Developing a community based response to promote family planning and reduce the rate of teenage pregnancy:
A KwaZulu-Natal Sexual and Reproductive Health Pilot Project

Formative Research Findings

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Executive summary

HIV/AIDS, sexually transmitted infections (STIs) and teenage pregnancy are key concerns for South Africa’s youth. Adolescent pregnancy is a major cause of interrupted schooling and drop-out in South Africa despite pregnant learners being protected by law. Incomplete education and early pregnancy are risk factors for HIV acquisition. This study aimed to develop deeper understanding of the uptake of Family Planning (FP) and other sexual and reproductive health (SRH) services by young people in KwaZulu-Natal; the magnitude of teenage pregnancy and access to antenatal care (ANC) for youth; and young people’s awareness of and access to medical male circumcision (MMC).

Focus group discussions were held with male and female learners (n=41, 4 groups), parents (n=19, 2 groups), educators (n=11, 2 groups) and community members (n=19, 2 groups) recruited through two schools in eThekwini District, KwaZulu-Natal, South Africa. Discussions were transcribed and translated. Data was coded, results organised according to key themes and NVivo used to facilitate data analysis.

Major discussion themes were unplanned adolescent pregnancy, FP and HIV/AIDS. Several factors, including poverty, substance abuse, age-disparate relationships and the media contribute towards early sexual initiation and unsafe sexual practices by young people. Despite good knowledge of modern FP methods, actual uptake of services and use of condoms and other contraceptive methods by sexually active young people is inconsistent. Similarly, young people demonstrated good knowledge of general HIV risk, yet personal risk perception was low and unprotected sex is reportedly common. Knowledge of MMC in relation to HIV risk was high, with a high proportion of learners reportedly undergoing the procedure. Teenage pregnancy was high. Negative attitudes towards pregnant learners were widespread. This is likely to be associated with late disclosure of pregnancy and presentation to ANC services, as well as psychological harm resulting from gossip.

Perceived barriers to young people accessing SRH services (including FP and HIV testing services) included inaccessible clinic hours, fear, negative attitudes and behaviours of health care providers, educators, and community members, relationship power dynamics and the perceived invincibility of youth. Conversely, risk awareness, the positive impact of peers and supportive educational environments were recognised as factors to facilitate access to these services and to encourage use of contraception. Although attitudes towards contraceptive use by youth were generally positive, there was a high level of stigma around youth sexuality.
Data showed possible solutions to the above. It was felt that parents should support, educate and advise their children around SRH, FP and HIV prevention. The majority of participants called for comprehensive SRH teaching for school-aged youth, especially within schools. However, some participants had concerns that SRH teaching would lead to promiscuity or was simply not relevant to learners. The need for support from the departments of health and/or education, as well as external assistance from specialist organisations such as NGOs was also recognised, since many educators are currently poorly placed to provide this type of education. Suggestions of ways to improve youth access to SRH services included mobile clinics, more accessible clinic hours, and provider training in youth-friendly services. FP and HCT provision in schools was also widely supported and debated as a way to increase access, potentially through an integrated school health clinic. Lastly, educators and parents called for a proactive, organised and coordinated response to SRH education between schools, parents and the community.
Acronyms

AIDS  Acquired Immune Deficiency Syndrome
ANC  Antenatal Care
DoH  Department of Health
FGD  Focus Group Discussion
FP  Family Planning
HIV  Human Immunodeficiency Virus
IPPF  International Planned Parenthood Foundation
KZN  KwaZulu-Natal
LO  Life Orientation
MMC  Medical Male Circumcision
NAFCI  National Adolescent Friendly Clinic Initiative
NGO  Non-governmental Organisation
PMTCT  Perinatal Mother to Child Transmission
PPASA  Planned Parenthood Association of South Africa
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infection
TOP  Termination of Pregnancy
YRHP  DFID-UNFPA Youth and Adolescent Reproductive Health Programme
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Introduction and Background: Situational analysis of adolescent sexual and reproductive health in KwaZulu-Natal, South Africa

The combination of unsafe sex and sexually transmitted infections (STIs) is the leading risk factor of ill-health in South Africa, contributing 31.5% towards the total national disease burden [1]. HIV/AIDS, STIs and adolescent pregnancy remain key sexual and reproductive health (SRH) concerns for the country’s youth and are recognised as priority policy areas both provincially in KwaZulu-Natal (KZN) [2, 3] and nationally [4-7]. With a population of 10.8 million people, KZN has the second largest provincial population in South Africa [8]. KZN also has the highest provincial HIV prevalence: in 2008 an estimated 25.8% of 15-49 year olds and 15.3% of 15-24 year olds were HIV positive [9]. Furthermore, HIV prevalence among women attending antenatal care (ANC) services in KZN in 2011 is the highest in the country (37.4%), with two districts reaching over 40% [10].

