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2013/4

PREPARE MANUAL for Nurses

'Building Trust, Promoting Health and Changing Communities'

This manual belongs to:

ADOLESCENT HEALTH RESEARCH UNIT

MANUAL FOR

Nurses

MANUAL FOR

Nurses

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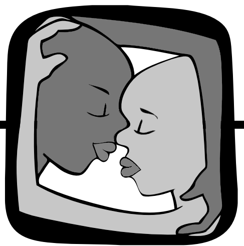

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See also the project homepage http://PREPARE.b.uib.no/

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1 Introduction

"Nothing is impossible, the word itself says 'I'm possible'!"

Audrey Hepburn

Working with young people can be a gratifying and meaningful experience, which requires a mature, responsible and compassionate attitude from a Clinic Nurse. You have been selected for your willingness to learn, your empathy and a belief in the rights of young people. It comes with a big responsibility. Your attitude and the information given during their clinic time can profoundly affect a young person at a vulnerable time.

"Never doubt the ability of a small group of intelligent, committed citizens to change the world. Indeed it is the only thing which ever has."

1.1 The manual

Thank you for being a part of the project. This manual for PREPARE Clinic nurses is a complement to the PREPARE training course and is intended to provide the foundation of knowledge, encouragement and inspiration necessary to set up a brilliant clinic in a school. There is a great deal to learn, but with the training and these reading materials you should have the tools needed as you set up, run with and develop your practice. Although important information will be found in this manual, it is through participating in the training that you will build on and develop the skills, abilities and faculties needed to become an excellent Clinic-in-Schools Nurse.

The manual carries the essentials of the PREPARE Project. It covers the main areas that affect young people's sexual health and emotional wellbeing, takes a look at life from their perspective, covers the evidence for good practice, gives examples of clinic paperwork and special situations as well as the importance of self reflection and role modelling. There are copies of paperwork at the back of this manual that can be freely copied for educational and clinic purposes (pages 78 - 111).

1.2 PREPARE Nurses

"It's the spark that makes us want to be our best selves, to love and be loved. I believe in that and nurturing that. To savour every moment, to be as good as I can to everyone and to be worthy of love myself."

The role of the PREPARE Clinic Nurse is to facilitate and help enhance positive attitudes around relationships and health, emotional wellbeing and equality. A school-based service is an ideal medium, because it naturally encompasses many of the elements that encourage discussion and support for young people in a safe and appropriate way.

1.3 The PREPARE project

"It's in the sharing of tasks that people do bigger things than they knew they were capable of, then there's really something to celebrate."

The PREPARE study is an EU-funded project. The proposed study to prevent HIV and intimate partner violence in the Western Cape is thus part of a larger project which aims to promote sexual and reproductive health among adolescents in sub-Saharan Africa including Limpopo in South Africa, Uganda and Tanzania. So you are part of a bigger family!

The project symbolizes a collaboration to support young people. We will work together to find positive outcomes and solutions for practitioners, young people, parents, caregivers, educators and professionals alike. Through these principles we will strive together to always put the young person's interest at the heart of our intention and of our work.

2 PREPARE

"It always seems impossible until it's done."

Nelson Mandela

2.1 Background Information

South Africa's community is made up of a wonderfully diverse mix of people. A significant proportion of the population is aged 10-24.

The 'World Health Organisation' (WHO) remind us that:

'Adolescents have specific health and development needs, and may face challenges that hinder their wellbeing, including a lack of access to health information and services, and unsafe environments. Interventions that address their needs can save lives and foster a new generation of productive adults who can help their communities' progress.' [1]

ADOLESCENT HEALTH FACTS

The state of adolescent health

One in every five people in the world is an adolescent, and 85% of them live in developing countries. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviour that began in youth, including tobacco use, a lack of physical activity, unprotected sex or exposure to violence. Promoting healthy practices during adolescence and efforts that better protect this age group from risks will ensure longer, more productive lives for many.

Violence

Among 15-19 year olds, suicide is the second leading cause of death, followed by violence in the community and family. Promoting nurturing relations between parents and children early in life, good relationships between young people, training in life skills, and reducing access to alcohol and lethal items such as firearms can help prevent violence. More effective and sensitive care for adolescents experiencing violence is needed.

Injuries and road safety

Unintentional injuries are a leading cause of death and disability for adolescents; and road traffic injuries, drowning and burns are the most common types of injury. Injury rates among adolescents are highest in developing countries, and within all countries, they are more likely to occur among adolescents from poorer families. Community actions to promote road safety (including the passing of safety laws that are well enforced) and public education targeted at young people on how to avoid drowning, burns and falls can reduce injuries.

Many adolescent health challenges are closely interrelated and successful interventions in one area can lead to positive outcomes in other areas.

The World Health Organization[1] reports that among women aged 15-45 years, gender violence accounts for more deaths and disability than cancer, malaria and traffic injuries put together. This has become an important factor affecting women's reproductive health. Forced sex is associated with a range of gynaecological and reproductive health problems including HIV and other sexually transmitted infections (STIs), unwanted pregnancies, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections. Studies have also linked abuse to unwanted pregnancies among adolescent females and violence has been seen to greatly limit married women's ability to use contraceptives.

In South Africa, an estimated 1 in 4 girls and 1 in 8 boys are sexually abused before the age of 16 years. In 80% of the cases the molester is known to the family or the child.

Violence can be prevented. This is not an article of faith, but a statement based on evidence. *Violence prevention: the evidence* is a set of seven briefings based on rigorous reviews of the literature which examine scientific evidence for the effectiveness of interventions to prevent interpersonal and self-directed violence. Each briefing focuses on a broad strategy for preventing violence, and, under that umbrella, reviews the evidence for the effectiveness of specific interventions. The violence prevention strategies covered in the seven briefings are:

1. Developing safe, stable and nurturing relationships between children and their parents and caregivers;
2. Developing life skills in children and adolescents;
3. Reducing the availability and harmful use of alcohol;
4. Reducing access to guns, knives and pesticides;
5. Promoting gender equality to prevent violence against women;
6. Changing cultural and social norms that support violence;
7. Victim identification, care and support programmes. [2]

HIV and young people

Young people aged 15-24 accounted for an estimated 45% of new HIV infections worldwide in 2007. They need to know how to protect themselves from HIV and have the means to do so. Better access to testing and counselling will inform young people about their HIV status, help them get the care they need, and avoid further spread of the virus.[3]

Adolescents, like many other age groups in South Africa, are greatly impacted by the HIV/AIDS pandemic. In fact, the National Strategic Plan on HIV & AIDS and Sexually Transmitted Infections identifies young people aged 15 – 24 years as a specific target group for all interventions. It is therefore important that safe sexual behaviour is encouraged and practised, and that patterns of high risk sexual activity, of which teenage pregnancy is one consequence, are also understood in the context of the HIV pandemic.

Adolescents need to have access to HIV prevention programmes before they have their sexual debut. This is particularly important in sub-Saharan Africa, where sexual debut at age 14 or younger is common [4,5] and where the burden of HIV and AIDS is highest in the world. Adolescents who have their sexual transition at a young age constitute a high risk group because they are less likely to use condoms and more likely to have multiple and casual sexual partners and to be involved in other risky behaviour such as substance abuse and interpersonal violence.

Early pregnancy and childbirth

About 16 million girls aged 15 to 19 give birth every year - roughly 11% of all births worldwide. The vast majority of births to adolescents occur in developing countries. The risk of dying from pregnancy-related causes is much higher for adolescents than for older women. Laws and community actions that support a minimum age for marriage, as well as better access to contraception, can decrease too-early pregnancies. [1]

In 2003, 12% of teenage girls aged 15 – 19 years had been pregnant or were pregnant at the time of the South Africa Demographic and Health Survey (SADHS). Factors that can contribute to teenage pregnancy are, for example, gender power imbalances (associated with significantly older partners in particular), early sexual debut, barriers to contraceptive use (seldom used at sexual initiation), and misinformation on sexual health matters. Pregnancy at a very young age may result in pregnancy complications that can lead to the death of the young mother and/or her baby. Other associated consequences include increased risk of infant morbidity, as well as the possibility of emotional and financial strain for the mother.

Malnutrition

Many boys and girls in developing countries enter adolescence undernourished, making them more vulnerable to disease and early death. Conversely, being overweight and obese - other forms of malnutrition with serious health consequences - are increasing among other young people in both low- and high-income countries. Adequate nutrition, healthy eating and physical exercise habits at this age are foundations for good health in adulthood.

Mental health

At least 20% of young people will experience some form of mental illness - such as depression, mood disturbances, substance abuse, suicidal behaviour or eating disorders. Promoting mental health, and responding to problems if they arise, require a range of adolescent-friendly health care and counselling services in communities.

Tobacco use

The vast majority of tobacco use worldwide begins during adolescence. Today more than 150 million adolescents use tobacco, and this number is increasing globally. Bans on tobacco advertising, raising the prices of tobacco products, and laws that prohibit smoking in public places reduce the number of people who start using tobacco products. They also help to lower the amount of tobacco consumed by smokers and increase the numbers of young people who quit smoking.

Harmful drinking of alcohol

Harmful drinking among young people is an increasing concern in many countries. It can reduce self-control and increase risky behaviour. Harmful drinking is a primary cause of injuries (including those due to road traffic accidents), violence (especially inter-personal violence), and premature deaths. Regulating access to alcohol is an effective strategy to reduce harmful use by young people. Bans on alcohol advertising can lessen peer pressure on adolescents to drink.

In South Africa four in ten children live far from their nearest health clinic. Worldwide evidence would argue for clinics that are specifically for young people, staffed by practitioners that are young people-friendly, in places where young people can access them easily and in confidence.

The evidence is clear. Where young people are given accurate, unbiased, relevant information regarding their sexual and reproductive health and where they can access services easily in confidence from an early age, the age of first sex increases and rates of Sexually Transmitted Infections and unintended pregnancy decrease. [6]

2.2 Mission statement

"The Purpose of the PREPARE School Clinic is to promote positive relationships and health and wellbeing through mentoring, role modelling, education, research and empathic service provision so that young people feel valued, respected and can enjoy positive self and peer relationships, free from harm."

2.3 A word on self reflection and role modelling

"We cannot pass on what we don't have for ourselves."

The training was a 'feelings-based' course. All emotions were welcome there. Whilst it is certainly possible to perform our jobs adequately without practising what we teach, if we do take the time to reflect on our own lives and choices, and take on board the messages in our adult lives, it can have a profound effect on our practice.

Each person has different ways of dealing with emotions, as well as a different capacity to do so. As practitioners we can easily connect to our own experiences and this can bring up all kinds of emotions.

These words of wisdom from Vimila Maclure are invaluable when working around sensitive topics:

WELCOME, ACCEPT, RESPECT

- Welcome emotions within yourself. It's all okay.
- Accept your role will be to listen, advise, support and encourage.
- Respect individuals and their ways of coping. Encourage, share, but never force.

Young people often complain that adults are out of touch or that they seem hypocritical: not practising what they preach. On the other hand, when we approach our work with sincerity, having undergone reflection and changed our behaviour, it is apparent in our way of working. To truly empathise with the difficulties and pressures facing young people it is crucial to take a step in their shoes from time to time. If we find challenging our own attitudes, behaviour and feelings difficult, imagine how much harder it is for a young person. Remember …. "If not me, then who?"

3 The benefits

It would take up a document to list all of the studies worldwide that 'proved' the benefits of young people-specific services and approaches. It is always wise to read studies, papers, testimonials and evaluations but, whilst doing so, be mindful of the individual experience and how that may differ from the report, article or study.

It is also worth noting that a person can only access the benefits of information, services etc. if they are in a position to feel able to take them on. Therefore not all young people will be ready to change risky behaviour, seek outside support or accept advice. But the information and support you give may still be taken on board and used later on in the person's life.

It is definitely an important aspect of your role to listen and explore and talk about the benefits of the service to parents, communities, teachers and young people. Factual information is often the very thing that helps sceptical people to open up to the idea of sex and relationship education and services. It will also help to motivate staff and colleagues to support your work.

3.1 The benefits of young people only services

- Safer for young people
- Staff trained in working with young people
- Not going to see a relative or parent at the service
- Reduces embarrassment
- Normalises sexual health
- Normalises attending a health clinic
- More likely to access other clinics
- Pathway into specialist services
- Young people feel less judged
- Feeling welcome
- Okay for young men and young women – adult services can often feel 'female' heavy
- Topics can be addressed that are specific to young people.

3.2 The benefits of clinics in schools

- Safer – not having to travel long distances
- Easier – less hassle – for young people who are impulsive or do not have health that high on their agenda, having an onsite service makes attending more likely
- More confidential – people from the community are not going to see you at the clinic
- Reliable with continuity of care
- Can receive age-appropriate information

- Accurate information
- Regular contact possible
- Trusts the service
- Starts a dialogue about safer sex practices
- More likely to use condoms
- Timely referrals to abortion services
- Students feel they have place to come whatever their issue may be
- Welcomes people regardless of race, gender, ethnicity, religion, wealth and status, sexual orientation
- Feel empowered to access contraception
- Earlier access to maternity services
- Can also discuss other health concerns such as drug and alcohol and nutrition.

3.3 The benefits of looking after ourselves

- Improved self-confidence
- More resilient in adversity
- Staying calm
- Better work/life balance
- Better able to empathize
- Better role model
- Better relationship with ourselves
- Better relationships with others
- Value our own importance and health
- Take steps to protect ourselves
- Start to build a community that values individuals
- Models respect, equality and compassion
- Greater awareness in our practice
- Improved understanding
- More able to support others
- Cope better with a stressful clinic
- Resolve to carry on
- Able to ask for help when needed
- Protecting ourselves from harm.

4 Personal Qualities and Abilities

"More than fame and more than money is the comment mild and sunny And the hearty, warm approval of a friend For it adds to life a savour, and it makes you stronger, braver And gives you hope and courage to the end."

4.1 The PREPARE Nurse:

… PREPAREs well… "Luck is what happens when preparation meets opportunity". Knows how to work with young people, check and triple check your resources kit and keep everything up to date and organised.

… "has hope and courage to the end" and gives unstinting praise to co-workers and to each and every young person. EVERYBODY has some good qualities.

… smiles because it is our jobs to contain and carry, for a while, the tensions and anxiety of our clients. And a smile can release pressure in young people. When they see you smile it clearly says 'it's okay to be here'. Smiling also releases relaxing hormones in our body – brilliant tools to call upon!

… celebrates diversity. Remember that the world is made up of individuals – all different and all beautiful regardless of age, status, wealth, religion, sexual activity, gender, ability, mental health, health, size, or who they fancy.

… welcomes every single person into the clinic…make no assumptions. Everyone has the right to information about sex and relationships. Anyone who goes through puberty will have sex feelings at some point.

… uses humour because sex is a messy business and if we can't laugh about this, then what can we laugh about? If we can take ourselves lightly it will shine through in our work. If we model forgiveness in ourselves, then young people will see that it's okay to make mistakes and move on.

… communicates clearly, gently and simply … Clarity and simplicity in conveying knowledge. It's okay not to know something!

… uses her/his voice with positivity and warmth …with the boys and the girls. People are much more receptive to encouragement and they are much more likely to be brave and try new things if they feel that you truly believe they can achieve. When a young person is upset

– you must respond with warmth.

… responds to boisterous behaviour or anger with calm, neutral tones…raising our voice in demands or anger is usually ineffective. This is not about winning a status battle, but by trying to remember what lies behind the behaviour.

… clarifies boundaries and practises flexibility…be clear what you can and can't provide, whilst being flexible in your approach. If the young person needs to talk about home life today and not about health or sex…let them…they'll leave knowing that you have really

heard them – this can do wonders for self-esteem. They'll come back when they need to for sexual health or health matters.

… follows Child Protection guidelines… not according to what colleagues, friends or others say. If in doubt you can always ring your manager and check it out.

… uses inclusive language…difference is normal, so assume nothing. Use 'partner' instead of girlfriend or boyfriend and remember that people can change who they are attracted to all through their lives. There are no rights or wrongs…Let someone identify for themselves how they would like to be recognised.

... keeps it confidential…if your co-worker doesn't need to know, don't tell them. Keep what is said in your session as if it is the most important treasure in the world. Even when you have to share information with another service or team member, impart only what is absolutely necessary and relevant, and check with the young person what you can share.

… faces challenges and unpredictability with courage…Running a clinic is a path for self-awareness and self-adjustment. The only predictable aspect of our clinics is that they are unpredictable!

… stands strong under pressure…remember why you are there even when a seemingly higher authority asks you to do something you know you shouldn't (e.g. letting them look over a young person's file).

… uses the evidence and keeps up to date with new practice and information…as a solid base of knowledge gives us confidence in our work.

… sits alongside the silences…silences can be golden, and giving enough space for a young person to formulate thoughts and feelings is invaluable.

… takes time to balance their own emotions…The very nature of our work brings up emotions (eg walking, talking, exercising, laughing, breathing deeply, splashing our faces with cold water, having a hot drink etc.). We need to leave as best we can our days at the door when we start the clinic. You can come back to them when the clinic is over.

… practises positive objectivity…Everything is okay! If the young person wants to laugh, cry, walk about, keep silent.

… acknowledges and expresses gratitude…thank a young person for sharing, being in the session, being in the waiting area. We couldn't do our work if it wasn't for them!

… supports the young person…Helps them manage their big feelings, issues, situations. You can't fix everything even though you may want to. It is enough to carry what they have told you for them so that they are not alone. If they are struggling, we do our best to help them feel more comfortable, without being patronizing or condescending.

… focuses on what is good…Sometimes young people can be a challenge! But we all have something good in us, and this is where we place our focus.

... listens actively…we listen and give signals that we have heard/understood. We talk about ourselves way from the clinic work. We don't add our ideas or beliefs to what is being said.

… accepts that they're not always right!...It's okay for people to have different ideas and views and to coexist in harmony.

… helps young people find a solution instead of giving them the answer…Think all the time

that they 'ARE mature enough' and 'they CAN do that'. Ask open questions 'how, when, why and what' to engage their problem-solving minds.

… is as direct as she/he can be…especially with the young men. Young men tend to struggle with communication and embarrassment. They might not discuss awkward topics, but they will appreciate a direct approach. Offering handouts and statements they can practise. 'Shall we use a condom?' as opposed to 'talk about it with your partner', is much better.

… responds to feelings not behaviour…and remembers that it is highly unlikely that you are the reason they are being distracted or grumpy.

… leaves their other 'hats' at the door. The clinic is about, and for, the young person. They don't need to know what your other jobs are, or about your accolades or opinions.

… remains humble…Allow the young person to be their own best advisor so that when you are not there, they can draw on their own resources.

… understands encouragement instead of forcing…If we push someone too far outside their comfort zone they will not learn and will probably withdraw completely from hearing you. Let the young person set the pace. Softly, softly is a much better approach.

… lets the young person go on their own adventure…you may know where you want them to be in terms of awareness and behaviour, but the learning can only ever truly happen when we go on our own journey of discovery.

… is clear about the topic of abuse and grooming, and never places blame on the young person…this can be a tricky one, but it is so very important. You must always be clear when with the young person who reports forced sex, abuse, pressure 'It was not your fault', 'it's never okay for someone to hurt you', 'it doesn't matter what you said or did, it's not your fault', 'even if you couldn't say 'no', they should not have gone ahead and ….'.

'It's never okay to hurt someone else…even if you think it's okay…or have reasons…it's still not okay'. 'It's really great that you have talked to me about it and I want something better for you.' 'Whilst hurting or pressurising someone else is never okay, let's talk about new ways of being with people or handling pressure.'

… gives them the chance to change and allows them to believe they can act differently.

… always believes what she/he is told by the young person…even if we know or think we know better or that they are misleading us…Always go back to the thought 'does it really matter?' Is the sky going to fall down because the young person tells me they've had sex with 500 people or that they've never been to clinic before?

… uses tenacity…I always remember the young man who tested positive for gonorrhoea and every day for 7 days came back to clinic with a new girlfriend to get her antibiotics, pretending it was his first visit to the clinic! What did we do? We went with what he said. After all, he was showing responsibility for their health by bringing them in, even if we had our personal opinions on his philandering ways!

… practises leadership…we have to keep the pieces together even in the face of chaos!

"Don't be afraid to be amazing."

Andy Offutt Irwin

4.2 Inner Marketing

"We're here for a short time, so we should try to do four things. Become wise, love ever more widely and deeply, witness beauty and fix this broken world in all the ways that we can."

Steve Greenberg

Before going about setting up your clinic, it is crucially important that you sit down with yourself and honestly clarify your goals and aims in regard to your new role as a PREPARE nurse. Having a thorough understanding of your own belief systems and fears will assist you in breaking through the comfort zones within which you currently operate, enabling you to live your goals, instead of just dreaming about them.

'Fear lies deep within us, both consciously and unconsciously. They come from our past, our education, life experiences, thought processes, personalities and from those who have had a direct influence on our lives.' As a PREPARE nurse we need to face our fears and overcome them, so that we become active workers.

Two tools below can help us on this journey. You can fill these in now, but keep coming back to them every now and again, to review your answers.

4.2a Answer these questions:

- Why do I want to be a PREPARE nurse?
- What are my specific personal goals?
- What am I going to do to facilitate and improve my journey of personal development in line with my career as a PREPARE nurse?
- Where am I confident?
- What are my strengths and weaknesses? what can I do about my weaknesses?
- What makes me doubt myself and my ability to reach my goals?
- What belief systems do I have that are stopping me?
- What am I afraid of?
- What can I do to actively break through a comfort zone which might be inhibiting me from reaching my goals?

4.2b Letter to me

Fill in this letter to yourself – it can be based on work or home life.

Letter to Me

Date:

Dear me

I have now completed the 'PREPARE' training on how to help young people to delay early sex. Three things I have learned are:

One way I am going to use what I have learned in the next week is:

One way I am going to use what I have learned in the next month is:

One way I am going to use what I have learned in the next year is:

From Me

4.3 Attitudes and Values

"Retreat and be still. Contemplate your choices. When you choose to use your power, use it justly, with great calm, and do not waver."

Most professionals involved in developing excellent health services, advice, support and sexually and reproductive health education for young people have become accustomed to living with tensions and dichotomies. For example, there may be disparities between their own ideas and feelings about 12 year olds having sex, and their commitment to ensuring those same young people have access to high-quality support and services when they <u>are</u> involved in sexual activities.

Living with these contradictions can be tiring – and we have become so steeped in the ethic of being non-judgemental, non-directive and not imposing our notion of morality on young people, that sometimes we may be in danger of ceasing to feel we have a right to our own values. Maybe we fear that these will somehow seep out and adversely affect our work with them. Or we may be anxious that if we voice any concerns or queasiness about the effects of very young people having sex, we are being reactionary and sex-negative – or will be perceived to be so by others.

It can be extremely debilitating constantly having to straddle this divide between our private feelings and our professional commitments. So it is important for our mental and emotional wellbeing to explore this area and to have the opportunity to discuss some of our unhappiness, reservations or understandable sadness about the effects of early sex.

Being able to share these feelings in this way can relieve a lot of the pressure in this area. It can re-motivate us to continue to advocate for excellent services, while also helping us to accept that we can play a vital role in supporting young people to delay early sex. In fact, these two supposedly disparate elements can be mutually supportive rather than oppositional.

Of course, what people usually come to understand from this is that feeling difficult about the idea of very young people having sex in no way impedes us from offering wonderful support. This allows people to see that, although they may not be entirely comfortable with the ideas of very young people having sex, this doesn't mean they have turned into some monster of reactionary and Victorian values!

It can also be helpful to know the contradictions we have to reconcile and accommodate in the course of managing our professional and personal selves. If we embrace these they can enrich rather than deplete or diminish what we bring to our work. [7]

The American poet Walt Whitman wrote:

"Do I contradict myself? Very well then, I contradict myself I am large – I contain multitudes."

We have the right to our feelings and responses provided that they don't inhibit the quality of the services and support we offer. Giving ourselves time and space to consider them in this way is likely to make us more comfortable in the work we do and the way we do it, and to enhance our awareness, understanding and skills – as well as being better for our emotional health.

People often comment that it is a relief to have the time and opportunity to reflect in this way. They will talk about finding it helpful that other people share some of their concerns.

