

DEPARTMENT OF HEALTH
Republic of South Africa



NATIONAL ADOLESCENT & YOUTH HEALTH POLICY 2016-2020

Foreword by the Minister of Health

Dr PA Motsoaledi (MP)

Message from the Director General of Health

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AYFS	Adolescents and Youth Friendly Services
CBO	Community Based Organisation
CHW	Community Health Workers/Community Care Workers
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
ISHP	Integrated School Health Programme
LGBTI	Lesbian Gay Bisexual Transgender Intersex
MCWH	Maternal, Child and Women's Health
MDR	Multi-drug Resistant
MRC	Medical Research Council (South Africa)
MMC	Medical Male Circumcision
NDBE	National Department of Basic Education
NDOH	National Department of Health
NGO	Non-governmental organisation
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement
NYP	National Youth Policy
NYDA	National Youth Development Agency
NYRBS	National Youth Risk Behaviour Survey
PHC	Primary health care
SANAC	South African National AIDS Council
SAPS	South African Police Service
SBIRT	Screening, Brief Intervention and Referral to Treatment
STI	Sexually Transmitted Infection
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TOP	Termination of Pregnancy
TWG	National Department of Health Paediatric, Youth and Adolescent Technical Working Group
UN	United Nations
UNCRC	United Nations Convention on the Rights of Children
USAID	United States Agency for International Development
WHO	World Health Organisation

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Introduction

This Adolescents and Youth Health Policy aims to promote the health and wellbeing of young people, aged 10-24 years. Over the past two decades in South Africa, we have focused on equitable distribution of health resources and the expansion of service delivery. This has transformed the public health service. In adolescent and youth health, evidence from research has improved our understanding of needs and responses, and programmatic innovation has expanded healthcare provision and awareness. Despite this progress, adolescent and youth still face risks. Persistent high rates of HIV transmission (particularly among young, black women), tuberculosis, unintended and unsupported pregnancy, sexually transmitted infections and substance abuse are major challenges for adolescents and youth, and for the health sector that services their needs.

The Department of Health strives towards a pro-active, preventative focus on health promotion and management. There is a greater recognition and focus on the behavioural and structural causes of health and disease, but there are still important opportunities for increasing the effectiveness of adolescent health programme, and for taking them to scale nationally. This Adolescent Youth Health Policy (AYHP) will aid the Department of Health, together with principal partners in government, to change national conceptions of effective health promotion among adolescents and youth in South Africa.

What can harm or help adolescent and youth health?

Health is determined by a web of factors operating at different levels. Individuals make choices within the context of their relationships, families, communities, economic circumstances, and the social norms and traditions that govern their lives. Laws, policies and programmes may help or obstruct these choices. Particularly for young women, social norms often limit their opportunities to make choices.

The National Development Plan provides government's vision of 'A Long and Healthy Life for All South Africans'.ⁱ Health promotion depends on providing functional and youth-friendly healthcare services, together with access to decent housing and sanitation, nutrition and education. The promotion of health is therefore dependent on service delivery by various government departments, and interdepartmental collaboration for common objectives. As numerous key policy documents and commitments highlight, health can only be improved through broadening the scope of community involvement in health provision and promotion at local level.

This policy provides an opportunity for government and communities to integrate and streamline their programmes and objectives to promote health among young living in South Africa. This follows the National Service Delivery Agreement, which commits to intersectoral initiatives (in collaboration with the Departments of Basic Education, Cooperative Governance and Traditional Affairs, Higher Education and Learning, Social Development and Trade and Industry, and with the criminal justice system) to promote improved health outcomes through the health and education system, and within households.ⁱⁱ

While the experiences and needs of adolescents and youth are at the centre of this policy, we know that health is not only a result of individual behaviours. Structural, family, systemic and social factors, including economic vulnerability, violence, victimisation, social isolation and harmful gender norms, affect health among adolescents and young people. Health is the result of a composite of factors operating at individual, household, community (including

schools, higher education institutions) and societal levels. For this reason, health programming alone will not necessarily guarantee improved health among adolescents and young people. As a result, this policy describes a package of interventions that operate within and across these four levels. This package aims to work synergistically – promoting health and mitigating risk factors and behaviours across these different levels.

