Baseline Situation Analysis for the Development of a model for effective implementation of Integrated School Health Programme at the Nzululwazi High School and Surrounding Community

REPORT

Prepared by
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
</tr>
<tr>
<td>CSTL</td>
<td>Care and Support for Teaching Learning</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Settlements</td>
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<tr>
<td>DoE</td>
<td>Department of Education</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>DoSD</td>
<td>Department of Social Development</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<tr>
<td>ISHP</td>
<td>Integrated School Health Programme</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>LSA</td>
<td>Learner Support Agent</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>RD</td>
<td>Restless Development</td>
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<tr>
<td>RHRU</td>
<td>Reproductive Health Research Unit</td>
</tr>
<tr>
<td>S&amp;RH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SAPS</td>
<td>South African Police Services</td>
</tr>
<tr>
<td>SPW</td>
<td>Student Partnership Worldwide</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SYP</td>
<td>Guard Young People</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>YRC</td>
<td>Youth Resource Centre</td>
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1. Introduction

According to the UNICEF, WHO & UNFPA (2009), worldwide, 430 000 children under the age of 15 years became newly infected with HIV by the end of 2008. During the same period, South Africa had approximately 280 000 children infected with HIV. A national HIV prevalence and risk survey conducted in South Africa on children, found a 2.5% HIV prevalence among children aged 2-14 years (Brookes, Shisana & Richter, 2004). Research shows that HIV infection rates among adolescents are on average five times higher among girls than among boys (UNICEF, 2008a).

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, 2002). Data from the 2003 Reproductive Health Research Unit (RHRU) survey also shows that teenagers aged 17-19 account for 93% of teenage fertility (Harrison, 2008b). It is evident therefore that 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 for early pregnancy, STIs and HIV (Kirby, 2007). Data from the 2003 RHRU survey 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 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 rate among teenagers may nearly double.

According to the Human Sciences Research Council research conducted on behalf of the Department of Basic Education, with support from UNICEF, teenage mothers are concentrated among those with only primary education (38.5%) but declines 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 estimating 30 000 teenage pregnancies over the period 2010 - 2014.
The situation of the Nzululwazi Senior Secondary School must be understood against the broad national backdrop outlined above. The school, located outside Mt Frere on the north-eastern periphery of Mpendla Village, is fairly new – it was only established in 1999 initially as a very modest structure with very poor pass rates up until 2001. Former President Mandela then leveraged MTN and Dimension Data financial support to build a new school. In July 2002 the school was re-launched as a R3.1-million, 10-classroom secondary school with library, IT media centre, science laboratory, a hall and an administration block complete with kitchen and four offices.\textsuperscript{iii} By December 2014 the school was reported to have suffered vandalism and theft.\textsuperscript{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 last 3 years. In 2012 Nzululwazi SSS obtained a 77.4% pass rate – the second highest in the district.\textsuperscript{v} The school experiences substance abuse / drug problems and lack of accommodation for learners who are outside the immediate area. Both of these factors are believed to influence pregnancy rates.\textsuperscript{vi} Restless Development reported 25 pregnancies at the school in 2014 and 15 for the period January to June 2015. There are however many different estimates for pregnancy rates at the school over the past two years. This report includes under section 4.1.1 the latest pregnancy data supplied directly by the Principal.

A report by Restless Development (June 2015) suggests that in 2014 Nzululwazi SSS was identified as a school that had 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 the figures 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 the 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 themed event in December 2014, under the theme Say no to HIV/AIDS, Teenage Pregnancy and Discrimination in Schools. In order to reduce teenage pregnancy in the district, the Department sought the assistance of Restless Development through the Safe Guard Young People (SYP) program 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 teachers, students and the Department of Health, Education and Social Development.

This formed the basis for the workshop that Restless Development facilitated at Nzululwazi High School from the 17th to the 19th of June 2015. At this event, school governing bodies confirmed the deep concern with escalating levels of teenage pregnancy, negative impacts on learner’s progress in school and further 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 (S&RH) that impeded learner performance. On the 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 the 11-13 August 2015, Restless Development conducted an Adolescent Sexual and Reproductive Rights Intergenerational dialogue in Nzululwazi High School in order to better understand the communication gap between parents and youth, and work with the community stakeholders together to further unpack the barriers preventing young people from achieving healthy safe sexual reproductive lives. This event identified cultural perceptions that inhibited the use of contraceptives, not only by youth but also for rural married women. The programme also delved into the influence of out-of-school youth, especially when it comes to drug use, youth unfriendly services and misinformation about contraceptives. Restless Development went on to launch a peer education programme and establish a local youth resource centre at Nzululwazi geared to coordinating health, social development and education services to the youth. By November 2015 this centre was in the final stages of development.

In conducting this baseline survey, every effort has been made to represent the situation prior to the Restless Development intervention however the local stakeholders see RD as an intrinsic part of their recent development history and in many narratives it was hard to excise the presence of RD from the situation analysis.
2. Purpose of the Survey

The SPW South Africa Trust (also known as Restless Development South Africa) in partnership with the United Nations Population Fund (UNFPA) leads the Safe Guard Young People (SYP) Programme in three districts (OR Tambo, Amathole and Alfred Nzo) in the Eastern Cape. The goal of the SYP programme is to contribute towards the improvement of the Sexual Reproductive Health and Rights (SRHR) status of young people aged 10 – 24, with a special focus on HIV prevention.

The Nzululwazi Senior Secondary School forms a special focus of this programme. 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 a selected site – Nzululwazi Senior Secondary School, just outside Mount Frere in Alfred Nzo district of the Eastern Cape. The issue to be addressed is the unusually high rate of rate of teenage pregnancies amongst learners, both within the high and primary schools. The main purpose of the SPW intervention is to reduce teenage pregnancy over a three-year pilot timeframe through:

- Improved coordination, collaboration and leadership of core stakeholders responsible for provision of sexual and reproductive health information and services
- Generally, expand the availability of appropriate sexual and reproductive health information and services to the community
- Ensure increased take up of SRH services delivered in the context of the Integrated School Health Programme
- 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 through their own resources and leadership (rather than externally driven)

