Case Study for Effective Implementation of the Integrated School Health Programme (ISHP):

Baseline Study at Nzululwazi High School and Surrounding Community

UNFPA

SPW
STUDENT PARTNERSHIP WORLDWIDE

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CSE	Comprehensive Sexuality Education
CSTL	Care and Support for Teaching and Learning
DHS	Department of Human Settlements
DoE	Department of Education
DoH	Department of Health
DoSD	Department of Social Development
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ISHP	Integrated School Health Programme
IUD	Intrauterine Device
LSA	Learner Support Agent
MRC	Medical Research Council
NGO	Non-Governmental Organisation
RD	Restless Development
RHRU	Reproductive Health Research Unit
SRH	Sexual and Reproductive Health
SAPS	South African Police Services
SPW	Student Partnership Worldwide
STI	Sexually Transmitted Infection
SYP	Safe Guard Young People
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YRC	Youth Resource Centre

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1. Introduction

In terms of teenage and learner pregnancy, it is estimated that fertility in South Africa rises from a low of 2% among 15-year-olds and peaks at 30.2% among 19-year-olds (DOH, MRC & Measure DHS). Data from the 2003 Reproductive Health Research Unit (RHRU) study also shows that teenagers aged 17-19 account for 93% of teenage fertility (Harrison, 2008b). Thus, female learners in their final years of schooling are especially vulnerable to unplanned pregnancy.

When teenagers initiate their sexual life early on, they place themselves at increased risk of early pregnancy, sexually transmitted infections (STIs) and HIV (Kirby, 2007). The 2003 RHRU study shows that the median age at first sex among 15-24 year olds was 16 years for males and 17 years for females.

In South Africa, coerced sex and sexual violence is a significant trend and is often aimed at the most vulnerable members of society, namely children. Sexual violence and coercion amongst children and adolescents increases susceptibility to HIV insofar as non-consensual sex is associated with increased genital trauma, coital injuries, and the likelihood of anal penetration.

Living circumstances are widely understood to present a significant risk for early pregnancy, STIs and HIV as a result of structural features such as access to health services, concentration of poverty and unemployment and poor educational attainment. Official health reports from South Africa and Southern Africa suggest that fertility rates among teenagers may almost double.

Research conducted by the Human Sciences Research Council (HSRC) on behalf of the Department of Basic Education, with support from UNICEF, shows that teenage mothers are concentrated among those with only primary education (38.5%) but decline progressively among those with some secondary education (12.9%), matric (7.9%) and those with higher education (4.0%). The Eastern Cape is reported to have high levels of early pregnancy with the Department of Education (DoE) estimating 30 000 teenage pregnancies over the period 2010-2014.[ii]

The situation at Nzululwazi Senior Secondary School (SSS) must be understood against the broad national backdrop outlined here. Located outside Mt Frere on the north-eastern periphery of Mpendla Village in the Eastern Cape, it is fairly new – it was established in 1999 initially as a very modest structure with very poor pass rates up until 2001. Former President Mandela then leveraged financial support from MTN and Dimension Data to build a new school. In July 2002 the school was re-launched as a R3.1-million, 10-classroom secondary school with a library, IT media centre, science laboratory, a hall and an administration block complete with a kitchen and four offices.[iii]

By December 2014 the school was reported to have suffered vandalism and theft.[iv] Currently it is in reasonable condition. It caters for grades 10-12 and has 22 teachers, one Learner Support Agent (LSA) and 650 learners in total. Nzululwazi is not listed as one of the *no-fee schools* for 2014. Nzululwazi SSS now performs above average academically with an average matric pass rate of 65% over the past three years. In 2012 it obtained a 77.4% pass rate – the second highest in the district.[v] However, the school experiences substance abuse/drug problems and a lack of accommodation for learners whose homes are outside the immediate area.

Both of these factors are believed to influence pregnancy rates.[vi] Student Partnership Worldwide (SPW) reported 25 pregnancies at the school

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in 2014 and 15 for the period January to June 2015. However, there are no accurate statistics for pregnancy rates at the school over the past two years. Section 4.1.1 of this report includes the latest data supplied directly by the Principal.

A report by SPW (June 2015) notes that in 2014 Nzululwazi SSS was identified as the school with the highest level of teenage pregnancy in the province – rumoured to be 70 pregnancies in just a year. There is a discrepancy between the 'rumoured' pregnancy figures and those provided by the school during the latest research. While the rumoured figures related to 2014 (a different period) it is likely that they were too high. Further research suggests that some learners become pregnant in primary school and enter high school in this state – usually undisclosed.

Although subsequent investigation showed this figure to be inflated, government responded and the Department of Basic Education hosted a World AIDS Day event in December 2014, under the theme *Say no to HIV/AIDS, Teenage Pregnancy and Discrimination in Schools.* As part of its response, the Department sought the assistance of SPW through the UNFPA funded Safeguard Young People (SYP) programme to train school governing bodies on the Integrated School Health Programme (ISHP). This intervention also seeks to build understanding and capacity around the policy amongst Life Orientation (LO) teachers, students and the Departments of Health, Education and Social Development.

This formed the basis for the workshop that SPW facilitated at Nzululwazi High School from 17 to 19 June 2015. At this event, school governing bodies confirmed their deep concern regarding escalating levels of teenage pregnancy, and negative impacts on learners' progress and highlighted other challenges such as drugs, Satanism and theft. It was resolved that everything possible should be done to resolve issues of sexual and reproductive health (SRH) that impede learner performance.

On 21 July 2015 a follow-up meeting of all the relevant role-players agreed on an implementation plan that specified actions for the respective departments and other role-players and efforts to improve coordination between the three main departments.

From 11-13 August 2015, with UNFPA support, SPW conducted an *Adolescent Sexual and Reproductive Rights Intergenerational dialogue* at Nzululwazi High School in order to better understand the communication gap between parents and youth, and work with community stakeholders to further unpack the barriers preventing young people from achieving healthy, safe sexual reproductive lives. This event identified cultural perceptions that inhibit the use of contraceptives, not only by youth but rural married women. It also delved into the influence of out-of-school youth, especially when it comes to drug use; youth unfriendly services and misinformation about contraceptives. Student Partnership Worldwide went on to launch a peer education programme and establish a local youth resource centre at Nzululwazi geared at coordinating health, social development and education services for the youth. By November 2015 this centre was in the final stages of development.

In conducting this baseline study, every effort has been made to represent the situation prior to the SPW intervention; however, local stakeholders regard SPW as an intrinsic part of their recent development history and in many narratives it was hard to excise the presence of SPW from the study.

2. Purpose of the Study

The Student Partnership Worldwide (SPW) South Africa Trust (also known as SPW South Africa) in partnership with UNFPA leads the SYP Programme in three districts (OR Tambo, Amathole and Alfred Nzo) in the Eastern Cape. The goal of the programme is to contribute towards the improvement of the Sexual Reproductive Health and Rights (SRHR) of young people aged 10-24, with particular emphasis on HIV prevention. At the request of the provincial Department of Basic Education, and in collaboration with the Departments of Social Development and Health, SPW was requested to focus on Nzululwazi Secondary School.

Given the unusually high rate of teenage pregnancies amongst learners, both within the high and primary schools in this area, the main purpose is to reduce teenage pregnancy over a three-year pilot timeframe through:

- Improved coordination, collaboration and leadership of core stakeholders responsible for the provision of sexual and reproductive health information and services.
- Expanding the availability of appropriate SRH information and services to the community.

- Ensuring increased take up of SRH services delivered in the context of the ISHP.
- Building a community owned and led intervention that is sustainable beyond the initial funding to ensure that core stakeholders on the ground are able to take the successes and lessons forward using their own resources and leadership.

As already noted, the subsequent intervention started in June 2015. However, SPW also recognised that good and promising practices are only properly understood if the situation prior to the intervention is properly assessed and recorded as a functional baseline. This allows progress to be tracked against an established baseline and the identification of opportunities for scale-up across the province and country. This research study therefore endeavours to record and understand stakeholder attitudes, values and behaviours that formed the baseline (pre-existing situation) *prior to the intervention*.

Based on these insights, it suggests how progress can be appropriately tracked while retaining community understanding and support. A further core aim is to use the study findings to frame a relevant three-year monitoring and evaluation tool for the project that clearly tracks and measures impact.

3. Approach and Methodology

The research used a mix of quantitative and qualitative methodologies including an inception meeting to map out the key stakeholders and the state of intervention at the research site (Nzululwazi High School).

A brief literature review was undertaken mainly using documents provided by SPW but also sourced from the Internet. Research instruments were designed including a self-administered questionnaire for learners, focus groups guides, individual interview guides and case study templates. Factors that impacted the study included the limited time period to conduct the field research, limited resources which prevented extensive periods in the field and timing as the field research occurred during exam time when many learners were not present.

As a consequence of the factors mentioned above, the sampling method agreed with SPW was largely purposive, i.e., it set out to engage as many learners as possible who could make informed input on the subject matter. The circumstances of the fieldwork and the time available for preparation did not allow a sample size or frame to be pre-determined, nor did it allow for clear determination of stratification. Prior discussion had already determined that a representative sample size would be achieved. In order to maximise the benefits of the purposive sample, the respondents were recruited by peer educators who had prior knowledge of the community and had already interacted with the study population.

It was acknowledged from the outset that the research would have a strong informal dimension. Had this been a *project evaluation,* this approach would have clearly been inappropriate; however, it was a *baseline study* that enquired into circumstances that prevailed prior to the SPW intervention. It is therefore unlikely that the peer researchers would have any vested interest in matters that occurred prior to their intervention. The learner study forms were translated into isiXhosa and distributed by SPW's peer educators to learner groups.

The field research was conducted over two days. Focus groups and interviews followed the participatory rapid appraisal method. Follow-up interviews were conducted telephonically with respondents not initially available or where further information was required. Prior to entering the learner study data onto a spreadsheet, quality assessments were made and any necessary data cleansing was undertaken.

Data analysis was then undertaken and the provisional narratives were written up. A presentation on key issues and provisional findings was made to SPW including a proposed outline of the type of indicators that might be part of the future monitoring/performance assessment tool.

Based on this feedback, the research was further refined and the provisional findings were adjusted.

The study was greatly assisted by the preparatory work undertaken by SPW in arranging interviews, introducing the service providers to key stakeholders and general logistical assistance. Student Partnership Worldwide ensured that both community and government respondents were properly briefed on the purpose of the exercise and the value it would have for the community in the future. As a result, most respondents were cooperative and did their best to fit into the tight field research schedule.

Factors that contributed to the independence of the data collection were:

- Assured confidentiality of the respondents in completing study questionnaires.
- Collection of forms via a 'ballot box' type arrangement.
- Respondents completed forms individually.

Other ethical considerations considered:

- Prior to the study it was determined that the crucial information that would benefit youth sexual health was not available from adults.
- Participation in all study formats was voluntary.
- In individual interviews respondents were asked if they were comfortable with researchers of a different gender.
- Every effort was made to ensure that respondents did not feel threatened or judged.
- The researchers made it clear that certain topics could be avoided or terminated if the respondent felt uncomfortable.
- The researchers were sensitive to the respondents' economic, social and cultural circumstances.

Furthermore, during the focus group with teachers and prior to the learner focus group, it was established that learners were already familiar with the sexual health and reproductive topics. Some had experienced this through SPW's intervention but as a whole, the subject, is also discussed in LO periods. The WHO has noted that there are no clear ethical justifications for excluding adolescent subjects below the age of legal majority from research.

If reproductive health problems exist that are restricted to, or also occur among adolescents that cannot be solved with existing knowledge, there is an ethical duty of beneficence and justice to conduct appropriate research to address these problems. Student Partnership Worldwide's prior involvement at the research site and their experience in working with youth enabled consultation on research ethics and the researchers endeavoured to keep within the parameters and conventions established by SPW.

4. Study Findings

4.1. Study of Learners: (Profile, Attitudes and Behaviours)

This study consisted of a self-administered questionnaire distributed by peer educators at the high school. The initial plan to study the junior school was not feasible due to time constraints and ethical concerns in relation to studying very young children. The questionnaire contained 23 questions of which five were open-ended and the remainder closed-ended. Learners were assured of anonymity and special provisions were made to preserve confidentiality when handing in the questionnaire.