They will mention that this relieves their sense of isolation and is useful in managing the tricky territory between some of our personally-held values and our desire and commitment to supporting young people's sexual health and right to services and support if they are sexually active.

After each clinic we ask that you make a few personal notes on how clinic was for you. It may be useful here to note the main topics that came up and what your reactions were to them – gut reactions. By practising this you can learn what issues conflict with your inner gut feeling and can make sure that you take these to supervision and remind yourself of your skill as a professional – it's okay to have contradictions! [7]

4.4 Expectations and limitations – doing what we can!

"If a thing's worth doing – it's worth doing badly!"

GK Chesterton

You are offering an amazing service to young people. If you treat, as best you can, everyone that comes to clinic with respect, compassion and a listening ear; if you strive to bring lightness and humour to your work and a sense of fun; if you work intelligently and professionally, but from your heart, and you feel that each young person leaves feeling that you care (even if you can't provide exactly what they needed), then this is enough.

We cannot be everything to everyone. It would be wonderful if we could have a clinic every day, and if you could see every young person for an hour. We all have limitations, both in the arrangements laid out for us at work and in our emotional and personal lives too. Some days you may have to turn people away if they arrive after the end of clinic, and as long as it is not an emergency, it's OKAY!

An important aspect of being an effective role model is looking after ourselves. You'll burn out if you are seeing people late after you should have finished.

Between the other worker and yourself agree when you might have to turn people away – making sure that it's for genuine reasons, not because a large group of young men are stressful to have in the waiting area!

Jo Adams writes: *'Sometimes it's true to say that the fear of doing something badly stops us from doing it at all. This is such a liberating notion for those of us driven by constantly striving for better and always feeling we are falling short of the impossible standards we set ourselves.*

We could strive instead to be good enough – that really is good enough! Life is imperfect and we would get a lot more done if we bore this in mind and would no doubt be a lot more relaxed in the process!' [8]

*"No one achieved anything who did nothing
because they could not do everything."*

Edmund Burke

5 Working with young people

5.1 Teenage development

"Smiles, tears, superficial fears, all are part of the teenage years.
First dates, first cars, having crushes on football stars.
First jobs, first kisses, one too many hits and misses.
The best years of growing up, with great achievements and screwing up.
Good girls, bad boys, finally throwing out old toys.
Sneaking out, getting caught, and remembering all the fights we've fought.
Boyfriends, girlfriends, hoping their love never ends.
Heart-breaks, making out, just to hear parents shout.
High school college, then it ends, it's time to change once again.
But we'll always remember all of the times,
when we won, when we lost and when we cried.
We'll always have memories of our fights and fears,
and all the good times spent in the teenage years."

There are so many factors that affect where a young person might be in their transition to adult life. One teenager might need certain things to help them, but be completely unable to ask for them – perhaps just be a bit sulky. For this teenager – asking if you can help them directly probably won't work. But raising topics in an indirect way can often work – 'what do you think about the way that (person in the magazine) is treating their (girlfriend)?', whilst doing the condom demonstration, or by taking blood pressure whilst asking about their family situation.

But this approach may be too vague for another young person who would actually like to tell you all about everything that's going on! Some young people can take in a lot of information and others just a little at a time – some might feel overwhelmed and scared by medical words and some love it!

During adolescence young people develop a stronger recognition of their own personal identity, including recognition of a set of personal moral and ethical values, and greater perception of feelings of self-esteem or self-worth. They start to comprehend the relationship between existing health behaviour and future health status, but their desire to fit in with peers may make it difficult for adolescents to make health-related choices based upon knowledge rather than peer pressure. The late stage of adolescence is characterized by the development of a strong personal identity. Biological growth and development have concluded among most young people and body image issues are less common.

Older adolescents are able to manage increasingly sophisticated social situations, are able to suppress impulsive behaviour, and are less affected by peer pressure. Economic and emotional dependence upon family is markedly decreased, and conflict over personal issues, such as food choices, also decreases. Relationships with a single individual become more influential

than those with a group of peers as a stronger sense of personal identity emerges.

The expansion of abstract reasoning skills continues to occur during late adolescence, which assists young people in developing an ability to comprehend how current health behaviour affects long-term health status. This is an especially important skill for adolescent females who plan to have children or who become pregnant during late adolescence. Older teens are now capable of learning problem solving skills that can assist them in overcoming barriers to behaviour change.

Below is a table that charts approximate changes that will occur as young people progress to adulthood. This highlights how capacity for reason and the ability to resist manipulation don't develop until much later on.

Psychosocial Processes and the Sub stages of adolescence			
Sub stage	Emotionally related	Cognitively related	Socially related
Early Adolescence	Adjustment to a new body image, adaptation to emerging sexuality	Concrete thinking: early moral concepts	Strong peer effect
Middle adolescence	Middle adolescence Establishment of emotional separation from parents/carers	Emergence of abstract thinking, expansion of verbal abilities and conventional morality; adjustment to increased school/ work/life demands	Increased health risk behaviour; sexual interests in peers; early vocational plans
Late adolescence	Establishment of a personal sense of identity: further separation from parents/carers	Development of abstract, complex thinking: emergence of post-conventional morality	Increased impulse control; emerging social autonomy; establishment of vocational capability

Ingersoll GM, Psychological and social development. In: McAnarney E. Textbook of adolescent medicine © 2002

And a final note – Teenagers are paradoxes: being capable of many responsibilities and able to make many choices about their lives, whilst at the same time being very vulnerable and in need of guidance and emotional support.

5.2 Why young people have early sex

During the training you will have had a chance to discuss the main reasons young men and women have early sex (aged 12-14). The activity was a vehicle to enable you to become clearer about the reasons driving young people to have sex and bring this into conscious awareness. You could call on this awareness, one on one in your clinic time, to try to unravel the main reason the young person is having sex (even if you are not asking them outright) and perhaps be prompted into suggesting less risky alternatives for them where you feel they are in a position to make a choice. It may be helpful to recognise why they might have sex and what the feelings/outcome resulting from this might be. This in turn will give you the opportunity

to aid in their reflection for gaining greater self-awareness, and through this will enable them to take greater control of their life choices and decisions, rather than simply being subject to what at times may otherwise feel like ungovernable forces. One-to-one you could establish what their main reason for having sex is (see section on asking questions) and offer advice on more reliable alternatives to meeting this need.

Here's a reminder of the activity and its learning. You could do this with a group of young people:

The Brainstorm

You started with a brainstorm "Why do girls have sex?" Primarily thinking of younger girls – say 12 to 14 year olds- and specifically meaning consensual and penetrative sex. Ask participants to call out all the needs girls may try to meet through having sex with someone else. Flip chart all their answers.

The answers tend to be wide-ranging. For example, "for things", "for shelter", "for money", "for status", "popularity", "to keep a boyfriend", " for attention", "for affection", "cuddles", "to rebel", "to feel grown-up", "to keep up with their friends" or "to belong" often figure. Having identified some of the reasons girls may be having sex and the needs they are seeking to meet through sex we went on to discuss whether these methods actually *work*. Does having sex with someone necessarily make you popular or stop a boyfriend from leaving?

Then you looked at other reasons for which boys and young men (again thinking of the younger end of the age group) might have sex which have not already been charted. These included "to prove they're a man", "to show they're not gay", "to tell their friends".

In fact, the learning here may be that the reality of what actually happens to girls after sex is often very far from meeting these needs although it may sometimes in the short-term seem to deliver. So, the initial motivating feelings of bleakness, loneliness or low self-esteem are in fact quite likely to be exacerbated, not lessened by an alienating sexual experience. Rather than helping them to feel better about themselves, it may in fact leave them feeling considerably worse.

You were asked which ones of these needs given can <u>only</u> be met through having sex with another person (by this we are assuming penetrative sex). Usually there are only one or two – e.g. to lose your virginity, to get pregnant. Then you had a chance to think about this mismatch of needs and young people looking to sex to meet them, and what the possible consequences or feelings might be after the sex. You also looked at how to offer alternatives.

A	B	C
NEED /REASON FOR HAVING SEX	WHAT MIGHT BE THE FEELINGS AFTERWARDS OR THE CONSEQUENCES?	HOW ELSE COULD THEY MEET THIS NEED? HOW CAN WE HELP THEM TO DO THIS?

Clearly, a key understanding should be that if young people look to sex to meet these needs they are likely to be disillusioned and disappointed, and often to experience blows to their own self-esteem, rather than improving it. Remember, too, that there may be some positive outcomes for young people who have genuinely made an informed, considered and emotionally-aware choice. Although we know that the levels of subsequent regret are very high for the younger age

group who have sex, there will be some for whom this is a happy, close, mutually pleasurable and fulfilling experience.

The strategies here are an attempt to work with young people to help them meet these needs in more reliable and healthy ways, so when they come to sex it will be because this is what they positively want and choose, rather than hoping it will solve other problems and be a universal panacea – something it usually fails to be!

5.3 Handling young people's behaviour in the clinic

Every single teenager that makes it through the door of the clinic will behave in a slightly different way. Some will come up to you boldly and quite happily explain to everyone in earshot what they need today. Some will pop their head around the corner of a door or a corridor and then hover or apologise and disappear. Some will come back time and time again even though you've explained that it's a long wait today. Some will scream and shout whilst another sits slowly sinking as far into their seat as humanly possible.

Most young people will be experiencing some mix of emotions, especially at their first appointment. Think back to the first session of the training. You may have had some preconceived ideas about the training, how people would treat you, what you would be expected to do or say. Whenever we try something new we are, of course, a little nervous. Now imagine that you are in pain, or worried about being pregnant and being asked to wait before you are seen. Every minute can seem like a lifetime and can intensify feelings of anxiety. Or you may feel frustrated for wanting to act responsibly and collect your condoms, but seemingly punished for positive behaviour by having to wait an hour in a queue.

Below is a table of the most common feelings young people say that they experience when coming to clinic and how this can manifest in behaviour – sometimes young people struggle to articulate how they are feeling, so you may have to look for these cues to work past their actions and figure out the best way to respond.

Each and every young person must be welcomed. It is a privilege to have them come to see us and we should honour their willingness by being discreet, friendly and welcoming. Sometimes it can feel very difficult when you have a long queue and people arguing and demanding or asking you questions. But welcome each and every one we must. A smile and a nod of recognition is all you need to let them know they are in the right place and you have acknowledged them.

Just remember that the very act of coming to a clinic shows a desire to look after oneself.

Here is a summary of the behaviour versus feelings and responses that you may encounter.

In the waiting area (overleaf)

In the waiting area

Behaviour	Feelings	Response
Opening doors to clinic room	Stress and boredom	Taking them to one side and kindly explaining how important we value privacy and that we understand it can be frustrating having to wait but that they are welcome and will be seen, but that it's not okay to interrupt somebody else's time.
Asking repeated questions about wait times	Anxiety and panic, fear, stress	Be compassionate, acknowledge the wait and reassure them that they will be seen even if it feels like a long time.
Hovering near to the clinic	Fear, uncertainty	Go to them and welcome them in so that they can be walked in with you. Explain what's going to happen.
Hardly speaking	Fear, panic, shame	Do not push for information, just welcome them in and explain that they will be seen in private at their appointment.
Pacing	Boredom, stress, anxiety, frustration	Have things to read and ideally 'do' such as activity sheets.
Walking about	Boredom, stress, anxiety, too much energy	Some teenagers just prefer to stand (especially young men) – if they are not asking questions of people in the clinic then let them walk about!
Blushing	Embarrassed, worried, panicked	Give some space – offer a glass of water and seat and suggest you will speak with them later.
Crying	Relief, tension, fear, anger, pain	If there is a quiet space to ask a few questions find out if you need to attend to something urgent with the young person. If there is a quieter spot for them to sit or be near you in the waiting area so that you can offer some support.
Demanding, raised voice, anger	Worry, panic, fear, frustration	Acknowledge and thank them for coming to the clinic and apologise if needed for the wait, and explain reasons for a wait if it doesn't breach confidentiality of other young people. Make sure you keep them updated as changes happen to the wait. This should usually defuse anger, but remember that you do have the right to work free from abuse and to feel safe and that you can invite a young person to return another time if they prefer if their behaviour becomes inappropriate.
Withdrawn and quiet	Shy, fear, stressed	Offer words of encouragement.
Chatting with friends	Any!	As long as their chitchat is not about other people waiting, this is all fine!
Asking other people why they are at the clinic	Bored, sense of entitlement, curiosity, fear, anxiety	Take them to one side and explain that we are not allowed to ask each other questions in the clinic so that the clinic stays private for everyone – keep it light-hearted.

In the clinic session

Behaviour	Feelings	Possible responses
Closed body language (arms crossed): Looking down at ground, shrugging	Invaded, vulnerable, insecure, fear of reaction	Offer the 'point to' sheets, ask if they would like your help with something, or try giving space for them to formulate thoughts. Or leave questions until another time. Especially with young men – they may feel like you have asked too many questions.
Uses ridicule or humour	Deflecting embarrassment	If you don't really need to challenge the statement, then don't. See it for what it is – deflection - and move on.
Crying	Pain, relief from tension built up coming into the room, grief, emotional pain	Reassuring them that it's okay to cry – that we need to cry. It's a normal human reaction. Give lots of time and space.
Fidgety, tense, stiff body language like they are trying to escape from the room!	Anxiety – possibly of a new situation. Or they may just be excited and have somewhere else to be!	Remind them that they have the right to not answer questions. Try to keep yourself and your voice as calm as possible. If you can move straight into practicals like height and weight – that may expend the nervous energy.

5.4 Managing their fears, anxieties and expectations

"If I had to go to the clinic I'd want to get to the point as quickly as possible and get out again. I wouldn't want the staff to be business-like, but friendly and to the point."

Young man [9]

"If I know that anything I say is okay, if I know that I can come back and say more another day, and if I know I won't be judged, then that's the best you can give me."

Young woman

"I was worried I was pregnant. It took everything I had to get myself into the clinic and the wait seemed so long. I expected to be seen straight away and every minute seemed like days! But the receptionist came over and explained how long the wait would be and apologised. She told me I could go outside and come back – I wouldn't lose my turn. She explained that sometimes other emergencies happen like someone has been badly hurt, and that can sometimes hold up a clinic. This meant the world to me. I felt respected and, even though she didn't know why I was at clinic, that I was important."

Young woman

Be honest with the young people. They might not like that you cannot fix their problem, give them what they need today or rescue them, but they will appreciate your honesty. You will never leave a young person feeling let down, yet again, by another adult if you are direct with them from the outset.

Ask yourself if their request is reasonable – even if it falls outside the usual realms of work. And if it is then see if you can help.

It is our role to be a centre point of calm and stability in the chaos! We can deal with how difficult it felt after clinic is over!

Do you like waiting in queues? It's especially difficult if you're expected to be somewhere else at a set time and the wait will make you late. It is definitely difficult having to wait if you are in pain or anxious. However, it is a necessity sometimes. A nod, a smile and 'I've not forgotten you are here, you will get seen' can do wonders to help you empathise with the worker/service and be a little more patient.

If a young person is behaving in a way that needs addressing you must always do this without humiliating them. This is not a power war! Whenever possible you go to them or invite them to a quiet, discreet place out of earshot and you deal with their feelings there. This shows respect, and after all isn't this how we would like to be treated?

You can have magazines and interactive tasks out to fill the time, having posters up that explain positively about the wait 'we know that waiting can feel really frustrating. Thank you for bearing with us….sometimes emergencies happen which can make the wait longer – we'll try our best to let you know if things change.' or similar . And do be honest – if it's going to take an hour – don't say it won't be long. This can feel dismissive and it's not true. If a young person has to go, they have to go.

5.5 Confidentiality

'Everything is a big deal!'

Confidentiality has got to be the issue that comes up time and time again for young people accessing services. Clear policies and demonstrated behaviour can make a good service great.

Treat everything you are told as if it's the biggest deal in the world. We may have become practised at handling relationships, pain, pressure, expectations. We, as adults will have a greater perspective of how life flows. But young people have not lived enough to learn this yet, and even if they have, it's still worth reacting like 'it's a big deal'.

If you treat the small things (like a broken heart) with compassion and confidentiality then the young person is much more likely to trust sharing the bigger issues with you.

It is humbling to see the level of trust a young person places in us when they share. We ask them to disclose more than we would often feel comfortable doing so ourselves with our closest confidant.

Explain clearly from the start that you won't tell anyone about their visit today without their permission. And explain that you would never tell a parent or a friend or a teacher about their visit. Be clear about the times that you might want to share or get help from another service – if you are worried that they are going to come to serious harm at the hands of another or

at their own hands. They then have a choice about whether to tell you something or not. And then if they do, it is likely that they are actually now asking for adult help with their situation.

This topic is tricky so here are some examples of when you might consider breaking confidentiality:

The young person is thinking about suicide. The young person is worried about their immediate safety. You suspect an ectopic pregnancy or other medical emergency.

And definite times when we wouldn't:

Just because they are under 16. If they are pregnant or going for an abortion. Because their partner insists. Because a parent turns up. Because they are HIV positive. Because they have reported rape. Because the police ask you to. We cover confidentiality in much greater detail in section 7. If you are unsure, firmly place the person in front of you at the centre of your decision making and discuss it with your manager.

5.6 Listening

"We don't see things as they are, we see them as we are."

Anais Nin

So we are human beings. And we make assumptions. But it doesn't mean we have to take our assumptions as fact. Young people will make assumptions about you, and we can demonstrate wonderfully here how assumptions can be wrong. By being interested, non-judgemental and active listeners.

Listen with your heart and then your head and you are much more likely to listen accurately to what is being said.

Remember the activity from the training – listening to actually what was said, without embellishing or assuming or filling in gaps, then use your intuition as to what was left unsaid.

If you are not sure what a young person has said – ask them to clarify.

It can be tempting to 'help' the client with silences. But try your hardest not to do this. They will usually get there if given the time to answer on their own.

Repeating back and summarising what has been said to you can help you remember for your file notes, but also can help check you have got it right. The young person can find it helpful to have their thoughts clarified in this way.

5.7 Power of friendships

"It's our friends who make our world."

It is crucial to understand the importance of friendships in building self-esteem. In addition, it reinforces the notion that young people get many of their emotional resources from their good friends, and can draw on them for support in making choices which are positive and healthy for them, rather than simply going along with a crowd. In the research focus groups carried out with young people by the Centre for HIV & Sexual Health, participants named good

friends as their main source of support in managing to resist the pressure to have early sex.

In times when competitiveness, bitchiness, and minor forms of bullying can prevail, it is especially essential that we encourage young people to think about the gifts, strengths and delights friendship can bring them. This then needs to be further reinforced by helping them gain the practical skills and emotional awareness to make and sustain strong, nurturing friendships which will see them through difficult times.

Finally, we need to remember that young people can get a strong sense of themselves, of being loved and valued and held in affection from their friends. If they are experiencing all these positive things through friendship, they are much less likely to feel they need to have sex to provide themselves with these – something which it all too often in fact fails to do for them.

In clinic you could ask a young person to think about a good friend – not their sexual partner

- and ask them:

- What do you value in this friendship?
- How does it make you feel about yourself?
- What positive role does your friend play in your life?
- What does the friendship help you do, feel, be, aspire to? Remember these points:
- Friendship is great for our self-esteem and for overcoming self-criticism. Often people will say ‘My friend knows all the awful things about me – and still loves me nonetheless.’
- It’s rare - and positive - to be asked to reflect on our friendships. We can take our friendships for granted – which in itself is in a way quite nice, a comfortable area in our lives.
- In our society, much more attention is given to sexual relationships than to friendships – let’s help to redress that imbalance.
- In our friendships we practise key relationship and communication skills. They are often the places where we learn about ourselves and where we have the space to talk about our feelings as well as listening to those of others.
- Because friendships help us to feel valued and special, they can be a great antidote to negative feelings about ourselves. For the same reasons, they can also give us the strength to withstand pressure.
- We can learn through our friendships that it’s ok to go through a rocky time – and forgive or be forgiven for arguments.
- Our friends are there for us when other people let us down, and teach us we have the right to expect to be treated well.
- Encourage young people to meet some of their social, relational and emotional needs through friendships and gain greater skills and understanding in this area. Currently so much status is accorded to sexual relationships that the effect is to downgrade the importance of friendships.
- Make sure the point is made that we want young people to build up a range of friendships, each of which may feed and speak to different parts of themselves. If young people invest totally in one person and that friendship fails, it can leave them feeling isolated, needy and vulnerable.
- We can be positive role models for young people in terms of the friendships and alliances we demonstrate and talk about which offer us support, succour and fun. So it is helpful

to watch for opportunities to model the positive power and central importance of friendship to young people.

- We all have the need for affection and belonging, for warmth and someone who cares about us. If young people can meet these needs reliably through friendship, they are much less likely to look to sexual relationships and partners for this.
- Classically, the first thing those 'grooming' young people for prostitution do is to cut them off from their friends and to create total dependence. This is precisely because they're clever enough to recognise that friendship is a powerful creator of self-esteem and feeds our selfhood in positive, strengthening ways. So we need to ensure that all young people – boys as well as girls – have access to this great source of support.
- Friendship is magical and practical, it can transcend obstacles, picks us up when we're down, it's exciting and exhilarating, it helps us move on, it gets us out of messes and trouble, and can take us on a journey to great places.
- In all – it's a ride of a lifetime and young people need both an awareness of the role of friendships in their lives and the skills and tools to make and sustain excellent ones. Only in this way will they be able to deal effectively with the pressures to have sex and to meet their emotional needs outside of a sexual relationship.

5.8 Understanding Pressure

When people are asked about their issues and concerns relating to young people and early sex, anxieties about the pressure on young people to have sex are often first and foremost in their thoughts. These pressures are seen to come from assumed cultural norms, gender roles, peers and partners, the media and a generally over-sexualised culture and from the assumption – which is in fact inaccurate and a key misconception – that everyone over 12 is "at it"!

We practised the 'pressure cooker' activity which gave invaluable experiential insight into the possible background we are dealing with when a young person presents at a clinic, asks for condoms or seeks our advice and support. It can provide a vivid illumination of the hidden nine-tenths of the 'iceberg' which may be hidden from us in our interactions with young people. Understanding what may in fact be going on for them can help us tailor our responses, and ensure we do not simply deal with the 'presenting problem'. In the case of the scenarios considered in this particular exercise, it helped us grasp the vital importance of working on issues with young people who may be at risk of having sex which is not really of their own choosing.

Incorporating this into our work with young people can enable them to take responsibility for their own choices and decisions – including the one to delay sex until they are ready for it, until it is genuinely an informed choice. Furthermore, giving them the awareness and skills to resist the pressure for sex allows them to prioritise their own wishes and needs and not simply give away their rights, bodies and choices to others.

Here's a reminder of the all the things young women may be feeling, thinking, wondering, anxious about – everything that may be going on for her when she comes to the clinic.

I'm so confused I don't want to lose him I'm the only one who hasn't done it
I can't say no I'm scared I feel powerless Pressured Panicked Afraid Ashamed
Worried I might get a reputation Scared of getting dumped/hurt

Points to note here:

- There tends to be little if any mention of pleasure or desire to have sex, simply the imperative to "do it" to keep her boyfriend.
- Usually there is a strong sense of isolation and lack of anyone to talk to about all her feelings and the situation she finds herself in.
- Her voices do not usually include ones which talk of *her* rights – for example to make her own choices for herself, rather than giving in to the needs of others.

And some of the things you can say to help relieve her pressure:

-You don't need to have sex -I'm wondering where you are in all of this -How would you like your first time to be? -If you're not sure then you are probably not ready -Well done for coming in to see me – that's a really brave thing to do -It's not okay for him/them to pressure you

So to are the pressures facing young men and therefore what they may be feeling, thinking, wondering, anxious about – everything that may be going on for him when he comes to the clinic include:

I've no choice Angry Sad Isolated Afraid Unsure Just want to fit in.
What if she is unhappy? Desperate

Points to note:

- How many pressures young men may be feeling to prove masculinity
- The fact that a major motivator is wanting to be able to tell his friends
- His strong sense of feeling under enormous pressure to perform
- This is accompanied by his being in the grip of fear that he may not be able to
- Again, there may be little reference in his thoughts and feelings of love, desire, intimacy or pleasure

And some of the things you can say to help relieve his pressure:

-You don't need to have sex -Have you got a girlfriend/boyfriend? -Have you talked to them? -I'm wondering where you are in all of this -How would like your first time to be? -If you're not sure then you are probably not ready -Well done for coming into see me – that's a really brave thing to do -It's not okay for her/them to pressure you -How else can you show you love someone? -What else makes someone a man?