Key drivers of the epidemic include inconsistent and incorrect condom use, intergenerational sex and multiple sexual partnerships [11]. The latter is most common in younger age groups: in 2008 30.8% of males and 6% of females aged 15-24 reported multiple partnerships in the previous year [9]. In 2009, 34% of females aged 15-19 reported having a sexual partner who was five or more years older than themselves [12]. Multiple social, economic, psychological and physical factors cause girls to enter into age-disparate relationships, such as peer pressure, poverty and materialism [13]. Importantly, condom use in age-disparate sexual relationships is rare and diminishes with increasing economic disparity between partners, reflecting the unequal power dynamics that limit a young girl’s ability to negotiate safe sex [13]. Furthermore, despite the higher risk of HIV infection [14], awareness of associated HIV risk within age-disparate sexual relationships is low [9].

South Africa has a relatively high contraceptive prevalence compared to other Southern African countries, however the couple year protection rate in KZN is lower than other provinces [15]. Nationally representative surveys have found that around half of sexually active women aged 15-24 use a modern contraceptive method; predictors of contraceptive use include fewer sexual partners over the past year, current employment or student status, having ever been pregnant and talking to a partner about condom use [14, 16]. Use of dual protective methods (hormonal contraceptive plus barrier method) in this age group is uncommon (around 7%) [17]. According to a 2001 survey of adolescent condom use in KZN, 59% of sexually active 15-24 year olds in the province were protected from both pregnancy and HIV the last time they had sex, 53% because they used condoms alone and 6% because they used condoms plus another method; 64% of male and female condom
users overall used this method to prevent both pregnancy and STI acquisition, including HIV. Interestingly, fewer than one in five viewed their risk of HIV infection as medium or high [18].

**Medical male circumcision (MMC)** has been offered in South Africa as part of a complete HIV prevention package for men since 2007. Studies have demonstrated high levels of acceptability in young men [19, 20] and an estimated 23.8% and 15.3% of men aged 18-24 have undergone medical and traditional circumcision respectively [19]. There is much debate however around the ethical and legal implications of routine MMC for boys under the age of 16 [21], and currently independent consent may only be given at the age of 18 and over [22].

Although declining, the **incidence of adolescent fertility** in South Africa has not fallen at the same rate as all-age fertility and remains a significant health and social problem [23]. According to a large population-based household survey in four provinces, 19.2% of females aged 15-24 had had an adolescent pregnancy and 5.8% of males of the same age had fathered a pregnancy between 12 and 19 years. 74.1% of women said that their pregnancies were unintended, yet only 6.8% had ever terminated a pregnancy or persuaded someone to do so [24]. According to Department of Education statistics, KZN has the highest provincial incidence of adolescent pregnancy, at 62 per 1000 students registered per year in the period 2004-2008 [23].

The **majority of adolescent pregnancies occur among black or coloured women** aged 17-19. Other strongly associated factors are poverty or economic instability, school drop-out, absent parents, and rural living. Most affected schools tend to be poorly resourced, practice age-mixing in classes and are located in poor neighbourhoods [23]. The level of stigma in a community surrounding youth sexuality is also thought to be a key factor in the incidence of adolescent pregnancy and subsequent late presentation to ANC, resulting from poor communication between young people and responsible adults in their immediate environment, including parents, educators and health care providers [23, 25].