4.1.1.Nzululwazi Senior Secondary School (High School)

Basic Description of the Study Population	
Total number of study respondents	184[1]
Grades covered	10-12
Gender breakdown	Female: 112 (60.9%)
	Male: 68 (37%)
	Not provided: 4 (2.1%)
Average age of respondents	17 years

Age and grade profile: The youngest respondent was 12 and the oldest was 24. The largest segment of respondents, 72 (39%) was from the age group 18 years. Other well represented age groups were those aged 16, 17 and 19 – all at roughly 16% of the total. The highest number of respondents were in Grade 11-131 (70.8%), followed by Grade 10-44 (23.8%) and Grade 12-5 (2.7%).

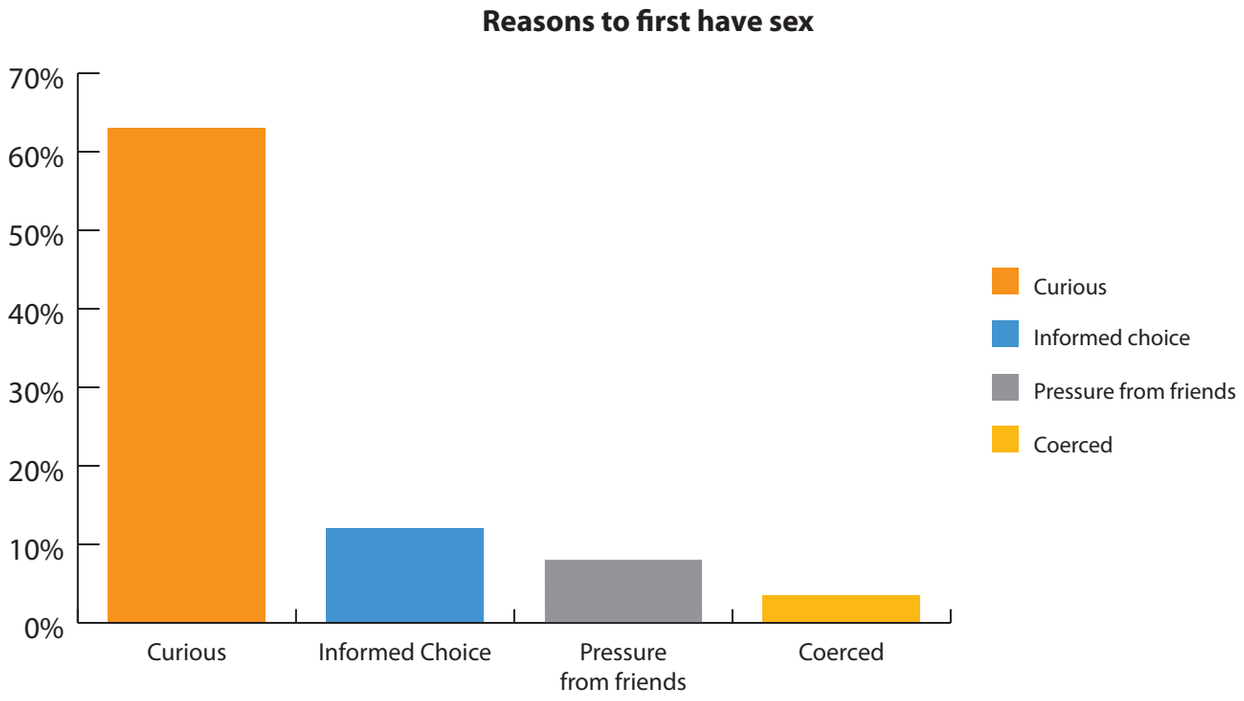
Living circumstances: Most of the respondents – 137 (74%) were from rural areas and only 42 (23%) lived in town. Most (64.3%) respondents lived with their families, nearly 20% lived with friends, 6.5% lived alone and roughly the same number said they lived in a school residence. Only two lived with a partner.

Relationships and sexual experience: The majority – 152 (82%) of learners described themselves as 'in a relationship' and 113 or 61% had experienced sexual intercourse.

Sexual Intercourse		Relationships	
39%	Had sex	18%	In a relationship
61%	Not had sex	82%	Not in a relationship

The earliest age at which a respondent said they had first had sex was five (the single male respondent said it was not coerced sex, although he had at other times experienced coerced sex.) This respondent claimed to have had his first sexual experience through peer pressure. One other respondent, also male, had experienced sex at a very early age (six) and said it was not coerced and that he'd never experienced coerced sex. Of the 113 learners who had experienced sex, 8 (7%) said they had been coerced into sex at some stage and 103 (91%) said they had never suffered coercion. Of those that had suffered coercion, five were female and three male.

[1] *This represents a sample of slightly over 28% of the total number of learners at NSSS.*



In response to the question *What was the main reason that led you to first have sex?* The majority of respondents (71 or 63%) said they were curious, 14 (12%) said they made an informed choice and 11 (8%) said they were pressured by friends.

Only four (3.5%) said they were coerced into their first sexual encounter and the same number did so in order to have a baby. Only one respondent reported having first had sex for a reward.

The following are some of the reasons that learners cited for choosing to have sex:

- I too wanted to experience sex.
- I wanted to because I love my boyfriend.
- My girlfriend and I felt we were ready.
- I wanted to because I wanted to feel how being a parent is.
- I wanted to make my partner happy and myself.
- I wanted to and I loved my partner and trusted him.
- I was horny.
- To me it was a game.

Reasons for having sex less clearly related to a freely exercised individual choice included:

- It was because I wanted to but my friends were also a bad influence.
- It was because my friends kept saying different things about sex.
- We wanted to trust one another.
- I wanted to and my peers were also doing it.
- My friends drove me to do it.
- My friends pleaded me to have sex and I was not ready.
- It just happened.
- My friends had sex already and I didn't want to miss out.

Instances where having sex clearly had nothing or very little to do with choice included:

- We were in a gang and he held me down forcefully, took off my clothes and forced himself on me.
- My partner forced me to experience it for myself.
- I was raped (reported by two learners).
- I was drunk and in the morning I woke up naked.

While only eight of 113 sexually active learners reported having being coerced into sex, a more careful exploration of the reasons for having sex suggests a range of circumstances and at least 12 instances where free choice and reasoned decision-making were compromised.

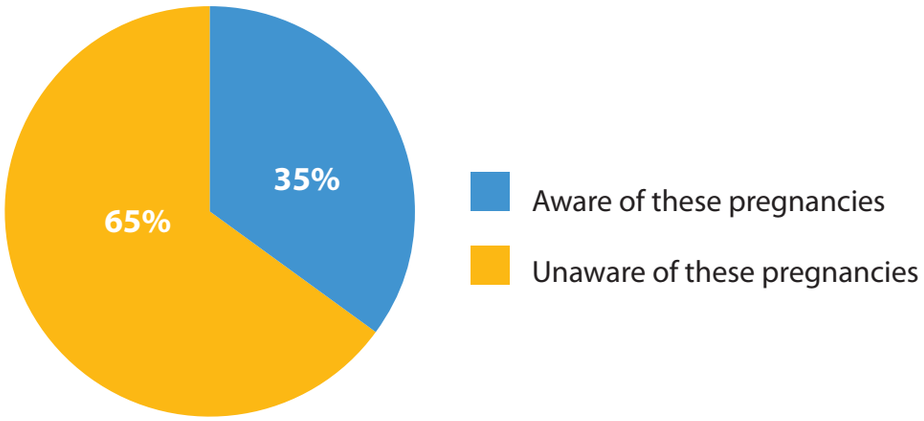
Apart from the two instances mentioned previously of very young sexual activity, it seems that there is a slow increase in the likelihood of first sexual intercourse from the age of around 10 which increases dramatically at aged 15 to 18 and then tapers off after age 18. Most learners report first sexual intercourse at the age of 15 and in the following three years. Nearly 64% of the respondents experienced their first sexual intercourse between the ages of 15 and 18.

Age at first Sexual intercourse	<10	10	11	12	13	14	15	16	17	18	>18
Number of respondents	2	5	1	6	7	9	21	19	16	16	3
% of Sexually active (113)	1.8%	4.4%	0.9%	5.3%	6.2%	8%	18.6%	16.8%	14.2%	14.2%	2.7%

Contraception: Of the 113 sexually active learners, 98 or nearly 87% claimed to use contraception and only 14 (12%) said that they did not do so. Of those that said they used contraception, 50 (51%) used a condom, 18 (18.4%) injections (Depo Provera)[2] and three oral contraceptives. Thus, about 27% of those who claimed to use contraception did not specify its form. This could cast doubt on the veracity of the number of respondents that claimed to use contraception.

[2] *No stakeholder made any mention of the transdermal implant contraceptives that the Minister of Health announced as freely available from February 2014.*

Unwanted pregnancy among close circle of friends within past year



Three questions in the questionnaire were designed to test learner knowledge of contraception. These related to the morning-after pill, alternatives to the male condom and where knowledge of sex and contraception was obtained. Only 10 (6.2%) of the 161 respondents who answered this question were aware of the morning-after pill and approximately half of these could provide a reasonable explanation of how it works. There was wide knowledge of an injection as an alternative to the condom. Other forms of contraception such as 'the pill', and the loop (IUD) were known to only a handful of learners. Several learners mentioned abstinence, withdrawal and masturbation which they considered as a method of contraception available to them.

There was a fairly even split amongst the 174 learners who responded to the question on where they received their knowledge on sex and contraception. The most common source was *own reading* (33%) followed by parents (31%), teachers (23%) and finally, friends at only 13%. These figures are surprising given the trends in the research study's other findings which suggest little influence by parents and major influence by peers and friends. Clearly learners may be influenced by peers and friends more than parents and teachers but they are more likely to seek information from the latter.

Scale of unwanted pregnancy: The question posed was, "Within your close circle of friends, has anyone become pregnant (unwanted) within the last year?" There were 165 responses to this question and 58 said they were aware of such pregnancies. It therefore seems that over a period of one year, slightly over 35% of learners knew someone within their immediate circle of friends who was pregnant. Pregnancy data was supplied by the Principal in early December 2015. It is important to note that the school has no official test to determine whether learners are pregnant and the data below appears to be based on observation or instances where the learner chose to divulge their status for whatever reason.

Year	2013	2014	2015
No. of pregnant learners	45	21	14[3]

HIV and AIDS

Learner knowledge was tested by asking them to assess the statement *A person living with HIV and AIDS is able to live a full and healthy life.* Of the 164 respondents, 145 (88%) said the statement was true as indeed it is, while 19 (12%) said the opposite.[4] A further test of learner knowledge was undertaken by asking for an assessment of various sexual and non-sexual activities in terms of HIV risk [no risk (NR), low risk (LR), high risk (HR)] The table on the following page illustrates the results of this assessment where the second row is the correct response and the third is the spread of learner responses with the correct response in bold.

[3] Cases the Principal was aware of as at 9 December 2015. However, he cautioned that the school might not be aware of all current pregnancies.
[4] HIV is a virus that causes the condition known as AIDS. A person may be infected by the virus without developing AIDS.

	Penetrative sex with a condom	Masturbation	Deep kissing	Anal sex without a condom	Sharing a toothbrush	Oral sex with a condom	Sharing a toilet with a person infected by HIV and AIDS
Correct Responses	LR	NR	NR	HR	NR	LR	NR
Learner Responses	**LR-26**	**NR-73**	**NR-90**	**HR-80**	**NR-18**	**LR-53**	**NR-66**
	NR-101	LR-10	LR-43	LR-34	LR-40	NR-42	LR-37
	HR-13	HR-57	HR-6	NR-22	HR-78	HR-41	HR-31

The following simple indices were used to rate the responses in terms of correct answers:

- 0-3 very weak understanding
- 4-5 moderate understanding
- 6-7 good understanding

Applying the above indices to the 139 respondents that answered this question, 95 (68%) had very weak understanding, 42 (30%) had moderate understanding and only 2 (1.4%) had a good understanding. Thus, while the initial responses on the life prospects of those living with HIV seemed to indicate fairly broad awareness and insight, the more specific enquiry into risk factors indicates that the majority of learners have very poor understanding of HIV and AIDS transmission risks. Of particular concern are the 57% who thought that sharing a toothbrush carries a high risk of HIV infection, half of the respondents who thought that sharing a toilet seat with an HIV positive person carries some level of risk and the 41% who thought that anal sex without a condom constitutes low or no risk.