Consider the following:

- What do the things young people are thinking and feeling tell us? The gendered nature of pressure is interesting to explore at this stage. Girls are usually focused on pleasing others and anxious about approval – for example from her boyfriend, parents, friends and clinic staff as well as having fears of pregnancy. Boys on the other hand tend to be focused on performing and being a good enough 'man'.
- Most thoughts and feelings are likely to be about anxieties and fears – very few, if any, about pleasure.
- At this stage, people are often bowled over by thinking about what may be going on for men, sometimes at the expense of giving proper attention to young women's predicaments. Watch out this doesn't happen for you, and ensure that you understand

that empathising with young men explains the pressure they are putting on women, but doesn't excuse this.

- Help young people be clear that they may be under huge pressure, but that passing this on to young women or indeed to other young men is no solution. It is the pressure itself that needs to be addressed and challenged.
- Our role is to interrupt and challenge behaviour while empathising with feelings and the effects of the pressure they are under. Both boys and girls need to be helped to understand that it's unacceptable for this pressure simply to be passed on to her.
- Carefully handled, discussing pressure like this can relieve young people's experience of isolation or of feeling they are the 'only one' to experience such dilemmas.

Remember one positive way to follow up a chat about pressure is to introduce the checklist on readiness "RU Ready- Or Not Quite Yet?" This resource can help young people to decide when they are genuinely ready for sex on their own terms, rather than to fit in with other's agendas, pressures and imperatives.[7]

5.9 Promoting self-esteem

Seems so simple doesn't it? If you don't place value on yourself and your right to a place in the world, then you are unlikely to have health high on your agenda. You are vulnerable to being persuaded into doing things you don't want to do if you see yourself as less important.

"My mother sat me down and said, ...you are beautiful to me but must know that you are beautiful for yourself. You should also be aware that true beauty is in the eye of the beholder, which means that how beautiful you are to other people is always going to be subjective to who is looking at you at that time, and since you will always be looking at yourself first, you should find your own beauty and feel good about who you are. She went on to tell me that I needed to take the time to identify those things that I found to be beautiful about myself, but also celebrate what I thought was weird or unusual because those were the special things that God had given to me that made me different from everybody else. I learned how to appreciate, embrace, and enhance those special things so that they would shine rather than be hidden...We learned to love and identify with what made us uniquely beautiful."

BeNeca Ward (born 1976);

One of the strategies which help young people to resist pressure is "Providing young people with trigger thoughts". Among the examples given of these is the one drawn from the practice of Julia Hirst, from when she was a teacher. She used to say to young people in her classes – "If you're coming under pressure from someone to have sex or someone's trying to push you into doing something you don't really want to, I want you to put your arms round yourself for a moment and say

'I am very precious, and very special'

and only then make your decision." Again and again young people would tell her that they had

done this, and it had made all the difference in coming to their final decision. Just asking young people to give priority to themselves, even for 30 or 40 seconds can have a profound effect.

The more young people believe that they are special and that they are in the centre of their own lives - not just on the peripheries of the lives of people they are trying to please - the more likely they will be to resist pressure. This in turn will make them more equipped to make their own choices, informed by a real understanding of what is best for them, not just what they hope will bring approval from others. So when they do remind themselves they're "precious and special", and still know that this is the right choice for them and not just to please someone else, it is so much more likely that the sex they have will bring them intimacy and pleasure.

It is this notion of informed choice, of a decision taken with our own wellbeing in mind, of connecting with our own needs and readiness rather than compulsively looking after other people's which is the true cornerstone of this work.

Take that idea as a foundation stone, using it as a reminder to young people that they have unique and special qualities which make each of them different and special.

Points to remember:

- We all believe our bad qualities, but are unsure about our good ones.

  We worry that claiming qualities is arrogant, big-headed and conceited because it goes counter-culture. We're supposed to be modest and to put ourselves down – otherwise people say "She really loves herself" or "He's really pleased with himself", but isn't that how we want people to be? It is worth pointing out that there is a difference between positive self-esteem and becoming a monster of vanity and selfishness. But often in our culture one is equated with the other, and we're encouraged to be self-critical and self-deprecating, never to be self-affirming.
- Ask yourself why we think we act as though simply claiming a quality will bring civilisation as we know it crashing down? And what is the effect on all of us of living in a society which is so averse to self-praise?
- It is really helpful to have a list of qualities for people to look at and take away with them, because people often say their mind goes blank when asked to think of positives about themselves exactly *because* it's so counter-culture.
- It is important for us as workers to work on our own self-esteem continually if we are to be positive role models for young people. In the spirit of Maya Angelou's words – "To love others, first of all we must love ourselves. We can't hand on what we haven't got". So getting better at this isn't self-indulgent, it's an important part of professional development!
- What stops us claiming our qualities is usually a harsh internal self-critic, but we can with practice lessen this or at least cease to believe it tells us the truth.
- Remember how it was listening to each other speak of their qualities: it was moving, heart-warming, pleasurable. This is useful because it counteracts the self-critical voice and reconnects people with the reality of what other people really think about us.
- Claiming qualities is often really hard the first time young people do it, but gets better with practice. Sometimes you will have a young person in your clinic who has become more adept and less embarrassed at claiming their own qualities and they can be really helpful role models, testifying to the positive effect of doing such an exercise – a gift. Someone in a group once said "I *know* now that I have beautiful warm brown eyes – and really believe it. It's taken a lot of exercises like this to get there – but they really do eventually work."

- Remember- small acts can bring about profound changes in self-esteem! A nurse who worked with boys with challenging behaviour had tried to find a way to let them know simply that she affirmed them and regarded them as worthy of respect. So she began shaking hands with them when she met them each week – and this brought about a major change in how they related to her, and then eventually to their behaviour with and attitudes toward other adults in the school too. [7]

5.10 RESISTING PRESSURE AND SAYING 'NO'

Sadly many young people may have experienced violence, sexual or otherwise. We'll deal with that separately, later on. What is worth noting is that this will undoubtedly have eaten away at a young person's ability to assert their needs in non violent situations. And this is where we can help them in a proven, positive way:

Reflect on what 'no' means for you here.

After you have done this you could do a variation with a young person or group of young people.

Think about all the things which stop you from easily saying 'No'. What do you fear people will think of you? What are you anxious may happen? Think for example of saying 'no' to friends (to lending money or going out maybe), at work (to taking on extra responsibilities perhaps), to parents (coming to live with you), to partners (this might be to going out or to sex maybe), to children (having all their friends visiting or washing the whole team's sports kit).

Think about the fears and anxieties which stop us saying 'no' when we really have a choice. We are looking at those times we say 'yes' when our guts are telling us 'no, no, no' - not issues such as the threat of violence, rape or sacking from a job which take you into another territory. You are dealing here with those occasions where you could say 'no' and want to say 'no', but unaccountably still find the words "Yes of course….." coming out of your mouth! What is it we fear that people will think about us, feel or do in these instances? The kind of list this brainstorm is likely to result in is often something like this:

What Stops Us Saying 'No' – the fears of what people will say/feel/think about us	
We'll upset someone	We'll be seen as lazy
We'll let people down	We'll be seen as unwilling
We'll be seen as obstructive	We'll be seen as unhelpful
Rock the boat	We'll be seen as selfish
'Awkward'	We'll be seen as difficult
Seen as stubborn	We'll feel guilty
Uncertain of people's reaction	We'll be seen as not a team player
We'll be seen as a spoilsport	We'll be seen as boring
We won't be asked again	We'll be seen as not a good friend
It will make us unpopular	We'll hurt people's feelings
We'll be seen as inadequate	We'll be seen as unsupportive
We'll miss out	We'll disappoint people
We'll be stuck with 'no' forever	We'll damage others' self-esteem

These are – in the vast majority of cases – fears and fantasies rather than the truth or reality. Most of us – when we were toddlers at 3, 4 and 5 – were told that saying 'no' was rude, disobedient, cheeky and selfish. We internalised these messages about saying 'no', as small powerless people do – and have carried them around with us at an unconscious level ever since. The fact these can be traced back to such early messages means saying 'no' can feel frightening because we still fear that it will lose us the approval, friendship and love of others.

GUIDELINES ON SAYING 'NO'

- Your immediate feelings will usually tell you whether you want to say 'yes' or 'no' to a request
- If you're not sure then ask for some specific information so that you know exactly what you are committing yourselves to
- Say 'no' for yourself, rather than referring to a higher authority or circumstances beyond your control
- If you don't say 'no' directly, then you will find ways of saying it indirectly
- Make it clear that you are refusing the request and not rejecting the person, the role, the job or the friendship
- The skill of self-disclosure is a big help in saying 'no'
- When you say 'no' to something you don't want to do, you are saying 'yes' to yourself and your own importance
- Saying 'no' and surviving the guilt gets easier! Reassure young people that we do survive the initial guilt caused by saying no although it feels incredibly difficult to do at first – but it truly does get easier with practice.

Think about a time you wanted to say 'no' and didn't when using these guidelines would have helped. Not a disastrous and life-changing event like agreeing to marry someone you didn't really want to – but something real but on a less traumatic scale. Then ask yourself and think about what the gain would have been if you had said 'no' in this way.

Think about just what the gain would have been for you if you had used these guidelines for saying 'no' and in this way had been able to take greater control over what happened.

These gains are likely to include things like this:

Gains from Saying 'No'	
More time	Doing what I want to
Quality rather than just quantity	Satisfaction
Achievement	Being a good role model
Self-esteem	Belief in myself
Respect from others	Self-respect
More energy	Better relationships/greater trust

All these factors add up to a positive recipe for self-esteem and for building a sense of ourselves being worth looking after. Remember:

- You don't have to use this tool and these guidelines – but having this skill in your repertoire

at least means you have a choice. Whether you use them or not is then entirely up to you.

- Admittedly this way of saying 'no' using these guidelines doesn't work 100% of the time – but mostly it does. Certainly it works better than the alternative – not saying no because we're still in fear and worry about what people will think of us. That way lies exhaustion, resentment and the feeling that we are giving away our choices in order to please others.
- You don't have shares in this! But if we're to model saying 'no' for the young people we work with, it's going to mean stopping being a doormat and taking back some control over our own lives.

This exercise is really useful in demonstrating graphically why the 'Just Say No' approach will never work – because it overlooks the powerful messages we have internalised about the dire consequences we fear if we say 'no'. Until young people are more aware of this, and of the barriers they may feel to saying 'no', then no amount of sessions and tips simply on how to say 'no' will have any effect. You can then build on it the awareness gained through this exercise and introduce all sorts of practical activities to build skills and confidence – but this work on the *feelings* about saying no is the foundation stone for all the rest.

WHAT 'NO' MEANS

This exercise is a way of exploring the meaning of 'no' in young people's lives – and seeks to redress some of the negative associations which accumulate around the word, replacing it with a more positive notion of 'No'. You could, one on one, ask a young person to think about what 'no' could mean for them, or provide them with this list.

-Making positive choices for yourself

- Making decisions
- Saying 'yes' to your own needs and wishes
- Not just going along with the crowd
- Weighing up possible outcomes and choosing between them
- Standing up for your beliefs
- Sticking up for yourself (or others)
- Refusing to be a doormat
- Taking more control of your life
- Taking responsibility for yourself
- Risking disapproval from others
- Facing up to your fears of disapproval or rejection.

6 The clinic set-up

Your clinic is ready to be set up! There a few important aspects to cover in this section all aimed at assisting you to create a safe, welcoming clinic that young people will value and keep coming back to. This is based on many years of consultations, trial and error and practical experience.

This may not be the case in your school but ideally there should be two of you at each clinic, one person (volunteer or clinic staff or nurse trainee or outreach worker) to manage the waiting areas, and a nurse to see drop-ins and appointments. All first time clients should ideally see the nurse.

You will be at the school once a week. One clinic will be appointments only (so that every student in the project gets time at the clinic at least once). The other will be drop-in appointments.

To begin with the services you will offer are:

1. A listening ear
2. Advice and information
3. A health check covering physical and emotional health and relationships
4. Support for intimate partner violence
5. Support and referral for mental health issues
6. HIV and STIs advice.

6.1 The ideal set-up

"Know in your heart that all things are possible.
We couldn't conceive
of a miracle if none had ever happened."

Libbie Fudim

The clinic and waiting area can be seen as a holding ground for young people. A place where they can come and unload their big feelings, get advice, feel grown up, take responsibility, get information, learn new things and ways of being. Ideally it will be a space designed for them, and by them.

If you always have them at the forefront of your mind, you will be able to create the ideal clinic in the most unlikely of spaces. It's not the size or 'glamour' of space, but the intention and what you do with it that matters.

You may not be able to do all of the following 'top tips' but do what you can – they are all important. You may see them as 'frills' but aren't these what give us the biggest 'thrills' in life?

There are good reasons behind all of the top tips.

- Have leaflets out at all clinics
- Have a walk-through before your first clinic with a young person to get advice about things our 'adult eyes' may have overlooked
- If possible have a radio in the clinic
- When clinic starts welcome every client in:

  "If you had to go to the clinic, you wouldn't want to be judged – you don't want to be there, so you want some encouragement that you've done the right thing. You're going to be edgy, looking for the odd look or comment. You're not there to be fixed and you'd want the staff to act normally." [9]
- Have signs and posters up that are factual and fun:

  "When you walk into a clinic, you don't want conversation. You're going to feel a bit ashamed – you don't want to have to talk about it. I wouldn't want posters of syphilis on the wall or about the problems of teenage pregnancy. It would be hard enough to get there, without being reminded of the pain!" [9]

  Having encouraging information is a great way of congratulating the young person for attending a clinic.
- Have 'point-to' sheets with pictures on in the clinical room to aid communication:

"I think that it would help if clinics had pictures of symptoms or a questionnaire to fill out that asked questions like 'is there pus?' I don't want to have to volunteer the words on my own." [9 10]

- And when you meet the young people:

  Have name badges on and introduce yourself by your first name and by what your role is. "Hi I'm Sarah and I'm your nurse here today, is this your first visit?"

  Explain at every visit what is going to happen
- Check your clinic supplies and order in advance
- Have the clinic near a toilet and ask staff not to use the toilets during clinic times
- Have young people decorate the clinic and waiting area
- Arrive early to set up, and centre yourself before the clinic – deep breaths etc.
- Assume a young person doesn't know how we get pregnant and have images on stand-by
- Look at others and yourself with kind eyes
- If possible always do a condom demonstration at the first visit – either to a group in the waiting area or in the clinic room – or both! Young people respond really well to practising and encouragement
- Talk in age-appropriate simple, not medical language. If a young person uses swear words to describe behaviour or body parts, that's okay. You can always explain what the scientific – non-swear word is.
- Don't use medical terms or acronyms like 'TOP'. Say 'terminating a pregnancy', or 'having an abortion'
- Report all accidents or incidents and record them in the clinic book

- Mention anything that has become a barrier. 'It's been a really long wait hasn't it everyone – thanks so much for your patience'
- Expect the unexpected at every clinic
- Have two people at the clinic to assist
- Use humour:

"I've always thought that a big laugh is a really loud noise from the soul saying, 'Ain't that the truth.'"

Quincy Jones

- Remember always that young people are just that – human beings just like you and I, just with fewer years to their name
- Lean on your colleague and ask for help when you need it.

6.2 Practical tips for demonstrating the service is confidential

Phones

If you have to make or receive a call about a young person make sure that your door is shut. If someone calls you back after you have left clinic, make sure no one can hear your conversation. Ask young people to take or make calls outside of the waiting area – it protects the people in the clinic.

At the waiting area

Don't ask for personal information in the waiting area. Use the 'point-to' sheet to determine if someone is here to see the nurse or to get condoms from you for example. You could have a sheet that asks if they are in any pain too. Hand out numbers instead of using names for those waiting for the nurse. If someone is an emergency, don't give them a number; just have them go straight in when the nurse is free.

Staff

It can be tempting to talk about the clients you have seen after the clinic has finished or in a quiet moment. But you mustn't! Ask yourself 'Do they really need to know?'

Notes

The young persons' care only ends when you have finished their notes and put their file away and out of sight, even if they have already left the room. Before the next person comes in be sure to have tidied everything away.

Names

It can feel a little strange at first, but young people say that they prefer to be called in to the nurse's room by their appointment number rather than their name.

Files

Keep files filed by numbers and not by names. You will have a box of index cards, that will have their name on, linking this to the file. By keeping these two things separate and taking the box away after every clinic, it will protect the identity of the young person should the school files get broken into.

Sending letters home or referrals on

Ask the young person every time you want to send a letter to them at home or to a referral appointment. If they think someone else will open their post, have them come to collect the referral letter at the next clinic. Check what information you can pass on to hospitals and other agencies first.

Volume

Check before your first clinic how the noise from your room carries – and adjust your volume accordingly.

In the Waiting area

Radio

Where this is possible, having a radio playing keeps tensions at a minimum, passes the time better for those waiting and keeps any conversations in the clinic room out of earshot.

Doors

Keep your door closed properly when you have a conversation on the phone or with a young person.

Parents, police and teachers

They might try, and they can be very persuasive, but we never ever give out files or information to third parties unless the young person asks us to or consents to it. And even then you don’t have to. Try to speak with the person in private, talking in general terms about a clinic and why we have our policies. Parents usually calm down once they realise that our role is not to promote sexual activity and that we do lots of other things!

At meetings, training and supervision

If you want to try to talk about a particular young person try not to use the names of the individuals. Bear in mind that other people might recognise your description of a client so if possible change the gender or age of the case. In supervision remember to only bring up the relevant bits of information.

At home

Unfortunately, you cannot talk about your clinic visitors when you get home. If you need to unload find another colleague running a PREPARE clinic to share and get support.

And finally, away from the clinic:

You may meet a young person away from the clinic setting – either in the school corridor or in the town. You have to NOT recognise them. Take the lead from them. If they say hello and

acknowledge you then go ahead and say 'hi' of course. This can feel strange (ignoring a client) but it's really important to protect their confidentiality. You can pre-empt this by explaining this to them at clinic sessions.

6.3 Paperwork and Files

Paperwork can sometimes feel overwhelming, especially during busy times. But it protects you and the young person, and it goes some way to show the amount of work you are doing.

Clinic files and recording:

All learners paperwork will be filled in and filed at the clinic. PREPARE will provide loose forms to nurses which will be completed for each learner that visits the clinic and filed. There will be 1 file for each of the forms. i.e. daily register, learner assessment and referral form files.

Completion of Daily Register

Information on each learner seen should be recorded in the daily register. This serves as a record of all learners seen, but also facilitates collection and collation of data which will need to be forwarded to the PREPARE project and the PHC facility at the end of each month. The register is retained by the school health nurse as her record of all the learners who have been seen.

The learner's name and surname are recorded in the second column, and other relevant boxes are ticked (or left empty). Any treatment given must be recorded in the final column (for legal purposes). When the sheet is full, the totals can be tallied in the last row. This will facilitate collation of data at the end of the month.

Completion of Learner Assessment Form

The form aims to provide both a guide to assist the nurse in her assessment and as a recording form. The assessment as well as an action taken should be recorded.

> NOTE: Any information that may harm a learner (e.g. issues regarding the sexual and reproductive health of learners, their HIV status or that the learner was sexually abused) must not be noted on the assessment forms. This information is considered particularly sensitive and confidential. Where there is a need to record this information, it must be kept on file by the nurse.

Pink copy belongs to PREPARE and should be filed in PREPARE file. White copies should be handed to Phc every month. Standard procedures regarding maintenance of confidentiality around learner files should be followed.

Completion of Referral Letter to Service Provider

This form should be completed where learners require referral. Although learners will most often be referred to a health facility, they may also be referred to other services, such as a social worker.

The referral form is in triplicate and should be completed with care. Information that may harm the learner should it be read by someone other than a health professional must not be stated on this form. The learner should then access the service and present the referral form to the service provider. The nurse should complete the form in triplicate and keep the pink copy. The learner then takes the white and yellow copy to the referral facility. The health care provider should fill the form and keep the white copy and the learner should return the yellow copy to the school nurse. The nurse should keep the original pink copy in the clinic file and keep the yellow copy in the PREPARE file.

It should be noted that learners may be advised to seek additional services without being officially referred. This applies mostly to older learners with regard to sexual and reproductive health issues. For example, a sexually active learner is advised to access family planning services. Because this is not a “referral” there is no need to fill-in a referral letter or to list the learner in the referral list for the school. This is done to ensure privacy and confidentiality. Furthermore the learner will be able to request the services at the facility, so no referral is required.

However if the learner requests a referral letter either to the service, he/she should be provided with the completed forms.

Learner Passport

The learner passport is held by the learner. Encourage them to take it with them to any healthcare facility they may visit. The passport shows services the learner has received. The nurse should fill in the date and tick the relevant columns during consultation. No confidential information should be recorded in the passport.

INTEGRATED SCHOOL HEALTH PROGRAMME DAILY REGISTER

PLEASE WRITE CLEARLY AND PRESS FIRMLY

health
Department: Health
REPUBLIC OF SOUTH AFRICA

basic education
Department: Basic Education
REPUBLIC OF SOUTH AFRICA

PREPARE

Name of School:

Sub-district:

Name of School health Nurse:

Name of liaison person at school:

Date of visit:

~~Total number of Grade 1 learners:~~

~~Total number of Grade 4 learners:~~

Total number of Grade 8 learners:

Total number of Other Grade learners:

NB: Each visit to the school by the ISHP team should be captured. Follow-up visits should be captured on a new sheet.

			LEARNERS SCREENED								REFERRALS													ACTIONS				
	CEMIS No. (School registration No.)	Learners Name and Surname	~~Under 5 years~~	~~Over 5 years~~	~~Grade R screened~~	~~Grade 1 screened~~	~~Grade 4 screened~~	Grade 8 screened	~~Grade 10 screened~~	Other Grades	Underweight	Overweight	Fine motor abnormalities	Gross motor abnormalities	Oral abnormalities	Visual abnormalities	Hearing abnormalities	Speech abnormalities	Referred after TB screening	Minor ailment referral	Psycho-social care/ support	Mental Health assessment	Other referrals	6 yr Td given	12 yr Td given	Deworming treatment administered	Date Referral Followed up	Comments
1																												
2																												
3																												
4																												
5																												
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18																												
19																												
20																												
		TOTAL																										

WHITE - HEALTH WORKER/SCHOOL NURSE • YELLOW - SCHOOL • PINK - CLINIC

learner assessment form

REFERRAL LETTER TO CLINIC/PRIVATE HEALTH CARE PROVIDER : **CONFIDENTIAL** 000001

health
Department: Health
REPUBLIC OF SOUTH AFRICA

basic education
Department: Basic Education
REPUBLIC OF SOUTH AFRICA

PREPARE

PLEASE WRITE CLEARLY AND PRESS FIRMLY
REFERRAL:
WHITE + YELLOW - FORWARDED TOGETHER TO CLINIC/PRIVATE HEALTH CARE PROVIDER
PINK - KEPT BY SCHOOL HEALTH NURSE/HEALTH WORKER
REPLY:
WHITE (BOTTOM HALF ONLY) RETURNED TO SCHOOL PRINCIPAL BY CLINIC/PRIVATE HEALTH CARE PROVIDER
WHITE (TOP HALF) + YELLOW - KEPT BY CLINIC/PRIVATE HEALTH CARE PROVIDER

Dear Colleague

Re: Referral for Further Assessment

During routine health screening at ______________________ (School name),

______________________ (School address),

it was found that ______________________ (Name and surname of child),

may have a problem with ______________________

____

______________________ and may require further assessment.

Kindly complete the follow-up form below indicating the outcomes of the assessment, for attention of the School Principal.

Yours sincerely

______________________ ______________________ ______________
SIGNATURE (School Health Nurse / Health Worker) PRINT NAME DATE

FOLLOW-UP OF HEALTH ASSESSMENT : **CONFIDENTIAL** 000001

Dear School Principal

Re: Follow-up of Health Assessment

PREPARE

The following child ______________________ (add full name and surname of child)

was referred to us ______________________ (add name of clinic / private health care provider) for further assessment as a result of the Integrated School Health Screening Programme.