Adolescent pregnancy has been cited as the **main reason for interrupted schooling** in South Africa [25]. Despite the fact that both law [26] and policy [27] protect the right of pregnant learners and young mothers to remain in school, only one third of young mothers return to school after giving birth [28]. Those that do experience significant practical and financial challenges and lack much-needed support from teachers [29]. The negative attitudes and practices of educators – who tend to frame teenage pregnancy and motherhood as moral problems – is likely to play a key role here [30]. Both incomplete education and early pregnancy are major risk factors for HIV acquisition [14].
Indeed, HIV prevalence among pregnant women aged 15-19 nationally was 12.7% in 2011 [10], significantly higher than recent estimates of HIV prevalence among the total female population in the same age group [9].

**Poor access to family planning (FP) and other SRH services** is frequently associated with low levels of condom and other contraceptive usage among youth, high STI and HIV prevalence, high incidence of adolescent pregnancy and delayed presentation to ANC. Major barriers include inconvenient opening hours, stigma and the negative attitudes of staff [31-33]. Qualitative research in Soweto found that many nurses providing SRH services believed young women should not be having sex before marriage and reported feeling frustrated that education and awareness campaigns were being ignored. Many felt that termination of pregnancy was a sin and that abstinence was the best form of FP [32], which may explain why a very small minority of pregnant adolescents undergo TOP [14, 24]. A number of youth friendly services providing FP and other SRH services have been initiated over the years in South Africa, some as part of the interest in expanding youth programmes such as the loveLife initiative [34]. The National Adolescent Friendly Clinic Initiative (NAFCI) is an accreditation program designed to improve the quality of adolescent health services at the primary-care level and strengthen the public sectors’ ability to respond to adolescent health needs. NAFCI originated as a collaborative project between loveLife, the Reproductive Health Research Unit and the Department of Health, launched in 2001 it established national standards for public health clinics to be accredited as adolescent-friendly. Although some studies show promising results of this initiative, the overall impact on attendance surrounding contraception and pregnancy has been limited [23]. Other initiatives included the DfID-UNFPA Youth and Adolescent Reproductive Health Programme (YRHP). The YARHP programme set up a network of youth centres providing essential SRH services for young people aged 10-24 years, in collaboration with provincial Departments of Health who contracted the now wound up Planned Parenthood Association of South Africa (PPASA) to undertake key components of the service. These opened between 1999 and 2000 with anticipation that after 3 years of support from DfID and UNFPA that the youth centres would be absorbed into the Departments of Health or continue under PPASA which was a non-governmental organisation (NGO) and an affiliate of the international Planned Parenthood Foundation (IPPF). In 1985 the KZN Department of Health (DoH) and Population Development initiated a youth programme combining education, counselling and clinical services in nine youth clinics across KZN. A national youth centre evaluation was conducted in 2000 of a sample of loveLife, YARHP and KZN youth clinical and peer educations services [35]. This evaluation included a detailed costing component [36]. The evaluation found that where there were predominantly clinical services for youth these were most likely to be attended by females who were out of school and older. Although
the clinics targeted youth, a significant proportion of clients were over the official age limit. The linkages between the recreational services some of the youth centres provided and the clinical services were not always clear cut. Subsequently funding restrictions limited the expansion of many of the youth centre programmes and several closed, indicating the need for sustainability to be at the core of any donor funded programme.

**National youth prevention interventions** such as loveLife and Soul City attempt to address SRH issues such as unsafe sexual relationships, unprotected sex and adolescent pregnancy though media campaigns and school-level interventions. Again, although positive results have been seen in some cases, implementation of these programmes varies in terms of coverage, reach and quality [23]. SRH education has also been incorporated into school curriculum through Life Orientation classes, which should be taught in all government schools. Topics such as contraception and teenage pregnancy are central to the school health education package from grade seven onwards, as defined in the Department of Education’s Integrated School Health Policy [4].

**We report here on findings from Focus Group Discussions (FGDs)** undertaken with learners, educators and community members in one urban and one rural community in KZN, designed to develop deeper understanding of the uptake of FP and other SRH services by young people in KZN; the magnitude of teenage pregnancy and access to ANC for youth; and young people’s awareness of and access to MMC. The perspectives of both young men and women is important for study results to be used to make recommendations for improving distribution and access to FP and HIV related services, in order to be able to reduce overall rates of unintended teenage pregnancies, and increase access to services so that these babies are delivered in a safe and supportive environment.
Methodology

Study design
This is formative research which was undertaken by way of FGDS. The FGDS were conducted in isiZulu with all groups except for one (among educators), which was done in English. All discussions were audio-recorded. In addition all FGD members completed a questionnaire on their background and basic demographic information.