General gaps in sexual and reproductive knowledge: The following table illustrates the main gaps in knowledge identified by the respondents and the weighting of the responses.

Knowledge gap	Number of respondents who mentioned	Weighting
Knowledge about STIs	28	24%
HIV & AIDS life expectancy	**14**	**12%**
How HIV infection occurs/can be avoided/ remedies/'cures'	14	12%
Teenage pregnancy/pregnancy	10	9%
Risks from anal/oral sex	9	8%
Other	8	7%
Abstinence/how to stop having sex	8	7%
Use of contraceptives (general)	6	5%
TB	5	4%
No gaps	4	3%
Sex in general	3	3%
Recommended age to become sexually active/how to decide when to have sex/how to exercise choice or say no	3	3%
How to avoid unprotected sex	2	2%
Safety in condom use	2	2%
Homosexuality	1	1%
Total	**117**	**100%**

This suggests that learners feel the most need for additional knowledge around sexually transmitted infections (STIs) and HIV and AIDS. Collectively this accounted for 48% of the knowledge needs expressed.

Assistance required in helping learners to be more in charge of their sexual and reproductive health

There were 132 responses to this question and the vast majority said that the use of condoms/ contraception would help them to feel more in charge. A handful mentioned assistance in exercising abstinence, advice from a nurse, assistance to become more comfortable/relaxed about having sex, getting to know more about sex itself and advice about staying safe. This suggests that learners may be more concerned about contraception than was indicated in the more interactive parts of the research.

Nearly 89% of the respondents felt that the clinic should provide such assistance, with only 10% citing the school. Other responses were, the church (2), SPW/other NGOs (3), parents (1), special programmes (3) and 'a loved one' (1). This underlines high expectations of the local clinic service and some concerns about the quality/ capability for such information to be provided at school level.

Accessibility and comfort in using services

Virtually all of the respondent assessments related to the clinic and 32% said it was very accessible, 60% that it was somewhat accessible and 8% said it was not accessible at all. A similar pattern emerged in relation to how *comfortable* learners felt using the service. Slightly over 58% said they were very comfortable using the service, 36% were somewhat comfortable and only 6% were not comfortable at all.

4.2 General Research

This emerged from all of the stakeholder focus groups and the individual interviews using the respective research instruments.

a. Sexual and Reproductive behaviour, attitudes and support

Describe how youth behave sexually and explore their sexuality

This question was posed to virtually all the respondents and there was a high degree of consensus in the responses. Learners and young people were generally described as highly sexually active from an early age. For example, teachers cited two learners who had fallen pregnant in Grade 9. Substance abuse, mainly alcohol and dagga is seen to contribute to sexual activity.

The school governing body (SGB) Chairperson in particular drew attention to this problem. Parents are particularly concerned about unfettered and 'rampant' sexual activity which they blame on TV and social media.

The Principal of Nzululwazi SSS holds the same view and suggested that high rates of teenage pregnancy are an indicator of the rate of sexual activity among learners and young people outside the school. He suspects that sexual activity starts in Grade 8 or 9 which he considers too young. He suggested that learner suicides may be linked to sexual activity amongst learners who are too young and cited an example of a learner who committed suicide because she became pregnant. Teachers also felt that the *Child Support Grant* had diminished learners' fear of pregnancy and perhaps even elevated *pregnancy* to a sought-after status.

Male learners apparently also regard their status as being elevated by having had a child. Parents endorsed this view and suggested that it was 'fashionable' to have a child – they cited evidence of young learners proudly giving the child their own name. Learners described their acknowledged high levels of sexual activity as *normal* and insisted that it is nothing to be embarrassed about. As more neutral observers, *peer educators* confirmed high levels of sexual activity and little concern for safe sex. It seems that many learners do not care about their sexual behaviour or its consequences. Peer educators ascribed this to a lack of facilities and information as well as dominant cultural beliefs within the community. Polygamy/multiple partners is deeply entrenched "…they think they can just continue what their parents did." In this view, while traditional beliefs may ostensibly advise abstinence or cautious sexual activity, learners see this as hypocritical. It was even suggested that the traditional *Inciyo* (the controversial virginity testing ceremony) is easily subverted by girls who insert a rolled up R100 note in their vagina to bribe the examiner.

Common youth attitudes to pregnancy and contraception

There were divergent views on these issues. Teachers felt that learners want contraception but find it hard to access. On the other hand, male learners dislike condoms and make little use of them. Some teachers erroneously believed that condoms were available at the school. It seems that although male learners have access to condoms,

they prefer not to use them. Peer educators made similar observations and noted that efforts to change the type of condom on offer had made little difference. According to teachers, 'sugar-daddies' are most likely to use condoms, as it is in their interests to avoid pregnancy from an illicit relationship. The topic of 'sugar-daddies' came up in most stakeholder discussions. Teachers claimed that it was fashionable amongst female learners to be in these relationships as 'sugar-daddies' are discerning and choose the most attractive girls who are in turn, 'afforded' (receive material rewards.) The SGB Chairperson also said learners had sex with little consideration for contraception and therefore became pregnant.

Male learners were open in their dismissal of condoms as a form of contraception, describing them as 'not safe' and 'useless.' Indeed, they were generally disinterested in contraceptive measures, describing them as spoiling the experience. One respondent frankly noted that "…having sex is the priority – (preventing pregnancy) is not my business." Peer educators confirmed that a 'don't care' attitude pervades and is sometimes unwittingly facilitated, e.g., mothers support pregnant girls. It was suggested that girls renting accommodation to be near school are most at risk since they are unsupervised and amongst these learners it might even be considered *fashionable* to be pregnant.

The Principal confirmed a general lack of interest in contraception but noted that some learners do take advice from parents and teachers. He noted that if a sample of 100 girl learners revealed that only 20% were pregnant, given the rate of sexual activity, it must be assumed that some take precautions.

Is the current rate of pregnancy among young women cause for concern?

The previous discussion topics revealed that teenage pregnancy rates are indeed cause for concern, except perhaps among learners themselves. Teachers are concerned because it negatively impacts the learner's performance at school and limits their opportunities in life. According to teachers there were 18 pregnancies at the school in 2014 and seven at the time of the research in 2015; these were only those that were detected. As noted earlier, the actual figures are rumoured to be significantly higher.

Teachers attributed the reduction to the fact that the issue was raised at the previous World AIDS Day where learners' right to use clinic services was stressed. The school as a whole supports interventions aimed at preventing unplanned pregnancies even though these may disrupt teaching. Parents were most concerned about pregnancies because they had to shoulder the burden of raising the children. All other stakeholder groups were very concerned and felt that this was the key priority for intervention. On the other hand, learners said they were no longer concerned about this issue.

They claimed that in most instances these pregnancies are now accepted as "part of our culture". They said that they either did not know about contraceptive measures or "did not want to know". They referred to their previous reservations about using condoms – "we do think about these things (HIV and AIDS & pregnancy)… but it is part of life."

How much do young people know about sexual and reproductive health rights and responsibilities?

According to teachers the sensitivity of such topics has diminished and learners do talk among themselves but apart from the World AIDS Day event and LO classes at school, not much has been done to create awareness and improve learner knowledge. Parents suggested that young people are both naïve and dismissive – they know about these topics but do not care. They do not choose to use the knowledge for their own safekeeping/protection. On the other hand, learners said that they do not talk about SRH rights and responsibilities but they suspect knowledge amongst their peers differs; most know, but some are less informed about these matters. Most do not allow such knowledge to curb or 'spoil' their sexual experiences.

Peer educators reflected similar views to learners. They suggested that some learners may have knowledge and some seek out contraception services but in general they are not 'invested' in such services, i.e., they recognise the value but ultimately do not commit to using the service. This poses a dilemma because while learners should be informed about such matters, parents often don't want to even acknowledge that their children are having sex. The stigma attached to STDs is also uneven. Amongst some learners, infections are regarded in a 'neutral' manner. Peer educators felt it was nonetheless important that learners be exposed to information.

The Principal felt that learners had been widely exposed to information about SRH rights and responsibilities through the government, NGOs and the media. "It's been talked about for the last 20 years. They know the do's and the don'ts." However, he noted that such knowledge may have little impact on sexual behaviour. "They still want to experiment – anything that is forbidden becomes attractive – they hear the message but they don't heed it." Asked why the message is ineffective, the Principal replied that it is "too liberal…too friendly, there needs to be more deterrence, it needs to be more harsh. Learners simply laugh it off." He reflected on emerging differences between urban and rural areas. Initially there were high pregnancy rates amongst learners in urban areas but this has been reversed. Those living in urban areas now heed the message while learners in rural areas seem to be belatedly experiencing their own sexual freedom and are excited by it. In the past, underperforming schools were called to meetings with the Minister where lessons were shared from the better performing schools. The message was clear – schools that deal strictly with pregnant learners (suspend them) perform better. But now the policy forbids such action. The SGB

Chairperson held similar views but noted some progress in terms of the right to refuse sex, "They do know - since this programme[5] started the rate of pregnancy has decreased. They know their rights and can now also say no to sex unlike before."

How do young people cope with the risk of HIV and AIDS? Does infection still lead to stigma?

Teachers are of the view that today, very little stigma is attached to HIV and AIDS infection amongst learners. "They know they can survive, they know people close to them that are infected and they are doing fine on treatment… they are not scared of disease… they are more scared of pregnancy." Some teachers felt that the strategy of de-stigmatizing the disease and making it manageable and survivable had backfired. The youth may have discarded prejudice and stigma against those infected but they also make no serious effort to avoid infection. "Now there are solutions for everything." Parents held similar views, noting that the virus is no longer feared or stigmatized because it is treatable. The SGB Chairperson held a similar view but attributed improved knowledge and reduced stigma to the SPW intervention – before that infection rates were high.

Learners were less ready to accept that all stigma has disappeared and claimed that some learners still distance themselves from those infected. However, the impression that they are now nonchalant about the risk of infection was reinforced by the following comment, "We are not really worried… it is only once you test positive that it becomes an issue…" Peer educators had already made their views clear on this matter, noting that stigma had been greatly reduced but still manifested occasionally.

The Principal noted that the school (DoE) policy is to encourage testing and avoid stigmatizing those who are infected. There are learners living with HIV at the school and they are supported by life skills teachers who try to ensure they receive nutrition in line with their treatment regime. Other measures such as the provision of clothes and groceries are also invoked where appropriate.

"Learners may be scared of HIV but they still experiment and want to have unprotected sex… they are not adapting in any way to the AIDS risk."

Who else is influential in shaping attitudes apart from the youth? What values do they try to instil?

Teachers felt that they are able to influence learners and to some degree, shape attitudes. The *LO* class is of particular value and the LO teacher's views and advice are generally trusted by learners. The information in the LO handbook is of good quality and is trusted by learners. Asked if they had been specifically trained to provide such counselling and advice, the teachers indicated that two (including the LSA) of the 22 teachers at the school had received such training. Parents were unsure who influenced learner attitudes to SRH but thought it was probably their peers. They claimed that they try to instil values within the family but did not seem convinced that

[5] *The programme referred to was the overall national programme to improve SRH amongst youth and reduce risk factors.*

they had succeeded, "pregnancy is not a stigma… it is a fashion…young men do not even become outcasts when they make a learner pregnant."