As already noted, the subsequent intervention started in June 2015. However, SPW also recognised that the good and promising practices are only properly understood if the situation prior to 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 survey therefore endeavours to record and understand the stakeholder attitudes, values and behaviours that formed the baseline (pre-existing situation) prior to the intervention. Based on these insights, the survey report will also suggest how progress can be appropriately tracked whilst retaining community understanding and support. A further core aim is to use the survey 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 was undertaken using 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 then undertaken using documents mostly provided by Restless Development but also sourced from the Internet. Research instruments were then designed including a self-administered questionnaire for learners, focus groups guides, individual interview guides and case study templates. Mbumba also compiled a list of key documents required to secure relevant data. Factors that impacted the survey included the limited period for implementing the field research, limited resources which excluded extensive periods in the field and timing in the sense that 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 Restless Development 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 determinations 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 organised by peer educators who had prior knowledge of the community and had already interacted with the survey population. It was acknowledged from the outset that the research would have a strong informal dimension. Had this project been a project evaluation, this approach would have clearly been inappropriate however it was in fact a baseline survey and enquired into circumstances that prevailed prior to the RD intervention. It is unlikely therefore that the peer researchers would have any vested interest in matters that occurred prior to their intervention.

The learner survey forms, translated into Xhosa, were then distributed by RD’s peer educators to learner groups and the field research was undertaken over a two-day period. 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 survey data into 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 of key issues and provisional findings was made to RD including a proposed outline of the type of indicators that might be part of the future monitoring / performance assessment tool. Based on this feedback further research was refined and provisional findings adjusted.
The survey was greatly assisted by the preparatory work undertaken by Restless Development in arranging interviews, introducing the service providers to key stakeholders and general logistical assistance. Restless Development ensured that both community and government respondents were properly briefed on the purpose of the exercise and the value it would have to 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 survey questionnaires
- Collection of forms via a ‘ballot box’ type arrangement
- Respondents completed forms individually

Other ethical considerations considered:

- Prior to the survey it was determined that the crucial information that would benefit youth sexual health was not available from adults
- Participation in all survey 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
- Researchers tried to make it clear that certain topics could be avoided or terminated if the respondent felt uncomfortable
- Researchers tried to be sensitive to the economic, social and cultural circumstances of the respondents

Furthermore, during the focus group with teachers and prior to the learner focus group, it was ascertained that learners were already familiar with the sexual health and reproductive topics. Some learners had experienced this through RD’s intervention but as a whole, the subject, is also discussed in Life Orientation (LO) periods. The World Health Organisation has noted that there are no clear ethical justifications for excluding from research adolescent subjects below the age of legal majority. If there are reproductive health problems that are restricted to, or occur also in, adolescents which cannot be solved with existing knowledge, there is an ethical duty of beneficence and justice to conduct appropriate research to address these problems. The prior involvement of RD at the research site and their prior experience in working with youth allowed for consultation on issues of research ethics and the researchers endeavoured to keep within the parameters and conventions established by RD.
4. Survey Findings

4.1 Survey of Learners: (Profile, Attitudes and Behaviours)

This survey consisted of a self-administered questionnaire distributed by peer educators at the high school. An initial plan to survey the junior school was not feasible due to time constraints and ethical concerns that related to surveying very young children. The questionnaire contained 23 questions of which five were open ended and the remainder were closed ended. Respondent 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 Survey Population

<table>
<thead>
<tr>
<th>Total number of survey respondents</th>
<th>184(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grades covered</td>
<td>10 – 12</td>
</tr>
<tr>
<td>Gender breakdown</td>
<td></td>
</tr>
<tr>
<td>Female: 112 (60.9%)</td>
<td></td>
</tr>
<tr>
<td>Male: 68 (37%)</td>
<td></td>
</tr>
<tr>
<td>Not provided: 4 (2.1%)</td>
<td></td>
</tr>
<tr>
<td>Average age of respondents</td>
<td>17 years</td>
</tr>
</tbody>
</table>

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 of 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 from 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%) were from 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 2 lived with a partner.

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\(^1\) This represents a sample of slightly over 28% of the total number of learners at the NSSS
Relationships and Sexual Experience: The majority – 152 (82%) of learners described themselves as ‘in a relationship’ and 113 or 61% had experienced sexual intercourse.

The earliest age at which a respondent said they had first had sex was 5 (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 (6) 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 such coercion. Of those who had suffered coercion, 5 were female and 3 were male.

In response to the question What was the main reason that led you to first have sex? the majority of learners (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 4 (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

The above suggests that while only 8 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 above 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 until 18 and then tapers off after age 18. Most learners report first sexual intercourse at the age of 15 and in the following 3 years. Between the ages of 15 and 18 nearly 64% of learners have experienced their first sexual intercourse.

<table>
<thead>
<tr>
<th>Age of first sexual intercourse</th>
<th>&lt;10</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>&gt;18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>21</td>
<td>19</td>
<td>16</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>% of sexually active (113)</td>
<td>1.8%</td>
<td>4.4%</td>
<td>0.9%</td>
<td>5.3%</td>
<td>6.2%</td>
<td>8%</td>
<td>18.6%</td>
<td>16.8%</td>
<td>14.2%</td>
<td>14.2%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>
Contraception: Of the 113 sexually active learners, 98 or nearly 87% claim to use contraception and only 14 (12%) say that they do not use contraception. Of the 98 who said they used contraception, 50 (51%) used a condom, 18 (18.4%) used injections (Depo Provera)\(^2\) and three used oral contraceptives. It is therefore clear that about 27% of those who claimed to use contraception did not specify what form. This might be seen to cast doubt on the veracity of the number who actually claim to use contraception.

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 only about 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’, 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 got their knowledge on sex and contraception. The most commonly selected source was own reading (33%) followed by parents (31%), then teachers (23%) and finally friends at only 13%. These figures are surprising given the trend in other parts of the research which suggested little influence by parents and major influence by peers and friends. Clearly learners may be influenced by peers.

\(^2\) No stakeholder made any mention of the transdermal implant contraceptives that the Minister of Health announced as freely available from February 2014.
and friends more than parents and teachers but they are more likely to seek knowledge 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 the question and 58 said they were aware of such pregnancies. It seems therefore that over the period of one year, slightly over 35% of learners know someone within their immediate circle of friends who has become pregnant.

The most official 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of pregnant learners</td>
<td>45</td>
<td>21</td>
<td>14</td>
</tr>
</tbody>
</table>

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%) thought the statement was true as indeed it is, while 19 (12%) thought it was not true.\(^3\)

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 below illustrates the result of this assessment where the 2\(^{nd}\) row is the correct response and third row is the spread of learner responses with the correct response in bold.