The AYHP uses the latest evidence of programmes that will not only combat existing problems, but also seek pro-active approaches to health promotion. Evidence suggests that comprehensive packages that incorporate the multiple needs of adolescents and youth have a greater impact on risk behaviours than single interventions. Rather than focusing on broad commitments and multiple objectives, this policy provides targeted, focused and practical overviews of four key outputs, sub-divided into key interventions that form a package to promote health among adolescents and young people in South Africa.

How was the Adolescent and Youth Health Policy developed?

South Africa is at the global forefront of progressive policy and programming to promote the health of adolescents and youth. The first National Policy Guidelines for Youth and Adolescent Health were published in 2001, and a partnership between government and civil society resulted in the completion of a draft Adolescent and Youth Health Policy in 2012. This draft policy captured ambitious national commitments to improving the health and wellbeing of young people, and served as a key referent for the final AYHP. This AYHP builds on the critical work of government partners, civil society organisations and other expert stakeholders, and situates adolescents and youth as key experts in health policy and programming. Current policies that provide the most proactive approach to youth empowerment and health promotion are other foundations for the AYHP. These include the National Youth Policy, and the World Health Organisation's Global Strategy for Women, Children's and Adolescent's Health 2016 – 2030.

Youth participation and empowerment has been a key part of developing this policy. In the course of seven years of participatory research as part of the Young Carers, Mzantsi Wakho and Sinovuyo Teen partnerships, the health challenges, needs and ambitions of adolescents and youth in South Africa were identified and mapped systematically. In the process of developing this policy, further engagement with adolescents, youth and other expert stakeholders was conducted in tandem with evidence-based reviews of current best practices. The aim was to integrate the needs of young people, the key target population for this policy, with the latest high-quality evidence regarding effective strategies and services for health promotion.

It is also important to ensure the inclusion of marginalised populations in the development of national policy. Following this, and guidance such as *Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond*, consultations included highly vulnerable groups of adolescents and youth, including those with communicable and non-communicable diseases, youth with disabilities and youth who were at risk of contracting HIV.

Methods

This engagement took three primary forms:

- 1) Consultations with adolescents and youth, caregivers, healthcare workers and social service providers
- 2) Evidence-based reviews of priority areas for adolescents and youth health
- 3) Policy-level and researcher consultations.

1) Adolescent, youth and caregiver consultations

Participatory research with diverse adolescents and youth established the core objectives for the policy. This included:

- Convening a Youth Health Parliament
- Visual exercises including 'dream consultations' and 'dream clinics'
- Participatory research to investigate substance abuse, mental health/illness and adherence to chronic medicines
- Health report cards in which adolescents and youth evaluated health services
- Focus groups on sexual and reproductive health, intimacy, romance, risk and aspiration among youth and adolescents and their caregivers

These activities were supplemented by an audit of health interventions with adolescents, caregivers, healthcare workers, traditional healers and faith-based organisations, in conjunction with key informant interviews in local, provincial and national settings.



Figure 1: A teen advisor fills out a 'clinic report card' at the Teen Advisory Group, marking the provision of health services in the local clinic with 'smiley face' or a 'thumbs down'.



Figures 2 and 3: A cabinet of youth health advisors (2014). Here, the appointed minister consults her cabinet on their experiences of health services. [Faces blurred to protect participant confidentiality.]