Learners conceded to being influenced by 'older people' but this seemed to relate to an only slightly older generation who had enviable lifestyles, i.e., not parents or teachers. Learners added that "…we want to be fashionable." Role-models for male learners seemed to be young men with nice cars and multiple girlfriends. For female learners it seemed to be their girl peers who succeeded in dating older men and thus gained some material benefits. Female learners used the expressions, "you get what you want" and "we are afforded." Peer educators claim that most of the influences on learners are bad, for example, predatory male teachers and management who 'date' the girl learners in their care. In their view, there is a lack of good role models and those that do play this role often turn out to be a disappointment. It was noted that the *transactional* nature of sugar-daddy relationships was often based on very modest rewards, e.g., toiletries, air-time and partying/ alcohol consumption. A member of the SGB made the same assessment – boys are influenced by men already having sex and "girls have sex with older men because they want cellphones, etc…"

A member of the school leadership felt that learners are influenced by broader shifts in societal values that have occurred since the advent of democracy in South Africa. Values are deteriorating, particularly in the African community. Single parents, divorce and multiple partners have become the norm – not just for youth but their elders. He cited examples of Friday night binge drinking by youth that continues into Saturday morning with wild partying and uncontrolled sex, sometimes in a taxi with others present. Parents may try to instil more conservative values but they are often also promiscuous and therefore vulnerable to accusations of hypocrisy or even blackmail from their own children.

Attitudes within the community to teenage pregnancy, sex education, contraception and sexual exploration

This topic was largely covered through expanded discussion of previous questions. Teachers felt that the role of the school in creating awareness and understanding of teenage pregnancy, sex and contraception is not readily understood by the community. While it is not possible to quantify reported perceptions, it seems that there are segments of the community who question why the school takes on this role when it should prioritise education. Different groups of respondents, for example, teachers, reported that there are some within the community who claim that it cuts into teaching time and is thus a waste of time. Families want to avoid learner pregnancies but don't want contraceptives to be introduced at the school – they see this as encouraging sexual activity. Teachers claimed that parents are often too shy to discuss these matters with their children. On the other hand, parents claim that they are now open to such discussions and are willing to promote sex education in the family setting. However, they feel that these interactions with their children often start off on the wrong footing. The parent is seen to peddle outdated values and traditions that are at odds with contemporary society. A key issue highlighted by teachers was the lack of interventions and SRH information at the primary school. Because these children are considered too young for sex education, they receive no information but they engage in sex anyway and some fall pregnant.

Amongst learners it was felt that more affluent families deal with these issues while poorer families side-step the topic. Poorer and more traditional households still regard contraception as taboo but learners from these homes have sex. A member of the SGB said that the community's endorsement of contraception was weakened by the fact that in general they regard unplanned pregnancy as 'normal.'

The role of community leadership (including traditional leaders and councillors) in shaping attitudes

Teachers noted that traditional leaders are trying to revive the *Inciyo* (virginity testing) ceremony and are talking to learners to try to instil pride in being an 'intact virgin.' However, the ceremony has limited support and only a handful of girls subject

themselves to the examination – generally those who live away from home and feel the need to prove themselves. In general teachers were of the opinion that parents do not support the practice. Teachers seemed to have mixed views on the ceremony itself but expressed no strong reservations. As far as municipal councillors are concerned, teachers are of the view that they play no part but have the potential to organise awareness programmes.

b. Sexual and reproductive health services

Despite repeated commitments and many well-intentioned plans, these services are not readily available. Teachers noted that learners seeking such services usually had to find about R20 in taxi fare and travel about 10kms to town (Mt Frere) to access SRH services including contraception.[6]

Awareness of sexual & reproductive health services and support

Some learners and teachers were under the impression that condoms are available at the high school and thought this was arranged by SPW. However, SPW clarified that condoms have never been routinely available at the school but have been distributed on school property during special events such as World AIDS Day and World Population Day. The resource centre was also widely mentioned as a source of service and support; however this was still under construction and is also an SPW initiative. A mobile clinic has been promised to provide SRH services but the last visit by the DoH was in 2014. It was not clear what services the DoSD provides, but they seem to relate to different grants and listing of persons who require assistance either as victims of abuse or some other form of misfortune. It seems that the LSA at the school is linked to the DoSD.

The DoE provides textbooks and ensures that the agreement not to expel pregnant learners is complied with. In a member of the school leadership's opinion, none of the three main line departments had as yet commenced any significant service and only SPW was helping to coordinate future service plans.

The DoH noted that apart from a sporadic mobile clinic service at a nearby community (general health services) there was no service to Nzululwazi and certainly no dedicated SRH service geared towards young people. While it acknowledged a service shortfall, not all learners considered either the town-based clinic or the mobile service as necessarily 'inaccessible'. While some remarked on the expense of travelling to town, they did not regard health services as entirely absent – as the formal study clarified, the vast majority of learners regard health

[6] *Condom distribution is not readily acknowledged as a school responsibility. Even if they were to be available in this manner, some learners express hesitation in accessing condoms this way.*

services as very or somewhat accessible. The DoE's HIV and AIDS & Safe Schools coordinator, Mr. Nonkonyela cited the services provided by SPW, the provision of Learner Support Agents (LSA) from his own department, 'HIV grants' from the DoSD and a *rescue center*[7] operated by the DoH.

Parents described the clinic service as good but irregular. There was some indication that learners travel to town for social grant services. Parents were aware of a single meeting with social workers but did not know of follow-up in terms of case work. Learners had experience of the local clinic, the hospital near town, private doctors and traditional healers (for STD treatment). They were aware of DoSD services but had not accessed this locally.

Peer educators were aware of roughly the same bundle of services but claimed that the DoE provided virtually no SRH related services and SPW was mainly supporting teachers in this regard. Attempts to access DoSD services for a learner requiring emotional and livelihood assistance had been unsuccessful and the grant service was regarded with skepticism – the DoSD was, in the view of peer educators, simply *flying the flag*.

The DoSD outlined the following general service approach. The department operates at three levels, District, Area and Service Offices. All three implement the following key programmes and their respective sub-programmes.

- Social welfare services
  - *service to all persons*
  - *service to persons with disabilities*
  - *service to people with HIV/AIDS*
  - *social relief service*

- Children and family services
  - *Care and service for families*
  - *Child care and protection*
  - *ECDC and partial care*
  - *Child and youth care centres*
  - *Community based services for children*

- Social crime prevention services and anti-substance abuse
  - *Crime prevention and support*
  - *Victim empowerment*
  - *Substance abuse and rehabilitation*
- Community development services
  - *Sustainable livelihoods*
  - *Women development*
  - *Youth development*

The DoSD later indicated which of these services it provided in Nzululwazi (see Section F. *Sector insights and specialist perspectives)*.

Effectiveness of SRH services

The DoE mentioned problems related to the 'rescue centre' and the difficulties of operating within the policy framework as well as the importance of regulation and local coordination. The respondents did not appear to be able or willing to assess any SRH service including those provided by the DoE. Teachers pointed out that there is no dedicated LO teacher at the school and only four LO textbooks have been provided per 80 learners (however, the content is relevant and user-friendly). There was also minimal or no training for teachers willing to undertake SRH counselling and advice. Parents, as mentioned, assessed the clinic service to be good but irregular.

Since learners mentioned a range of services that were not all local and did not necessarily fall within the integrated SRH services, their assessment was not fully relevant and they appeared to have difficulty in making any detailed assessment. Asked to choose the service they found most useful, only one learner responded and mentioned traditional healers for STD cures. Peer educators felt that more teachers need to be trained to provide SRH counselling and advice. They also suggested that DoSD services needed to be more responsive to local needs.

A member of the school leadership felt that health services need to be closer to the community. He noted that the DoSD was largely reliant on NGOs for the roll-out of services to identify neglected and vulnerable youth and provide the necessary assistance (admission to school, arrange grants and school uniforms). He acknowledged that social workers do sometimes visit the school for specific

[7] *It emerged that the informant was referring to the resource centre still being established by SPW.*

cases. The DoH said it was too early to assess the effectiveness of SRH services in the community as the process had just begun. The respondent was concerned about the confusion around the clinic service, pointing out that the planned service was both a general clinic service and an SRH service directed specifically at the youth. The mobile clinic will apparently set aside certain days for the SRH service. It is now apparently accepted that this service will be through the school. In general, however there still seems to be some uncertainty about this service.

The DoSD remarked that, "It is still early to make that judgment since the Nzululwazi School initiative is still in its early stages." A member of the SGB was the most optimistic about services and mentioned that the DoH helps with choices regarding contraceptive use, DoSD provides awareness and "DoE has not fully come on board but they were responsible for the first mobile clinic coming to the community." It became clear, however, that much of this was anticipated improvement arising from the SPW intervention.

Is the information and service provided of good quality?

This was largely addressed in previous assessments of effectiveness. The DoE felt the information they provided was of good quality because it factored in changing circumstances, e.g., drug usage. Learners noted that the content of the LO textbooks is useful. They added that by speaking to their peers it is possible to find out where to get information, e.g., at the clinic. The DoSD simply said "yes" and did not elaborate. Most seem to agree that information is available 'out there' but may not be accessible locally.

Do young people make use of these services?

The DoE respondent claimed there was take-up of the service; however, the example he cited was a health service (HIV and AIDs testing) and it emerged that there is little take up of voluntary testing. Most learners only discover their status when taking a pregnancy test. Parents were unsure of learner usage patterns but reported rumours that condoms were available at school and that learners sought the services of the clinic[8]. Learners had already outlined their use of services which was broad but did not necessarily reflect SRH relevance or local availability.

The DoSD said there was take-up of the child support and foster care grants managed by the SASSA and explained that:

- The child support grant is given to unemployed parents until the child is 18.
- The foster care grant is given to orphans and child headed homes.

Obstacles that prevent these services from having more impact

The DoE respondent appeared unable or unwilling to identify current obstacles that prevented greater impact. Instead he hypothesised that "if the community was to withdraw, that would be an obstacle…" Teachers suggested that it should be easier for girl learners to access contraception that is not condom based and that condoms should be available at outlets other than the school (learners would be more likely to collect these if they were not under school scrutiny). A member of the SGB said that service improvement would be achieved through the new youth resource centre. Learners mentioned the affordability of travel to the clinic and charges levied by traditional healers as well as being unable to make confidential use of the clinic. The DoH felt that impact was constrained by coordination problems in availing the service and the community's resistance to contraception as a solution to widespread unplanned pregnancies.

The DoSD mentioned abuse of child support grants, i.e., children getting pregnant on purpose in order to receive the grant. The DoSD respondent also felt that lack of security at the resource centre could lead to resources being stolen.

Attitudes of SRH service providers

Teachers reported mixed experiences of the Gateway clinic in Mt Frere. One teacher in particular reported a negative experience in seeking a voluntary HIV and AIDS test – the nurse

[8] *Note the previous clarification that condoms were only distributed at the school during special events.*

gave her the result and said sarcastically "Come back when you are positive." Teachers also thought that learners had experienced negativity but acknowledged that the clinic had ensured that learners did not have to queue. They were also of the view that little counselling was done prior to testing and only those who tested positive were counselled. A member of the SGB noted "Nurses sometimes scold at them and judge them." The DoE was unsure of service staff's attitudes but said that the school generally reported good service from staff in other line departments.

Parents reported positive experiences of the mobile clinic service, when it was available. They described nurses as having a positive and caring attitude and providing a good service in testing for pregnancy and other services. Learners reported mixed experiences. Some said the clinic nurses were "…the worst – they insist on giving a lecture." Others said in relation to HIV and AIDS testing, "…it depends who you get – some give good treatment, some give bad…" Turning to traditional healers they noted neutral attitudes "…they don't care – as long as you have money." Peer educators noted only that there are attitudinal issues at both clinics.

A member of the school leadership acknowledged that his views on this issue arose from learner and teacher reports and related to "town-based services". There have been reports of negative attitudes and learners insist that it happens but nurses deny such attitudes. He felt it was hard to make any assessment across the different SRH frontline services as these were provided some distance from the community. Once the service becomes local it will be much easier to monitor and control. The DoH acknowledged that there might be mixed experiences of clinic services – this often relates to workload and the person on duty at the time. Many so-called attitudinal problems result from the stress of having to deal with both general clinic functions as well as SRH services. The new resource centre will be able to take up SRH issues and reduce the workload.

The DoSD respondent acknowledged that frontline services may not meet expectations, "Based on my experience as a social worker, people's behaviour may fall short – there are still people who are ignorant and arrogant when it comes to doing their work, this can be seen by their bad attitudes towards those coming to them for help and advice."