Further Assessment Required? ☐ *Yes* ☐ *No* *(tick whichever applicable).*

Follow up date: The child must return to the clinic for further treatment on ____________ (date) ________ (time).

Care and support at school level: The school can assist the child in the following ways:
(Add simple interventions e.g., 'sit at the front of the class' for vision problems)

____

____

____

Please do not hesitate to contact the clinic / private health care provider should you require additional information at

______________________ /______________________ (Contact numbers)

Yours sincerely

______________________ ______________________ ______________
SIGNATURE PRINT NAME DATE

referral form

SHS 5b : LEARNER ASSESSMENT FORM : SENIOR AND FET PHASES : **CONFIDENTIAL** 000001

health
Department: Health REPUBLIC OF SOUTH AFRICA

basic education
Department: Basic Education REPUBLIC OF SOUTH AFRICA

PREPARE

☐ FIRST VISIT ☐ FOLLOW-UP VISIT #1 ☐ FOLLOW-UP VISIT #2 Date:

Learners name + surname:

School:

Grade: Age: Sex: ☐ Male ☐ Female

PLEASE WRITE CLEARLY AND PRESS FIRMLY

SCREENING OR ON-SITE SERVICE	ADDITIONAL NOTES	ACTION (e.g. referral)
Consent ☐ No ☐ Yes Assent ☐ No ☐ Yes Referral ☐ No ☐ Yes If yes, circle one: Self Teacher Parent Other Date of last screening/treatment ________	Reason for teacher., parent or self-referral?	
NUTRITIONAL ASSESSMENT Height ________cm Weight ________kg BMI ________ Classification ☐ Stunting ☐ Normal ☐ Wasting ☐ At risk overweight ☐ Severe stunting ☐ Underweight ☐ Severe wasting ☐ Overweight ☐ Severe underweight ☐ Obese	RECORD Z-SCORES (SD) Weight for age ________kg Height for age ________cm BMI for age ________kg	
EYES Discharge ☐ No ☐ Yes Inflammation ☐ No ☐ Yes Squint ☐ No ☐ Yes Other abnormalities ☐ No ☐ Yes VISION Wears glasses ☐ No ☐ Yes NPC > 6cm ☐ No ☐ Yes No glasses: Right eye 6/ Left eye 6/ With glasses: Right eye 6/ Left eye 6/	Record other abnormalities:	
ORAL HEALTH Dental caries ☐ No ☐ Yes Thrush or sores ☐ No ☐ Yes Gum disease ☐ No ☐ Yes Other abnormalities ☐ No ☐ Yes	Record other abnormalities:	Oral health staff on site? ☐ No ☐ Yes Treatment:
EARS Discharge ☐ R ☐ L ☐ No Inflamed eardrum ☐ R ☐ L ☐ No Wax impaction ☐ R ☐ L ☐ No Other abnormalities ☐ R ☐ L ☐ No Wears hearing aid ☐ No ☐ Yes ☐ R ☐ L	Record other abnormalities:	
TB SCREENING 1. Cough ☐ No ☐ Yes 3. Hot body/fever ☐ No ☐ Yes 2. Weight loss ☐ No ☐ Yes 4. Night sweats ☐ No ☐ Yes	Abnormalities detected?	
IMMUNIZATION ☐ No ☐ Yes ☐ 12yr Td (NB can be given between 12 to 14 years)	Any outstanding?	
MINOR AILMENTS (skin condition/head lice Record ailment ☐	Treatment given?	
ANAEMIA SCREENING Pallor ☐ No ☐ Mild ☐ Severe ~~Hb (all girls. Boys if pallor present) ______g/dl~~	Advice given?	
SEXUAL AND REPRODUCTIVE HEALTH COUNSELLING Advice on Menstruation ☐ No ☐ Yes Advice on medical male circumcision ☐ No ☐ Yes Other advice given ☐ No ☐ Yes		
OTHER IDENTIFIED PROBLEMS Long-term health problems ☐ No ☐ Yes	Is care adequate? Are additional services required? Record action:	
OTHER: INTERPERSONAL STRESS SCREENING What is stressing you at school? What is stressing you at home? What is stressing you with your friends? What is stressing you with people of the opposite sex?	Is care adequate? Are additional services required? Record action:	

WHITE - HEALTH WORKER/SCHOOL NURSE • PINK - CLINIC

QUINTILE: ________ PROVINCE: ________ DISTRICT: ________ SUB-DISTRICT________

learner passport

Learner First Name | Surname | Date of Birth | Grade | Date of first screening

		Date	Date	Date	Date	Referral	Follow-up
Vision Screening	Yes / No						
Hearing Screening	Yes / No						
Speech Screening	Yes / No						
Oral Health Examination	Yes / No						
TB Screening	Yes / No						
Blood Sugar Test	Yes / No						
Body Mass Index / Weight and height	Yes / No						
Physical Assessment (Gross and Fine Motor)	Yes / No						
Deworming Medication Given	Yes / No						
12 Yrs Tetanus and diphtheria (Td)	Yes / No						
Rotavirus Vaccine	Yes / No						
Pneumococcal vaccine (PCV)	Yes / No						
Measles 2nd Dose	Yes / No						
Other Immunizations	Yes / No						
Psychosocial Care and Support screening	Yes / No						
HIV Counselling ~~and Testing~~ (Do not record result)	Done/Not Done						
Know your body information (Provided)	Yes / No						
Sexual Reproductive Health Rights (Information)	Yes / No						
Life Style Information (Drugs, Alcohol, Smoking and Diet)	Yes / No						
Male Medical Circumcision (Information)	Yes / No						
Other	Yes / No						

The results of the above interventions are kept confidentially in the learner profile and can only be released with Authorization.

6.4 Protecting personal property and protecting yourself

You may never need to protect your personal things, but it is better to have the 'just in case' mentality. So during clinic you should lock your (and your co-worker's) personal belongings away. This protects you and your clients. It is better not to provide the opportunity.

You should always leave the clinic and school property together. Make sure you have agreed with the school how the building is left as secure as possible and who to contact in the event of key loss or other incident.

6.5 Health and Safety

It is PREPARE's policy, so far as is reasonably practicable, to ensure the health and safety at work of all its employees and of all other persons and members of the public.

It is a duty of us all to exercise personal responsibility and to do everything within our power to prevent injury to ourselves, our colleagues and all others who may be affected by our acts or omissions by, for example:

- working safely and efficiently;
- adhering to health and safety rules and procedures, including providing adequate warning of hazardous areas to other staff and the public;
- reporting, as soon as possible, incidents or defects that may have led or may lead to injury, and report these through the usual channels;
- co-operating in the investigation of accidents to aid prevention of a re-occurrence;
- undergoing suitable and appropriate training to fulfil their responsibilities as employees.

It's best to familiarise themselves with the location of First Aid Boxes, to know Emergency Procedures and where the fire exits are at the clinic/school.

Cleanliness

Desk tops and floor space around desks should be kept tidy. Flammable material should not be left near heaters.

Storage and stacking

Shelves (if you have them) should not be overloaded. Use a ladder to reach high shelves; do not climb on desks or chairs. Do not lift heavy loads without assistance. Desk and filing cabinet drawers and cupboard doors must be kept shut when not in use. Never open more than one filing cabinet drawer at a time.

Waiting areas

Keep waiting areas clear of obstructions. Do not leave materials where people can trip over them. Do not allow wires or cables to trail across walkways.

Electrical equipment

Any faults with plugs and cables need to be reported.

Heaters

Do not cover heaters. Do not store paper or other flammable material near heaters.

6.6 Equal opportunities and diversity statement

Declaration

I am committed to promoting equal opportunities and valuing diversity. I will strive to achieve this throughout employment practice, service provision, policy work and communications. I aim to treat current and potential clients, staff and volunteers with fairness, dignity and respect regardless of age, disability, HIV status, gender, race, ethnicity, sexuality, family situation, trade union activities, beliefs, religion or economic and social standing and to meet the identified needs and priorities of the young people.

I agree with the following objectives:

- To provide services that are accessible and acceptable to all young people
- To meet the needs of diverse and hard to reach groups
- To follow practices that are fair and promote diversity
- To provide equal opportunities for all staff and volunteers, ensuring that all are treated with dignity and respect
- To represent the interests of all young people in relation to their sexual health and wellbeing and to be proactive in challenging inequality
- I will adhere to measures introduced by my organisation to make sure there is equal opportunity and non-discrimination. I am required to show respect to others and must not harass, abuse or intimidate other employees on any grounds or victimise individuals because they have made complaints or provided information about discrimination or harassment.

Implementation points

I will

- Provide services that are accessible and acceptable to all young people and those involved in promoting their health.
- Involve young people, particularly those from high risk and hard to reach communities, in identification of local needs and the evaluation of service provision.
- Develop and display information and publicity materials that include images and information relevant to diverse groups of young people.
- Display signs making it clear that harassment, abuse or intimidation of other clients or staff on any grounds will not be tolerated.
- Ensure, as far as possible, that premises are accessible.
- Use signposting that is clear and user friendly, giving particular thought to the needs of people with visual impairments or literacy problems.

7 Protecting young people

7.1 Confidentiality

PREPARE is committed to providing a confidential health service to young people.

This means that no identifiable information is passed to anyone or any other agency, without the express permission of the client, other than in the most exceptional circumstances where you feel that a young person is at serious risk of harm or where there is a statutory requirement to do so.

Research shows that young people want a confidential source of advice about their health and particularly their sexual health. Therefore fears about a lack of confidentiality deter many from seeking help. It is officially recognised that unless services give a clear assurance of confidentiality, they will not be used. [26]

You are encouraged to share any concerns about clients with other members of the team in order to promote effective mutual support within the team. However, careful consideration should be given in deciding whether or not to reveal details which would personally identify the young person to your colleague(s).

Suggestions for maintaining a confidential service:

Registering young people

- Explain the confidentiality of the service, i.e. no-one will be informed about the young person's visit without permission unless it is believed they are in danger, and then they would be informed first;
- that they will not be contacted at home unless willing;
- that they may see their records but that no-one else can have access without the young person's permission.
- Always ask if it's okay to use their home address - if not get a contact address, or another appropriate method of contact, and check it at each visit. It is helpful to have some way of contacting the young person so that safeguarding concerns can be followed up and in the rare event that confidentiality has to be breached, they can be informed first.
- Make sure the client's notes are clearly marked to indicate no contact at home
- Check if the client is willing to have their doctor contacted (and check it at each visit)

Telephone Calls

- Learn techniques for handling appointments and enquiries without giving away confidential information, such as: Not repeating clients' names which might be overheard by visitors or other clients Not giving or confirming information about clients or their appointments Telephoning back to doctors, hospitals, laboratories, social services or other agencies to allow time for checking young person's notes for permission to disclose information
- Remember that the person on the telephone may not be who they say they are
- Be alert to the possibility that clients are being overheard at their end of the telephone: ask 'is it difficult to talk?' and explain that you will phrase your questions so that callers can answer 'yes' or 'no'
- Messages should never be left with third parties or on voicemail or answer machines or sent by text or email without the prior consent of the young person.

Referrals

- If the young person has requested strict confidentiality (e.g. no contact at home or with the doctor) this must be communicated to the agency referred to and clearly recorded on all paperwork.

During the clinic visit

- Ensure that the door to the clinic room is properly closed when talking with or examining clients.
- If young people are accompanied by a parent, carer, partner or friend they should always still be offered a private consultation. Some clients may choose to be accompanied during the consultation but they should always be seen in private initially in order to be able to make that choice of their own accord.
- Speak in a clear but low voice that cannot easily be overheard outside the clinic room.
- Place notes so that the young person cannot read the name on another young person's file.
- Ensure that any completed referral forms, samples are not visible to other young people.
- When taking a phone call do not use the young person's name if you have another young person in the room.
- If it is a sensitive call arrange to call back or ask the young person to call at the end of the clinic.
- Disclosures of harm/abuse must be handled according to local procedures and guidelines.
- Other agencies should not be allowed access to individual records.
- Young people should be made aware of how and where their records will be stored.

Observation of consultations

Occasionally, students and other colleagues such as health professionals from other settings (including potential employees) may observe client consultations as part of their development.

In such circumstances, it is vital that the young person understands the situation and is explicitly asked to give their consent to be observed *before* the observer enters the clinic room. Permission should be sought in private, not in the waiting room or reception area, and without the observer present.

The young person should be told they may ask the observer to leave at any point and you should be sensitive to clients who appear uncomfortable or reluctant to answer questions, in which case the worker should ask the observer to leave.

Deceased clients

Deceased clients remain entitled to confidentiality.

Loss of client data

In the event that any client data is lost the Prinicpal investigator (Dr Catherine Mathews) must be notified immediately.

Parental requests for client information

The service will be provided to all Grade 8s in the school. It is a universal service. However for repeat visits to the clinic it is important not to confirm that the young person has been to the clinic or for what purpose.

Information provided by parents/guardians

Occasionally, a parent or guardian may contact you by telephone or in writing to tell you that they are aware that their child is a client but that they are concerned that their child is not aware of, or has failed to communicate an important piece of information that could alter the health advice or treatment offered. You should never confirm that the young person is a client or not.

Encourage the parent to speak to their child directly. The parent should be advised that they can write with details of the important piece of information, along with the young person's full name and date of birth. It should be explained that this letter will be kept on file but that, if indeed the young person is a client, they will be told about the letter upon their next visit. The young person is your client first and foremost.

Other requests for information

All requests for disclosure of information should be referred to your manager/the project Principal Investigator. Police with a search warrant can search for 'relevant evidence' to help in the detection of crime, but, even so, generally do not have a right of access to confidential information.

The courts have the power to require the disclosure of confidential information in some situations, such as where it is in the public interest, or where there is a statutory duty, or an order of the court.

7.2 Appropriate behaviour in working with young people

Staff will be in a relationship of trust with the young people who attend the clinic. A position of trust can be described as one in which one party is in a position of power or influence over the other by virtue of their work or the nature of their activity. Staff are expected to maintain that relationship of trust.

These guidelines are intended to prevent staff from deliberately or inadvertently entering into inappropriate behaviour with a young person. It is intended to protect both young people and yourself. The principles apply to all staff who work in the PREPARE school-based clinics.

Behaviour which is likely to be in breach of a position of trust may take different forms, including physical, verbal, psychological, sexual or other behaviour. The Code of Conduct outlines what we regard as appropriate and inappropriate behaviour with young people. The circumstances listed cannot be regarded as exhaustive but are intended to act as a general guide as to what would be regarded as acceptable and unacceptable behaviour by a member of staff.

Code of conduct:

- Staff must respect young people and their right to confidentiality
- Staff should be aware of situations that present risk to the young people or themselves and take steps to manage these
- Staff should inform their manager of any outside activity or employment which could be perceived as a potential conflict of interest with PREPARE's ethos and values
- Staff should help ensure that a culture of openness exists so that clients and staff feel able to raise issues of concern
- Staff working practices should empower young people to know their rights, what is acceptable and unacceptable and what they can do if there is a problem or they are unhappy about something
- Staff should always explain to clients the reasons why sensitive personal questions have to be asked
- Staff should check that clients are satisfied with the service they have received and listen to what they say.

Inappropriate Behaviour

The following is an illustration of behaviour that would be regarded as inappropriate. Again, It is not intended to be an exhaustive description.

- Sexual relationships between staff and clients are wrong and any behaviour that might allow such a relationship to develop must be avoided.
- Sexual activity between a member of staff/volunteer and a young person is a breach of their position of trust. Sexual activity would include sexual intercourse, masturbation, oral sex, sexual harassment, bullying, blackmailing, bribing, propositioning, inappropriate sexual remarks or other sexual activity that a reasonable observer would consider was sexual in all the circumstances.

- Staff must not make remarks of a sexual nature to clients and/or engage in sexual discussions which have no relevance to the client’s care.
- Any physical contact which harms young people or is likely to cause them unnecessary and avoidable pain and distress is inappropriate.

Staff must avoid actions or behaviour that could be construed as poor practice or potentially abusive. For example they should never:

- Demonstrate disrespect for the young people through verbal or non-verbal behaviour
- Make remarks which may be perceived to be demeaning, humiliating, intimidating
- Take a young person to their home
- Visit young people in their homes unless the nature of their job demands it
- Make contact with a young person outside of working hours, in person, by telephone, email or other methods of communication.Where it is deemed necessary, the prior consent of the Director must be obtained
- Ask clients to give personal details about themselves which have no relevance to their care
- Disclose your personal information to young people including personal contact details
- Disclose personal sexual experience or opinions to clients
- Collude with young people if their actions or attitudes are harmful or negative to others.

Raising concerns

If you are concerned about the behaviour of other members of staff, volunteers or other professionals you are encouraged to raise that concern. This includes a duty to raise concerns that arise within the context of partnership or multi-agency working.

There are many reasons why staff may be reluctant to raise concerns or make a complaint about a colleague. Concern about getting it wrong, fear of victimisation or a sense of loyalty to colleagues are major factors which inhibit reporting but it is essential, where suspicions do exist, to focus on the welfare of the young person.

Any behaviour listed as inappropriate by the ‘Code of Conduct’ should be formally reported so that it can be investigated.

It is equally important to raise concerns about failure to observe good practice as this may be an indication of inappropriate behaviour or may highlight a training need. Such concerns should also be reported to your manager and the Principal Investigator (Dr Catherine Mathews).

If you make a complaint in writing about another member of staff you should be aware that it may be held in their employment file to which they are entitled to request access. If you make a verbal complaint you may request that it remains anonymous.

Staff who are concerned that they themselves are developing a relationship which could represent an abuse of trust, who are concerned that a client is becoming attracted to them or who are concerned that their actions or words have been misunderstood, should speak to their manager as a matter of urgency.

Complaints by young people

Young people may make complaints verbally or in writing. Any concern raised verbally with you should be reported as a matter of urgency. The staff member should explain to the client that this is required so that the matter can be investigated and appropriate action taken.

Investigating complaints

Complaints made by staff or clients about inappropriate behaviour will be dealt with as necessary. After the complaint has been made an initial meeting will be held with the person against whom the complaint has been made. If a complaint is upheld the seriousness of the incident will determine the action to be taken.

Staff or volunteers who are suspected of having behaved inappropriately may be subject to disciplinary procedures. The seriousness of the incident will determine the action taken, but dismissal for gross misconduct is a possible sanction. Some allegations may be so serious as to require immediate referral to the police for investigation.

7.3 The legal and professional framework

Confidentiality Article 16 of the UN Convention on the Rights of the Child gives people a right to respect for their private and family life. [11]

HIV testing

Currently, children can consent independently to an HIV test from the age of 12, when it is in their best interests, and below the age of 12 if they demonstrate 'sufficient maturity': they must be able to understand the benefits, risks and social implications of an HIV test. [12]

Access to contraceptives

Currently, children can consent to contraceptives and contraceptive advice from the age of 12.

Termination of pregnancy

Currently, girls can consent to a termination of pregnancy at any age.

Consent to medical treatment

Young people over the age of 12 can consent to medical treatment without parental involvement if they have sufficient maturity and judgement to enable them fully to understand what is proposed. [13]

It is good practice to follow the criteria known as the Fraser Guidelines for under 16's which require the professional to be satisfied: [14]

- That the young person could understand the advice and had sufficient maturity to understand what was involved in terms of the moral, social and emotional implications
- That you could neither persuade the young person to inform the parents, nor to allow you to inform them, that contraceptive advice was being sought
- That the young person would be very likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment
- That, without contraceptive advice or treatment, the young person's physical or mental health, or both, would be likely to suffer
- That the young person's best interests required you to give contraceptive advice, treatment or both without parental consent.

Young people under the age of 16 have as great a right to confidentiality as any other person in your care. If someone under 16 is not judged mature enough to consent to treatment, the consultation itself can still remain confidential.

It should not be assumed that young people lack the ability to make decisions if they have a learning disability. The key factor is their ability to weigh-up the information needed to make a decision, and if information is presented in an appropriate format, many people with learning disabilities will be able to consent to their own treatment.

Consent to sexual relationships

Sexual offences legislation assumes that children and young people under 12 do not have the capacity to consent to sex and that the consent of 12-15 year olds is immaterial in order to protect them from abuse and exploitation. The fact that someone under 16 gives consent to sexual activity is only relevant in law in that it may absolve the defendant from being charged with a non-consensual offence such as rape or indecent assault where the child is over 13. However, young people are unlikely to be prosecuted for mutually agreed sexual activity where there is no evidence of exploitation.

A person may not have the freedom to consent because she/he is forced by, for example, violence or threat of violence, to engage in sexual activity. A person may not have the capacity to consent to sexual activity because of, for instance, a mental health issue.

It is an offence to intentionally engage in sexual touching with a young person aged 12, 13, 14 or 15. ‘Touching’ covers all physical contact, including touching with any part of the body, with anything else and through anything, for example, through clothing. It includes penetration.

Young people under 12 are regarded by the law as unable to consent to sexual activity. Intentional sexual touching of a young person under 12 is an absolute offence.

Homosexual intercourse between men is legal provided both are 16 or over and the act takes place in private.

The only offence concerned with lesbianism is that of indecent assault. Therefore, provided both women consent and neither is under the age of 16, acts of lesbianism are legal.

It is an offence for a person of 18 or over to engage in sexual activity with a person under that age where there is a position of trust between them.

Sexual images of children

It is an offence to take, distribute and possess an indecent photograph of a child or young person under 18. ‘Sexting’ - taking explicit photographs of yourself or others and forwarding the images to other people - is likely to be covered by these offences. However, the intention of these offences is to protect young people from harm so whether action would be taken where young people have acted consensually is a different matter. As with other sexual offences prosecution tends to be reserved for cases where there has been duress, disparity of age, or exploitation.

Social, cultural and religious practices

Every child has the right not to be subjected to social, cultural and religious practices which are detrimental to his or her wellbeing. Genital mutilation or the circumcision of female children is prohibited. Virginity testing of children under the age of 16 is prohibited. Circumcision of male children under the age of 18 is prohibited, except when a religious practice is concerned

and in the manner prescribed; or if circumcision is performed for medical reasons on the recommendation of a medical practitioner. Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision.

Information on health care

Every child has the right to have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction; have access to information regarding his or her health status; have access to information regarding the causes and treatment of his or her health status; and confidentiality regarding his or her health status.

8 Helping with Specific Situations

"Wherever there is a human in need, there is an opportunity for kindness and to make a difference."

In this section there are guidelines for helping with some of the bigger issues that may come up in the clinic session. Included are guidelines which already exist or which are drawn from consultations with young people who have given us insight as how to best serve their needs. Of course a young person may present with several of these happening in his or her life all at once. Then you have to get creative – and remember that your willingness to try and help will speak volumes to a young person.

8.1 Pregnancy [15]

A pregnancy test request may come loaded with a whole range of fears and anxieties. She may have no idea how pregnancy happens and be in a state of shock. The possible pregnancy may be from a violent sexual experience or she may have been using contraception but has accidentally fallen pregnant. She may be trying to get pregnant and need encouragement and support if she is pregnant – even if it's not what we think is best for her future.

Your main role will be to support her to explore all of her options in relation to pregnancy outcomes: to consider the possible short, medium and long-term implications of those options, and to reach a confident decision that she feels is the right one for her.

You can talk to her in confidence about all her options.

'The nurse spent a long time with me before we actually did the test, asking about how I'd feel if the test was negative, or positive. When I got the result it was so much better because I had had a chance to think already about what I wanted. It was less of a shock.'

'She could just handle anything I said. It was all okay and I was so worried that she would judge me and make me feel guilty.'

Young women need to be able to access timely, accurate information and support. This can help them explore their options and reach a confident, informed decision that they consider right for them. It can help to ensure that they are referred as quickly as possible to the appropriate service whether that is for abortion or for antenatal advice and information. Young women may be vulnerable to pressure and coercion and may need support to help them identify their own needs and desires in relation to pregnancy. Research suggests that the outcomes for the woman are more positive if she has had the opportunity to make an informed decision about her pregnancy, to recognise that the decision is hers and to acknowledge responsibility for her decision.

Young women experiencing unintended pregnancy can find seeking help extremely challenging. They can be reluctant to talk to health professionals at first. Young people are most likely to want to talk to someone they already know e.g. a teacher, youth worker, or care worker. Many of these people are skilled at listening to and talking about personal problems and dilemmas with their clients and those in their care, but feel anxious and unsure about discussing pregnancy choices, even though the topic is one that they are frequently asked to address. Often their automatic response to a request for support on pregnancy is to signpost their client to another service.