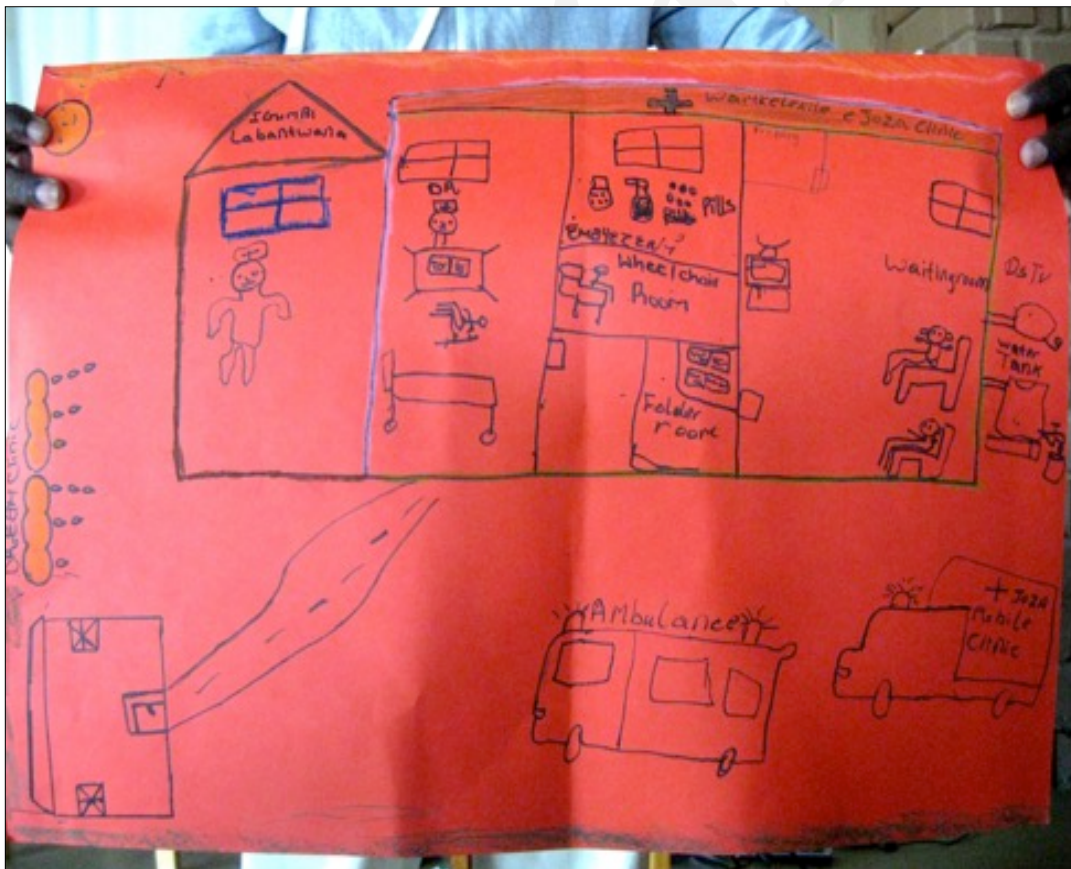


Figure 4: 'Dream Clinic'. Notable features – an ambulance and a mobile clinic, a wheel chair room, a water tank, a comfortable waiting room and DSTV

2) Evidence-based Reviews

Evidence reviews were conducted of published, peer-reviewed literature and grey literature. Context is vital in the design and implementation of effective health interventions, and so evidence from Southern Africa was prioritised. Reviews focused on priority areas identified by adolescents and youth together with other experts. Rather than an exhaustive list of health challenges, these focal areas represent the most critical health matters identified by youth and adolescents, and other expert advisors, through participatory research. Priority areas were also informed by the imperatives of feasibility and scalability.

Priority areas are: (i) adolescent and youth friendly services; (ii) drug and substance abuse; (iii) HIV/AIDS and TB prevention; (iv) HIV/AIDS and TB treatment; (v) mental health/illness; (vi) sexual and reproductive health and (vii) violence prevention.

AYHP objectives were developed based on findings from youth engagement, broader stakeholder consultation and evidence-reviews. To achieve the stated objectives, the AYHP recommends a series of interventions. In addition to the centrality of youth engagement and expert consultation, these interventions are based on (a) acceptability and sustainability and (b) alignment with national and global development priorities.