Do government and NGOs cooperate and work together in providing services?

The DoE claimed that there is a district support team which includes NGOs and brings them into discussions about interventions at Nzululwazi and how to coordinate these interventions. However, the respondent, Mr Nonkonyela was not able to name any of the NGOs involved. Teachers were also under the impression that such coordination exists but did not elaborate. Parents noted that there were at least three NGOs working in the HIV and AIDS sector with government. They identified them as Siyayinqoba, Hospice and Masizakhe and noted that they work with the municipality. Learners were mainly aware of SPW and noted that LoveLife works in some villages and cooperates with the DoH. A member of the school leadership was of the view that such cooperation had yet to commence but in the preparatory phase it seems that NGOs and government will cooperate and coordinate their interventions. A member of the SGB said "… I hear from the children what they have learned and I realise that good work is being done." The DoH was not certain about NGOs working in the area on health matters but was vaguely aware of Siyayinqoba and Hospice. The DoH supported such cooperation. The DoSD felt that such cooperation existed but that the local municipality "never comes to the party."

c. Coordination and cooperation among the three main departments (Health, Education and Social Development)

Do the three main departments meet their own mandate (do what they are supposed to)?

The DoE claimed that there was 75% achievement of this objective; however, the respondent did not explain how he came to this rating. He also did not distinguish between departments or the functions they are supposed to perform. He said he would have provided a 100% rating if not for the absence

of other line departments, e.g., Agriculture. A member of the SGB was similarly positive about departmental performance, e.g., the DoE offers sports and nutrition and LO teachers 'get training.'

Teachers said that only the DoH makes a serious effort to meet its commitments through condom distribution and the clinic. They felt that the DoSD makes promises around ID services and LSA counselling but delivers little. In relation to the DoE, teachers noted "…they do not even make promises." Parents and learners had little knowledge of the role played by the three main departments or how they performed. Peer educators felt that they had already made their views on departmental performance clear, i.e., they were generally unimpressed and when they sought specific services, these were usually not forthcoming. A member of the school leadership repeated his assertion that since integrated SRH services had not yet commenced, it was impossible to make an assessment. The DoH respondent held a similar view and was prepared to accept that the department had not always fully met its obligations in the Nzululwazi area. She did not comment on the other two departments.

How well do the three main departments work together and do they collectively provide a full SRH service for young people?

The DoE respondent claimed that the three main departments "call meetings together" and that he expected the collaboration to improve once the 'rescue centre' (resource centre) was functioning. He singled out the DoH as effective but felt that the provision of SRH services was incomplete due to the absence of the Department of Agriculture (presumably to assist with food nutrition for those living with HIV). Learners and parents had very limited insight into departmental issues.

Peer educators noted that "…they all pull in different directions and have their own imperatives." The DoH felt that coordinated provision of a comprehensive service had yet to be tested but also seemed to place some reliance on SPW and the resource centre to make this a reality in the future.

Apart from the 2014 World AIDS Day and World Population Day events in July 2015, and the general concept and planning the resource centre, virtually none of the stakeholders were able to recall any particular example of successful collaboration between the three main departments.

The DoE respondent made reference to 'pregnancy campaigns' but could provide little detail. The two events mentioned above apparently included great fanfare and many pledges that most stakeholders regard as unfulfilled.

The exception was the respondent from the DoSD who claimed that the three departments generally work well together and meet and plan together. In addition to World AIDS Day, she cited the example of the youth resource centre where the municipality (local councillor) was involved in the beginning, and discussions were held about the lack of sanitation and water. This, of course, relates to an SPW initiative.

d. Community and government relations

Community support for programmes like SRH and SYP – does government do enough to encourage partnerships and what level of community ownership exists?

The DoE respondent was confident that such support exists and cited community liaison and ward councillor reports at municipal level which showed high levels of community support for such initiatives.[9] His idea of community ownership is that "government educates the community about how to be creative…they (the community) appreciates everything that is coming…" He also felt that government does enough to promote partnerships. Teachers endorsed the idea of community support but qualified this by noting that municipal councillors are not liaising between the community and the municipality, "the link is broken."

They also noted that the community was quite happy to hand responsibility for SRH to government. Peer educators said community support was uneven but otherwise agreed with

[9] *It was not possible to verify such reports. It should be noted that the sources mentioned are usually highly politicised.*

the teachers' assessment, noting that government did not do enough to encourage partnerships. "The community is very passive, they acknowledge the need but because it is only relevant for some, there is a culture of *sit back*."

A member of the school leadership held a similar view, noting that "…the community is enthusiastic and sees the need, they want change… but they are not willing to play a critical role, even though they feel the effects, for example, babies end up with *gogos*."

Parents were less convinced of community support and claimed that the community had little knowledge of the SRH programme and was disengaged. Contrary to the teachers' views, parents claimed to take responsibility for talking to learners about SRH issues and noted that this needed to start at an early age. The respondent from the DoH felt that government needed to do more to educate communities and overcome fears and prejudices against SRH services. The community needs to "…create a separate space for youth to benefit – get it out in the open, talk about female condoms etc… understand how young people deal with these issues… it's not just about contraception."

e. Obstacles and gaps

Most of the problems of imperfect bureaucracy, poor coordination, fragmented services and logistical/resource constraints had already been discussed by the respondents. Reference had also been made to unhelpful cultural practices and changes in societal values that are antithetical to healthy and responsible sexual behaviour. Some of the respondents regarded polygamy as unhelpful but often the reference was more broadly to cultural practices and beliefs that do not support SRH improvement.

A member of the SGB noted that the clinic is not accessible and available (once a month is not enough, twice a week could have impact). He urged continued awareness raising on sexuality, rights and the use of contraceptives. Parents felt that the whole discourse around SRH lacked candour and integrity, "We do not call a spade a spade…" Parents are not informing their children because the old style of guidance and discipline has collapsed and is rejected by the youth. The new message is widely heard and has some good principles but seems to have become confused because the youth think they are free to engage in wild and unsafe sex and pass the unwanted children onto their parents. A member of the school leadership held a similar view, noting that peer pressure was driving irresponsible sexual attitudes and behaviour but in the final analysis the problem is also about managing the perfectly natural sexual drive of young people "…they want to see, feel, experiment…"

The DoSD respondent also felt that the main challenge lay with learners. "Young people engage in unprotected sex and put their lives at risk, partly due to drug and substance abuse. Some want the grant money. Because some children come from distant villages and stay on their own at Nzululwazi, they are vulnerable and make some risky lifestyle choices. In order to address all these issues, awareness raising initiatives should be implemented."

f. Sector insights and specialist perspectives

Department of Education

According to this respondent, there is little wrong with the institutional and learning culture at Nzululwazi. The SRH discussion is out in the open and the teachers talk about these matters. The ISHP policy is in place; therefore the teachers have the necessary CSE and LO training to advise and assist learners. However, the Department does have financial constraints. The district offices are supposed to have a budget for information/ resource material but instead are reliant on the provincial office and it is difficult to adapt this for specific sites. "The parents, teachers and even traditional leaders must talk to the learners about sexual and reproductive health."

Teachers

The culture and environment at the school is good and conducive to openness about SRH. However little is done to train and equip teachers for this

role. The teachers' main expectation of parents is to allow their children to take up these services and not to build prejudice against it – they accept that it is hard for them to do more.

Parents

Parents accept responsibility and claim that they do talk to their children about SRH. They agree that such discussions should be honest and frank. They think that the school could do more in this regard, would be happy if the clinic visited more regularly and would also appreciate some basic interaction with DoSD. They feel that NGOs are generally doing well. All the parents claimed they would deal with an unwanted pregnancy by showing love and understanding and avoiding domestic violence – while trying to provide better guidance for the future.

Learners

Decisions about sex and SRH are mostly informed by peers and there is pressure to be sexually active. Role models for male learners are "guys with cars who can hook up with more women" while for female learners it is girls who have sugar-daddies. There is some recognition that this lifestyle creates its own problems but unwanted pregnancies and STDs are a minor deterrent. "We don't know about condom availability because we are not that interested – we might use them more if they were available away from the school authority eyes." Despite this general indifference, learners feel that the SPW programmes offer the best option for those who wish to avoid the pitfalls of irresponsible sexual behaviour.

Principal

The Principal feels that the culture and environment at the school are good and there is sound knowledge within the curriculum. Life Orientation and other teachers are willing to take up the challenge. The Principal encourages teachers to use the last five minutes of the teaching period to deal with LO and SRH matters. It is important to demonstrate examples that give hope (turnaround) and to drum home the value of education. The DoE is trying to train and equip teachers and they have called in NGOs to assist, in addition to the CSTL programme. Workshops have been held. The problem is time, e.g., there is no time for drug testing when a learner appears intoxicated. The Principal feels that, in general, the school system is suffering because outcomes-based education is not working – there is not enough structure or effective discipline. Furthermore, schools should have dedicated nurses, counselling facilities and personnel to maintain discipline. The SRH intervention should start much earlier at primary school – by the time it gets to high school it is just damage control. With regard to parents, the Principal expects maximum cooperation with any officially endorsed programme and trust in the school – "don't continually question or challenge decisions". At home, people may choose to follow the *Inciyo* ceremony or other traditional interventions. The ISHP is just starting up and it is too early to make judgements – it is only SPW that is bringing the various role-players (SAPS Child Protection, DoH and DoSD) together.

Chairperson of the School Governing Body

The SGB Chairperson feels that the institutional and learning culture at the school does assist learners to gain knowledge about SRH issues. All teachers but especially LO teachers are equipped and motivated to assist learners with information about such issues. Both the Principal and the SGB Chair provide leadership and encourage openness and good healthy lifestyles. The DoE provides some support and resources for the school to provide effective guidance and information to learners, but it could do more. As the SGB head, the chairperson has interacted with the DoE, DoH and the DoSD on these matters and also interacts with NGOs. "I am involved as the chair in almost all meetings and discussions such as the accessibility and frequency of the mobile clinic." The SGB Chair feels that the local school system could perform better if there was a platform for the junior schools and the high school to engage in discussions around these issues. The NGO SPW should replicate its work in the junior schools. The ISHP could be improved. Within the School-Based Support Team (SBST) the SGB is leading the matter of the clinic and involvement of parents.

Department of Health

It was noted that in the past, the mobile clinic

visited about once a month at a nearby settlement but it was not a service designed for Nzululwazi. A school health service should be a dedicated on-site service that is able to provide SRH assistance like contraception – not a general clinic. The opportunity to refer learners to the resource centre will help – the DoSD will have their own office there. The different service providers will be able to build relationships between themselves by working locally – this model has proven itself elsewhere. The representative noted that it is important for the school and parents to realize that DoH personnel need to spend time with the learners in order to be effective. It could be that the pregnancy rate is not exceptional – understanding is required of the full problem not just the symptom. It is important that people like the Principal remain involved – he controls things like the admission policy and must be given information. Parents tend to treat children as innocents; this is not realistic. They need to be less naïve and open to new values. At the same time parents must accept some responsibility – dress codes are out of control and the circumcision age has been disregarded.

Department of Social Development

The DoSD did not offer any uniquely social development perspective on existing conditions at Nzululwazi. Instead the Mt Frere Service Office pledged to implement the following key programmes for the new SPW driven project:

- Children and families' services
  - *Care and service for families*
  - *Child care and protection*
  - *ECDC and partial care*
  - *Child and youth care centres*
  - *Community based services for children*

- Community development services
  - *Sustainable livelihoods*
  - *Women development*
  - *Youth development*

The social worker team for Nzululwazi will take up issues of SRH and rights by supervising foster care placement for orphans and along with SASSA, ensure that the conditions for grants are adhered to.

4.3 Case Studies

a. Learner 1

Learner 1 is a 16-year-old female student in grade 11 who lives in the local rural area with her family. She is sexually active and in a relationship. Within the relationship she seeks "Love, I need somebody to share secrets with…" She does not conduct sexual relations outside the relationship and on principle will have only one partner, "I believe in having only one partner, I just cannot handle many people…" She first had sexual intercourse at the age of 15 and the reason she cited was that she "wanted to have the experience…"

She uses contraception in the form of a male condom and believes it is her responsibility to prevent pregnancy. She is concerned about the high rate of unplanned pregnancy among young women, "Pregnancy among young women is not cool."When such pregnancies do occur, she believes it is the girl who is mostly held responsible. "In many instances boys run away, they do not want to take responsibility and the girl is left alone."