Study sites and populations
This research was undertaken within two communities in the eThekwini District, namely Umnini (rural) and Umlazi (urban). Twelve schools, that fall in the ‘most deprived’ category (lowest wealth quintile), with high adolescent pregnancy rates, were identified in these urban and rural areas. One school was purposively chosen from each area, and the study population was drawn from each of these schools and surrounding community. For confidentiality purposes, the names of the two schools chosen are not specified in this report.

FGDs were undertaken with learners, educators and parents drawn from the two participating schools, as well as with general members of communities, from within which the schools were located. Community members included community leaders, community organizations, clinic/school health providers and peer educators. Learners from Grade 10 and above, who were aged 16 and over, were invited to participate. Those learners between the ages of 16 and 17 had to obtain written parental consent and provide written individual assent to participate. The learners aged 18 and above provided written individual consent to participate. All educators in both schools were invited to participate, and interested educators provided consent and were enrolled. Eligible parents of children in the two schools were identified by educators and learners, and were invited to participate, and those who were willing provided informed consent. Key informants from the communities assisted with identification of community groups operating in the areas, and representatives of these groups were invited to participate in the FGDS. Eligible and interested community representatives provided informed consent to participate.

A total of ten FGDS were conducted using standardised qualitative interview guides as follows:

- One FGD was conducted with educators, and one with parents in each of the two schools (a total of 2 FGDS with parents, and 2 with educators). These FGDS explored parent involvement in school health activities; challenges that parents confront in addressing adolescent SRH, how schools can improve engagement with parents to ensure greater
engagement between schools and parents; and how schools can build the leadership and parenting skills of parents.

- One FGD with female learners and one with male learners were undertaken in each of the two schools (a total of 4 FGDs with learners). These FGDs examined learner knowledge of available methods; the barriers to the uptake of FP methods; and the main communication channels that are used within the communities through which men and women gain access to information on SRH.

- Finally one FGD was undertaken with other community level key-stakeholders in each of these two areas (a total of 2 FGDs with community level key-stakeholders) to understand issues of accessibility and availability of FP and HIV services in these communities.

Table 1: Breakdown of FGDs and participant numbers

<table>
<thead>
<tr>
<th>FGD type</th>
<th>Umnini (n=43)</th>
<th>Umlazi (n=47)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Educators</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Parents</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Learners: Male</td>
<td>12</td>
<td>N/A</td>
<td>11</td>
</tr>
<tr>
<td>Learners: Female</td>
<td>N/A</td>
<td>8</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Members</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total number participants</strong></td>
<td>18</td>
<td>25</td>
<td>20</td>
</tr>
</tbody>
</table>

**Data analysis**

Demographic data was entered into excel and was descriptively analysed. All FGDs were transcribed and translated into English where necessary. A qualitative data analysis software program, NVivo (version 10, QSR International) was used to organize, code, and analyze qualitative data. Two researchers independently reviewed a subset of the transcripts to develop a code list. The data was coded and results organised according to emergent themes, which were guided by the questions asked. Two interviews were double-coded to strengthen the reliability of the coding.
Results

1. Participant socio-demographics
Learners’ ages ranged from 16 to 21 years, with mean age of male learners being 17.9 years, and female learners 16.4 years. Mean age of educators was 46 years, parents’ mean age was 46.7 years, and community members’ was 39.8 years. (See Table 2 for breakdown of participants’ ages).

Table 2: Age of participants (n)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Learners: Male</th>
<th>Learners: Female</th>
<th>Educators</th>
<th>Community</th>
<th>Parents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-18</td>
<td>15</td>
<td>18</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>33</td>
</tr>
<tr>
<td>19-21</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>22-24</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>25-34</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>35-44</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>45-54</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>55-64</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>65+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3: Education level of educators, parents and community members (n)

<table>
<thead>
<tr>
<th>Education level</th>
<th>Parents</th>
<th>Educators</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub A/B/Gr 1-2</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Std 1-2/Gr 3-4</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Std 3-4/Gr 5-6</td>
<td>-</td>
<td>1</td>
<td>-</td>
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<tr>
<td>Std 5-6/Gr 7-8</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Std 7-8/Gr 9-10</td>
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<tr>
<td>Std 9/Gr 11</td>
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<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Std 10/Gr 12</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Incomplete post-secondary</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Complete post-secondary</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Honours Degree (Other)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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Educators on the whole had a higher level of education than parents and community members that participated in the study, with all educators having some level of post-secondary education. More than half the parents (n=10) had an education level of Grade 8 or less. The community members had a higher level of education than the parent participants, with more than a quarter (n=5) reporting having some post-school education (see Table 3).