<table>
<thead>
<tr>
<th>Penetrative sex with a condom</th>
<th>Masturbation</th>
<th>Deep Kissing</th>
<th>Anal sex without a condom</th>
<th>Sharing a toothbrush</th>
<th>Oral sex with a condom</th>
<th>Sharing a toilet with a person infected by HIV and AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LR</td>
<td>LR-26</td>
<td>LR-73</td>
<td>LR-90</td>
<td>LR-80</td>
<td>LR-18</td>
<td>LR-53</td>
</tr>
<tr>
<td>NR-101</td>
<td>NR-10</td>
<td>LR-43</td>
<td>LR-34</td>
<td>LR-40</td>
<td>NB-18</td>
<td>LR-66</td>
</tr>
<tr>
<td>HR-13</td>
<td>HR-57</td>
<td>HR-6</td>
<td>NR-22</td>
<td>HR-78</td>
<td>HR-41</td>
<td>LR-37</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HR-31</td>
</tr>
</tbody>
</table>

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

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

\(^3\) Cases the Principal was aware of as of 9 December 2015. The Principal cautions that the school may 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 the condition of AIDS.
Applying the above indices to the 139 respondents to this question, 95 (68%) had a very weak understanding, 42 (30%) had a moderate understanding and only 2 (1.4%) had a good understanding. Thus while the initial question about life prospects of those living with HIV seemed to indicate fairly broad awareness and insight, the more specific enquiries 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 only low or no risk.

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

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

The above suggests that learners feel the most need for additional knowledge around sexually transmitted diseases 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 result underlines a trend that suggests that learners may be more concerned about contraception than was indicated in the more interactive parts of the research.

Nearly 89% thought that such assistance should come from the clinic and only 10% said the school. Other responses were, the church (2), Restless Development / other NGOs (3), parents (1), special programmes (3) and ‘a loved one’ (1). These responses appear to further underline the very high expectations of a local clinic service and an indication that there might be some concern 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% said it was somewhat accessible and 8% said it was not accessible at all. In terms of how comfortable learners felt using the service, a similar pattern emerged. Slightly over 58% said they were very comfortable using the service, 36% were somewhat comfortable and only 6% were not at all comfortable.
4.2 General Research
This emerged from all of the stakeholder focus groups and the individual interviews according to the respective research instruments.

a. Sexual & Reproductive Behavior and Attitudes and Support

*Describe how youth behave sexually and explore their sexuality?*

This question was posed to virtually all respondents and there was a high degree of consensus in the response. Learners and young people were generally described as highly sexually active from an early age. Teachers for example cited two learners who had fallen pregnant in Grade 9. Drug use, mainly alcohol and dagga is seen to contribute to sexual activity. The 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 SS School holds the same view and suggests that high rates of teenage pregnancy is simply the indicator of rates of sexual activity by learners and young people outside the school. He suspects that sexual activity starts in Grade 8 or 9 – at an age which he considers too young. He suggests 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 learner’s fear of pregnancy and perhaps even elevated pregnancy to a sought-after status. Male learners apparently also see their status as being elevated by having had a child. Parents endorse this view and suggested that it was “fashionable” to have a child – they cite evidence of young learners proudly giving the child their own name. Learners describe their acknowledged high levels of sexual activity as normal and insist that it is nothing to be embarrassed about.
As more neutral observers, Peer Educators confirm high levels of sexual activity and little concern for safe sex. Many learners it seems simply do not care about their sexual behaviour or its consequences. Peer Educators ascribe these patterns to lack of facilities and information as well as the dominant cultural beliefs within the community. Polygamy / multiple partners is seen to be deeply entrenched “...they think they can just continue what their parents did.” In this view, traditional beliefs may be ostensibly towards abstinence or cautious sexual activity but 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 traditional examiner.

Common youth attitudes to pregnancy and contraception

Views on this were more divergent. Teachers for example, feel that learners want contraception but find it hard to access. Male learners on the other hand 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, it being in their interest 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 discriminating 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 of 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, male learners were generally uninterested in contraceptive measures describing these as spoiling the experience. One respondent frankly noted that “…having sex is the priority – (preventing pregnancy) is not my business.” Peer Educators confirmed that the ‘don’t care’ attitude was most pervasive and sometimes unwittingly facilitated e.g. mothers support pregnant girls. It was suggested that girls renting accommodation to be near school were 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. To illustrate this point, he noted that if a sample of 100 girl learners revealed that only 20% were pregnant, given the rate of sexual activity, we must assume that some take precautions.
Is the current rate of pregnancy among young women cause for concern?

The previous discussion topics had revealed that teenage pregnancy rates are indeed cause for concern, except perhaps for learners themselves. Teachers are concerned about these pregnancy rates because it negatively impacts the learner’s performance at school and limits the person’s opportunities in life. According to teachers there were 18 pregnancies at the school in 2014 and 7 thus far in 2015 – these were the pregnancies detected. These figures are significantly different to the rumored rates quoted in some of the original problem statements. Teachers attributed the reduction to the fact that the issue was raised at the previous World Aids Day – the right of learners to use the services of the clinic was stressed. The school as a whole supports interventions aimed at preventing unplanned pregnancies even though these may be disruptive to teaching. Parents were mainly concerned about such pregnancies because they had to shoulder the burden of raising these children. All other stakeholder groups were very concerned about such pregnancies and felt it was the key priority for all planned interventions. Learners on the other hand said they were no longer concerned about this issue. They claim that in most instances these pregnancies are now accepted as ‘part of our culture.’ Learners said that they either did not know about contraception 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 regarding such topics has diminished and learners do talk among themselves but apart from the World Aids Day event and life orientation 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. Learners on the other hand said that they do not talk about sexual and reproductive health 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 suggest 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 recognize 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 the information.

The Principal felt that learners had been widely exposed to information about sexual and reproductive health 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 behavior. “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.” The Principal reflected on emerging differences between urban and rural areas. Initially there were high pregnancy rates amongst learners in urban areas but this has now reversed. Urban areas now heed the message while learners in rural areas seem to be belatedly experiencing their own sexual freedom and youth are excited by this freedom. In the past, underperforming schools used to be called to meetings with the Minister where lessons were shared from the better performing schools. The message was clear – the 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 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 there is now very little stigma 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 now they also make no serious effort to avoid infection themselves. “Now there are solutions for everything.” Parents held similar views, noting that the virus is no longer feared or stigmatized because it is now treatable. The SGB chairperson held a similar view but traced the better knowledge and reduced stigma to the RD 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 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 according to 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 instill?