While the objectives of the AYHP are ambitious, the policy aims for a realistic, practical approach to health programming. The policy identifies the stakeholders involved in promoting health among adolescents and youth, approaching health promotion as intersectoral and collaborative. As a policy focused on health needs, the AYHP emphasises the commitments of the National Department of Health. However, it foregrounds the critical role of various government departments and agencies in the supportive, streamlined and successful implementation of health programmes. Each objective therefore identifies government departments whose policy objectives and goals align with each of the AYHP priority areas, and whose partnership will promote the health and wellbeing of adolescents and youth. Ambitious objectives are broken down to identify primary stakeholders, with Department of Health commitments indicated.

3) Expert consultation

An expert consultation was convened by the National Department of Health and UNFPA, and focused on intervention strategies and implementation plans. Here, targeted advice combined technical expertise with real-world programmatic experience and critical engagement by civil society, bilateral partners and researchers.

These experts highlighted the importance of locating the AHYP within current and international laws and policies. They also saw health promotion from the perspective of primary prevention within the community and the household. Standard approaches to improving adolescent and youth health have focused on single 'problem behaviours' (such as condom use or the delay of sexual debut). This AYHP moves away from single-focus prevention initiatives. It highlights the co-occurrence of risk behaviours and promotes a more comprehensive, holistic understanding of health determinants.

The Adolescent and Youth Health Policy is aligned with the following national and international policies and plans:

- South Africa's National Strategic Plan on HIV, STIs and TB (2012-2016)
- The World Health Organisation's Global Strategy for Women, Children's and Adolescent's Health 2016 - 2030
- South Africa's Negotiated Service Delivery Agreement (NSDA) for Outcome 2: A Long and Healthy Life for All South Africans
- Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond
- South Africa's National Contraception and Fertility Planning Policy and Service Delivery Guidelines
- South Africa's National Contraception Clinical Guidelines
- UNAIDS 90-90-90: An ambitious treatment target to help end the AIDS epidemic
- Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR DREAMS Partnership Initiative
- The World Health Organisation's Consolidated Guidelines on HIV Testing Services
- UNAIDS Fast Track – Ending the AIDS Epidemic by 2030
- The World Health Organisation's Global Standards for Quality Health-care Services for Adolescents: A Guide to Implement a Standards-Driven Approach to Improve the Quality of Health-Care Services for Adolescents
- South Africa's National Adolescent Sexual and Reproductive Health Rights Framework 2014-2019
- The South African Government's National Development Plan 2030
- South Africa's National Youth Policy 2015 – 2020
- South Africa's Integrated School Health Policy
- Strategy for the Prevention and Control of Obesity in South Africa 2015 – 2020
- ALL IN to #EndAdolescentAIDS' (UNICEF, UNAIDS, MTV Staying Alive, Young People Living With HIV Partnership, the Global Fund, UNFPA, PEPFAR and the WHO).

Key objectives of the AHYP

The AYHP identifies six principal objectives:

1. Use innovative, youth-oriented programmes and technologies to promote the mental health and wellbeing of adolescents and youth
2. Provide comprehensive, integrated sexual and reproductive health services
3. Test and treat for HIV/AIDS and TB
4. Reduce substance abuse and violence
5. Promote healthy nutrition and reduce obesity
6. Empower adolescents and youth to engage with policy and programming on youth health.

To achieve these outputs, a core package of evidence-based interventions must be brought to scale. Some of these interventions aim to improve health directly, and will be led by the Department of Health. Others will improve health more distally – by influencing structural and contextual factors that boost resilience or reduce vulnerability, and are led by other government departments and agencies.

Objective 1: Use innovative, youth-oriented programmes and technologies to promote the mental health and wellbeing of adolescents and youth

Adolescence is a period of emotional-social development, growing independence and changing relationships with families, peers and romantic partners. Associations between risk behaviours, poverty and inequality are complex. Research has established that social and structural deprivation, intersecting with gendered norms that disempower girls and women, are key drivers of risky behaviours and poor health outcomes. These deprivations include poverty and exclusion, income shocks, mental health distress, stigma, harsh parenting and abuse. Exposure to multiple stressors can have cumulative effects, maximising risk behaviours. In addition, these risk behaviours are primarily extra-clinical, occurring beyond the health system, in contexts in which adolescents and youth live, have fun, and take risks.