This is a missed opportunity. It can take a young woman some time to decide to seek help and often the first professional a young person presents to is the one person she feels comfortable with. If this professional can provide some immediate information, reassurance and guidance for a 'supported referral', it can increase the speed with which the young person accesses appropriate health professionals. Some young women fall through the gap between their known and trusted professional and the service to which they have been signposted, leading to the continuation of a pregnancy by default rather than choice, delayed access to antenatal care or delayed access to abortion services.

Pregnancy, abortion, religion and culture

Professionals can often feel wary of raising the issue of abortion or adoption because of religious concerns. Their concerns about a particular culture's views on these issues may stem from familiarity OR ignorance of the culture. Either way it might lead them to avoid the topic, assuming that it is too much of a taboo, or for fear of offending the client or losing their trust. In order to ensure that all users of the clinic are offered a non-judgmental and non-discriminatory service, every young woman should be provided with a brief explanation of all the options available. This keeps the conversation general before moving to her specific needs, and allows her to identify those that she feels she could consider and those that are unacceptable to her.

It may be a client feels she has to end her pregnancy in order to conceal from her family that she has been sexually active. She may come from a community in which abortion is the norm for women who become pregnant outside of marriage. Conversely, she may experience pressure from her family to continue with her pregnancy because of their views on abortion or because early motherhood is the norm in her community. It is essential that she is given an opportunity to consider all the options for herself and that she knows what support there would be for her outside the family for each of the pregnancy options.

Professionals' personal views

Many people have strong personal views on the different pregnancy options because of their religion, culture or personal experience. Additionally professionals might have pre-conceived ideas about individual clients and how each pregnancy option might impact on them. For example, many people assume that abortion is always traumatic, though research demonstrates that abortion rarely leads to psychological illness and most women do not regret their decision.

It is essential that the professional's personal views or concerns are not an obstacle to providing client-centred support to all service-users.

What do professionals need to provide?

- A safe, confidential space in which the young person can identify her own hopes, fears, needs and desires in relation to this pregnancy, her relationships, and her future
- A realistic timeframe for making a decision
- Accurate, accessible, and young people-friendly, evidence-based information about pregnancy, parenthood, abortion and adoption from reputable sources
- Decision-making techniques which facilitate a non-judgmental exploration of all the options
- An opportunity to consider the client's existing support networks, and help to identify appropriate people she can talk to
- Support to communicate with parents or carers and partner
- Supported referral into the appropriate medical service.

Who can provide this support?

- Professionals with non-judgmental listening skills and clearly defined personal and professional boundaries
- Professionals who will provide a supported referral to a trained counsellor or other specialist service if they identify that their clients' complex emotional needs are beyond the scope of their work
- Professionals who have considered their own beliefs and values and feel genuinely able to provide non-judgmental support for all pregnancy options
- Research suggests that the emotional outcome is more positive for a woman when she has confidence that the decision she has made is right for her.

Some young people will already have decided what they want to do in relation to their pregnancy and may feel reluctant to explore the decision they have made. However, they might not actually know about or fully understand all their options or have taken the time to consider them all. Often they will accept the opportunity to consider the degree of confidence they have in the decision reached as long as they understand why the opportunity is offered and are reassured that nobody is going to try to change their mind.

Some people feel they can reach the right decision about their pregnancy. Others find they struggle to have confidence in their decision. Fear of making the wrong decision can lead to no decision being reached. For those who are unable to feel there is a right decision, supportive discussion can give them the confidence that they have at least reached a decision for the right reasons.

Decision-making support in practice

First things first – confirming the pregnancy

Your first priority is to confirm the pregnancy. Has she already had a positive pregnancy test result? If not, find out why she thinks she may be pregnant, when she menstruated last, whether she has had unprotected sex since then, and if so when.

This discussion will help you:

- to establish if her need is for emergency contraception rather than a pregnancy test
- to estimate the gestation of the pregnancy in the event that she is pregnant
- to understand her patterns of contraceptive use/lack of use to inform future contraceptive planning.

Negative result

If the result is negative, your client should take another test after a week and again if she fails to menstruate after that, as pregnancy tests can show false negatives if taken too early. In the meantime she should ideally abstain from sex, or use condoms correctly and consistently until she has a period. If she chooses to use another contraceptive method she should continue to use condoms as well in order to protect herself against STIs.

Whatever the result, your client has been at risk of pregnancy and therefore needs to consider her future contraceptive use. The relief expressed by someone receiving a negative test result is a good starting point for a conversation about accessing and using an effective contraceptive method. A young woman who expresses disappointment at a negative result might be prepared to discuss with you her desire for pregnancy and how that fits into her current relationship, circumstances and life plans.

Timeframe for decision-making

Although making a decision about pregnancy is often a process rather than a one-off discussion, it is necessarily time-limited. Let your client know how often she can be seen and when – allowing two days, ideally, between sessions to give her time to reflect on the discussion/s so far and to read any information leaflets. She can make a booking for an appointment in the local abortion service even if at this stage she is not absolutely sure of her wish to have an abortion and wants to continue discussing it with you. This might be especially appropriate if there is a long waiting time locally either for a first appointment or between initial consultation and abortion procedure. Women can change their mind about having an abortion right up to the time of the procedure.

Things to discuss

- Her feelings about her pregnancy
- Whether she knows about the three options: parenthood, adoption or abortion
- Whether she has, or hopes for, support and involvement from her partner
- The potential impact of each option on her relationships with those significant to her
- Her belief system about parenthood/abortion/adoption and what or who has influenced it
- Her hopes and plans for the future and how they might be affected by each option
- Her current life circumstances
- Who else she has spoken to
- What support she needs in relation to accessing continuing pregnancy/abortion services
- What support she needs in accessing other specialist services
- Future contraceptive planning.

Strategies to encourage discussion

All pregnancy options need to be fully considered in order for the young person (and you) to have confidence in the decision. She might say that she has already decided what to do and doesn't need to think about all of the options. A good question to ask in this situation is "What has brought you to the decision to...?" and to give her the space to revisit and review her decision-making process and assess whether she feels that she has made an informed and reasoned decision. Ask what would have to be different for her to make a different decision. Sometimes this can help identify the way in which those around her are influencing her decision

or help her further assess the confidence she has in the decision she's reached.

The young woman may have ruled out one option without discussion. For example, many consider adoption the most difficult option of all. Being able to take the time to consider all options and rule out ones that the client feels is not acceptable to her can again contribute to her confidence in decision-making. It can be useful for the client who discounts an option to consider "what is it about this option that makes it unacceptable to me?"

What would you do? The role of the professional in decision-making

Some young women don't know how they feel about the news that they are pregnant. They may never have had to make an important decision before and don't know where to start. They may want someone to make a decision for them. They might ask 'what would you do?'

For a client who asks 'what would you do?' it can be useful to ask the young person "If I was to make a decision for you, what would be important for me to take into account? What things would you want me to think about to come to a decision?" This can help the young person consider their feelings in a more externalised and less threatening way.

In order to clarify their roles it might be helpful both for the professional and the young person to consider the following analogies for the process of supported decision-making:

- *A pros and cons list*- This can include everything from the most significant factors to the most trivial: practical factors as well as emotional ones. After completing the list the young person can rank the importance of the different factors (from 1 to 5 for example) and add up the points so that the balance of factors in favour of and against having a baby at this time starts to emerge. Sometimes in spite of overwhelming evidence against continuing with the pregnancy or having an abortion, it becomes clear that this is what your client wants. Then the pros and cons list can become a useful tool for identifying what support she will need in order to act on her choice.
- *Envisaging the future*- By annotating simple stick drawings, your client can represent the way she wanted or pictured her life to be in 2 years time and in 5 years time, before she became pregnant. She can then add to and amend the same drawings to describe her idea of what her future would actually be like if she went ahead with this pregnancy or had an abortion. This can help her to identify the gap between her idealised version of her life and a realistic version of life depending on her decision.
- *Represent her support networks*- by writing her name in the centre of a piece of paper. Then add her friends, family members, partner, and any professionals she is in contact with using the distance away from her on the paper to represent the importance of their influence and their potential for supporting her.
- *Draw a figure with a head and a heart and a hand*- to represent the different aspects of the decision. Any words that represent her feelings about this pregnancy, about abortion, about motherhood, about her relationship with her partner and family can be linked to the heart. Help her to identify whether the thoughts and feelings are hers or whether some of the words are more representative of other people's thoughts and feelings. Any words representing her practical concerns can be attached to the head. Some of the head words will be questions that you can answer or help her find the answer to or problems that have practical solutions. Finally words coming off the hand can represent all the practical things she has to help her deal with the dilemma and the outcome such as her personality and her skills e.g. strong, stubborn, sense of humour, nice, imaginative, positive, good with children, decisive, sensible ... etc.

For all the exercises above, be prepared to write or draw yourself unless the young person wants to do it herself. It might help to have prepared cards with some of the common words and phrases used in these exercises, simple pictures or symbols to represent different emotions and print-outs of stick figures etc.

Using role-play you can rehearse the conversations she needs to have with others around her. This can help her to practise the actual vocabulary she will need in talking to them and to predict a range of reactions.

Telling it as a story- Using open questions find out what her thoughts, feelings and actions have been since finding out she's pregnant. This can elicit a lot of information. Start by considering at what point she started to suspect she might be pregnant? What was she thinking/feeling at that point? When she had decided to take a pregnancy test what did she hope the result would be? At that point was she able to consider 'what if ... ?' How does she feel now? Has anything changed and if so what brought about the changes?

Some clients find it helpful to write down the reasons for their decision to refer to at a later point in time. The process of writing down their thoughts about their current circumstances and how pregnancy fits into this and their plans and aspirations can be a helpful process. It can also leave them with something to look at it in future if they begin to doubt or question.

8.2 Abortion [15] [16]

"A little less hypocrisy and a little more tolerance towards oneself can only have good results in respect for our neighbour; for we are all too prone to transfer to our fellows the injustice and violence we inflict upon our own natures."

Carl Gustav Jung (1875-1961)

In 1997, South Africa became the only country in the world to legislate access to abortion services. The Choice on Termination of Pregnancy Act not only affirmed the right of women to choose abortion, it also encouraged the development and integration of abortion as part of reproductive health services at the primary health care level.

Although any young person of any age can self-refer into abortion services if you can offer to do this with them/for them it may be easier. It is important to support them in finding the clinic, phoning the clinic and explaining what is going to happen.

Who has abortions?

Lots of women have abortions –so there's no such thing as the kind of woman who has an abortion! That means that although it's not spoken about very often, everyone already knows someone who's had an abortion

Why do women have abortions?

Because they don't want, or are unable to have a child (or another child) at this point in their life. This could be for many different reasons. Some common ones are:

- She wants to carry on with her job/education/career
- She feels too young to be a parent

- She already has children and feels too old to start again
- She does not have the support she needs from her partner or her family
- She cannot provide for the child right now
- She does not feel this is the right relationship in which to start her family
- She does not want to have children
- Her contraception failed because no method is 100% reliable and one of the above reasons also applies.

Is abortion safe?

Abortion is safe – in fact it is safer than pregnancy and childbirth provided it is carried out at a proper clinic. It is rare that complications arise from abortion. There may be small of risk of infection. Abortion does not affect fertility.

Can I talk to a young person about abortion in confidence?

A young person has the right to talk to a doctor or nurse in complete confidence about issues concerning his or her health and welfare. The only reason a medical professional can share information with another professional is if sharing that information is necessary to protect a child from harm or abuse. Even in this situation the young person should be informed of who else needs to know and why.

The same rules apply on confidentiality for under 16s. Unless disclosure is necessary to protect a young person or child from harm or abuse, any discussion with a medical professional should remain confidential.

Even if a doctor decides that a young person is not mature enough to make a decision about their treatment, the conversation should remain confidential.

How can I help a young man whose girlfriend is pregnant?

Although a man does not have a legal right to decide whether or not his partner should continue with or end her pregnancy he may have very strong feelings about what he would like her to do and may find it helpful to share his thoughts and feelings with you.

He might not know whether it is appropriate to share his feelings with his girlfriend, but it can be useful for him and for her to have an honest discussion about what they want to do. Even if they do not ultimately agree, he may find it easier to come to terms with her decision and to support her if he has had a chance to hear her thoughts about the pregnancy. Her decision too should be informed by an understanding of what he wants her to do and why.

If the young man's girlfriend chooses to go ahead with the pregnancy he might need to take financial as well as parental responsibility.

Why talk to young people? Because...

- They have a right to comprehensive sex- and relationships education.
- Abortion is a legally available option that young people are entitled to know about.
- So that young people can acknowledge and consider different points of view.
- To encourage empathy and understanding.
- To explore myths and clarify facts.
- To give information.

- To reduce the stigma and taboo associated with it.
- To give young people an opportunity to explore the issues before ever needing to cope with a real situation.
- So that young people know that if they or their partner ever experience unintended pregnancy or abortion, they're not alone.
- To make it a safe subject to discuss.
- To direct them to appropriate sources of help and advice.
- So young people know their rights.
- To enable an informed choice.

To avoid unintended pregnancy

Unintended pregnancy is experienced by far too many young people. It's essential, therefore, that young people have the opportunity to consider all of their options around pregnancy – one of those options is abortion.

Talking to young people about abortion means they can explore fully the issues unintended pregnancy presents -in doing so they are better placed both to avoid unintended pregnancy in the first place, and to manage it should it ever become a reality.

Because young people will hear about it anyway

Abortion features regularly in newspaper headlines, in film and on TV. It might be discussed by friends or by family at home, school or work. Providing an environment in which young people can reach their own conclusions and learn the facts about abortion is essential to informed choice. Addressing abortion within sex and relationships or religious education provides the ideal opportunity to explore the issue in a safe and engaging way.

Because young people need accurate information

Outside of formal education there may be far fewer opportunities for a young person to receive accurate and impartial information and advice about pregnancy or abortion. Where advice is sought it is likely to be because the young person already suspects or has confirmed a pregnancy. Enabling a young person to access support, to explore and weigh-up each of her options and to reach her own decision is essential to securing a good outcome for her.

8.3 Supporting clients who are Lesbian, Gay, Bisexual, Transgender (LGBT) or Questioning their Sexuality

"All young people, regardless of sexual orientation or identity, deserve a safe and supportive environment in which to achieve their full potential."

Harvey Milk

In 76 countries around the world being LGBT is a criminal offense. In 10, it is legal grounds for execution or life imprisonment. Even in countries where LGBT people have secured basic

rights, many LGBT people are denied the opportunity to live full and equal lives and endure daily homophobia.

Violence and abuse are never okay. Sometimes we may have a difficult time accepting that people are gay, lesbian, bisexual and everything in-between, but they are. And it's okay! Who somebody feels attracted to is something they feel from their heart. The capacity to love is amazing and should be at all times encouraged and celebrated.

- What someone says they are, may be very different to your idea when faced with their sexual history – always go with how they define themselves
- Remember research shows time and time again that most people in the world fancy someone of the same sex at some point in their life
- Having sex with one person of the same sex does not label you as anything
- Give yourself your own label if you want to, but remember you can change that label at anytime
- You cannot help who makes your heart race – and why would we want to?
- Violence never gets rid of someone's sexual orientation
- Assume that every client is possibly straight, gay, bi, all or none – because being any orientation is normal
- Always challenge homophobic comments without humiliating the person
- Always allow for someone to hear your challenges in their own time – it may well be that they themselves are gay, and for the first time ever have heard someone say that it's okay
- Offer extra support, because sometimes we need extra help to feel equal
- Always ask whether their partner is a boy or a girl, at every clinic – they may have been testing you out at their first visit and building trust
- Being LGBT is nothing to panic about, and someone doesn't need counselling because of their sexual orientation
- Be aware that LGBT young people are more likely to suffer from bullying, self-harm and attempt suicide
- Be aware that saying and doing nothing speaks volumes – don't see bullying and then look away
- Have resources available that are for young people of all sexual orientations
- Remember that gay people still have sex with the opposite gender sometimes
- Being LGBT does not imply being a paedophile, in fact most child sex abuse is carried out by men on young females.

8.4 Depression and Mental health [17-19]

Suicide among young people is becoming more common every year in South Africa. In fact only car accidents and homicide kill more young people between the ages of 15 and 24. In South Africa 9% of all adolescent deaths are caused by suicide. The fastest growing age is young people under 35, specifically female suicides which peak between 15 to 19 years.

Research suggests that although more females attempt suicide, more males succeed. This is due to the more violent methods males select. Girls are more likely to overdose on medication,

or take chemicals, whereas boys often find access to firearms or hang themselves.

There is a major link between depression and suicide. Most of the time depression is a passing mood. Sadness, loneliness, grief and disappointments we all feel at times, and are normal reactions to life's struggles. However, undiagnosed depression can lead to tragedy. Up to one third of all suicide victims had attempted suicide previously.

However, Depression is treatable! There is help available and with treatment, over 70% of people can make a recovery.

KEY SIGNS OF DEPRESSION:

- Loss of interest in things you like to do
- Sadness that won't go away
- Irritability or feeling angry a lot.

OTHER SIGNS INCLUDE:

- Feeling guilty or hopeless
- Not enjoying things you once liked
- Feeling tense or worrying a lot
- Crying a lot
- Spending a lot of time alone
- Eating too much or too little
- Sleeping too much or too little
- Having low energy or restless feelings
- Feeling tired a lot
- Missing school a lot
- Hard time making decisions
- Having trouble thinking or paying attention
- Thinking of dying or killing yourself.

Take a look at the list above with a young person and check the things that describe their thoughts, feelings or actions in the last two weeks.

WHAT TO SAY TO SOMEONE WHO IS DEPRESSED

"I'm all alone"

Don't say: "No you're not! I'm sitting here with you right now. Doesn't my caring about you mean anything?" **Do say:** "I know that you're feeling alone right now. Is there anything I can do to help? I'm just glad to be with you – together we'll get through this lonely feeling."

"Why bother? Life isn't worth living. There's no point in going on"

Don't say: "How can you think that? You have a great job and people who love you. You have everything to live for." **Do say:** "I know it feels that way to you right now, but I want you to know that you matter to me and you matter to others who love you. We'll get through this hopeless feeling together."

"I'm dragging everybody else down with me"

Don't say: "No you're not! You see, I'm fine! I had a good day today. And besides, your friends and family are doing everything in the world to help you." **Do say:** "I know it feels that way to you right now, and yes, at times it is difficult for both friends and family – but remember you'll get through this hopeless feeling together."

"What would it be like if I wasn't here anymore?"

Don't say: "Don't be silly – what's wrong with you?" **Do say:** "People and I would miss you terribly as you're very important to us. People want to grow old knowing you're around. We'll get through this together."

"I'm not important to anyone"

Don't say: "If you felt better about yourself, you wouldn't say stupid things like that." **Do say:** "I know you're feeling worthless right now, but we'll get through this."

"Nothing I do is any good. I'll never amount to anything"

Don't say: "What are you saying? You're a highly respected (student), you're a good (son/daughter). You're blowing everything out of proportion." **Do say:** "I know it's upsetting when things don't work out the way you want them to – it's upsetting for me too! Failure feelings are really painful, but we'll get through this together."

"How long am I going to feel this way? It's as if I'll never get better"

Don't say: "Come on. Nothing lasts forever – you know better than that." **Do say:** "I know it's scary to be in so much pain. Feelings come and go. We'll get through this together."

If you need any further information, call SADAG on 011 262 6396 or 0800 567 567 or sms 31393, they are open 7 days a week from 8am – 8pm. You can also go to their website for more information *www.sadag.co.za*

How does depression affect adolescent girls?

Before adolescence, girls and boys experience depression at about the same frequency. By adolescence, however, girls become more likely to experience depression than boys. Research points to several possible reasons for this imbalance. The biological and hormonal changes that occur during puberty are likely to contribute to the sharp increase in rates of depression among adolescent girls.

In addition, it has been suggested that girls are more likely than boys to continue feeling bad after experiencing difficult situations or events, suggesting they are more prone to depression. Often girls tend to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys. The girls with these views are more likely to have depressive symptoms as well.

Also, girls may undergo more hardships, such as poverty, poor education, childhood sexual abuse, violence and other traumas than boys. One study found that more than 70 percent of depressed girls experienced a difficult or stressful life event prior to a depressive episode, as compared with only 14 percent of boys.

How can I help a young person who is depressed?

If you think the young person may be depressed, the first and most important thing you can do is to help him or her get an appropriate diagnosis and treatment. You may need to make an appointment on her behalf. In addition, you can also:

- Offer emotional support, understanding, patience and encouragement.
- Engage him/her in conversation, and listen carefully.
- Don't negate any feelings she expresses, but point out realities and offer hope.
- Never ignore comments about suicide.
- Remind her that, with time and treatment, the depression will lift.
- S/he may feel exhausted, helpless and hopeless. It may be extremely difficult to take any action to help them. But it is important to realize that these feelings are part of the depression and do not reflect actual circumstances.
- Suggest they engage in mild activity or exercise. Go to an event or do an activity that they enjoy. Participate in religious, social or other activities.
- Set realistic goals for themselves.
- Break up large tasks into small ones, set some priorities and do what they can as they can.
- Suggest they try to spend time with other people and confide in a trusted friend or relative. Suggest they try not to isolate themselves.
- Let them know to expect their mood to improve gradually, not immediately. Do not expect to suddenly 'snap out of' depression. Often during treatment for depression, sleep and appetite will begin to improve before their depressed mood lifts.

8.5 Physical Disabilities [20] [21]

If a young person has a disability, they still have equal rights to quality relationships. If their family or carers find it difficult to discuss their relationships with them, they may need to have someone they feel able to talk to about it, or help with starting conversations with their family or carers.

If they have a disability, they still need to understand:

- How their body works and grows
- What changes to expect at puberty
- The name of all the sex organs and how they work
- Relationships and responsibility
- How society expects us to act in public
- Keeping safe
- How to prevent an unwanted pregnancy
- How to prevent STIs.

And they will need:

- Social life with children or young people of a similar age
- Friendship

- Romance
- To explore their sexuality
- Access to good quality sex education
- Privacy.

This article gives a little insight into the dilemmas regarding disability and sex:

Sex between disabled people is taboo, but denying its existence has never made it go away. Some argue that, by denying a sex life, we deny disabled people their full human rights. Disabled people who want a sexual relationship are not just up against the perception that they don't have sex.

Perhaps the most difficult impairment to reconcile with a healthy sex life is learning disability. Victoria McKenzie, a counsellor, says the big issue is consent. "People with learning disabilities must understand that sex is a choice and it has consequences. A lot of these people, women in particular, are sexually abused."

Generally speaking though, sex and disability remains taboo.

8.6 Alcohol and Substance misuse [22]

Few social issues impact so comprehensively on society as substance misuse. Alarmingly, children and young people are increasingly misusing alcohol and illegal drugs. Consequences range from non-attendance and poor attainment at school, poor health, committing crime to support 'habits' and also increased risk of being a victim of violent crime and sexual exploitation.

In addition to this, many children and young people who live with substance-misusing parents and carers suffer its ill effects. They are often neglected, suffer from domestic violence and are at an increased risk of misusing alcohol and illegal drugs themselves.

As young people get older communication may become more difficult. This does not mean you should not try. Before you do talk to the young person about drugs, make sure you have accurate, up-to-date information about different types of drugs and make the time to have the conversation.

It's important to stay calm and open-minded. Getting too intense will put pressure on them, so encourage a relaxed conversation, starting with questions about the 'bigger picture'.

Although there are many stories in the media about drugs leading to addiction, crime and death, it is important to remember that:

- For most young people illegal drug taking is not a part of normal life;
- Most people who do try drugs do not continue using them.

There are serious risks involved in drug use but most of those who try illegal drugs do not usually suffer any long-term harm to their health.

Remember that there are different reasons why people take drugs. It may be as simple as, 'to have fun'. The drugs might make the person feel relaxed, sociable and full of energy, and this may be a phase that they are going through. It's important to explain that some drugs are illegal and can affect their physical and mental health, and to let them know that while you

may not approve, they can always talk to you about any worries they may have.