The majority of learners who participated in the FGDs were completing Grade 10 (see Table 4).

Table 4: Current educational level of learners

<table>
<thead>
<tr>
<th>Current grade</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Std 8/Gr 10</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Std 9/Gr 11</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Std 10/Gr 12</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>18</td>
<td>41</td>
</tr>
</tbody>
</table>

The most common relationship status amongst educators, parents and community participants was “regular partner, not living together” (n=17) and “married and living with partner” (n=15). Only one participant with a regular partner was living with her. Only one participant who was married did not live with her partner. The most common relationship status amongst learners was “regular partner, not living together” (n=20), although 11 learners had “no current partner” (see Table 5).

Table 5: Relationship status of learners, educators, parents and community members (n)

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>Learners</th>
<th>Educators</th>
<th>Parents</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Married, living together</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Married, not living together</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>No current partner</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Casual partner</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other (widow)</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Regular partner, not living together</td>
<td>20</td>
<td>7</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Regular partner, living together</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>
All parent and community group participants had children, the majority in both groups having between 3 and 4 children (see Table 6). Parents had a mean number of 5.2 children, and community members had a mean number of 3.9 children.

Table 6: Number of children in parent and community groups (n)

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Parents</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1-2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3-4</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>5-6</td>
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<td>3</td>
</tr>
<tr>
<td>7-8</td>
<td>0</td>
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</tr>
</tbody>
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2. Setting the Scene

i) Learners’ sexual experiences

Table 7 summarises the sexual experience of learners. Just over half reported never having had sex (n=24). Age of first sex in those with sexual experience was at 15 years and older in females. Five boys reported having sex at ages 13 or 14 years. More male than female learners reported ever having had sex (see Figure 1) and the same 4 female learners who reported ever having sex had all been pregnant. The ages at which these 4 learners had become pregnant were between 145 and 17 years. All pregnant learners had kept their babies, 3 of whom were being cared for by another family member and 1 being cared for by the learner.

Table 7: Sexual experience of learners (n)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never had sex</td>
<td>10</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>Not currently sexually active, had sex in past</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Sexually active</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Been pregnant</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Contraceptive use amongst learners was relatively low, with only a few sexually active learners reportedly using male condoms (MC) (n=4) and the 3-month hormonal injectable (n=3) (see Figure 2). No participants in the urban male learner group responded to this question (possibly due to its position on the back page of the questionnaire).
ii) Problems facing youth

All FGD participants were asked about problems that they felt youth in their communities were facing. Major discussion themes in all ten FGDs were adolescent pregnancy and substance abuse; other themes were sex and relationships, poverty, HIV/AIDS, poor communication with parents and peer pressure.

It was generally agreed that the frequency of adolescent pregnancy was excessively high in both urban and rural communities – problematic in the sense that girls of school age are too young to take on the responsibility of motherhood, which interferes with schoolwork and only leads to unhappiness:

“You see maybe in my neighbourhood there are too many young kids who have babies but when you make a follow up on the children that have babies, you find that there is just misery. She does not even know that father of a child or maybe sometimes he has run away. You can see clearly now that it is sorrowful.” (Urban community members)

“Okay, hence they are getting pregnant they do not end up only pregnant, they also lose their virginity firstly and the second thing she becomes a mother and then when she is a mother she fails to face responsibilities as a mother...” (Urban parents)

A large number of ‘damaging’ legal and illegal substances were reportedly in common use by young people, including Whoonga (or Nyaope, a street drug cocktail rumoured to contain illicit drugs and antiretroviral medication), cocaine, tobacco, marijuana and alcohol. Discussions framed substance abuse as the centre of a high-risk lifestyle adopted by many youth involving sex, drugs, school absenteeism, adolescent pregnancy and disease acquisition.