Health promotion programmes need to focus on individual behaviours, complemented by support, education, empowerment and health service delivery programmes based in schools, families and communities (including traditional and religious systems). The power and practicality of digital health tools can be leveraged to advance health education, information and support.

The Department of Health (as well as Department of Basic Education) commits to providing interventions including in-school and out-of-school classes, with interactive methodologies. It has also committed to implementing social outreach interventions at local, district, provincial and national levels, and in schools, clinics, communities and workplaces.

The conceptualisation and implementation of Adolescent and Youth Friendly Services will need to be tailored to the needs and capabilities of specific facilities, and developed in collaboration with adolescents and youth on clinic committees, and with healthcare staff. It will be important to ensure that adolescents and youth are able to retain privacy without exclusion, and that clinic operations are facilitated and not obstructed.

Objective 1: Interventions

Department of Health-led programmes

- A. Train healthcare workers to provide and promote Adolescent and Youth Friendly Services through incorporating an AYFS curriculum. The curriculum must include psychosocial and communications skills that promote the specific developmental needs of adolescents and youth.
- B. Scale up virtual platforms to promote engagement of adolescents and youth with the health service and to widen and strengthen digital channels of education, information and support. By leveraging mobile technologies, create health information applications, health monitoring tools and patient satisfaction feedback mechanisms.

Inter-Departmental programmes with Department of Basic Education, Higher Education and Social Development

- C. Through the Integrated School Health Policy, review and revise school-based programmes to actively promote health through evidence-based programming. The curriculum must include accessible and practical information about HIV/AIDS and TB, mental health, sexual and reproductive health, nutrition and healthy weight, substance abuse and violence prevention. Evidence suggests that interactive behavioural skills practice (such as role-plays) and non-judgemental, non-moralising teaching styles are important for youth engagement with health curricula. (See evidence review for specific programmes recommended.)
- D. Work with community health workers, Social Development staff and community-based organisations to implement evidence-based parenting/caregiver programmes with demonstrated effects on adolescent health risk and protective behaviours. Examples include Families Matter (CDC), Sinovuyo Teen (UNICEF/WHO). Include specific programmes to promote mental health and positive prevention for HIV-positive adolescents and youth CHAMP+ (U Columbia/HSRC).
- E. Led by Social Development, SASSA and Department of Basic Education, implement social protection interventions for 10-24 year olds, using combined social and economic empowerment strategies. Examples include: social grants or apprenticeship schemes for 18-24 year olds as continuation of the Child Support Grant, free education and school meals.

Target groups: Adolescents and young people, teachers, caregivers.

Implementing partners: **Departments of Basic Education, Health, Higher Education and Learning and Social Development, SASSA, SANAC.**

Objective 2: Provide comprehensive, integrated sexual and reproductive health services

Key bilateral partners: **PEPFAR through the DREAMS initiative, Global Fund, UNICEF.**

Sexual and reproductive health services have traditionally focused on women of reproductive age. They often do not meet the needs of youth and adolescents, including those living with disabilities and chronic illnesses, LGBTI, or adolescents and youth in risky sexual relationships. Comprehensive SRH services must be tailored to the needs of adolescents and youth, based on recognition of the specific challenges that they face.ⁱⁱⁱ

The Department of Health policy *Sexual and Reproductive Health and Rights: Fulfilling Our Commitments (2011)* describes the package of essential services to be provided at district level. These objectives include strengthening the referrals system, integrating services, meeting the diverse needs of different users, and involving sexual partners. The interventions described here are aligned with extensive national and international commitments to improving sexual and reproductive health among diverse populations.