Alternatively, they may be using drugs to escape pressure at school or at home, or because they are having difficulty in coping with stressful situations. Again, it's important to talk calmly and get to the root of any problems, so that you can find a way to work through these problems together and help them manage these situations without drugs.

Research shows that where young people do develop a problem with drugs, the involvement and support of parents and families can make a big difference to the person's health and their ability to deal with their drug habit.

8.7 Intimate Partner violence, abuse and rape [18 23]

"Choose love and peace will follow. Choose peace and love will follow."

Child sexual abuse is largely a silent and witness-free crime, often leaving no physical signs and actively hidden by perpetrators. These features of sexual abuse make its detection very difficult, with increasing importance placed on the victims' disclosure of abuse for investigative and treatment purposes. It is recognized however, that children and young people may not readily tell somebody about – i.e. 'disclose' ¬experiences of sexual abuse. It is important that children can safely tell someone about their abuse to make it stop, and for them to receive help and support. This briefing looks at research on children telling somebody about sexual abuse: who, how and why they tell, and how those who are told about it might respond. [24 25]

Key findings

- Many incidents of child sexual abuse go unreported, and delayed disclosure is common.
- Children may disclose sexual abuse by directly telling someone about it. They may also disclose less directly, sometimes unintentionally, over a period of time, through a variety of behaviour and actions, including discussions and indirect non-verbal cues. In this respect, disclosure should be seen as a process that occurs over time.
- Not enough is known about factors that influence disclosure or non¬disclosure, although we know that both individual and contextual factors are important.
- Retrospective studies of adults suggest that factors such as the relationship to the perpetrator; age at first incident of abuse; use of physical force; severity of abuse and demographic variables such as gender and ethnic group impact on a child's willingness to disclose abuse.
- If this is the case, abuse that may be the most harmful (long-term abuse by a parent or other relative that starts at a very young age) is the type of abuse that is the least likely to be disclosed.
- When children do disclose, it is frequently to a friend or a sibling. Of all other family members, mothers are most likely to be told. Whether or not a mother might be told will depend on the child's expected response from the mother. Few disclosures made in childhood are to authorities or professionals. Of all professionals, teachers are the most likely recipient of a disclosure.

- Historically, professionals promoted the idea that children frequently report false accounts of abuse. Current research, however, lacks systematic evidence that false allegations are common. Recantations of allegations of abuse are also uncommon.
- Disclosing is difficult for children for a variety of reasons. The research shows that some children do not tell because they feel they will not be believed or be taken seriously. For this reason, it is fundamental that adults, whether family members, friends or professionals, actively listen and respond sensitively. Creating a safe space for children to talk is crucial in breaking down barriers to disclosure.
- Research also indicates that children do not seek help from formal agencies or professionals because they do not know they exist; they are unsure what help they can get from them; or they worry about losing control over the information they share.

What is child abuse?

All parents upset their children sometimes. Saying 'no' and managing difficult behaviour is an essential part of parenting. Tired or stressed parents can lose control and can do or say something they regret, and may even hurt the child. If this happens often enough, it can **seriously** harm the child. That is why **abuse** is defined in law. Abuse should be considered to have happened when someone's actions have caused a child to suffer **significant harm** to their health or development.

Significant harm means that someone is:

- punishing a child too much
- hitting or shaking a child
- constantly criticising, threatening or rejecting a child
- sexually interfering with or assaulting a child
- not looking after a child – not giving them enough to eat, ignoring them, not playing or talking with them or not making sure that they are safe.

Who abuses young people?

Young people are usually abused by someone in their immediate family circle. This can include parents, brothers or sisters, babysitters or other familiar adults. It is quite unusual for strangers to be involved.

How can you tell if a young person is being abused? Physically abused young people may be:

- watchful, cautious or wary of adults
- unable to engage and to be spontaneous
- aggressive or abusive
- bullying other children or being bullied themselves
- unable to concentrate, underachieving at school and avoiding activities that involve removal of clothes e.g. at sports lessons
- having temper tantrums and behaving thoughtlessly
- lying, stealing, truanting from school and getting into trouble with the police
- finding it difficult to trust other people and to make friends.

Sexually abused children may:

- suddenly behave differently when the abuse starts
- think badly of themselves
- not look after themselves
- use sexual talk or ideas in their conversations that you would usually see only in someone much older
- withdraw into themselves or be secretive
- under-achieve at school
- start wetting or soiling themselves
- be unable to sleep
- behave in an inappropriately seductive or flirtatious way
- be fearful and frightened of physical contact
- become depressed and take an overdose or harm themselves
- run away, become promiscuous or take to prostitution
- drink alcohol or start using drugs
- develop an eating disorder such as anorexia or bulimia.

Emotionally abused or **neglected** children may:

- be slow to learn to walk and talk
- be very passive and unable to be spontaneous
- have feeding problems and grow slowly
- find it hard to develop close relationships
- be over-friendly with strangers
- get on badly with other children of the same age
- be unable to play imaginatively
- feel bad about themselves
- be easily distracted and do badly at school.

It can be hard to detect **long-standing abuse** by an adult the child is close to. It is often very difficult for the child to tell anyone about it, as the abuser may have threatened to hurt them if they tell anybody. A child may not say anything because they think it is their fault, that no one will believe them or that they will be teased or punished. The child may even love the abusing adult – they want the abuse to stop, but they don't want the adult to go to prison or for the family to break up. If you suspect that a child is being abused, you may be able to help them to talk about it.

Specialist treatment

Many children need specialist treatment because of the abuse they have endured. Some receive help from family centres run by social services. If they are worried, depressed or being very difficult, the child and family might need help from the local child and adolescent mental health service. These specialists may work with the whole family, or with children and adolescents alone. Sometimes they work with young people in groups. Individual therapy can be especially helpful for children who have been sexually abused, or who have experienced

severe trauma. Children who have suffered serious abuse or neglect can be difficult to care for, and the service can offer help and advice to parents and carers.

Intimate partner Violence

"Where hope grows, miracles blossom."

Elna Rae

We know that sexual violence in intimate relations is common. The risk of being sexually violent is associated with the use of violence to solve other problems from other settings, having more than one current partner, alcohol abuse and verbally abusing a partner. It is also associated with particular types of conflict stemming from ideas of male sexual entitlement and dominance.

What you can do in the clinic that may help tackle IPV for young people:

- Help a young person to come up with ideas about how they can sort out a conflict without violence
- Ask them what the benefits could be of being kind and gentle with a partner?
- Give a handout of statements by young women about the positives of being kind, non-violent partners, 'we like it when our partner is kind and gentle – we are more likely to respect them, be faithful to them, support them'
- Suggest they bring their partner to clinic with them so you can support them both
- Ask 'what are the other ways of proving you are a man that are not sexual or violent?'
- Make sure you always raise the self-esteem of the young person with an affirming statement – 'it's not okay to hurt someone but it's really brave to be honest and talk about it, I want to value that by suggesting ways we know will feel better for you in the future'
- Hand out statements with suggestions of 'what makes a man'
- Use the blobby tree to explore how their life is and other areas of their lives to see if the violence is stemming from a need to control.
- Ask if they have a daughter how they would like a boy to treat her. And why?
- Hand-out on 'the good things about girls are….' Not to do with sex
- Famous people in SA giving statements rejecting violence

"Sometimes the most important thing in a whole day is the rest we take between two deep breaths."

Etty Hillesum

PHYSICAL VIOLENCE SEXUAL
USING COERCION AND THREATS
• Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to social services • making her drop charges • making her do illegal things
USING INTIMIDATION
• Making her afraid by using looks, actions, gestures
• smashing things
• destroying her property
• abusing pets
• displaying weapons
USING ECONOMIC ABUSE
• Preventing her from getting or keeping a job
• making her ask for money
• giving her an allowance • taking her money • not letting her know about or have access to family income
USING EMOTIONAL ABUSE
• Putting her down
• making her feel bad about herself • calling her names
• making her think she's crazy
• playing mind games • humiliating her • making her feel guilty
POWER AND CONTROL
USING MALE PRIVILEGES
• Treating her like a servant
• making all the big decisions
• acting like the "master of the house" • being the one to define men's and woman's role
USING ISOLATION
• Controlling what she does, who she sees and talks to, what she read, where she goes • limiting her outside involvement
• using jealousy to justify actions
USING CHILDREN
• Making her feel guilty about the children • using the children to relay messages
• using visitation to harass her
• threatening to take the children away
MINIMISING, DENYING AND BLAMING
• Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behaviour • saying she caused it
PHYSICAL VIOLENCE SEXUAL

Intimate Partner Violence (IPV) Screening & Treatment Guidelines for Medical Providers

Screening	Assessment	Intervention	Documentation	Reporting
1. Establish privacy (screen patient alone) 2. Use staff or professional translator for translation (not family or friends) 3. Ask direct questions: • Has your partner ever hit you, hurt you, or threatened you? • Does your partner make you feel afraid? • Has your partner ever forced you to have sex when you didn't want to? 4. Ask indirect questions: • How does your partner treat you? • Do you feel safe at home? 5. Also ask about past history of IPV: • Have you ever had a partner who hit you, hurt you, or threatened you? • Have you ever had a partner who treated you badly? • Have you ever had a partner who forced you to have sex when you didn't want to?	*Assessment of current IPV* Assess immediately: 1. Assess for safety in clinic • Is perpetrator with patient? 2. Assess for current safety • Threats of homicide • Weapons involved • History of strangulation or stalking 3. Assess for suicidal and homicidal tendancies 4. Assess for safety of children Assess over time: 5. Assess for pattern of abuse 6. Assess history of effects of abuse • injuries/hospitalization? • physical and psychological health effects? economic, social, or other effects? 7. Assess for support and coping strategies 8. Assess for readiness for change *Assessment of past IPV* 8.1. Assess for current safety ("Are you (and any children involved) safe from this person now?") 8.2. Assess history of effects of abuse • injuries/hospitalization? • physical and psychological health effects? economic, social, or other effects?	1. Give repeated messages of support 2. Offer crisis phone numbers 3. Assist in preparing a safety plan (or connect patient with a person who can) 4. Offer advocacy and counselling 5. Offer police and legal assistance 6. Arrange for follow-up visits and a safe way to contact patient 7. Expand the patient's support to multiple members of a multidisciplinary team (provider, community and clinic-based advocates, social worker, PHN, counsellor, etc.) if patient willing	1. History: • Write legibly • Use patient's own words in quotes • Document as much info as patient will provide regarding specific events (who, what, where, when) 2. Physical Findings: • Describe injuries in detail • Draw diagrams of injuries • If patient consents, take photographs of injuries • Take serial photographs of injuries over time 3. Physical Evidence: • If patient consents, preserve physical evidence in paper bag • Describe physical evidence in detail	1. If patient is injured, file a mandatory health care report to police 2. If you suspect children are being neglected or harmed, file a CPS report. (Advocate on behalf of adult victim/ survivor's safety with CPS) 3. If patient is 65 or a dependent adult, file an APS report

Leigh Kimberg, MD LEAP (Look to End Abuse Permanently) at *www.leapsf.org* Maxine Hall Health Center 415-292-1300 updated 2/2/05

R U READY – OR NOT QUITE YET?

- You feel you could say no if you wanted to
- You can have fun together without anything sexual involved
- You each want it for yourself, not for the other person or to fit in with friends or others' expectations of you
- Nobody's forcing you, pressuring you or making you
- You have discussed using condoms and contraception, and agreed what happens next and whether or not to tell your friends afterwards as well as talking about the implications if you become pregnant

You probably won't be ready for sex till you can tick *all* these boxes. But remember even once you are ready – it still doesn't mean you have to!

Remember too that just because you've already had sex – it doesn't mean you have to again.

You can take some time-out

TEN STRATEGIES FOR SUPPORTING YOUNG PEOPLE

- **Address and build strong friendship skills**
- **Building a sense of rights, self-esteem & aspirations**
- **Offer drama, excitement and alternatives to sex**
- **Address gender issues and do boys work**
- **Assertiveness skills, dealing with pressure, lines to say "no"**
- **Ensure excellent life orientation education which includes condoms, sexuality, contraception, how to access services and lots of work on relationships**
- **Work imaginatively with parents and carers**
- **Give them 'trigger' thoughts**
- **Work on sensuality and the senses**
- **Give young people the whole picture**

SOME LINES ABOUT DELAYING SEX FOR US TO TAKE WITH YOUNG PEOPLE

"I'm not happy with that – I want something better for you"

"If you're not sure then you're probably not ready"

"Putting off sex for a while can help you feel more in control of your life"

"Just because you're saying 'No' for now doesn't mean you always will"

"If he'd/she'd dump you if you won't – do you really want him/her?"

"How do you feel about it?"

"You do have the right to say 'no' you know"

"It's not unusual for someone of your age not to be having sex"

"Most people aren't having sex yet - even though they may say they are!"

"Whenever you say 'no' to one thing, you're saying yes to something else"

"Most people don't have sex till after they're 16, you know"

"What kind of relationship do you want?"

And of course…

"I'm wondering where YOU are in all of this?"

IT'S NOT A TREADMILL, YOU CAN GET OFF

Sometimes we discuss sex as though the only life stages are before and after starting to have it with a partner. This attitude is a real pitfall when working with young people, because it understandably can lead them to assume that once you have started to be sexual with someone else, you always will be. It buys into the old lie that there is no reason not to be sexual.

However, many young people may have sex once or twice or a few times for a whole range of reasons, to see what it's like, out of curiosity or the desire to get it over with, to prove they are normal and all their 'bits' work, to be able to say they have done it or to belong to the gang.

We can let young people know in all the ways we talk with them about sex and relationships that it's fine to take time out for themselves. This could mean putting sex aside and coming back to it later, once they want to explore this aspect of their experience with a partner they feel sure of and committed to. So starting doesn't contain an imperative of carrying on. Working with young people on this, we can ask them to consider all the reasons they might want to take time out from being sexual with someone else, when they have already had sex at least once.

For example, these might include:

"I want to concentrate on other things – like school work or activities"

"Because I didn't like it that much"

"I don't want to risk getting pregnant yet – there's too much else I want to do first"

"I only did it the first time because I didn't know how to say no/felt I had

to/was pushed into it – and I'm not going to let that happen again"

"I want to wait for someone who wants ***me****, not just for a sex machine*

"It's boring….."

"I got talked about afterwards and people shouted "slag" when I went past and I hated that"

"I only did it to tell my friends – and now I have, I don't want to go on"

THE RULES OF **SPACE** SEX

***S**afe*

Don't have sex unless you know how to stay safe.

Don't hurt others.

Protect yourself from sexually transmitted infections

And from pregnancy

***P**rivate*

Sexual stuff should be private, but not secret.

If you're not sure whether something is OK, check it out

With someone you trust.

***A**ge*

The law says that you have to be 16 years or older to have sex

With someone else

This is the same whether you are straight, lesbian, gay or bi-sexual.

***C**onsent*

You must both consent or agree and also understand what you're agreeing to.

Remember:no one should have sex if they don't want it, or aren't ready for it.

***E**very time*

Sex can be great, but only if we stick to the rules

Keep these rules every time you're thinking about doing something sexual.

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The Sexual Offences Act & The Child Justice Act

Dr Kelley Moult
Gender Health & Justice Research Unit
University of Cape Town

Overview

- CHILD JUSTICE ACT
- SEXUAL OFFENCES ACT
  - Objectives of the 'new' Sexual Offences Act
  - New definitions
  - New offences
  - Mandatory reporting of sexual offences
  - Teddy Bear Challenge & Rabie Judgment

The Child Justice Act

ACT 75 OF 2008

Child Justice Act

- Aimed to establish a criminal justice system for children in conflict with the law that:
  - Expands and entrenches the principles of **restorative justice** as foundational
  - Values principles of **rehabilitation & reintegration** as core to the system
  - Ensures that children take responsibility and accountability for crimes committed
  - Balances the interests of children and those of society

Child Justice Act

- Purpose of the Act (Preamble):
  - To establish a criminal justice process for children accused of committing offences
  - To uphold their constitutional rights and ensure the protection of society
  - Recognises the 'best interests of the child' (with due regard to victims)
- Act applies to all criminal offences
  - Divides into 3 schedules depending on seriousness
  - Have different implications (e.g. most serious can only be diverted in exceptional circumstances)

Child Justice Act

- Affords children particular safeguards:
  - Right not to be detained except as a measure of last resort (and if detained, only for the shortest period time).
  - Right to be treated and kept in conditions that are cognizant of the child's age
  - Right to be detained separately from adults
  - Right to be protected from abuse, maltreatment, neglect and other forms of degradation.

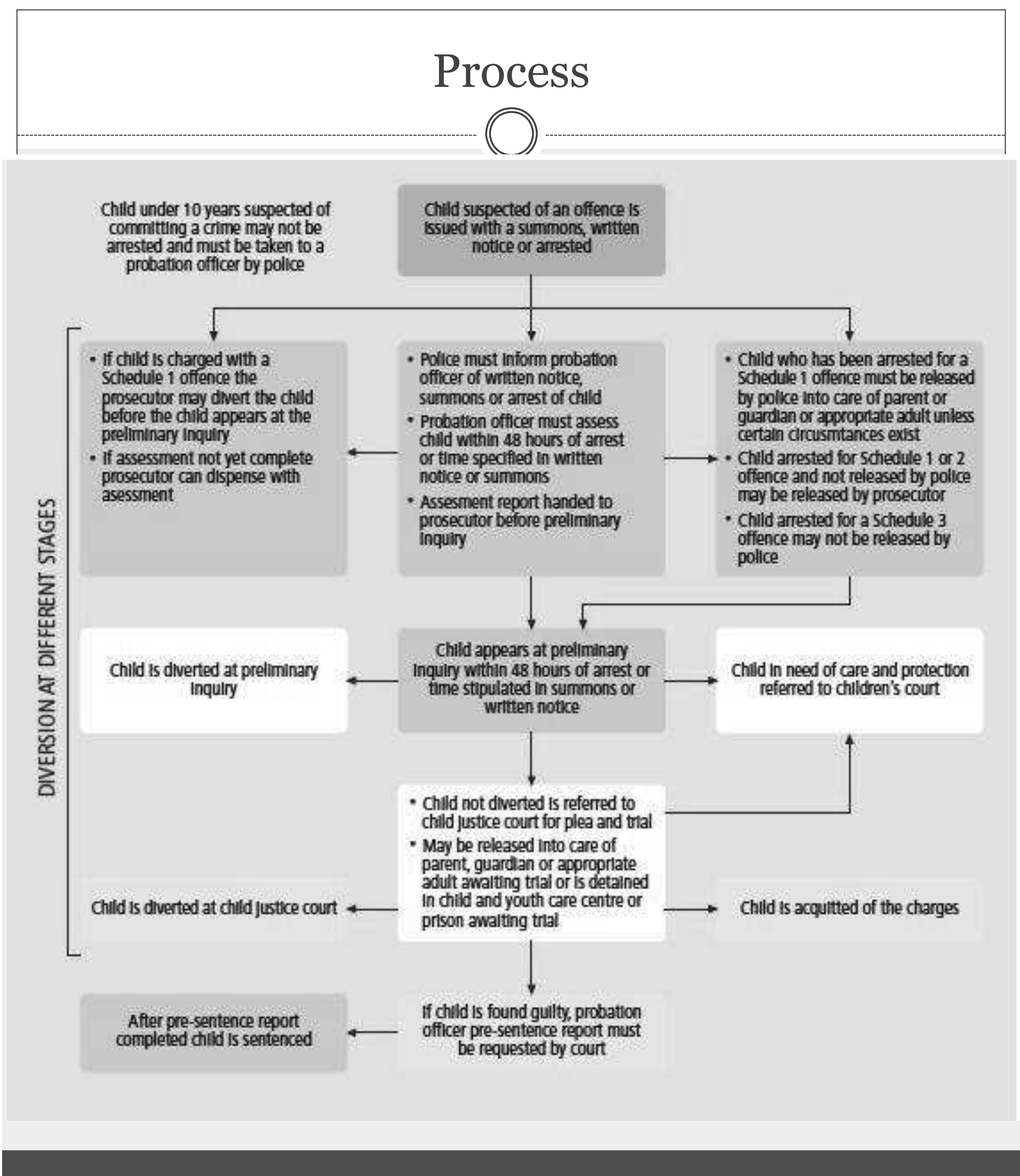
Child Justice Act

- The Act creates three categories of children to which it applies:
  - Children under 10 years old.
    - Guide what happens to children who are not considered criminally liable (children's court, or counselling).
  - Children aged 10 years and older, but younger than 18 years at the time of arrest or when the summons or written notice was served on them.
    - Intends to protect offenders who are children while in the criminal justice system, not children who were only arrested later for crimes they committed as children.
  - Persons who are 18 years or older but under 21 years of age and who committed an offence when under 18 years of age.
    - Recognises that 18 to 21 year olds are still young and can benefit from the procedures provided in the Act.

Process

- Children under 10 years of age and who are alleged to have committed an offence:
  - Referred to a probation officer to conduct an assessment as to child's age
  - Other provisions related to criminal capacity (right/wrong)

- Children 10-18 and those 18-21 who committed an offence while under 18:
  - Assessment by probation officer prior to preliminary enquiry
  - Can be considered for diversion before or at the preliminary enquiry
  - If not diverted, must be referred to a child justice court.
  - If referred, can still be considered for diversion prior to finalisation.


Process
Child under 10 years suspected of committing a crime may not be arrested and must be taken to a probation officer by police
Child suspected of an offence is issued with a summons, written notice or arrested
• If child is charged with a Schedule 1 offence the prosecutor may divert the child before the child appears at the preliminary inquiry
• If assessment not yet complete prosecutor can dispense with asessment
• Police must inform probation officer of written notice, summons or arrest of child
• Probation officer must assess child within 48 hours of arrest or time specified in written notice or summons
• Assesment report handed to prosecutor before preliminary inquiry
• Child who has been arrested for a Schedule 1 offence must be released by police into care of parent or guardian or appropriate adult unless certain circusmtances exist
• Child arrested for Schedule 1 or 2 offence and not released by police may be released by prosecutor
• Child arrested for a Schedule 3 offence may not be released by police
DIVERSION AT DIFFERENT STAGES
Child is diverted at preliminary inquiry
Child appears at preliminary inquiry within 48 hours of arrest or time stipulated in summons or written notice
Child in need of care and protection referred to children's court
• Child not diverted is referred to child justice court for plea and trial
• May be released into care of parent, guardian or appropriate adult awaiting trial or is detained in child and youth care centre or prison awaiting trial
Child is diverted at child justice court
Child is acquitted of the charges
After pre-sentence report completed child is sentenced
If child is found guilty, probation officer pre-sentence report must be requested by court

Diversion

- Child can be diverted at preliminary inquiry or trial if:
  - The child acknowledges responsibility for the offence;
  - The child has not been unduly influenced to acknowledge responsibility;
  - There is a *prima facie* case against the child;
  - The child has consented to the diversion along with his or her parent, guardian or appropriate adult if available; and
  - The prosecutor (in relation to Schedule 1 and 2 offences) or the Director of Public Prosecutions (in relation to Schedule 3 offences) indicates that the matter may be diverted.

The Sexual Offences Act

THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT
ACT 32 OF 2007

The Sexual Offences Act

- **Objectives:**
  - Replacing/redefining outdated common law crimes
  - Creating new statutory offences to criminalise *all* forms of sexual abuse
  - Providing certain services such as PEP and compulsory HIV testing of the perpetrator to protect complainants from secondary victimisation
  - Giving proper recognition to the needs of victims of sexual offences

Changes in definition

Old Common Law Definition	New Definition (SOA)
• Rape consists of a man having unlawful & intentional sexual intercourse with a woman without her consent	• Any person who … commits an act of sexual penetration with another person without such person's consent … is guilty of the offence of rape.