In considering the main issues a young person should take into account before having sex, she rated unwanted pregnancy and the financial burden of a child as of little concern and was slightly more concerned about the reputation of her family and herself. She was most concerned about STDs including HIV and AIDS. Her previous caution around unwanted pregnancy and her efforts to avoid it seemed slightly at odds with rating it as a "matter of little concern." For reproductive health/sex related problems or questions she seeks advice from the clinic and a social worker. She made these choices because, "Nurses have better knowledge and at the clinic you are given medicines."

In response to the question designed to test knowledge of HIV and AIDS, she understood the most serious risk as that posed by "vaginal sex without a condom" and "sharing a toothbrush." While the first answer may be considered correct, the second suggests limited knowledge of HIV transmission. She believed that young people

should only become sexually active at the age of 17 and cited the reason that "the women's body is ready"; however, she applied this age parameter to both women and men. She felt that adolescent pregnancy should be avoided, "Because they are not employed and as such will suffer in bringing up the child." She cited the greatest threats to young people in her community as diseases including HIV and AIDS, sexual abuse, prostitution/sex for favours, substance abuse and a life of crime. She viewed violence inside and outside the home and economic exploitation (working for little money) as moderate risks. She said that there was "not that much violence" involving young people but when it did occur it was typically at the taverns and involved drunkenness and violence against women and some men. The violence was typically perpetrated by young men who "always hang out at taverns" rather than attending school.

She would feel more in charge of her sex life/ reproductive health if she was able to obtain assistance from the DoH and the nurses – these services should be based at the clinic.

b. Learner 2

Learner 2 is a 15-year-old male student in grade 11 who lives outside the area and therefore rents a house at a nearby village, "I am originally from Mahamane Village and renting a house near the school at Cabase Village." He lives alone and is not currently in a relationship, having recently broken up with a girlfriend but has been sexually active in the past. He first had sexual intercourse at the age of 11 when he was in grade 7. This appears to have arisen from child's play "We were playing - I was a father and part of role was to have sex…" Within his previous relationship he was "looking for love…" Although he is not currently sexually active, he would in principle have sex outside the relationship and does not believe that young people should be limited to one partner:

> *A person must have a second option (so you can have sex with whoever you want to), you cannot force a person to be in a relationship with one person if they do not want to…I am not ready to commit to one partner yet… Maybe when I am 18 years old I would commit to one partner.*

He does not use any form of contraception but believes it is both his and his girlfriend's responsibility to avoid pregnancy. He is concerned about the high rate of unplanned pregnancy among young women, "They are still very young and their bodies are not ready for bearing children". When such pregnancies occur, he believes it is the boy who is mostly held responsible but he could not explain the reason for this view. When he assessed the main issues a young person should consider before having sex, he rated *unwanted pregnancy* as a moderate concern and the *reputation of his family* and *the financial burden of a child* as of little concern. He was however greatly concerned about STDs including HIV and AIDS. For reproductive health/sex related problems or questions, he seeks advice from the clinic and a social worker. He made these choices because "You get all the help from the nurses…"

In response to the question designed to test knowledge of HIV and AIDS, he understood the most serious risk to be posed by "vaginal sex without a condom". He did not have a firm view on the age at which it was advisable to become sexually active but eventually opted for the age of 18 for both women and men and noted that in his home community virginity testing stopped at the age of 18. He felt that adolescent pregnancy should be avoided, "Because the time is not right and at that age a person cannot provide for the baby."

He felt that the greatest threats to young people in his community were diseases including HIV and AIDS, sexual abuse and prostitution/sex for favours. He considered substance abuse to be a moderate threat and a life of crime, economic exploitation and violence in and outside of the home were all considered a low risk. He claimed that there was no violence against young people in his community.

The learner claimed that there were no gaps in his sexual and reproductive knowledge; however, he also noted that a more available and accessible local clinic, "…as well as advice and guidance from our parents" would make him feel more in charge of his sex life/reproductive health. Most of his service expectations in this regard related to health services and the clinic.

c. Learner 3

Learner 3 is a 16-year-old female student in grade 11 who lives alone in a rented home in Cabase Village because her family home is some distance away in the town. She is sexually active and has been in a relationship since 2014. Within the relationship she seeks, "…prestige, all my friends are in relationships and I don't want to miss out…." She does not conduct sexual relations outside the relationship but is open to the idea of more than one partner because "… one does not necessarily have to have one partner. If my partner cannot limit themselves to one partner, then why should I have one?" She first had sexual intercourse at the age of 15 and the reason she cited was that she wanted to share the experience with her 'lifelong partner' but "… my peers also pressured me." She uses contraception in the form of an injection but was unsure of whose responsibility it should be to prevent pregnancy. She is not concerned about the high rate of unplanned pregnancy among young women, "Pregnancy among young women is no longer a cause of concern, it is like the norm now…" When such pregnancies occur, she believes it is the girl who is mostly held responsible. She could not explain the basis for this view but firmly insisted it was the reality.

In considering the main issues a young person should consider before having sex, she rated her and her family's reputation as the greatest concern followed by the risk of STDs including HIV and AIDS. Unwanted pregnancy and the financial burden of a child were of little concern. She did not know where to seek advice on reproductive health/sex related problems or questions.

In response to the question designed to test knowledge of HIV and AIDS she understood significant risk to be posed by "sharing a toothbrush", suggesting very limited knowledge of HIV transmission. She believed that young people should only become sexually active at the age of 23 and older and cited the reason that "They are mature, responsible and wise." She also believed that this age parameter applied to both women and men. She felt that adolescent pregnancy should be avoided, "Because they cannot take care of the baby as they are still young." She cited the greatest threats to young people in her community as diseases including HIV and AIDS, sexual abuse, prostitution/sex for favours and substance abuse. She viewed violence outside the home as a moderate threat. Economic exploitation (working for little money) and a life of crime were considered a low risk. She said that there was no violence directed at young people within the community.

She claimed that there were no gaps in her knowledge of sexual and reproductive matters and declined to answer questions about services/ assistance that would make her feel more in charge of her sex life/reproductive health or how such services should be sourced.

d. Traditional Leadership

Chief Mncedisi Dabula was assisted by his mother Mrs. N.J Dabula of the Imbumba Yamakhosikazi Akomkhulu[10] (IYA) in outlining the views of the Traditional Council. Most of the responses relate to the experiences of Mrs. Dabula and the IYA's dealings with young women.

It was said that:

Girls are pressurised into having sex because they fear that refusal will cause their boyfriends to leave them. Learners behave badly and treat sex as something fashionable. Pregnancy and contraception are not considered when girls have relations with older men who are sometimes infected. Learners are not afraid and do not think of the consequences of their actions. Pregnancy rates are high and start at the feeder schools – they have only started to decrease since the SPW programme started.

There is some awareness of sexual and reproductive health rights and responsibilities and learners are informed about contraceptive options at clinics and how to get help. There is also *Inciyo* (virginity testing) under the supervision of the *Imbumba Yamakhosikazi Akomkhulu* women. The community's attitude towards *Inciyo* differs – some parents allow their children to get tested and some are persuaded by their children to avoid the test. "Children who are not virgins anymore do not want to be tested."

In terms of HIV and AIDS, support programmes for healthy living and the use of medication/treatment has reduced the stigma associated with the disease. It is not clear who is influential in shaping attitudes and instilling values but TV, other media and social networks as well as *sugar-daddy* incentives (e.g., cellphones) play a role.

Attitudes within the community to teenage pregnancy, sex education, contraception, and sexual exploration are not good. On the face of it the community is supportive of the clinic service, testing etc., and many parents have hopes for their children. Yet, when learners are encouraged to go to clinics and use contraceptives, this is not always well-received by the community. "As traditional leaders we have a responsibility to look at the well-being of our subjects. We encourage use of contraceptives and most importantly *Inciyo*. Before the *Inciyo* ceremony, parents and daughter are sat down and the process of a girl's development is explained."

SRH services are currently available at a monthly mobile clinic and the DoSD promotes awareness of teenage pregnancy and contraceptives. *Imbumba Yamakhosikazi Akomkhulu* supervises *Inciyo*. There are still some challenges in this regard as the DoSD regards virginity testing as a violation of the girl child's body. On the other hand, awareness alone does not really help because children still neglect to use condoms and get pregnant. *Imbumba Yamakhosikazi Akomkhulu* is trying to show that there is a difference between girls who have gone to *Inciyo* and those who have not. Those who have, get pregnant later. More impact could be achieved if parents encouraged their children to go to *Inciyo*. It would also help if the mobile clinic visited more often. The community and local leadership should exert pressure for a more regular service and show that it will be used and appreciated. It should be made clear that responsible parents talk to their children about their sexuality. "Those who have lost their way must be encouraged to get back on track." In general, the three departments are responsive to traditional leaders' inputs and feedback, except the DoSD that still views virginity testing as a violation – "but we are engaging them in this regard".

e. Principal

The Principal is committed to any measures to advance SRH including the ISHP but clearly has reservations about the more liberal dimensions of such programmes. He points out that SRH programmes have carried the same message for 20 years and learners are well versed in the principles and values; however, they still choose to experiment sexually and pay little heed to the basics of safe sex. In his view, learners have "not taken the message" and the focus should thus shift to a clearer and harsher stance on deterrence. He also looks to lessons from urban/rural experiences of the ISHP – pregnancy rates at urban schools are decreasing while rural schools show the opposite trend. He seems to

[10] *An organisation of women who organise and conduct virginity testing.*

suggest that this is because experiences of the new democracy and liberalisation have been slower to reach rural areas and rural youth are still excited by these *new freedoms* and exploring the boundaries. However, the Principal does not simply 'blame learners' – he points to a general decline in societal values, particularly in African communities where traditional systems and guardianship by parents seems to have been over-powered by modernist influences. These influences, he suggests, are a subversion of the societal vision and values that the new South Africa was supposed to embrace. Parents and so-called community/traditional leaders contribute to this deterioration through their poor example – promiscuity, drunkenness, etc. Consequently they are easily manipulated by the youth and forced to 'spoil' their children, rather than taking a firm stance on bad /risky behaviour. Like the teachers, the Principal seemed to have modest expectations of parents, simply asking that they trust the school and give it the space to do its job in respect of SRH for learners.

The community is generally enthusiastic about ISHP/SRH programmes and supportive of the change objectives e.g., they want fewer *gogos* to be burdened with childcare. However, it stops short of playing an active role and invariably expects government role-players to sort out the problem.

The Principal also identifies a disjuncture between ISHP policy and actual evidence. Better performing schools tend to be those that suspend or send home pregnant learners (contrary to the policy). Schools that accommodate pregnant learners in terms of the policy, often battle to perform in terms of pass rates. In terms of HIV and AIDS, the Principal encourages voluntary testing and seems happy to follow the prescribed protocols for providing nutrition support and other welfare assistance to infected learners. He accepts that such systems are necessary and useful but is concerned that learners are not changing their sexual behaviour in response to the threat of HIV and AIDS.

More than any other respondent, the Principal was adamant that the ISHP and related SRH services have not been a reality in Nzululwazi to date and that any movement in this direction has come from

SPW only since 2015. He is particularly adamant that learners must be served by health services much closer to the community that are also able to address psycho-social problems. In respect of social development functions, there has been some roll-out of services directed at neglected youth – securing social grants, funding uniforms and arranging admission to school. These services appear to have been provided by NGOs contracted by the DoSD. The DoSD has on occasion also sent social workers to assist with individual cases. It seemed clear that ISHP existed in name only in Nzululwazi prior to SPW's involvement and that the future of any integrated service rests with the SPW intervention and the resource centre in particular.