Objective 2: Interventions

Department of Health-led programmes

- A. Implement single service point of delivery models for the integration of HIV and sexual reproductive health services where feasible. Where this is not possible, strengthen referral systems and ensure easy access for adolescents and youth of these linked services. Adolescent and youth-friendly clinic spaces must aim to meet the practical and psychosocial requirements of their target users, including operating hours that accommodate learners' timetables, privacy and non-judgemental staff.
- B. Expand and improve the contraceptive method mix, including interventions for dual protection and safe conception. Increase access to medical male circumcision (including school-friendly opening times).
- C. Accredit eligible facilities to provide termination of pregnancy services, and train clinic staff to counsel, treat and support adolescents and youth seeking termination of pregnancy.

Inter-Departmental programmes with Department of Basic Education, Higher Education and Social Development

- D. Led by Social Development, SASSA and Department of Basic Education, implement social protection interventions for 10-24 year olds that include both 'cash' and 'care' elements (i.e. cash transfers/free school meals and parenting support). See Objective 1 for details, but evidence suggests that this intervention is especially important for adolescent girls and young women in HIV-prevention. Ensure access to cash plus care programmes for adolescent girls and young women whose financial and social circumstances render them especially vulnerable to transactional sexual exploitation: orphans, those in illness-affected families and those with a history of abuse.

Target groups: **Adolescents and young people, healthcare workers, police services, judicial services and social workers.**

Implementing partners: **Departments of Health, Justice and Constitutional Development,**

Objective 3: Test and treat for HIV and TB, and retain patients within healthcare services (supporting better adherence to medicines)

Correction Services, and Social Development, SAPS.

Key bilateral partners: **PEPFAR through DREAMS, Global Fund, UNFPA, UNAIDS.**

South Africa has the largest national number of HIV-positive adolescents in the world, and girls are at higher risk. As the National Strategic Plan states, South Africa also has the third highest level of TB in the world. Over 60% of HIV patients are co-infected with TB.^{iv} Existing, ambitious HIV/AIDS and TB treatment targets provide roadmaps for significantly reducing HIV and TB transmission and promoting better treatment outcomes. These include the NSP and international initiatives such as UNAIDS 90-90-90, All-IN and the DREAMS initiative.

The TB and HIV epidemics must be prevented and treated in tandem, through integrating programmes and services and adapting these the needs of adolescents and youth. HIV/AIDS and TB treatment and testing must be supplemented by better integration and patient support. In particular, use of condoms and adherence to ART remain haphazard, with evidence that social and structural deprivation is negatively impacting adolescents' capacity to protect themselves and others. Comprehensive adolescent-friendly TB and HIV treatment services must provide more than just TB and HIV treatment, but also offer career advice, fertility and contraception counselling, health and active living techniques, mental health and substance use services (aligned with AYHP objectives 4 and 5).

Objective 3: Interventions

- A.** Expand HIV and TB prevention and treatment to 10 – 24 year olds, utilising mobile clinic services. HIV testing and counselling must follow the latest WHO guidelines on HIV testing according to the 5 C's: consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment.
- B.** Improve the transition from paediatric to adult care and down-referral processes for HIV-positive adolescents through monitoring and support by healthcare workers trained in Adolescent and Youth Friendly Services. Work with health support workers and patient advocates to support the transition stage of moving to a new clinic and care provider.
- C.** Provide counselling and support in the stages between testing positive, ART eligibility and initiation to reduce dropout rates amongst youth.
- D.** Improve adherence to chronic medicines, including ART and TB medicines, through patient literacy and support programmes, strengthened outreach services and parenting support services to reduce family conflict. Although there is little clear evidence yet of effective interventions to improve adherence, new research results are anticipated in 2016 and 2017 and these may be used to guide programming.

Department of
Health-led
programmes

Target groups: **Adolescents and young people, caregivers, healthcare workers, teachers and social workers.**

Implementing partners: **Departments of Basic Education, Health and Social Development.**

Objective 4: Prevent violence and substance abuse

Key bilateral partners: **UNAIDS and UNICEF through the All In initiative.**

Violence and substance abuse have major negative impacts on the health of adolescents and youth in South Africa, and increase risks to physical and mental health. The abuse of drugs and alcohol is increasing among adolescents and youth, with alcohol abuse in particular linked to high levels of violence and motor vehicle accidents. Post-violence care is part of the comprehensive package of sexual and reproductive health and emergency services, but the provision of post-exposure prophylaxis for rape survivors remains inadequate.