Teachers felt that they are able to influence learners and to some degree, shape attitudes. The Life Orientation (LO) class is of particular value and LO teacher’s views and advice is 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 sexual and reproductive health but thought it was probably their peers. They claimed to try to instill values within the family but did not seem convinced that 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 a generation only slightly older 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 who had nice cars

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\(^5\) The programme referred to was the overall national programme of improving sexual and reproductive health amongst youth and reducing risk factors.
and multiple girlfriends. For female learners it seemed to be their girl peers who succeeded in dating older men and thus gained some sort of material benefit. Female learners used the expression “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 under their care. In their view there is an absence 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. The SGB chairperson made the same assessment – boys are influenced by men already having sex and “girls have sex with older men because they want cellphones etc...”

The Principal felt that learners were influenced by broader shifts in societal values that had occurred since the advent of democracy in South Africa. Values, particularly in the African community, are deteriorating. Single parents, divorce and multiple partners have become the norm – not just for youth but also 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 instill more conservative values but they are often also involved in promiscuity and therefore vulnerable to accusations of hypocrisy or even blackmail from their own children. Learners are thus able to manipulate their parents.

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

This topic had largely been covered through expanded discussion of previous questions. Teachers however felt that the role of the school in creating awareness and understanding of teenage pregnancy, sex and contraception was 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 whilst it should prioritize education. Different respondent groupings for example teachers, report that there are some within the community who claim that it cuts into teaching time and is a waste. 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. Parents on the
other hand claim that they are now open to such discussions and are willing to promote sex education in the family setting. They feel however that these interactions with their children often start 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 absence of interventions and SRH information at the primary school. Because the 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 the more affluent families deal with these issues while poorer families side-step the topic. Poorer and more traditional households still see contraception as taboo but the learners from these homes have sex anyway. The SGB chairperson said the community’s endorsement of contraception was weakened by the fact that in general they regarded unplanned pregnancy as ‘normal.’

*The role of community leadership (including traditional leaders and councilors) 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 instill pride in being an ‘intact virgin.’ The ceremony however 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 thought that parents did not support the practice. Teachers seemed to have mixed views of the ceremony itself but expressed no strong reservations. As far as municipal councilors are concerned, teachers are of the view that they play no part but they have the potential to organize awareness programmes.

**b. Sexual & 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.  

*Awareness of Sexual & Reproductive Health Services and Support*

Some learners and also some teachers were under the impression that condoms are available at the high school and thought this was an arrangement by Restless Development. Restless Development clarified that in fact 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.

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6 Condom distribution is not readily acknowledged as a school responsibility. Even if condoms were to be available in this manner, some learners express hesitation in accessing condoms this way.
The resource center was also widely mentioned as a source of service and support however this was still under construction and is also an RD initiative. A mobile clinic has been promised to provide S&RH services but the last visit by the Department of Health was in 2014. Services from the Department of Social Development were unclear but seem to relate to different grants and the listing of persons who require assistance either as victims of abuse or through some other form of misfortune. It seems that the LSA at the school is linked to the DoSD. Regarding the Department of Basic Education, the service seemed to be the provision of LO textbooks and the ‘agreement not to expel pregnant learners.’ In the view of the Principal, none of the three main line departments had as yet commenced any significant service and only RD was helping to coordinate future service plans.

The Department of Health asserted that apart from a sporadic mobile clinic service to a nearby community (general health services) there was no service to Nzululwazi and certainly no dedicated S&RH service geared to young people. While the Department of Health 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, learners certainly did not regard health services as entirely absent. – as the formal survey clarifies, the vast majority of learners’ regard health services as very or somewhat accessible.

The Department of Education, through its HIV and AIDS & Safe Schools coordinator, Mr. Nonkonyela, mentioned the services of RD, the provision of Learner Support Agents (LSA) from his own department, ‘HIV grants’ from DoSD and a rescue center operated by the DoH.

Parents described some experience of a clinic service which they regarded 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 clinic locally, 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

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7 It emerged that the informant was referring to the resource centre still being established by Restless Development
Educators were aware of roughly the same bundle of services but claimed that DoE provided virtually no S&RH related services and it was mainly RD 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 Department of Social Development outlined the following general service approach. The DoSD operates at three levels, the District, Area and Service Offices. All the three levels implement the following key programmes and their respective sub-programmes.

- **Social welfare services**
  - Service to all persons
  - Service to person with disabilities
  - Service to people with HIV/AIDS
  - Social relief service
- **Children and families’ services**
  - Care and service for families
  - Child care and protection
  - ECDC and partial care
  - Child and youth care centers
  - 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 livelihood
  - Women development
  - Youth development

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

**Effectiveness of S&RH services**

The Department of Education 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 respondent did not appear to be able or willing to assess any S&RH service including that of the DoE. Teachers pointed out that there is no dedicated LO teacher at the school and only four LO textbooks have provided for 80 learners (the content however is relevant and user-friendly). There had also been minimal if any training for teachers willing to undertake S&RH counselling and advice. Parents, as mentioned, assessed the clinic service to be good but irregular.

Since learners had mentioned a range of services that were not all local and which did not necessarily fall within the integrated S&RH services, their assessment was not fully relevant and they appeared to have difficulty in making any detailed assessment. When 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 needed to be trained to undertake S&RH counselling and advice. They also found that DoSD services needed to be more responsive to local needs.

The Principal adjudged that health services needed to be closer to the community. He noted that the DoSD was largely reliant on NGOs for the roll-out of services needed to identify neglected and vulnerable youth and provide the necessary assistance (admission to school, arrange grant and school uniform.) He acknowledged that social workers do sometimes visit the school for specific cases.

The DoH said it was too early to assess the effectiveness of S&RH 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 S&RH service directed specifically to youth. The mobile clinic will apparently set aside certain days for the S&RH service. There is now apparently acceptance that this service will be through the school. In general, however there still seemed 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.” The SGB chairperson was the most optimistic about services and mentioned that 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 from the RD 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 noted that by speaking to their peers it is possible to find out where to get information e.g. at the clinic. The DoSD said simply “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 rumors that condoms were available at school and that learners sought the services of the clinic⁸. Learners had already outlined their use of services which was broad but did not necessarily reflect S&RH 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 years old.
- The foster care grant is given to orphans and child headed homes.

