthy sexual behaviour;
- build youth capacity, involvement and leadership in integrated youth programme development and implementation;
- recognise the limitations of interventions aimed at shifting individual health behaviour and address changes needed in social contexts;
- mobilise communities to address gender inequality and promote youth health; and
- engage with young men to encourage equitable and safe relationships.

The health problems reviewed in this chapter share many common underlying interpersonal, social and economic causes such as peer pressure, lack of positive family or community role models, poverty, poor quality education and unemployment. This underscores the need for integrated and multi-pronged health strategies, including those focusing on mental health, to promote youth health and well-being.[92]

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