Regarding the attitude of frontline staff providing health and social development services, the Principal was reluctant to make any *hard and fast*

calls. He pointed out that most of the services are currently town-based and therefore not easily monitored. He has heard stories of poor attitudes to learner clients but the nurses usually deny this and there may well be reasons that learners complain unnecessarily. On the other hand, he accepts that government service providers often find many excuses for not complying with their own services standards (*Batho Pele*). Integrated local service would make it much easier to monitor and provide feedback to the respective departments. The Principal felt it was too early to make any assessment of coordination and cooperation between the three main departments but his previous remarks on community experience in the past suggested that it was weak.

5. Conclusions and Recommendations

a) General

This baseline study had some limitations in terms of timing, and the ability/willingness of government departments to share reliable information and data. It was nonetheless possible to sketch a fairly detailed picture of the situation at Nzululwazi prior to SPW's involvement. In general, the main challenges in making the ISHP a reality in the Nzululwazi community seem to relate to the need for a clear and realistic overview of SRH services and systems that are feasible and implementable, where a particular role player can be held responsible, be it a department, parent, school or NGO. Policy and promises have clouded many basic delivery issues and youth/learners have taken up many of the sexual and reproductive freedoms and rights within the new value framework without adhering to ethical norms that safeguard their own and others' sexual and emotional well-being.

Sexual and Reproductive behaviour, attitudes and support

Nzululwazi learners and young people in the community are highly sexually active from an early age, specifically from 10 onwards. In the high school as many as 61% of learners had sexual intercourse. Learners see this as 'normal'. Substance abuse plays a role, particularly in diminished decision-making capacity and coerced sex. Learners are widely criticised for being 'out of control' but many stakeholders acknowledge that they reflect the norms and values of the surrounding community, although not necessarily those that are officially endorsed. Most learners are motivated to have sex out of curiosity. While instances of coerced sex appear low (about 7%) there appears to be a much larger segment of learners who engage in sex for reasons other than their free choice and the influence of others plays an important role. *Sugar-daddies* are a significant feature in female choices about sex. Role models are those that appear to live the high life and are promiscuous (males and females). Levels of SRH risk are linked to living circumstance, e.g., boarders are more vulnerable

The Child Support Grant has diminished learners' fear of pregnancy and many now regard it as 'fashionable' to get pregnant. There is little concern for safe sex; however, learners are more concerned about HIV and AIDS than pregnancy. Some see cultural beliefs as the cause of the problem, while others cite modernity and the undermining of tradition. Virginity testing (*Inciyo*) is generally avoided or subverted. In any case, there is little evidence that it causes learners to be more sexually cautious or indeed inhibits teenage pregnancy.

Learners claimed high (87%) use of contraception. About half of those who claimed to use contraceptives use condoms, approximately 18% use the injection and very few use other forms of contraception like the pill, etc. The fact that 27% of the respondents claimed to use contraception but could or would not specify the type raises doubt about the veracity of the claim of *any* contraceptive use. This is reinforced by stakeholder narratives that suggest little concern for contraception – for example, males dislike condoms and label them smelly, uncomfortable and unsafe. Many male learners take the attitude that contraception is 'not my business'. All stakeholders are ostensibly troubled about high teenage pregnancy rates except for learners who, while showing some concern, consider it 'part of life' and are more concerned about STDs. Apart from condoms and

the injection, learner knowledge of contraception is very limited.

Pregnancy rates are hard to determine without reliable data. Slightly over 35% of the learners knew someone within their immediate circle of friends who had fallen pregnant within the past year. Reported pregnancy rates declined from 45 in 2013 to 21 in 2014 and 14 in 2015. Although STDs and HIV and AIDS are pressing concerns for most learners, HIV and AIDS are now less feared due to the availability of treatment. Some consider it "part of life" and stigma has decreased. Basic enquiry into knowledge of HIV and AIDS seemed to indicate fairly broad awareness and insight; however, specific enquiries into risk factors indicate that the majority of learners (68%) have very poor understanding of HIV and AIDS transmission risks.

Concerning general gaps in SRH knowledge, there are indications that most stakeholders know that knowledge and information is widely available in broader society but not always locally. Many stakeholders feel that learners *get the message* but ignore it. Forty eight per cent of the learners expressed the need for more knowledge about STDs and HIV and AIDS. Basic knowledge of sexuality and pregnancy may already be part of learner awareness but is not significantly impacting sexual behaviour.

In terms of the assistance required to help learners to be more in charge of their sex life/reproductive health, learners unexpectedly turned to the use of condoms/contraception as a measure that would help them feel more in charge. A handful mentioned assistance in exercising abstinence, advice from a nurse, being more relaxed about having sex, getting to know more about sex itself and advice about staying safe. This suggests that while learners may ostensibly be blasé about contraception, it is of concern to them. Nearly 89% felt that such assistance should come from the clinic. Considering the different narratives regarding the accessibility of the clinic (Gateway is distant and the mobile clinic visited infrequently and was not local) and rumours that learners often feel uncomfortable with the attitudes of frontline staff, these learner responses were unexpected. Not only did 92% of learners say that the service was very or somewhat accessible, but only 6% said they were uncomfortable with using it.

Sexual and reproductive health services

Despite repeated government commitments and many well-intentioned plans, these services are not readily available. For example, the mobile clinic was supposed to supplement the distant Gateway Clinic but was neither regular nor local and did not provide dedicated days for SRH services. The DoSD presence is weak and its services are not fully

understood (grants, case work by social workers, welfare measures for learners). Much has been said and promised but these services are not readily on hand. The most significant service seems to be condom availability but there is much confusion about *how and where* and who introduced it to the school.

Teachers currently receive minimal SRH support and training – only one and the LSA have received such training and the DoE provides minimal support to the LSA. The LO textbooks have good content and are relevant but are in short supply.

There is little or no coordination among the three main departments and in general services are not effective apart from the DoH and then to a limited extent. The DoH has demonstrated a service presence and its clinic service in particular is valued. However, it does not play a coordinating role and it is generally understood that the DoSD should take up this role. Indeed, there is very little evidence that the ISHP previously made any impact on the school and its learners.

The planned *localisation* of the service through the resource centre is seen as key to future improvement; however, the learner study suggests that the obstacles posed by accessibility and sound staff attitudes may have been over-estimated. Nonetheless, there seem to be good prospects of better learner take up of the services once they become local and regular. The a*ttitudes of SRH service providers* are reflected in mixed experiences and some cases of poor service attitudes and prejudice have occurred but in respect of a very small minority (6%) of learners.

There is some vague evidence of government/ NGO cooperation but no department has a good overview of this or plays any overall coordinating role. There is in fact very little evidence of any form of sustained coordination apart from public showcase events like World AIDS Day – cooperation then ceases until the next major event. As the peer educators observed, "…they all pull in different directions and have their own imperatives."

Community and government relations

The research suggests that the community is generally passive in receiving services and looks to government to take the lead. There does not seem to be any antipathy towards the ISHP or SRH services although some sectors of the community may not agree that such services should be school based or should make any claim on 'teaching time'. Parents were least convinced of community support and claim that the community knows little of SRH interventions.

The DoH felt that government needs to do more to educate communities and overcome fears and prejudices against SRH services. The research revealed little evidence of participatory governance and active citizenry. Most stakeholders, apart from the DoE informant, said that the local municipality is largely absent and does not engage or consult the local community.

Obstacles and gaps

Many of the obstacles to the planned programme at Nzululwazi are generic and predictable in rural South Africa and the public service. The area has poor roads and generally weak infrastructure. The local economy is mainly retail/consumption based with some subsistence agriculture and very low job creation prospects. All services are accessed through an imperfect and over-stretched state bureaucracy marked by poor coordination, fragmented services and logistical/resource constraints. The local and district municipalities are some of the weakest in the province. It is difficult to see any progress being made at Nzululwazi without a coordinating agent permanently within the community.

There seems to be no strategic framework that binds all the actors including the three core departments to a specific set of realistic local deliverables that can be measured and for which accountability is clearly assigned. Most stakeholders regard youth attitudes as the biggest obstacle, e.g., *"Young people engage in unprotected sex and put their lives at risk, partly due to drug and substance abuse. Some want the grant money. Because some children*

come from distant villages and stay on their own at Nzululwazi, they are vulnerable and make some risky life style choices…"

b) Recommendations for Future Intervention

The following recommendations relate to the future programme content/strategy at Nzululwazi and the manner in which its performance and impact can be measured:

- As part of the on-going project management and M&E function, the learner study should be repeated at regular intervals and include a component to measure the drop-out rate due to unplanned pregnancy.
- Include measures to build more coherence and unity in the leadership message about SRH matters (School Principal, managers from three core departments, municipal councillors and traditional leaders).
- Partner with the Community Policing Forum/ SAPS sector policing to obtain statistics on the number of learner/youth violence and sexual violence cases linked to substance abuse as reported to SAPS. Use this statistical evidence to track project impact.
- Peer educators are a key component of the programme and should play a key role at the Youth Resource Centre (YRC) and its outreach programmes in the local community.
- Introduce increased dialogue and informed discussion on the topic of 'sugar-daddies' and the pitfalls of transactional sex.
- Draw in traditional healers and brief them on ISHP and related protocols for referral of learner/ youth clients to clinic/other SRH services.
- The SGB should use parent meetings to win parent support for ISHP and SRH interventions – explore the possibility of the school and parents adopting an SRH charter.
- The YRC should develop a simple but effective system to record client turnover and client feedback on service quality and integration at the centre.
- Explore easier access to non-condom contraception for girl learners/youth – the Depo Provera injection or the more recent implant seem to offer the best prospects for expanded usage. However, it is also crucial to recognise the role that condoms play in effectively preventing HIV transmission. A future programme should therefore focus on 'dual protection' messaging.
- The SRH message should be realigned to give more emphasis to the negative consequences of living with HIV and AIDS and unplanned pregnancy.
- More teachers should be trained in CSE/LO and more LO resources should be on hand.
- The ISHP/SRH awareness programme should be extended to all feeder schools for HSS.
- The DoE should clarify its role and obligations in terms of ISHP and commit to a clear programme of action for Nzululwazi.
- The YRC should strengthen its partnership with the municipality and share information on all SRH interventions in the area including NGO programmes.
- The role of the local municipality in the programme should be better defined and it should endorse and support the YRC and mention it in its Integrated Development Plan.
- Until such time that inter-governmental coordination initiatives show real benefit, SPW outcomes could be at risk. Longer term planning for sustainability beyond the project intervention should consider the risk that intergovernmental coordination and cooperation remains an aspiration rather than an assured part of state machinery.

6. References

Draft Implementation Plan for Strengthened Intervention to Address High Teenage Pregnancy Rates Through Best Practice Modelling of the Integrated School Health Programme (ISHP) and Comprehensive Sexuality Education (CSE) in Nzululzwazi Secondary School and Surrounding Communities, Mount Frere, Alfred Nzo July 2015.

Department of Health – Integrated School Health Policy 2012.

Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA) document – 7 December 2013.

National Adolescent Sexual & Reproductive Health and Rights Framework Strategy 2014-2019.

Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). *Teenage pregnancy in South Africa – with a specific focus on school-going learners. Child, Youth, Family and Social Development*, Human Sciences Research Council research conducted on behalf of the Department of Basic Education, with support from UNICEF.

Student Partnership Worldwide, *Report on School Visit 17-19 July 2015*.

Student Partnership Worldwide, *Notes on Implementation Plan Meeting with Partners 21 July 2015*.

Student Partnership Worldwide, *Notes on Intergenerational Dialogues 11-13 August 2015*.

Student Partnership Worldwide, *Outcomes of the World Population Day Nzululwazi High 30 July 2015*.

Summary of an in-depth Regional Report into the education and sexual reproductive health status of adolescents and young people in Eastern and Southern Africa (ESA).

*www.mrc.ac.za/crime/**Chapter8**.pdf* (Chapter 8 Medical Research Council – Sexual Violence and HIV).

7. Endnotes

http://www.mrc.ac.za/crime/Chapter8.pdf.

[i] Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). *Teenage pregnancy in South Africa – with a specific focus on school-going learners. Child, Youth, Family and Social Development*, Human Sciences Research Council. Pretoria: Department of Basic Education.

[ii] *The Herald* 9 April 2015.