⁸ Note the previous clarification that condoms were only distributed at the school during special events.
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 hypothesized 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.) The SGB chairperson said that service improvement would be achieved through the new youth resource centre.

Learners mentioned the affordability of travel to the clinic and traditional healer charges as well as the inability to make confidential use of the clinic. The Department of Health thought impact was constrained by coordination problems in availing the service and the resistance of the community to contraception as a solution to widespread unplanned pregnancies.

The DoSD mentioned the abuse of child support grants, i.e. children getting pregnant because they want this money. The DoSD respondent also thought that lack of security at the resource centre could lead to resources being stolen.

Attitudes of S&RH service providers

Teachers reported mixed experiences of the Gateway clinic in Mount Frere town. One teacher in particular reported a negative experience in seeking a voluntary HIV and AIDS test – the nurse gave her the result and said sarcastically “Come back when you are positive.” Teachers also thought that learners had experienced negativity but also acknowledged that the clinic had ensured that learners did not have to queue. Teachers were also of the view that little counselling was done prior to testing and only those who tested positive were counselled. The SGB chairperson noted “Nurses sometimes scold at them and judge them.” The DoE was unsure of service staff attitudes generally 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 in other services. Learners reported a mixed experience. Some said the clinic nurses were “...the worst – they insist on giving a lecture.” Others however said in relation to HIV and AIDS testing, “...it depends who you get – some give good treatment, some give bad...” In relation to treatment by traditional leaders 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.

The Principal 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 S&RH frontline services as these were provided at 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 work stress of having to deal with both general clinic functions as well as S&RH services. The new resources center will now be able to take up S&RH 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 behavior 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 the NGOs as Siyayinqoba, Hospice and Masizakhe and noted that they work with the municipality. Learners were mainly aware of RD and noted that Lovelife works in some villages and cooperates with the DoH. The Principal was of the view that such cooperation had yet to commence but at the preparatory phase it seems that NGOs and government will cooperate and coordinate their interventions. The SGB chairperson said “… I hear from the children what they have learned and I realize 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 thought that such cooperation existed but that the local municipality “never comes to the party.”

c.  **Coordination and cooperation among the 3 main departments (Health, Education Social Development)**

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

The DoE claimed that there was a 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 the absence of other line departments e.g. Agriculture. The SGB chairperson was similarly positive about departmental performance e.g. the DOE undertakes sports and nutrition and LO teachers “get training.”

Teachers on the other hand 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 out specific services, these were usually not forthcoming. The Principal repeated his assertion that since integrated S&RH services had not yet started it was impossible to make an assessment. The DoH respondent held a similar view and was prepared to accept that he 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 center’ (resource center) was functioning. He singled out the DoH as effective but felt that the provision of S&RH 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, like the Principal felt that the coordinated provision of a comprehensive service had yet to be tested but they also seemed to place some reliance on RD and the resource center to make this happen in the future.

Apart from the 2014 World Aids Day, the World Population Day event in July 2015, and the general concept and planning of the resource center, 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 an 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 RD initiative.

d. Community and government relations

Community support for programmes like S&RH and SYP – does government do enough to encourage partnership and what level of community ownership exists?

The DoE respondent was confident that such support existed and cited community liaison and ward councillor reports at municipal level which showed high levels of community support for such initiatives. His idea of community ownership was that “government educates the community about how to be creative…they (the community) appreciates everything that is coming…” The DoSD also thought that government did enough to promote partnership.

Teachers endorsed the basic 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.” Teachers also noted that the community was quite happy to hand responsibility for S&RH to government. Peer Educators said community support was uneven but otherwise agreed with the teacher assessment, noting that government did not do enough to encourage partnership. “The community is very passive, they acknowledge the need but because it is only relevant for some, there is a culture of sit back.” The Principal held a similar view, noting that “…the community is

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9 It was not possible to verify such reports. It should be noted that the sources mentioned are usually highly politicised.
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 S&RH programme and was disengaged. Contrary to the teacher’s view, parents claimed to take responsibility for talking to learners about S&RH 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 S&RH 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 respondents. Reference had also been made to unhelpful cultural practices and changes in societal values that are antithetical to healthy and responsible sexual behavior. Some of the respondents regarded polygamy as unhelpful but often the reference was more broadly to cultural practices and beliefs that do not support S&RH improvement. The SGB cited the clinic that is not accessible and available (once a month is not enough, maybe twice a week could have impact). He urged the continuation of awareness raising about sexuality, rights and the use of contraceptives.

Parents felt that the whole discourse around S&RH lacked candor 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. The Principal held a similar view noting that peer pressure was driving irresponsible sexual attitudes and behavior but in the final analysis the problem was 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*

There is little wrong with the institutional and learning culture at Nzululwazi according to the respondent. . The S&RH 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. The Department does however have financial constraints. The district offices are
supposed to have a budget for information / resource material but instead are reliant on the provincial office to provide this 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 S&RH. However little is done to train and equip teachers for this role. Our main expectation of parents is to allow their children to take up these services and not to build prejudice against it – we accept that it is hard for them to do more.

Parents

They accept the responsibility and claim that they do talk to their children about S&RH. They accept that such discussions should be honest and frank. They think that the school can do more in this regard, would be happy with the clinic if it visited more regularly and would appreciate some basic interaction with social development. NGOs are generally doing fine. All claim they would deal with an unwanted pregnancy by showing love and understanding and avoiding domestic violence – whilst trying to provide better guidance for the future.

Learners

Decisions about sex and S&RH are mostly informed by peers and there is pressure to be sexually active. Role models are ‘guys with cars who can hook up with more women’ – for male learners. 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 think that programmes run by RD offer the best option for those who wish to avoid the pitfalls of irresponsible sexual behavior.

Principal

The culture and environment at the school is good and there is sound knowledge within the curriculum. Both LO 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 life orientation and sexual / reproductive health 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. In general, the school system is suffering because the outcomes-based education approach is not working – there is not enough structure or effective discipline – schools should have dedicated nurses, counselling facilities and disciplinary personnel. The S&RH 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 the home people may choose to follow the Inciyo ceremony or other traditional interventions that help. The ISHP is just starting up
and it is too early to make judgement – it is only RD that is bringing the various role-players (SAPS Child Protection, DoH and DoSD) together.