New definition of rape

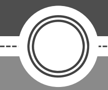
- Both victim & perpetrator can be male or female
- Key element of the crime: 'sexual penetration'
  - Genital organs of one person into the mouth, genital organs or anus of another person
  - Any other body part, any object or part of the body of an animal into genital organs or anus of another person
  - Genital organs of animal into mouth of another person
- Penetration = 'into or beyond' the genital organs, mouth or anus
- Without consent

Consent

- Consent means voluntary or un-coerced agreement
  - free and deliberate
- Agreement is not voluntary if-
  - use of force or intimidation against the complainant or another person or their property
  - threat of harm against complainant or another person or their property
  - abuse of power or authority

Consent (continued)

- Agreement is not voluntary if –
  - Obtained through ‘false pretences or fraudulent means’
  - The complainant is incapable under the law of ‘appreciating’ the nature of the act
    - asleep, unconscious or in an “altered state of consciousness” (under the influence/drugged) to the extent that their judgment is adversely affected
    - mentally disabled
    - below the age of 12



Sexual Assault

(Similar to old Indecent Assault)

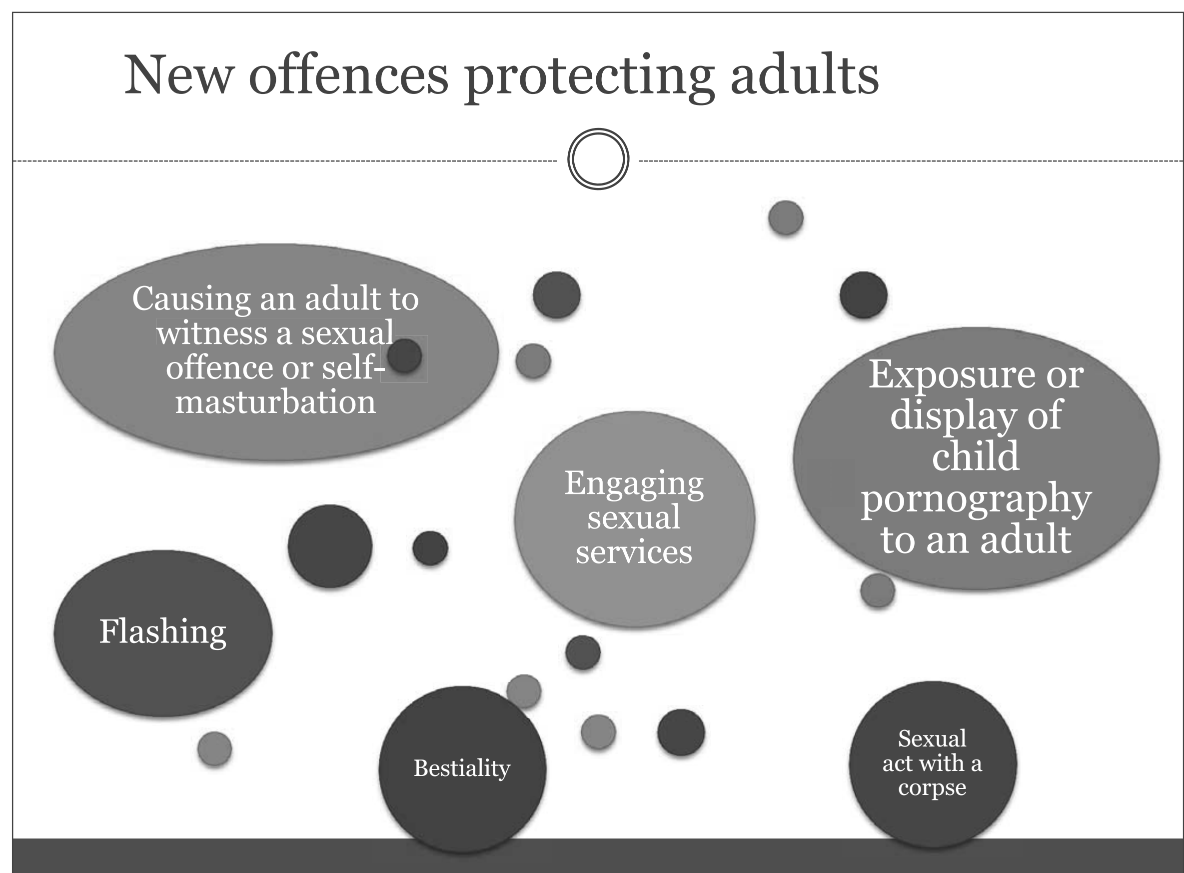
- A person who unlawfully and intentionally sexually violates another person without the consent of this person

Sexual Assault (previously Indecent Assault)

- Key element: ‘sexual violation’ which includes:
  - contact between genital organs/anus/female breasts of one person and any body part of another person/animal/object
  - contact between mouth of one person and genital organs/anus/female breasts/mouth of another person
  - forced masturbation of one person by another person
- Sexual violation excludes all acts of penetration
  - Exception: insertion of *object resembling genital organs* into mouth is sexual assault
- Without consent

Compelled rape/sexual assault

Compelled rape	Compelled sexual assault	Compelled self-sexual assault
• Perpetrator compels a third person to commit a rape	• Perpetrator compels a third person to commit a sexual assault	• Perpetrator compels the victim to self-masturbate or penetrate his/her own genital organs or anus



Sexual offences against children & mentally disabled persons

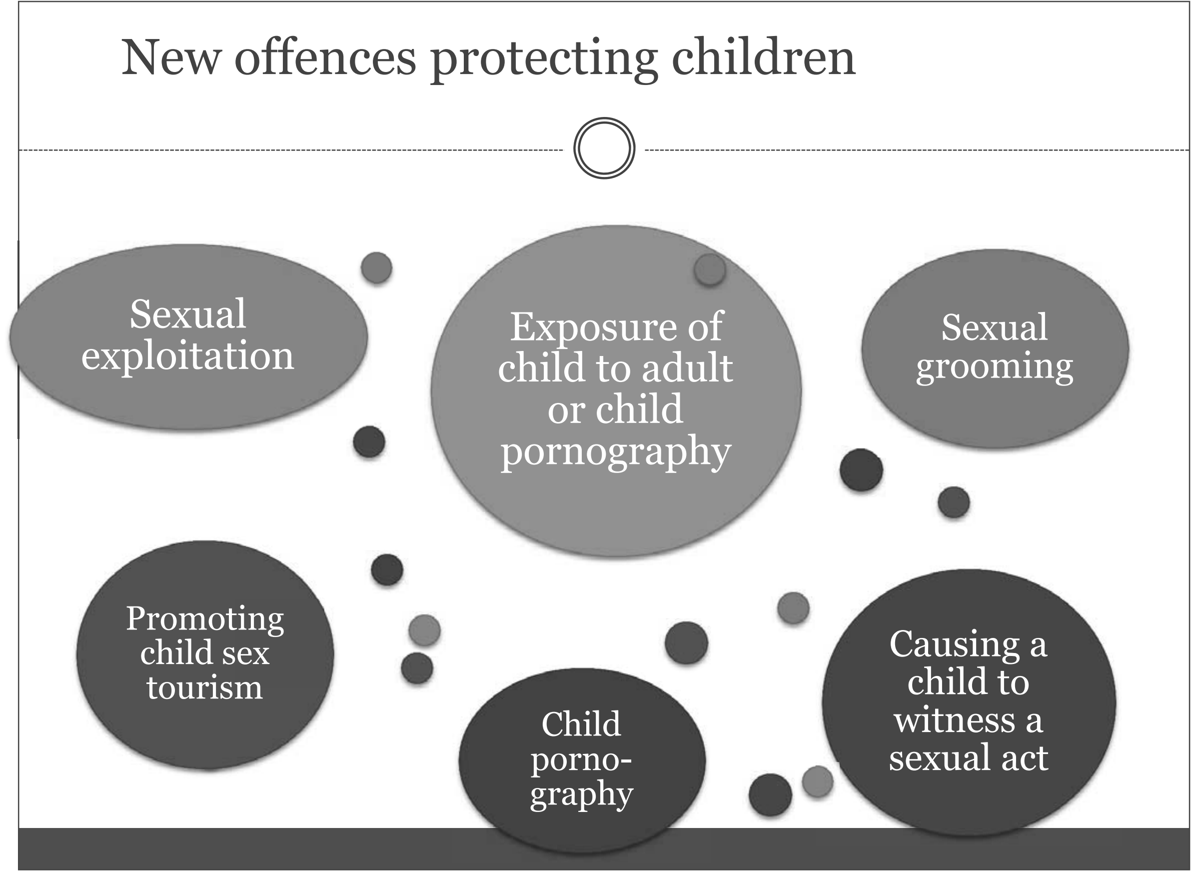
Definitions

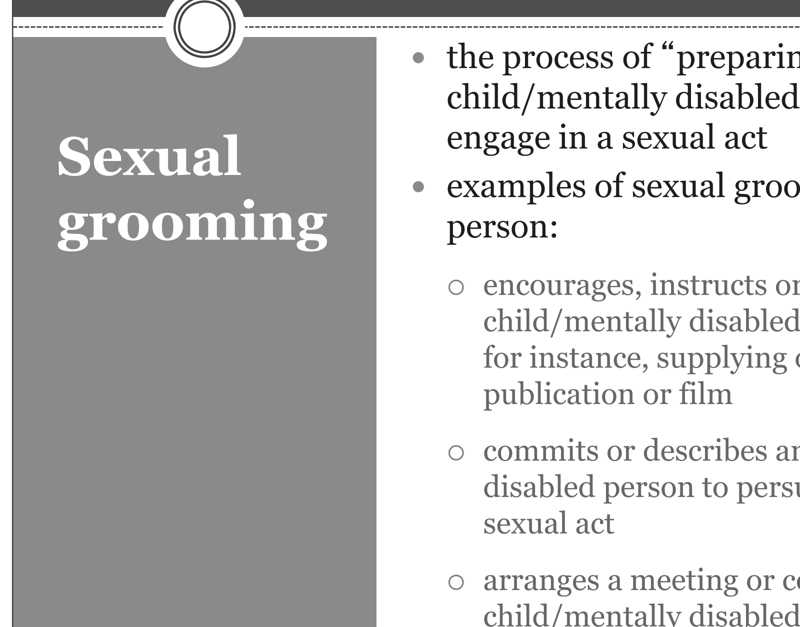
Child

- 'Child' defined under SOA as a person under the age of 18 years
- All new offences that are meant to protect children → below 18 years
- **Exception**: statutory rape & statutory sexual assault

Mentally disabled person

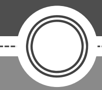
- Person affected by any mental disability or any disorder/ disability of the mind:
  - unable to appreciate the nature and consequences of a sexual act;
  - able to appreciate, but unable to act in accordance with that appreciation;
  - unable to resist the commission of any such act; or
  - unable to communicate his or her unwillingness to participate in any such act





Sexual grooming

- the process of "preparing" or "making a child/mentally disabled person ready" to engage in a sexual act
- examples of sexual grooming are where a person:
  - encourages, instructs or tries to persuade a child/mentally disabled person to a sexual act by, for instance, supplying or displaying pornographic publication or film
  - commits or describes an act to a child/mentally disabled person to persuade him/her to perform a sexual act
  - arranges a meeting or communication with a child/mentally disabled person, by any means, with the intention to commit a sexual act with the child/mentally disabled person
- the offence covers *promoting* sexual grooming *and* sexual grooming itself



Sexual exploitation

- person who **engages** the sexual services of a child/mentally disabled person for financial or other reward, favour, or compensation
  - irrelevant whether the sexual act is performed or not!
  - irrelevant whether child/mentally disabled person consents or not!
- person who **offers** the services of a child/mentally disabled person to a third person for financial or other reward for commission of sexual act with the child
- person who **benefits** from the earnings of sexual exploitation of a child/mentally disabled person

Case study:

Jo goes to visit his neighbor Jack. He says he has just come back from a successful business trip and hands Jack a brand new cell phone. ‘You can keep it’ Jo says, ‘but you know, I do want a little favor in return. I’ve been so lonely since my divorce and your daughter Cynthia, she’s so pretty. She is almost 18 and I think she likes me…” The men agree that Jo can have sex with Jack’s 16-year old daughter. On the next day Jo approaches Cynthia. She agrees to have sex with him.

- Who committed an offence? What kind of offence?
- Does it make a difference whether Cynthia is 16 or 15?

Statutory Rape/Sexual Assault

Consensual Sexual Acts with Certain Children

Rape and Statutory Rape (current)

- **Consensual sex with a child under the age of 12**
  - This is rape/sexual assault even if without coercion or force, because a child below the age of 12 cannot legally consent to sex
- **Consensual sex with a child between 12 years and 15 years**
  - This is statutory rape/statutory sexual assault
  - Relates to consensual sex between a child 16-17 and another age 12-15 (A is guilty of an offence)
  - Relates to consensual sex where both are 12-15 (A & B are guilty of an offence)
  - If both (the "perpetrator" + "victim") are children, the crime can only be prosecuted with the written authorisation of the National Director of Public Prosecutions
- **Consensual sex with a child who is 16 years or older**
  - Not a crime, because children 16 and older can "fully" consent to sex according to the law

© Steffi Röhrs, Gender, Health & Justice Research Unit, UCT

Is this a crime? Who is prosecuted?

- Boyson is 21 and his girlfriend Joy who is 11 have consensual sex.
- James is 14 and his girlfriend Louise who is 11 have consensual sex.
- Sipho is 15, his girlfriend Denise is 13. They have been going out for 6 months. One night they decide to "take their relationship to the next level" and have consensual sex.
- Dan (17) and Barbara (15) have been together for a few weeks. One night after a party they have consensual sex.

Mandatory reporting

Mandatory Reporting

- No legal obligation to report a sexual offence if the victim is an adult
  - No obligation for the rape survivor to report to get medical care
- Legal obligation to report when patient is a child or a mentally disabled person
  - Rationale behind obligation to report:
    - Protect the affected child from further harm
    - Protect other children from harm by perpetrator
    - Deter perpetrators

Reporting Obligations: SOA

- Children:
  - "A person who has knowledge that a sexual offence has been committed against a child [i.e., a person under the age of 18] must report such knowledge immediately" to the police
- Mentally disabled person:
  - "A person who has knowledge, reasonable belief or suspicion" that a sexual offence has been committed against a person who is mentally disabled must report to the police

Reporting obligations: Children's Act

- If there is a **reasonable suspicion** that a child is being abused in a way that causes **physical injury, sexual abuse or neglect**, certain persons have a duty to report such abuse.
- Professionals include, for example, social workers, teachers, legal practitioners, medical practitioners, traditional and religious leaders, etc.

Differences in reporting

	Sexual Offences Act	Children's Act
Who must report?	'A person' (any)	Certain professionals including health care professionals
What must be reported?	**Knowledge** of a sexual offence against a child or a a mentally disabled person: • Rape & Sexual Assault • Statutory Rape & SA • Consensual Acts child/child • Various Other Offences	**Reasonable belief** that a child has been sexually, physically or emotionally abused: • Physical abuse causing injury • Deliberate neglect • Sexual abuse – includes sexual offences

Differences in reporting

	Sexual Offences Act	Children's Act
When must you report?	If you have knowledge that a sexual offence has been committed against a child	If you "conclude on reasonable grounds" that a child has been: • abused in a manner causing physical injury, • sexually abused or • deliberately neglected
To whom must be reported?	Police	- Designated Child Protection Organisation - Dep. of Social Development - Police

Consensual Sexual Activity between Teens

- These provisions (sections 15 & 16 of the Sexual Offences Act) were challenged in the High Court for being unconstitutional *(Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Others. Case No. 73300/10)*
  - Challenges the criminalisation of **consensual** sex between adolescents (statutory rape, statutory sexual assault)
  - Challenges the reporting obligation for **consensual** sexual activity between adolescents
  - Challenges the requirement to include children found guilty under these offences to be included in the National Sex Offender Register

Rationale vs. Reality?

- Rationale:
  - Protect the affected child from further harm
  - Protect other children from harm by perpetrator
  - Deter perpetrators
- Reality:
  - This objective can only be achieved if the report is followed up with an adequate protection response
  - Failure to do so can lead to:
    - Consequences of reporting for child victim
      - Further harm once perpetrator knows they have told, lack of belief
      - Secondary traumatisation by failures of the criminal justice system & welfare systems
      - If perpetrator is breadwinner = loss of income to the household
    - Consequences of reporting for children as a group
      - No deterrent effect
      - Recidivism by offenders

Source: Children's Institute

To Report or Not?

- To report or not to report?
  - Will it be in this child's best interests to report?
  - If I report will it cause more harm?
  - If I do not report will it cause more harm?
- The impact of criminalisation:
  - Traumatisation through exposure to the criminal justice & welfare systems.
  - Emotional distress in the form of shame, embarrassment, anger, humiliation and regret → have long-term consequences in terms of sexual health and self-esteem
  - Prevent adolescent from seeking supportive help (e.g. counselling and health treatment) because they fear being charged with a crime. Fear and stigma will keep them away from social workers, counsellors and clinics.
  - Restricts the child's autonomy.
  - Children are being given the message that consensual healthy sexual behaviour is wrong and deserves to be punished.

Source: The Children's Institute

Rabie Judgment

- North Gauteng High Court delivered judgment in January 2013 that found:
  - Infringe a number of rights of children
  - Provisions may cause undue harm to children
  - Are an unjustified control into the private sphere of children
  - Violate protections of dignity of children
  - Violate ability to control their own bodies and to make decisions about reproduction
  - Violate right to private, intimate and personal relationships
  - Criminalise the activity of "significant numbers of children"
  - Create harm, whether ultimately prosecuted or not
  - Diversion doesn't necessarily protect the individual
  - Relies on prosecutorial discretion (no guidance)

Rabie Judgment

- Addressed instances where children are both between 12 and 16, or where one is 16-18 and the other is between 12-16, but the age gap is <2years:
  - A person (A) who commits an act of sexual penetration with a child (B) is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration of a child, ***unless at the time of the sexual penetration (i) A is a child or (ii) A is younger than 18 years, and B is two years or less younger at the time of such an Act.***

Rabie Judgment

- Addressed instances where children are both between 12 and 16, where there is an age gap of >2 years:
  - A person (A) who commits an act of sexual penetration with a child (B) is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration of a child, ***unless at the time of the sexual violation A is a child.***

Role of Police in Reporting

- One of the many goals of the SOA was to improve the reporting and management of cases at the police level.
- How a member of the police responds to a report of a rape is possibly the most important indicator of how rape cases will be treated in the remainder of the criminal justice process.
  - The police are the entry-way to the criminal justice system.
  - Affects the extent to which victims of alleged sexual offences proceed with the criminal justice process.
  - Affects the quality of police investigations.

Role of Police in Reporting

- According to s4(6) of the National Instructions for SAPS members on the new Sexual Offences Act:
  - ‘Any person who reports the alleged commission of a sexual offence to a member **must be treated in a professional manner** and must be **reassured that the report is viewed in a serious light and will be thoroughly investigated.**’
  - Further, s5(5) states, ‘A member **may never be judgmental** while interacting with the victim irrespective of the circumstances surrounding the offence.’
  - S 5(4) states that **no victim may be turned away.**

Role of Police in Reporting

- Section 5 of the National Instructions – entitled *Victim Assistance* – requires members of the SAPS to:
  - Ask the victim to accompany him or her to a private area.
  - Reassure the victim that he or she is safe and will be protected.
  - If there is a domestic relationship, advise in terms of the DVA
  - Determine whether the victim requires medical assistance and if so make arrangements for the victim to obtain medical assistance as soon as possible.
  - Inform the victim that he or she may have another person present with him or her during the interview and if so allow that person to be present
  - Put the victim at ease and ensure that the victim is not exposed to any further trauma
  - Listen to what the victim says, without interruption
  - Write down everything that the victim says (and make investigative notes)

Opening a Docket

- If the member is satisfied that there are reasonable grounds to believe the offence was committed, he or she must take an affidavit, open a docket for investigation of the offence and register the docket in the CAS system.
  - Affidavit must include:
    - the time and date on which the offence was allegedly committed
    - the place where the office was allegedly committed
    - the nature of the alleged offence
    - the manner in which it was allegedly committed
    - the first person to whom the victim reported the alleged offence, before reporting to the police
    - any details regarding the alleged offender(s)
    - any details regarding possible witnesses

Skeleton Dockets

- If the victim is unable to make a coherent statement, a skeleton docket must be opened, until the victim is in a position to make a coherent statement. If the complainant is accompanied by another person, a statement must be taken from this person

Deciding Not to Open a Docket

- If the member is not satisfied that there are reasonable grounds to believe the office was committed, he or she must consult with the CSC Commander.
  - The Commander must make a comprehensive entry into the OB (Occurrence Book) stating the reasons why he or she is unsatisfied with the complaint.
  - The particulars of the complainant must be recorded in order to locate the person for an interview, if necessary.

Providing Information

- Must as soon as reasonably possible inform the victim of:
  - The case number
  - The details of the investigating officer
  - The processes that follow next
  - The importance of undergoing a medical examination as soon as reasonably possible and that the examination will be conducted at State expense
  - Services relating to HIV post-exposure prophylaxis (PEP) and compulsory HIV testing, as well as about the victim protection programme

Warning Signs of Violent or Abusive Relationships

Here are twenty warning signs that may show up early on in a relationship if a person is likely to be possessive, controlling, or violent.

- **Too good to be true:** Has he/she has become totally occupied with you, such as calling you every hour just to "hear your voice," leaving and picking you up at school, and doing things that you were doing for yourself, thus taking charge of your life?
- **Temper outbursts:** Does he/she have outbursts of anger or a quick temper, such as swearing, throwing things or kicking doors? These outbursts may not necessarily be directed towards you, but towards anybody or anything?
- **Violent or demeaning language:** Does he/she use derogatory terms for other women (or you), such as, "whore" or "slut" etc.? Or does he/she use racist or other hateful language? Or does he/she make threats toward others?
- **Sexist attitude:** Does he/she have strong ideas about the place and position of women vs. men, for instance, does he/she insist that "a man or a woman should know their place"? Think back to what you learned about gender and power in earlier Sessions to help you understand what ideas and beliefs your boyfriend or girlfriend has about how to be a man and how to be a woman.
- **Insults:** Does he/she put you down for your opinions or laugh at what you believe in? Does he make you feel stupid, ignorant, or incompetent?
- **Psychological abuse:** Does he/she make you feel that you can't do anything right or that you can't get along in the world without his help? Does he/she tell you that "you're no good"?
- **Ridicule or humiliation:** Does he/she make fun of you alone or in other people's presence?
- **Rage for past relationships:** Notice how he/she talks about his/her ex- or previous partners. Does he/she seem to be extremely angry towards a previous relationship or does he/she call their ex-partner names or use other insulting terms to describe him/her? Remember that later he/she might turn the same rage or anger and insults towards you.
- **Alcohol and drug abuse:** Does he/she have a drinking or drug problem? Think about the risks of using drugs and alcohol in a relationship that you discussed in a previous Session – are any of those things happening in your relationship?
- **Blaming others:** Does he/she have a habit of blaming others for decisions or actions that he or she makes him/herself?
- **Violence under the influence of alcohol or drugs:** Does he/she become verbally or physically abusive under the influence of alcohol and drugs? Does he/she change a lot

after drinking or using drugs and try to pressure you to do things you do not want to do (e.g., join them in drinking or using drugs, have sex, go for a drive somewhere, fight with another group of people, etc.)?

- **Verbal or physical abuse towards others:** Is he/she verbally or physically abusive towards others, like people in the restaurant, other drivers on the street, people he/she comes in contact with, etc.?
- **Extremely critical of you or your family:** Does he/she say negative things about you or your family?
- **Extreme sexual jealousy:** Does he/she say "I love you so much that I can't stand you spending time with other people"?
- **Possessive behaviour:** Is he/she unhappy or moody when you spend time with your friends or family? Does he/she always want to know exactly where you are and what you are doing? Does he/she get very upset or angry when you don't answer your phone or respond to messages quickly? Does he/she expect you to be around to see him/her whenever he/she wants?
- **Restricting and controlling behaviour:** Has he/she told you to not keep any contact with your friends and family? Has he/she told you what to wear or what not to wear? Does he/she try to tell you things you can do and places you can go and things you can't do or places you can't go?
- **Jealous accusations:** Has he/she jokingly or seriously complained that you were trying to attract other men/women by the way you walk, dress, or behave?
- **Checking and tracking:** Does he/she keep track of where you went, who you met, and how much time did you really spend with another person or doing something else? Does he/she try to check the calls and messages on your phone?

If you answered "yes" to any of these questions, chances are that they will get worse as time goes on putting you at risk of being in a violent relationship. If you notice several of these signs in your relationship, it may be best for you to break up. If you (or someone you know) has experienced verbal, emotional, or physical violence, you should get help by speaking to a trusted adult, the prepare facilitator, or contact one of the organisations listed on the resource sheets you have received.