Preventing violence and substance abuse is the responsibility of all sectors of government and society. In order to be effective and sustainable, interventions to detect, treat and reduce violence and substance abuse must be rooted in families, schools and communities. The commitment and leadership of the Departments of Social Development and Basic Education is therefore crucial to achieve the present violence and substance abuse among youth and adolescents, through interventions that foster understanding and awareness of violence and substance abuse, that reduce the appeal and availability of alcohol and drugs to adolescents and youth, and through the promotion of positive parenting, conflict and anger management, and gender equity. Schools- and community-based interventions that provide youth and adolescents with the skills to recognise, avoid and report violence and victimisation must be provided.

Objective 4: Interventions

Department of
Health-led
programmes

- A. School-based interventions, led by community health workers in collaboration with Education staff, which use evidence-based programmes to prevent substance abuse (see evidence review ii for programmes). These should include curriculum integration, continuous classroom management, safe school environment promotion; and SBIRT (Screening, Brief Intervention and Referral to Treatment). CBOs to provide similar programmes to out-of-school adolescents and youth.
- B. Community Health Worker-led parenting support programmes to reduce adolescent problem behaviour, including substance use and aggression. These should use the best evidence-based programmes (see evidence reviews ii and vii) and support families to keep adolescents safe in community settings.
- C. Provide easily accessible, 24 hour, post-violence treatment to youth and adolescents, including post-exposure prophylaxis to rape survivors. This should be provided in non-judgemental settings and include referrals to counselling.

Inter-
Departmental
programmes
with
Department of
Basic
Education,
Higher
Education and
Social
Development

- D. Gender-based transformative programmes, in collaboration with DSD and CBOs. These should be programmes with evidence of effectiveness (see evidence review vii).
- E. School-based violence prevention programmes, such as tested in the Good Schools Study, in collaboration with Social Development and Community-based Organisations.
- F. Training of staff at drinking venues (formal and informal) to enforce compliance with reducing access to alcohol to children and adolescents.

Objective 5: Promote healthy nutrition and reduce obesity.

Global rates of obesity have escalated rapidly in recent decades. The number of overweight and obese people now rivals the number of underweight people. South Africa's National Income Dynamics Study reported that one third of women and 11% of men over the age of 15 were classified as obese. The 2008 Youth Risk Behaviour Survey reported that 41.5% of learners did not participate in sufficient physical activity. In addition, youth and adolescents continue to experience hunger and malnutrition, at the same time as national obesity rates continue to accelerate. Often, underweight and overweight occur simultaneously among different household members. These recommendations follow closely the recent guidance in South Africa's Strategy for the Prevention and Control of Obesity 2015 – 2020.

Objective 5: Interventions

Inter-
Departmental
programmes
with
Department of
Basic
Education,
Higher
Education and
Social
Development

- A) Include nutrition and wellness components in Life Skills and Life Orientation curricula at schools.
- B) Work with Social Development, Education and Community-Based Organisations to promote adolescent and youth engagement in physical activity.
- C) Engage and involve youth and adolescents in activities that promote their access to healthy food choices, including food gardening.

Objective 6: Empower adolescents and youth to engage with policy and programming on youth health.

It is essential that adolescents and youth are integral to the development, implementation and oversight of this policy. Social asset-building amongst adolescents and youth can allow them to engage with policy-makers and programmers to influence the implementation of this policy, and the health services that they use.

Objective 6: Interventions

Department of
Health-led
programmes

- A. Youth involvement in health care provision and oversight: local, district and provincial level. Three adolescents and youth to be on 1) Every clinic and hospital committee; 2) Every district AIDS council; 3) Every Provincial health committee.