**Chairperson of the School Governing Body**

The institutional and learning culture at the school does assist learners to gain knowledge about sexual and reproductive issues. All teachers but especially LO teachers are equipped and motivated to assist learners with information about S&RH issues. Both the Principal and the SGB Chair, provide leadership and encourage openness and good healthy lifestyles. The Department of Education 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 had interaction 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 local school system could do to better if there was a platform for both the junior school and the high school to engage in discussions around these issues. The NGO RD should also replicate this 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**

In the past the mobile clinic visited about once a month at a nearby settlement but it was not a service meant for Nzululwazi. A school health service should be a dedicated on-site service able to provide S&RH type services like contraception – not a general clinic. The opportunity to now refer learners to the resource center 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 – it is a model that has proven itself elsewhere. It’s important for the school and parents to realize that we need our own time with the learners to be effective. It may be that the pregnancy rate is not exceptional – we need to understand the full problem not just the symptom. It is important that people like the Principal remain involved – he controls things like 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 RD driven project:

- Children and families’ services
  - care and service for families
  - Child care and protection
  - ECDC and partial care
  - Child and youth care centers
  - Community based services for children
• Community development services
  ▪ Sustainable livelihood
  ▪ Women development
  ▪ Youth development

The social worker team for Nzululwazi will take up issues of S&R health and rights by supervising the 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.”

When 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 sexually transmitted diseases including HIV and AIDS. Her previous caution around unwanted pregnancy and her efforts to avoid it seemed slightly at odds with the rating of 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 the question designed to test knowledge of HIV and AIDS, she understood the most serious risk to be posed by “vaginal sex without a condom” and “sharing a toothbrush.” Whilst 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 also believed that the age parameter applied 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.” In her community she thought the greatest threats to young people were diseases including HIV and AIDS, sexual abuse, prostitution / sex for favors, 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 Department of Health 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 has to rent 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. His first sexual encounter 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 do occur, he believes it is the boy who is mostly held responsible but he could not explain the basis 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 sexually transmitted diseases 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 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.”

In his community he thought the greatest threats to young people were diseases including HIV and AIDS, sexual abuse and prostitution / sex for favors. Substance abuse he considered 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 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 do 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.

When she rated 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 sexually transmitted diseases including HIV and AIDS. Unwanted pregnancy and the financial burden of a child were of little concern. For reproductive health / sex related problems or questions she does not know where to seek advice.

In the question designed to test knowledge of HIV and AIDS she understood the significant risk to be posed by “sharing a toothbrush”, thus 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 the 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.” In her community she thought the greatest threats to young people were diseases including HIV and AIDS, sexual abuse, prostitution / sex for favors and substance abuse. She viewed violence outside the home as a moderate threat. Economic exploitation (working for little money) and a life of crime she 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 about 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 service 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.*

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 get little consideration when girls have relations with older men who are sometimes infected. The learners are not afraid and do not think of the consequences of their actions. Pregnancy rates are high and start at the feeder schools – it has only begun to reduce since the RD programme started.

There is some awareness of sexual and reproductive health rights and responsibilities and learners are informed of contraceptive options from clinics and how to get help. There is also the *Inciyo* practice (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 the TV, other media and social networks as well as the *sugar-daddy* incentives (e.g. cellphones) to sleep with older men does play a role.

Attitudes within the community to teenage pregnancy, sex education, contraception, 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 often when learners are encouraged to go to clinics and use contraceptives, it is not received well by the community. *“As traditional leaders we have a responsibility to look at the wellbeing of our subjects.”* We encourage use of contraceptives and most importantly *Inciyo.* Before the Inciyo (virginity testing) ceremony, both parents and daughter are sat down and the process of a girl’s development is explained.

Currently S&RH services available are a mobile clinic monthly and the DoSD promotes awareness of teenage pregnancy and use of contraceptives. *Imbumba Yamakhosikazi Akomkhulu* supervises Inciyo (virginity testing) practice. There are still some challenges in this regard as the DoSD views 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. For those who have gone through Inciyo, it has been noted that they get pregnant later than those who did not. 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

¹⁰ An organisation of women who organise and conduct virginity testing.
three departments are responsive to our inputs and feedback, except the DoSD, who still views virginity testing as a violation - but we are engaging them in this regard.

e. Principal

The Principal of Nzululwazi High School, Mr. S.F. Makaula plays a clear leadership role in the school and the surrounding community. In his dealing with educational matters and young people, he is very much ‘old school’ – by his own declaration. According to Mr. Makaula he has served in Mkhonto We Sizwe, worked as a teacher in Nigeria and has experience of the Transkei Bantu stan educational system. He is clearly proud of these wide experiences and makes use of his accumulated knowledge in his current role of running and leading the school. He is an avowed disciplinarian and very hands-on in patrolling the school grounds and dealing with infractions such as late-coming. He interrupted our interview to hold a meeting with parents and a learner facing a serious disciplinary issue. He clearly takes such matters very seriously. The Principal wished for a school environment with more structure, clearly assigned learner support and control functions and dedicated personnel who can provide S&RH support to learners.

He is very alarmed by learner attitudes to sexuality and reproductive health which he regards as far too liberal and virtually anarchic. In his view, learners become sexually active when they are far too young to cope with serious emotional attachments and pregnancy – this sometimes leads to suicide. Learners show little concern for contraception or the advice of teachers and parents. He is realistic in acknowledging that some learners must be using contraception because sexual activity is rising whilst pregnancy rates are not escalating at the same pace.

Mr. Makaula is committed to any measures to advance S&RH including the ISHP but clearly has reservations about the more liberal dimension of such programmes. He points out that S&RH 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 now the focus should shift to a clearer and harsher stance on deterrence. He also looks to lessons from the urban / rural experiences of the ISHP – pregnancy rates at urban schools are now reducing while rural schools show the opposite trend. He seems to suggest that this is because the experiences of the new democracy and liberalization programme have been slower to reach rural areas and rural youth are still excited by these new freedoms and exploring the boundaries. Mr. Makaula however 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 overpowered 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. As a consequence, they are easily manipulated by the youth and forced to ‘spoil’ their children, rather than taking a firm stance on bad /risky behavior. Like other
teachers, the Principal seemed to have modest expectations of parents, asking simply that they trust the school and give it the space to do its job in respect of S&RH for learners.