GUIDELINES ON SAYING 'NO'

- Your immediate feelings will usually tell you whether you want to say 'yes' or 'no'
- If you're not sure then ask for some specific information so that you know exactly what you are committing yourself to
- Say 'no' for yourself, rather than referring to a higher authority or circumstances beyond your control
- If you don't say 'no' directly, then you will find ways of saying it indirectly
- Make it clear that you are refusing the request and not rejecting the person, or the friendship
- The skill of self-disclosure is a big help in saying 'no'
- When you say 'no' to something you don't want to do, you are saying 'yes' to yourself and your own importance
- Saying 'no' and surviving the guilt gets easier!

Introduction

The purpose of the SHP

- The development of any country is measured by the health of its children
  - Children must be healthy to benefit from education
  - Children's health and well being can be addressed in the school's environment

This policy wants to ensure that school-going children, including those in remote areas, have **equal access to quality health services**

Western Cape Government
Health

Introduction

The revision of an existing SHP

- School Health Services have been available for sometime in South Africa (SA)
  - Implementation in provinces inconsistent
  - Suboptimal services
  - Does not address current burden of childhood disease
    (Especially older learners)

Development of the new **Integrated School Health Program (ISHP)**

Western Cape Government

ISHP Background

- The South African Government has pledged to "put children first" by:
  - becoming a signatory to the United Nations Convention on the Rights of the Child
  - Affording children special recognition in the Bill of Rights of the South African Constitution.
- The World Health Organization (WHO) defines a school health programme as a combination of services ensuring the physical, mental and social well-being of learners so as to maximize their learning capabilities.
- The World Education Forum held in Dakar in 2000 that the provision of effective school health services is an important strategy for achieving Education for All.
- The forum further recommended that the following basic components of a school health programme should be provided together in all schools:
  - Health-related school policies
  - Ensuring a healthy physical, learning environment, emphasizing safe water and sanitation
  - Skills-based health education
  - School-based health and nutrition services

Western Cape Government

Introduction

- The development of any country is measured by the health of its children:
  - Children must be healthy to benefit from education
  - Children's health and well being can be addressed in the school's environment

This policy wants to ensure that school-going children, including those in remote areas, have **equal access to quality health**

Introduction

- School Health Policy of 2003 has been revised and some changes have been made.
  - Implementation no longer done in phases.
  - Target groups changed
  - Indicators added.

ISHP Background contd.

- Socio – economic factors (child-headed households, Early childhood Development, grants
- Health related factors (vision, hearing speech, mental health, oral health, substance abuse, etc)
- Health promoting schools
- Applicable policies and legislation (health, education and social development)

ISHP Background contd.

- **Collaboration** between all role-players, with the Departments of Health (DOH), Basic Education(DBE) and Social Development (DSD) taking joint responsibility for ensuring that the ISHP reaches all learners in all schools.
- **Provision of services** to learners in all educational phases.
- **Provision of a comprehensive package of services,** which addresses not only barriers to learning, but also other conditions which contribute to morbidity and mortality amongst learners during both childhood and adulthood.
- **A systematic approach to implementation.** Although the ISHP will initially target the most disadvantaged schools, sequenced plans for progressive implementation aim to ensure that all learners are reached.
- **Implemented within the Care and Support for Teaching and Learning Framework** that is currently being used by the DBE to cohere all care and support initiatives implemented in and through schools including school health services.

Legislative, policy and programmatic context

- The Constitution of South Africa (Act No.108 of 1996)
- The Children's Act (Act No. 38 of 2005) as amended.
- The South African Schools Act (Act No. 84 of 1999)
- The National Health Act (Act No. 63 of 2003)
- The Mental Health Care Act (Act No. 17 of 2002)

There are linkages with other policies and programmes within the Departments of Health, Education and Social Development

Principles

- Focus on achievement of **health and educational outcomes**;
- Be implemented within a **child's rights approach.**
- **Full coverage of all learners** starting in the most disadvantaged schools;
- Ensure that **appropriate assessment, treatment, care and support services** are available and accessible to all learners who are identified as requiring them;
- Be informed by **local priorities**;
- Take into account **quality** and **equitable distribution of resources**;
- Be implemented as a **partnership** between the Departments of Health (DOH), Basic Education (DBE), Social Development (DSD) and all other relevant stakeholders and role-players;
- Be guided by **ethical standards** as outlined in the principles of professional bodies

Implementation of ISHP

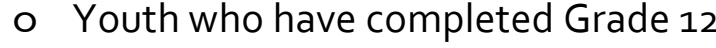
- 5 year phased roll out
  - Roll out to all Quintile 1 and Q2 Grade 1 in 1st year
  - By end 2 years, all Q1 and Q2 schools
- Specialised School Health Mobile Units will be deployed
  - To facilitate follow-up in remote areas – starting in ten NHI pilot districts
  - Bringing services and follow up care closer to learner
- Stronger M+E focus on coverage and quality of service

Target groups

- **Primary target group**
  - Main focus is school-going children.
  - The primary target group of this policy is all children and youths, regardless of age, who attend learning sites.
  - This covers children from Grade 1 to Grade 12 and Grade R where this is attached to formal schools.

- **Secondary target group**
  - The school community which includes educators, school management, school administrators and auxiliary staff, as well as parents and other caregivers – should also benefit from the programme.
  - The school community should work in partnership with the school health programme in shaping, informing and sustaining the "healthy" status of learning sites, e.g. HPS.

- **Children not covered by this policy**
  - Pre-school children
  - School going children not attending school
  - Youth who have completed Grade 12



Western Cape Integrated School Health Policy and Implementation Framework

Presented by:
Date:

W.C. Integrated School Health Policy & Framework

- The HOD, Prof Househam, instructed Mr. J. Ledwaba (Chief Director: Programmes) and Dr. K. Cloete (Chief Director: MDHS) to lead a task team in drafting the WC Integrated School Health Policy.
- SteerCom Members serving on the team are:
  - Mr. Ledwaba (Chief Director: Health Programmes)
  - Dr. Cloete (Chief Director : MDHS)
  - Dr. E. Lawrence (MDHS: School health doctor)
  - Dr. T. Hawkridge (Prov. DD: Child Health)
  - Ms. M. Williams (Prov. ASD: School Health)
  - Ms. B. Daniels (Director: WCED)
  - Dr. T. Bothma (DD: Specialized Education – WCED)
  - Ms. L. Rose (WCED)

Background

- A priority of NDOH is to strengthen the health system through revision of the Primary Health Care Package.
- The PHC Re-engineering process, as a national health reform, has brought about three core streams, namely:
  - (i) Outreach teams responsible for all households in a ward that are linked to local facilities, support groups, créches/ECD , EHOs etc.
  - (ii) Districts Maternal & Child Health specialists teams in each district who are responsible for clinical governance, mentorship and support to health professionals.
  - (iii) School health services provision as proposed by National health and DBE have drafted a School Health Policy & Implementation Guidelines, dated June 2011 which replaces the 2003 School Health policy.
- Collaborative effort between WC DoH and WCED and other key partners.

Current situation in the Western Cape province

- The current National School Health Policy is aimed at screening the grade R/1 pupils to identify problems and manage appropriately via assessments for hearing, eye, gross motor and anthropometrics (weight and height).
- The school health services were re-established in certain rural districts in 2006. Since July 2007 all districts in the Western Cape Province are implementing Phase 1 and Phase 2 of the National School Health policy.
- Schools under the administration of the Western Cape Education Department are visited by nurses rendering school health services employed by the Western Cape Department of Health.
- Specialized Education schools within the Western Cape have designated nurses appointed by the Department of Education to attend the learners of these schools. However, these nurses do not perform assessments on the learners as per the National School Health Policy.

Content of WC ISHP

- The policy and strategic contexts of the WC DoH and the WCED
- A situational analysis of the implementation of the 2003 National School Health Policy
- The vision, goals and objectives of the WC ISHP
- The School Health package of services
- Governance and drivers of the implementation process
- A monitoring and evaluation framework
- Deliverables for the implementation plan

Purpose

Guides the implementation of the Integrated School Health Policy (ISHP) which seeks to promote the desired health and educational outcomes and the general wellbeing of learners in the Western Cape.

Vision and goal of WC ISHP

The **vision**
•provide optimal health and educational services and
•to promote the development of school-going children and the communities in which they live and learn.

The **goal** is
•to contribute to the improvement of the educational outcomes of school–going children by focussing on the improvement of general health as well as the environmental conditions in schools to address health barriers to learning.
•to provide services to the learner at a place where the learner is easily accessed to deliver the ISHP activities.

Objectives of WC ISHP

- To provide preventative and promotive services that address the health needs of school-going children and youth with regard to both their immediate and future health;
- To support and facilitate learning through identifying and addressing health barriers to learning;
- To facilitate access to health and other related services where required; and
- To support the school community in ensuring that schools are health promoting.

Target groups & Implementation of ISHP

- A phased in approach will be used to provide the package of services:
  - Phase one focusing on grade R and 1 learners in the Quintile 1 and 2 schools
  - Phase two focusing on grade R, 1 and 4 learners in all schools
  - Phase three focusing on grade R,1, 4 and 8 learners in Quintile 1 and 2 schools
  - Phase four focusing on grade R, 1, 4 and 8 learners in all schools; and
  - Phase five focusing on grade R,1, 4, 8 and 10 learners in all schools.

Package of health services

The package of health services that will be provided in all schools will be delivered using the Care and Support for Teaching and Learning (CSTL) framework and will include:

•Promotion of Schools as Centres of Care and Support for Teaching and Learning
•Learner assessment and screening
•Management of health ailments
•Preventative Strategies

Care and Support for Teaching and Learning

- What is the CSTL?
  - SADC initiative adopted by DBE Ministers -2008
  - **Its Goal:** realise education rights of all children through schools
    - To become centres of learning and care & support
  - **CSTL** combines many existing sectors
    - to prevent and mitigate factors that have a negative impact on the enrolment, retention, performance and progression of vulnerable learners in schools by addressing barriers to learning and teaching.
  - Provides an all-encompassing framework for existing programmes

CSTL Priority areas

- Nutritional Support
- Health Promotion
- Infrastructure, Water and Sanitation
- Social Welfare Services
- Psychosocial Support
- Safety and Protection
- Curriculum Support
- Co-curricular Support
- Material Support

Schools as Centres for Care and Support for Teaching and Learning

- Provide effective skills-based health education (health education should ideally be incorporated into the school curriculum and provided through the LO curriculum. Department of Health staff can be used as resources/ consultants to assist with providing health education);
- Implement school policies and practices that support health;
- Provide a safe, healthy and supportive environment, both physical and psycho-social;
- Strengthen relationships with the community.
- Draw on local and regional support services;
- Promote self care and wellness of all members of the school community
- Engage health and education officials, educators, learners, parents and community leaders in efforts to promote health

Learner Assessments

- Barriers to learning are identified via
  - (SIAS) Screening, Identification, Assessment and Support
  - School Health assessments
    - anthropometric screening (height, weight and BMI),
    - eye and hearing screening,
    - ear examinations,
    - oral cavity examination,
    - motor skills (both gross and fine motor),
    - skin examinations for infections,
    - Screening for anaemia, and Tuberculosis.
  - Any abnormalities detected whilst delivering the school health package of services will result in referral to the appropriate member of the multidisciplinary team.

Management of Health Ailments

Minor ailments:

•Any learner found to have a health ailment (e.g. eczema) during screening or who is referred with such an ailment will be assessed onsite by the school nurse who will **refer** appropriately to the nearest health facility.

Chronic illnesses:

•Learners with known chronic illnesses (e.g. asthma, HIV) who are identified during screening or referred to the school nurse will be assessed onsite for efficacy of current care and **referred** appropriately if care not optimal. In this way the school health team will act as the safety net for learners who are not managed adequately at facility level.

• Any learner diagnosed with an acute or chronic illness during screening or when referred will be managed and/or referred appropriately by the school nurse.

Management of Health Ailments

- **Outbreaks:**
  - The school should report any suspected outbreaks e.g. measles or hepatitis to the nearest local authorities clinic.
  - Staff from the clinic will assess the situation and manage and/or refer appropriately.
  - The school health team may be asked to assist if necessary.

- **Emergencies and injuries:**
  - Each school should be equipped with a first aid kit supplied by the WCED, which is checked and
  - refilled regularly. At least 2 staff members at the school should be trained in first aid (and updated
  - regularly). All learners and staff should be knowledgeable about and able to practice universal precautions.

Western Cape
Government

Preventative Strategies

Deworming and sanitation programme

•Gr R to 7 learners (and staff) at identified schools will be dewormed en mass at school every 6 months during a deworming week as per the Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines

•Deworming medication to be administered by the nurse rendering school health services to learners with parental consent on a six monthly basis.

•Access to running water and toilets at schools with the assistance of Environmental Health Practitioners and Circuit Team Managers

•Learners need to be educated regarding the spread of worms (e.g. hand washing) through the LO curriculum, and they need to have access to clean toilets.

Prevention of Diseases

Immunization

•Immunization of learner's aged 6 and 12 years onsite with Td vaccine as per the Expanded Programme on Immunization (EPI - SA) with parental consent. Catch-up immunizations and newly introduced vaccines will be treated in the same manner.

•Immunizations may also be administered to learners during mass campaigns, e.g. polio and measles with parental consent.

Preventative Strategies contd.

Sexual and Reproductive Health

•Learners seeking advice and counselling from the School Health Team members for Sexual and Reproductive Health services, e.g. pregnancy testing; contraceptives; condoms; the testing; treatment, management and care of Sexually Transmitted Infections and HIV, will be referred to nearest healthcare facility for the appropriate intervention and care.

Tuberculosis

•Learners presenting to the School Health Team members with symptoms of Tuberculosis will be screened by the team member and referred for the appropriate testing; treatment, management and care to the nearest healthcare facility.

Consent and Assent

- Learners below the age of 18 years should only be provided with school health services with written consent of their parent or caregiver.
- However, learners who are older than 14 years may consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver.

Human Resource capacity

- **Permanent SH Team members**
  - Professional Nurse
  - Community Health worker
- **Adhoc SH team members**
  - Dietician
  - Speech therapist
  - Occupational Therapist
  - Oral Hygienist

Roles and responsibilities – National level

- The national level will support provinces in development, monitoring and implementation of the ISHP.
- Establish a National ISHP Task Team who will be responsible for the ISHP from the Departments of Basic Education, Health and Social Development, as well as other stake-holders.
- The task team will:
  - Provide technical support regarding the content of the ISHP and its implementation.
  - Develop a five-year implementation plan for the ISHP
  - Develop standardized guidelines for implementation and service provision with corresponding training packages.
  - Develop appropriate norms and standards for all aspects of the ISHP
  - Ensure that the resources necessary for implementing the ISHP are in place - this includes human, financial and other (such as equipment, materials and medication) resources.
- Monitor and evaluate the implementation and impact of the ISHP.
- Review the policy and package of services at appropriate intervals.
- Identify research priorities for school health

Roles and responsibilities – Provincial level

- Province will establish a joint Steering Committee (SteerCom) comprising of representatives from WC DoH and WCED supported by key sectors.
- Provincial task teams with representatives from WC DoH, WCED, WCDSD and other key stake-holders needs to be established.
- These Provincial ISHP Teams are responsible for ensuring that school health services reach all learners, and should work in close collaboration with the Provincial Task Teams which have been tasked with implementation of the CSTL framework.
- Key responsibilities include:
  - Developing a five-year implementation plan for the ISHP in the province, as well as a detailed implementation plan for the first year.
  - Securing the required financial, material and human resources.
  - Identifying and prioritizing the most disadvantaged schools which should be targeted during the early phases of implementation
  - Ensuring that appropriate referral facilities and processes are in place
  - Ensuring that an appropriate and adequate training programme for new and existing staff is in place.
  - Monitoring implementation of the ISHP in the province.

Roles and responsibilities – District level

- Responsible for the implementation of the school health programme in all sub-districts and reaches all schools and learners.
- Establish a team which is responsible for overseeing school health services, the District-Based Support Team **(DBST).** The team is jointly responsible for overseeing and co-ordinating the ISHP within the district.
- Each district will need to:
  - Ensure that the ISHP plan is developed and integrated into the district health and other relevant plans.
  - Allocate a person to oversee and manage the ISHP.
  - Conduct an audit of existing capacity for the delivery of the ISHP
  - Appoint School Health Teams who are responsible for providing and co-ordinating provision of the school health package to all targeted learners
  - Strengthen existing systems for communication, transport, equipment and referral
  - Monitor implementation of the ISHP as outlined in the ISHP monitoring and evaluation plan

Conduct capacity building of both health professionals and educators The expectation is that improved health outcomes will have a positive impact on educational outcomes.

WCED: All support staff of WCED will report information via the SLES head to the **District Education and Health Coordinating Committee.**

WC DoH: School health teams who will report to the Facility Managers and School Health Co-ordinators (Community-based Services)

Roles and responsibilities – PHC level

- Ensuring that all schools are reached.
- Each school health team will be based at a PHC facility, and will report to the facility manager.
- The facility manager is responsible for overseeing the day-to-day activities of the School Health Teams including logistical support, supplies and medicines.
- Statistics on the ISHP will be part of the facility statistics.
- PHC facilities also play an important role in providing services to learners who are referred.

Roles and responsibilities – School level

Institutional Level Support Team (ILST)

• Implementation of the ISHP at school level is the responsibility of the Institutional Level Support Team (ILST) under the guidance of the school principal.
•This team should include the ILST co-coordinator and other staff members.
•The team can consult with members of the different departments, members of the DBST, NGOs/ CBO's, Community Health Forums and other specialists.

Specific tasks include:
•Mobilizing and liaising with the school community including educators, the school governing body and other role-players
•Ensuring that all components of the ISHP package are provided to all parents and learners.
•Ensuring that data on the ISHP is collected, collated, stored and forwarded as outlined in the ISHP monitoring and evaluation plan.
•Managing any equipment that is provided to the school as part of the ISHP
•Building partnerships with external providers including NGOs Community Health Forums and other community organizations.

Roles and responsibilities – School level contd

With regard to learner assessment and provision of on-site services, the SBST should:
•Develop a schedule for learner assessments and ensure that DBE officials are available to support the activity
•Manage distribution and preparation of consent and assent forms and Road to Health Cards
•Orient learners on what to expect on the day
•Identify an appropriate space for learner assessments and ensure that the necessary infrastructure is available
•Ensure that a list of learners who are referred is kept, and that the learners access the services to which they have been referred
•Ensure that letters for follow-up reach parents or caregivers
•Liaise with DSD if parents are unable to access referral services in collaboration with the DBST.
•The SBST should also play a role in providing ongoing support and assistance to learners with long term health conditions.

Roles and responsibilities – School level contd

Role of learner during assessments

•The learner is expected to hand the consent form to the parent/caregiver for permission to participate in the school health learner assessments.
•Learners to hand their original or certified copy Road to Health Card/Booklet to the class teacher prior to the school health assessment so that the SHN can record the findings on the RtHC/B on the day of the screening.
• School health assessments will be conducted during the school day/ time with minimal disruption to the academic programme by the SHT.
•Learners with identified health problems including barriers to learning will receive a referral letter from the SHT and referred to the closest PHC facility.
• Learners may see the SHT on their own request for possible interventions and referral to other members of the multidisciplinary team.

Roles and responsibilities – School level contd

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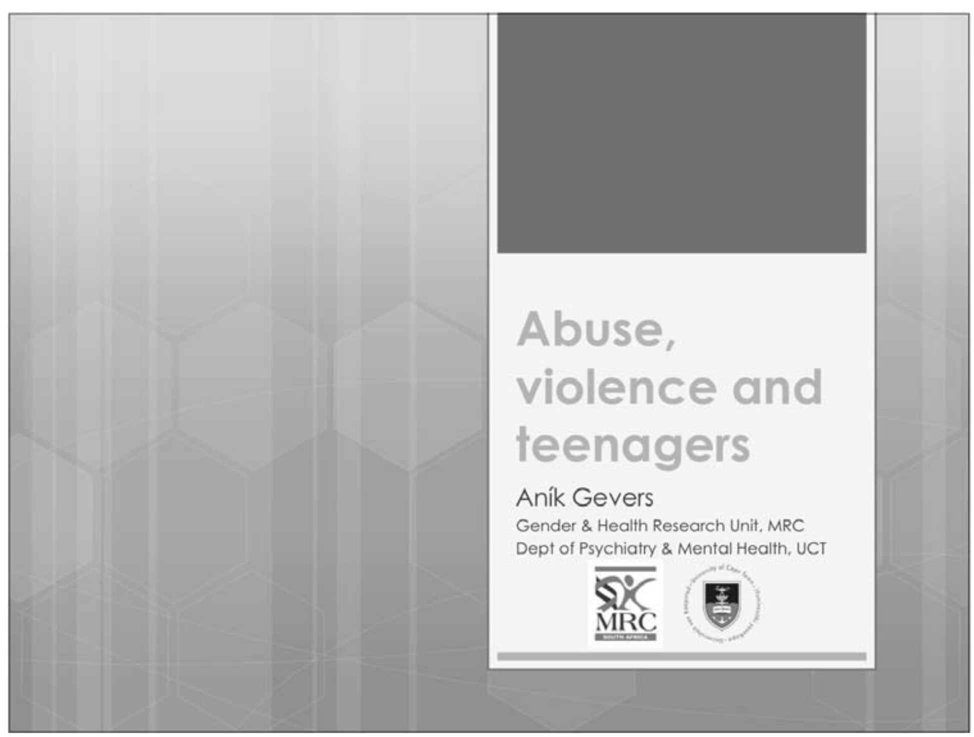

Who and what is in the room?

- Our own "stuff" and patient's "stuff"...and what happens when they meet
- What do we listen to?
- Not everyone is the same
- Coping and solutions

Reaching adolescents

- Are you comfortable? Are you present?
- What non-verbal messages are you sending out?
- Building a reputation
- WHAT you say and HOW you say it

Violence and abuse in teens' lives

- Witnessing abuse and violence
- Experiencing abuse and violence

- Types
  - Abuse/Violence
    - Emotional
    - Physical
    - Sexual
  - Neglect

Recognising warning signs

- Everyone responds to trauma differently
- Typical effects on adolescents living in abusive homes
- Typical signs of an abusive adolescent relationship

How to help

- Believe them
- Empathic and supportive response
- Safety plan
- Referral
- Follow up?

Specialised Learner & Educator Support Services (SLEs)

If you come across a case where psycho social support is needed and you do not know whom to contact, please contact the SLEs head of the school district where the learner comes from. The SLEs head will point you in the right direction.

DISTRICT	NAME	DISTRICT TEL. NO.	DIRECT TEL. NO.	FAX NO.	POSTAL ADDRESS	E-MAIL
CENTRAL	Mr. E. HASSEN	021 673 1300	021 673 1319	021 673 1318	Private Bag X4, ATHLONE 7760	Ehassen@westerncape.gov.za
SOUTH	Mrs GUILOT De KLERK	021 370 2000	021 370 2090	021 372 1856	Private Bag X2, MITCHELL'S PLAIN 7785	Gdeklerk@westerncape.gov.za
NORTH	Mr. W LAUBSCHER	021 938 3000	021 938 3063	021 938 3180	Private Bag, X45, PAROW, 7500	Wlaubscher@westerncape.gov.za
EAST	Ms. D NAIDOO	021 900 7000	021 900 7187	021 903 9484	Private Bag X23, KUILSRIVER, 7579	Danaidoo@westerncape.gov.za
WEST COAST	Mr. A ARENDSE	021 860 1200	021 860 1209	021 860 1231	Private Bag X3026, PAARL, 7620	Abrey.Arendse@westerncape.gov.za
WINELANDS	Mr. G BARKHUIZEN	023 348 4600	023 348 4656	023 348 4656	Private Bag X3102, WORCESTER, 6849	Gbarkhui@westerncape.gov.za
OVERBERG	DR. R BOUMA	028 214 7300	028 214 7376	028 214 7400	PO Box 588 SWELLENDAM, 6740	Rbouma@westerncape.gov.za
EDEN KAROO	Mr. F TALLIE	044 803 8300	044 803 8355	044 873 2253	Private Bag X6510, GEORGE, 6530	Fernando.Tallie@westerncape.gov.za

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