In order to make this possible, a number of provisions are required:
 1. The chair of the committee is responsible for arranging transport for youth, and transport costs will be covered.
 2. Committee meetings will take place out of school hours and not in evenings where it is unsafe for youth to travel back home.
 3. Committee meetings must be youth-friendly in their approach, and technical language clearly explained so that authentic participation is ensured.
 4. Each youth will have a mentor within the committee who will be responsible for supporting participation, and who will be in bi-monthly contact with the youth by cellphone or the social media of youth preference.

5. This engagement will support long-term employment prospects through mentoring and skills transferral.

- B.** Youth involvement at National DoH level: There will be three adolescents and youth on: 1) The Technical Working Group for Pediatric HIV at National DoH; 2) The NHI steering committees in pilot districts and then nationally.

All requirements for real participation (1-5 above) will be implemented at National level. In addition, the Deputy Director - General: HIV/AIDS, TB and Maternal, Child and Women's Health in the National Department of Health will meet on an annual basis with the adolescent representatives on the TWG and NHI to review progress and challenges with the implementation of the Adolescent and Youth Health Policy.

**Department
of Health-led
programmes
(cont.)**

- C.** Youth leadership in training health service providers. Youth need to be involved in development of training materials for services providers who will be in contact with them.
- D.** Establish youth-friendly spaces within health facilities, and operationalize clinic hours that accommodate learners' timetables. Work with mobi-health innovations to create application-based programmes that promote youth engagement with services.
- E.** Following the 'Roadmap for the Reform of the South African Health System', train, support and reward healthcare workers to provide adolescent and youth-friendly services, and to promote easy and accessible referral systems for youth between different services within the health system. Support for healthcare staff includes non-clinical staff such as patient advocates within community-based organisations, who provide psychosocial and treatment support to adolescents and youth.
- F.** Utilise youth-friendly technology – for example, develop mobile-led systems to allow youth to review the health services that they receive, and for youth to access information and support through cellphones and the internet. Rigorously evaluate these new interventions.
- G.** Work over time to provide health data that disaggregates adolescents and youth from pediatric and adult populations. Over time, introduce progressive implementation of a unique patient identification system for adolescents and youth via the national patient electronic health record. In the long-term, aim for a 'Youth Health Passport' (see evidence review) that works with biometric data to facilitate referral systems and collect data.

Target groups: **Healthcare workers, community health workers, extra-clinical healthcare staff, healthcare management, Universities and teaching colleges training healthcare staff.**

Implementing partners: **Departments of Health, Higher Education and Learning and Trade and Industry.**

Key bilateral partners: Universities, NGOs.

Policy Implementation, monitoring and evaluation

Effective and transparent governance and institutional arrangements must be established to ensure that the AYHP is implemented effectively and efficiently. For the NSP, this role is played by SANAC. The Departments of Health, Basic Education, Justice and Constitutional Development, Social Development and Trade and Industry, and the South African Police Services, may wish to establish an interdepartmental committee to support, monitor and evaluate the implementation of the AYHP.

The feasibility of these activities is dependent on their integration into existing government initiatives, so that the package of interventions is incorporated into existing systems and structures. It is crucial that the functionality and durability of local health, education, social development, judicial and criminal justice programmes and initiatives form the programmatic backbone of this package of interventions.

This policy will also need to be accessible to service providers and to the public. A targeted, national campaign will communicate the strategic aims and commitments of the AYHP to government partners at national, provincial and local levels, to the broader public, and importantly to adolescents and youth in South Africa.

A monitoring and evaluation programme, supported by local research institutions, will be developed to track and measure the implementation of the AHYP, and to assess progress against indicators.

Costing and financing the AYHP

Costing models must establish the cost of implementation of these plans at national and provincial levels, to be completed in conjunction with the recommended interdepartmental mechanism. Donor funding will provide an important source for numerous interventions described here. However, the majority of AYHP funding will come from government and the private sector. Domestic funding for health services is the key to long-term sustainability.

ⁱNegotiated Service Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans, p. 3.

ⁱⁱNSDA p. 20.

ⁱⁱⁱSexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond XX

^{iv} SANAC, NSP 2012 - 2016, p. 4.