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

Mr. Makaula 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 behavior in any way in response to the threat of HIV and AIDS.

More than any other respondent, Mr. Makaula was adamant that the ISHP and related S&RH services have not been a reality in Nzululwazi to date and that any movement in this direction has come from RD only since 2015. He is particularly adamant that learners must be served by health services that are in the future much closer to the community and are also able to address psycho-social problems. In respect of social development functions, there has been some roll-out of services directed to neglected youth – securing social grants, funding uniforms and arranging admission to school. These services appear to have come from NGOs contracted by the DoSD. The DoSD has on occasion also sent social workers to undertake work on individual cases. It seemed clear that ISHP existed in name only in Nzululwazi prior to RD’s involvement and the future of any integrated service rests with the RD intervention and the resource center in particular.

Regarding the attitude of frontline staff providing health and social development services, Mr. Makaula was reluctant to make any hard and fast calls. Most of the services, as he points out, are currently town-based and therefore not easily monitored. He has heard stories of poor attitude 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). A future integrated local service will 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 actual community experience of this in the past suggested it was weak.
5. Conclusions and Recommendations

a) General
This baseline survey had some limitations in terms of timing, the ability / willingness of government departments to share reliable information and data. It has nonetheless been possible to sketch out a fairly detailed picture of the situation at Nzululwazi prior to the involvement of Restless Development. In general, some of the main challenges in making the ISHP a reality in the Nzululwazi community seem to relate to having a clear and realistic overview of S&RH services and systems that are feasible and implementable and where a particular role player can be held responsible, be it department, parent, school or NGO. Policy and promises have clouded many basic issues of delivery and youth / learners have learnt to take up many of the sexual and reproductive freedoms and rights within the new value framework without holding themselves accountable to the required ethical norms that will safeguard their own and others sexual and emotional well-being.

Sexual & Reproductive Behaviour and Attitudes and Support

Nzululwazi learners and young people are highly sexually active from an early age, specifically from 10 years onwards. In the high school as many as 61% of learners have 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 will acknowledge that the learners reflect the real norms and values of the surrounding community, although not necessarily those 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 it is 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 sexual and reproductive risk are linked to living circumstance e.g. boarders are more vulnerable.

The Child Support Grant has diminished learner’s 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, others see modernity and the undermining of tradition as the cause. Virginity testing (Iciyo) is generally avoided or subverted. There is in any case little evidence that it causes learners to be more sexually cautious or indeed inhibits teenage pregnancy.
Learners claim a high (87%) use of contraception. About half of those who claim to use contraceptives use condoms, about 18% use the injection and very few use other forms of contraception like the pill etc. Concerning the 27% who claim to use contraception but cannot or will not specify the type, there must be some doubt about the veracity of the claim of any contraceptive use. This is reinforced by stakeholder narratives that suggest little concern for contraception – males for example 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 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 discern without reliable data. Slightly over 35% of learners know someone within their immediate circle of friends who has become pregnant within the last year. Reported pregnancy rates have declined from 45 in 2013 to 21 in 2014 and to 14 in 2015.

Although STDs and HIV and AIDS are the pressing concern for most learners, HIV and AIDS is now less feared due to availability of treatment. Some consider it ‘part of life’ and the stigma has reduced. Basic enquiry into knowledge of HIV and AIDS seemed to indicate fairly broad awareness and insight, however specific enquiries into risk factors indicates that the majority of learners (68%) have very poor understanding of HIV and AIDS transmission risks.

Concerning general gaps in sexual and reproductive 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. The largest segment of learners (48%), want additional knowledge about sexually transmitted diseases and HIV and AIDS. Basic knowledge of sexuality and pregnancy may already part of learner awareness but is not significantly impacting sexual behavior.

In terms of assistance required in helping learners to be more in charge of their sex life / reproductive health, learners unexpectedly turned back to the use of condoms / contraception as a measure that would help them to 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 remains a worry to them. Nearly 89% thought 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 the rumors that learners often feel uncomfortable with the attitudes of frontline staff, the actual 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 the service.

**Sexual & Reproductive Health Services**

Despite repeated government commitments and many well-intentioned plans, these services are not readily available. The mobile clinic for example was supposed to be a supplement to the distant Gateway Clinic but was neither regular nor local and did not provide dedicated days for S&RH services. The Department of Social Development 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 get minimal S&RH 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 critically short supply.

There is little or no coordination among the three main departments and in general services are not effective apart from the Department of Health and then to a limited extent. The Department of Health has demonstrated a service presence and its clinic service in particular is valued. It does not however play a coordinating role and it is generally understood that the Department of Social Development should take up this role. Indeed, there is very little evidence that the ISHP has 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 survey suggests that the obstacles posed by accessibility and sound staff attitudes may have been over-estimated. Nonetheless there seems to be good prospects of better learner take up of the services once they become local and regular. The attitudes of S&RH service providers are reflected in mixed experiences but certainly some cases of poor service attitudes and prejudice have occurred but mostly only 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 form of overall coordinating function. 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 generally suggests that the community is generally passive in receiving services and looks to government to take the lead. There certainly does not seem to be any antipathy towards the ISHP or S&RH 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 S&R interventions. The DoH felt that government needed to do more to educate communities and overcome fears and prejudices against S&R services.

In terms of participatory governance and active citizenry principles, there is little evident from the research. Most stakeholders, apart from the DoE informant, said the local municipality is largely absent and does nothing to engage or consult the local community.

Obstacles and gaps

Many of the obstacles to the planned programme at Nzululwazi are generic and predictable to rural South Africa and the public service. The area is accessed via 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 of the actors including the three core departments into a specific set of realistic local deliverables that can be measured and for which accountability is clearly assigned.