[iii] http://www.itweb.co.za/index.php?option=com_content&view=article&id=86443 (Accessed 25/11/2015).

[iv] *The Herald Online,* 3 December 2014.

[v] http://www.gov.za/eastern-cape-mec-education-mandla-makupula-says-rationalisation-necessity-mount-frere (accessed 25/11/2015).

[vi] Student Partnership Worldwide, *Report on School Visit 17-19 July 2015*.

8. Annexures

Annexure 1: Field Research Plan[vi]

Plan for field research at Nzululwazi School 12-13 November 2015

Day 1: Thursday

Time	Activity	Venue	Responsible
09.00 – 09.30	Introduction meeting with main stakeholders – describe process/get all on board	Nzululwazi School	All – led by Athini
09.30 – 11.00	FG 1: Parents	Nzululwazi School	Len, Glenn & Athini
11.10 – 12.40	FG 2: SGB	Nzululwazi School	Len (Glenn to support)
11.10 – 12.40	FG 3: Teachers	Nzululwazi School	Athini (Glenn to support)
12.40 – 13.15	Break & assess		
13.15 – 14.45	FG 4: Learners	Nzululwazi School	Len (Glenn to support)
14.55 – 16.15	FG 5: Local leadership (WCllrs, TLs)	Nzululwazi School	Len, Glenn & Athini
16.30 – 17.30	Interview: Principal	Nzululwazi School	Glenn
16.30 – 17.30	Interview: Chair of SGB	Nzululwazi School	Len
17.30 – 17.45	Team debrief		All

Shaded = parallel sessions

Day 2: Friday

Time	Activity	Venue	Responsible
09.00 – 10.30	Individual or small group interviews: DoE	Nzululwazi School	Glenn
09.00 – 10.30	Individual or small group interviews: DoH	Nzululwazi School	Len
10.40 – 12.00	Individual or small group interviews: DoSD	Nzululwazi School	Glenn
10.40 – 12.00	Individual or small group interviews: Peer educators	Nzululwazi School	Len
12.10 – 13.30	Individual or small group interviews: Clinic staff	Nzululwazi School	Len & Glenn
13.40 – 14.30	Team debrief + top up	Nzululwazi School	All

Follow up telephone interviews/info collection

- UNFPA
- SPW staff debrief
- Hospital staff via GIZ
- Case studies (Chair of SGB, Principal, 2 x HS learners (preg/non-preg) – dates and times to be arranged during visit
- NGOs

Annexure 2: Case study questionnaire for learners

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Part of the Safe Guard Young People programme at Nzululwazi High School and surrounding community

CASE STUDY: **LEARNERS**

The purpose of this interview is to document the past (before June 2015) situation regarding the learner's sexual and reproductive health behavior and how this can be improved and safeguarded by government and NGO programmes in Nzululwazi High School and surrounding community. The respondent will not be identified but the profile below is an important part of the case study.

A. Basic profile

1.	Gender	Male		Female
2.	Age in years			
3.	Grade			
4.	Where do you live?	Town		Rural area

5.	Who do you live with?	
	Family	
	Friends	
	Partner	
	Alone	
	In a school residence	

B. Sexual behaviour and attitudes

6. Are you in a relationship?

Yes ☐ No ☐

If Yes, what do you seek from this relationship? (e.g. prestige, money, love, companionship etc.)

.....

.....

.....

.....

7. Are you sexually active[vi]?

Yes ☐ No ☐

- Is your sexual activity limited to the relationship you are in or are you active outside the relationship?
- In principle do you believe in having only one partner at a time? Explain.

.....

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.....

.....

.....

.....

.....

If the answer to the above question was "no", please disregard questions 8-10.

8. At what age did you first have sexual intercourse?

9. What was the main reason you decided to first have sex?

.....

.....

.....

.....

.....

.....

10. If yes, do you use any form of contraception? (e.g. a male or female condom, injection, pill etc.)

Yes ☐ No ☐

Specify .....

.....

.....

.....

.....

.....

.....

.....

.....

.....

11. Do you believe it is your responsibility to prevent an unwanted pregnancy?

Yes ☐ No ☐

12. In your view is the current rate of pregnancy among young women cause for concern?

Yes ☐ No ☐

Why? .....

.....

.....

.....

.....

.....

- When an unwanted pregnancy occurs in your community who is mostly held responsible?

  ☐ boy ☐ girl

- Explain the pressures they face

.....

.....

.....

13. What are the main issues a young person should consider before having sex?
(1= little concern; 5 = great concern)

Unwanted pregnancy	
Sexually transmitted diseases including HIV and AIDS	
My or my family's reputation	
The financial burden of a child	

If the answer to the above question was "no", please skip to question 14.

14. When you have a reproductive health/sex related problem or question, where do you seek help or advice?

Seek no help or advice	
Parents	
Teachers	
Friends	
Local clinic or social worker	
Other (specify)	
Don't know	

15. Which of the following pose a significant risk of contracting HIV and AIDS?

Penetrative sex with a condom	
Masturbation	
Deep Kissing	
Anal sex without a condom	
Virginal sex	
Sharing a toothbrush	
Oral sex with a condom	
Sharing a toilet with a person infected by HIV and AIDS	

16. Do you believe that there is a minimum age at which young people are able to choose whether to become sexually active?

Yes ☐ No ☐

a. What age? ☐

b. Why?

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c. Is it the same for girls and boys?

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17. In your opinion, are there any reasons why pregnancy/ child birth should be avoided when a person is in his/ her adolescence?

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18. In your community, what are the greatest risks to young people?

Risk	High	Moderate	Low
Diseases including HIV and AIDS			
Prostitution/sex for favours			
Violence inside home			
Violence outside home			
Being exploited (working for little money)			
Substance abuse			
A life of crime			
Others (Specify)			

19. Is there violence against young people in your community?

a. Who are the main perpetrators?

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b. Who are the victims?

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c. What are the main causes?

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d. Where does it typically happen?

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20.	What are the gaps in your sexual and reproductive knowledge that you would most like to fill?
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21.	What form of assistance/support would make you feel more in charge of your sex life/reproductive health?
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22.	Who do you think is best placed to provide the support mentioned above?	
	School	
	Clinic	
	Church	
	Other	
	Specify	
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Annexure 3: Focus Group Guide (General)

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Part of the Safe Guard Young People programme at Nzululwazi High School and surrounding community

FOCUS GROUP

A focus group is really just a discussion among a group of people on a subject in which everyone has some experience or knowledge. Everyone should participate equally and there are no right or wrong answers. The purpose of this focus group is to discuss the past (before June 2015) situation regarding sexual and reproductive health behavior amongst young people and how this can be improved and safeguarded by government and NGO programmes in your community.

- Introductions
- Ensure that discussion is recorded on paper – Flipcharts ideally
- Try not to exceed one hour (about 12 minutes per section)

1. Sexual & Reproductive Behavior and Attitudes

a) Describe how youth behave sexually and explore their sexuality
b) What are the most common youth attitudes to pregnancy and contraception?
c) In your view is the current rate of pregnancy among young women cause for concern – why?
d) How much do young people know about sexual and reproductive health rights and responsibilities?
e) How do young people cope with the risk of HIV and AIDS? Does infection still lead to stigma?
f) Who else is influential in shaping attitudes apart from the youth? What values do they try to instill?
g) In general, how would you describe attitudes within the community to teenage pregnancy, sex education, contraception, sexual exploration (think parents, teachers, clergy, civil servants)?
h) What role does community leadership (including traditional leaders and councilors) play in shaping attitudes?

2. Sexual and Reproductive Health Services and Support

a) List the services that you are aware of
b) How effective are these services and why?
c) Is the information and service provided of good quality?
d) Do young people make use of these services – why? Why not?
e) What are the main obstacles that prevent these services from having more impact?
f) What are the main attitudes displayed by service providers when dealing with:
   - Young people needing information and advice
   - Persons needing treatment for HIV and AIDs
   - Requests for contraception
   - Teenage pregnancy and pre/post-natal care
g) Do government and NGOs cooperate and work together in providing services – explain?

3. Coordination and Cooperation among the three Main departments (Health, Education and Social Development)

a) Briefly discuss whether the Departments meet their own mandate (do what they are supposed to)?
b) How well to the 3 departments work together?
c) Would you say that they collectively provide a full SRH service for young people?
d) Please provide an example of joint action by the three departments?

4. Community and government relations

a) Is there support within the community for programmes like SYP – explain
b) Does government do enough to encourage community partnership and joint responsibility/ initiative?
c) Does the community do enough to take ownership of these programmes or is it passive?

5. Obstacles and gaps

When you think over everything discussed, what are the biggest obstacles and gaps for young people to gain more control of their sexual and reproductive health?

Annexure 4: Snapshot Study Questionnaire (Learners)

SNAPSHOT STUDY: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Part of the Safe Guard Young People programme at Nzululwazi High School and surrounding community

The aim of these questions is to find out how your sexual and reproductive health can be improved and safeguarded by government and NGO programmes in your community. This is a voluntary study and you will remain anonymous when returning the form. In order to ensure this, please fold the completed form lengthwise and place it in the box provided.

1.	Gender	Male		Female
2.	Age in years			
3.	Grade			
4.	Where do you live?	Town		Rural area

5.	Who do you live with?	
	Family	
	Friends	
	Partner	
	Alone	
	In a school residence	

6.	Are you in a relationship?	Yes		No
7.	Have you ever had sexual intercourse[vi]?	Yes		No

If the answer to the above question was "no", please disregard questions 8-12.

8.	At what age did you first have sexual intercourse?			
9.	If yes, do you use any form of contraception? (e.g. a male or female condom, injection, pill etc.)	Yes		No

Specify .....

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10.	Have you ever been coerced (forced) into sex?	Yes		No

11.	What was the main reason that led you to first have sex?	
	Coercion (forced)	
	Pressure from friends	
	Promised reward	
	I was curious	
	I made an informed choice	
	Reproduction (to have a baby	

12.	If your first experience of sex was not by your choice, please explain how this came about
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13.	Are you aware of the morning-after pill?			
	Yes		No	
	Briefly explain how it works			
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14.	List at least one method that can be used to prevent pregnancy (besides a male condom)
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15.	Where did you get this knowledge of sex and contraception? (mainly)	
	Parents	
	Teachers	
	Friends	
	Own reading	

16.	Assess the following statement: A person living with HIV and AIDS is able to live a full and healthy life.			
	True		False	

17.	Please rate the following in terms of risk of contracting HIV and AIDS NR = no risk ; LR = low risk; HR = high risk	
	Penetrative sex with a condom	
	Masturbation	
	Deep kissing	
	Anal sex without a condom	
	Vaginal sex	
	Sharing a toothbrush	
	Oral sex with a condom	
	Sharing a toilet with a person infected by HIV and AIDS	

18.	What are the gaps in your sexual and reproductive knowledge that you would most like to fill?

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19.	Within your close circle of friends, has anyone become pregnant (unwanted) within the last year?	Yes		No	

20.	What form of assistance/support would make you feel more in charge of your sex life/reproductive health?

Briefly explain how it works .....

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21.	Who do you think is best placed to provide the support mentioned above?	
	School	
	Clinic	
	Church	
	Other	

Specify .....

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22.	How accessible are these services to you?	
	Not at all accessible	
	Somewhat accessible	
	Very accessible	

23.	How comfortable were you in using this service?	
	Not at all comfortable	
	Somewhat comfortable	
	Very comfortable	

Notes

UNFPA - because everyone counts.

UNFPA Country Office

5th Floor, Metropark Building, 351 Francis Baard Street
PO Box 11465, Tramshed 0126, Pretoria, South Africa
Tel: 012 354 8401 | Fax: 012 354 8419

KwaZulu-Natal Office

Liberty Towers North Tower, Suite 91
214 Dr Pixley Ka Seme Street
PO Box 1503, Durban, KZN, South Africa
Tel: 031 332 2123 | Fax: 031 332 2154

Eastern Cape Office

No 1 Amatola Business Village, Bisho, 5605,
Eastern Cape, South Africa
Tel: 040 635 0517 | Fax: 040 635 0517

http://southafrica.unfpa.org

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