Most stakeholders however see the youth attitudes themselves 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, repeat the learner survey at regular intervals and include component to measure the drop-out rate due to unplanned pregnancy
- Include in the programme measures to build more coherence and unity in the leadership message about S&RH matters (School principal, managers from 3 core departments, municipal councillors and traditional leaders)
- Partner with the Community Policing Forum / SAPS sector policing to get statistics on 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 into 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 S&RH services
- The SGB should use parent meetings to win parent support for ISHP and S&RH interventions – explore possibility of school and parents adopting a S&RH charter
- The Youth Resource Centre (YRC) should develop a simple but effective system for recording client turnover numbers 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 seems to offer best prospects for expanded usage. However, it is also crucial to recognise the crucial role that condoms play in effectively preventing HIV transmission. A future programme must therefore ensure a focus on ‘dual protection’ messaging.
- The S&RH 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 / S&RH 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 S&RH interventions in the area including NGO programmes
• The role of the local municipality in the programme should be better defined and the local municipality 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, Restless Development outcomes could be at risk. Longer term planning for sustainability beyond the project intervention needs to consider the risk that intergovernmental coordination and cooperation remains an aspiration rather than an assured part of state machinery.
6. References

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


Restless Development, *Notes on Implementation Plan Meeting with Partners 21 July 2015*

Restless Development, *Notes on Intergenerational Dialogues 11-13 August 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)


Endnotes

i [www.mrc.ac.za/crime/Chapter8.pdf](http://www.mrc.ac.za/crime/Chapter8.pdf)


ii The Herald 9 April 2015


iv The Herald Online 3 December 2014


Annexures

Annexure 1: Field Research Plan

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

**Day 1: Thursday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 - 0930</td>
<td>Introduction meeting with main stakeholders - describe process / get all on board</td>
<td>Nzululwazi School</td>
<td>All – led by Athini</td>
</tr>
<tr>
<td>0930 – 11.00</td>
<td>FG 1: Parents</td>
<td>Nzululwazi School</td>
<td>Len, Glenn &amp; Athini</td>
</tr>
<tr>
<td>11.10 – 12.40</td>
<td>FG 2: SGB</td>
<td>Nzululwazi School</td>
<td>Len (Glenn to support)</td>
</tr>
<tr>
<td>11.10-12.40</td>
<td>FG 3: Teachers</td>
<td>Nzululwazi School</td>
<td>Athini (Glenn to support)</td>
</tr>
<tr>
<td>12.40 – 13.15</td>
<td>Break &amp; assess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.15 – 14.45</td>
<td>FG 4: Learners</td>
<td>Nzululwazi School</td>
<td>Len (Glenn to support)</td>
</tr>
<tr>
<td>14.55 – 16.15</td>
<td>FG 5: Local leadership (WClrs, TLs)</td>
<td>Nzululwazi School</td>
<td>Len, Glenn &amp; Athini</td>
</tr>
<tr>
<td>16.30 – 17.30</td>
<td>Interview: Principal</td>
<td>Nzululwazi School</td>
<td>Glenn</td>
</tr>
<tr>
<td>16.30 – 17.30</td>
<td>Interview: Chair of SGB</td>
<td>Nzululwazi School</td>
<td>Len</td>
</tr>
<tr>
<td>17.30 – 17.45</td>
<td>Team debrief</td>
<td></td>
<td>All</td>
</tr>
</tbody>
</table>

Shaded = parallel sessions

**Day 2: Friday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 – 10.30</td>
<td>Individual or small group interviews: DoE</td>
<td>Nzululwazi School</td>
<td>Glenn</td>
</tr>
<tr>
<td>0900 – 10.30</td>
<td>Individual or small group interviews: DoH</td>
<td>Nzululwazi School</td>
<td>Len</td>
</tr>
<tr>
<td>10.40 – 12.00</td>
<td>Individual or small group interviews: DoSD</td>
<td>Nzululwazi School</td>
<td>Glenn</td>
</tr>
<tr>
<td>10.40 – 12.00</td>
<td>Individual or small group interviews: Peer educators</td>
<td>Nzululwazi School</td>
<td>Len</td>
</tr>
<tr>
<td>12.10 – 13.30</td>
<td>Individual or small group interviews: Clinic staff</td>
<td>Clinic</td>
<td>Len &amp; Glenn</td>
</tr>
<tr>
<td>13.40 – 14.30</td>
<td>Team debrief + top up</td>
<td>Nzululwazi School</td>
<td>All</td>
</tr>
</tbody>
</table>
Follow up telephone interviews / info collection

- UNFPA,
- RD 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
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?
   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.

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?

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 – the boy or the 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

Explain…………………………………………………………………………………………………………………………………….

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?

- a. What age?
- b. Why?
- c. Is it the same for girls and boys?

17. In your opinion, are there any reasons why pregnancy/child birth should be avoided when a person is in his/her adolescence?
18. In your community, what are the greatest risks to young people?

<table>
<thead>
<tr>
<th>Risk</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases including HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostitution / sex for favours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence inside home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence outside home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being exploited (working for little money)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A life of crime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Is there violence against young people in your community?
   a. Who are the main perpetrators?
   b. Who are the victims?
   c. What are the main causes?
   d. Where does it typically happen?

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

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

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

If other, please specify:........................................................................................................................................

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 & 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 need 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 3 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 do 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 Survey Questionnaire (Learners)

SNAPSHOT SURVEY: 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 survey 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?*
   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:...........................................................................

10. Have you ever been coerced (forced) into sex?
11. What was the main reason that led you to first have sex?

<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion (forced)</td>
</tr>
<tr>
<td>Pressure from friends</td>
</tr>
<tr>
<td>Promised reward</td>
</tr>
<tr>
<td>I was curious</td>
</tr>
<tr>
<td>I made an informed choice</td>
</tr>
<tr>
<td>Reproduction (to have a baby)</td>
</tr>
</tbody>
</table>

12. If your first experience of sex was not by your choice, please explain how this came about

13. Are you aware of the morning-after pill?

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

Briefly explain how it works

14. List at least one method that can be used to prevent pregnancy (besides a male condom)

15. Where did you get this knowledge of sex and contraception? (mainly)

<table>
<thead>
<tr>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>Teachers</td>
</tr>
<tr>
<td>Friends</td>
</tr>
<tr>
<td>Own reading</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>True</td>
</tr>
<tr>
<td>False</td>
</tr>
</tbody>
</table>

17. Please rate the following in terms of risk of contracting HIV and AIDS

<table>
<thead>
<tr>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>NR = no risk</td>
</tr>
<tr>
<td>LR = low risk</td>
</tr>
<tr>
<td>HR = high risk</td>
</tr>
</tbody>
</table>
18. What are the gaps in your sexual and reproductive knowledge that you would most like to fill?

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?

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

If other, please specify:........................................................................................................................................

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?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all comfortable</td>
<td></td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td></td>
</tr>
<tr>
<td>Very comfortable</td>
<td></td>
</tr>
</tbody>
</table>

*THANK YOU VERY MUCH FOR YOUR TIME AND EFFORT*