Many parents and community members expressed a sense of hopelessness that their children have become involved with drugs, knowing that their addiction has come to ‘dominate’ them:

“Eeh the story lies in the fact that, these learners are more focused on taking drugs and they say there are these drugs called nyaope, whoonga. All these things eeh are destroying learners, it does destroy because even when you talk nicely with a child they fail to respond in a good manner, only to find that [s/he] is not controlling him/herself and is controlled by this thing.” (Urban parents)
Poor communication between parents and their children was also raised by parents in urban settings in relation to their inability to discuss matters regarding safe sex.

More general aspects of sex and relationships remained key concerns of community members, learners and parents, especially in urban communities. Many parents felt that youth nowadays rush into sex at a young age without knowing the risks, thus impacting their health and schooling:

“Currently our children are no longer going to schools now. They say that they are going to schools whereas they have gone to boys. They come back sick and having all diseases now and I can see that it goes wrong when they leave home to go to school and they get many chances [to do other things, like see boys].” (Urban community members)

Some adults felt that this trend is associated with a lack of discipline or the effect of young people having too much freedom:

“Yes I think that maybe it depends on the rights that they were given. They are allowed to have sex without sitting down and educating them and telling them about what the importance and risks of sex are. They do not know the outcomes thereof. They rush to what is important...they think whatever is important to them is important because they were not told. That is why they think that it is the important thing.” (Rural parents)

Although poverty was cited as an independent problem by a number of participants, the need to survive or the desire for material goods in the context of poverty was frequently associated with youth sexual relationships, causing young girls particularly to engage in risky relationships with older men in exchange for goods or money:

“When he was younger he didn’t care about all these things but growing up nicely and forgetting that if he can continue with schooling and grow up nicely then he can be successful and stop looking at his/her background then they end up getting themselves into trouble, especially girls they end up dating older boys, like father, I can say because they want to make money in order for them to survive. A person should look at themselves and say ‘I am so young and I am dating this father, what type of life am I living’.” (Urban male learners)
HIV/AIDS was raised explicitly (rather than a general reference to sexually acquired infections) in seven of the ten FGDs, including all urban groups and rural parents and educators. The interconnectedness of HIV acquisition and adolescent pregnancy was recognised in all groups, with unsafe sex as a common antecedent:

“It is two-fold now. Firstly, she is pregnant. If she is not pregnant, she has a disease and she is sick.” (Rural parents)

Moreover, participants recognised synergistically negative effects of the two:

“Again you find that she will be infected with HIV and when she is affected she ends up losing the focus completely at school because she will be concentrating on a child and that child is also infected including her, she is infected with HIV.” (Urban parents)

Finally, parents and male learners in two FGDs brought up peer pressure as an important problem. Independent psychological and physical outcomes of peer pressure were recognised, as was the interaction with other social ills such as poverty and substance abuse:

“The problem we are facing as scholars is that when you do right things at school and not involve yourself in bad things like smoking and all those things you see, those people who are doing it just criticise you and then they will say you are so bad, why you are not doing things like these you see. Now that makes you not to see something that is wrong due to peer pressure, there is a lot of peer pressure at school and it is peer pressure that destroys us the most.” (Urban male learners)

“You will find that a person knows that this is what is done at home and this is how to behave eeh, I get satisfied by what I have when it’s given to me but when she gets to school and see, there will be that pressure that she must reach the standard of others and start wanting to become like others whom she is not related to and not living with, eeh, that can make her to end up stealing so that she can meet the same standard like others.” (Rural community members)
3. Youth sexual behaviour

i) Perceived age of sexual initiation
Perceived age of sexual initiation varied within and between groups from 8 or 9 years to 18 years, with the bulk of groups suggesting sexual initiation was between 11 and 13 years. Learners suggested slightly higher ages of sexual initiation than other groups, between 13 and 15 years, “when they reach puberty” (Urban male learners), “when she has reached adolescent, adolescent stage” (Urban female learners). In general it was perceived that girls become sexually active about two years before boys.

ii) Factors influencing sexual initiation

Boyfriends
The urban community group and learners from both schools felt that boyfriends influenced initiation of sex in girls, either in terms of trying to keep their boyfriend, or because youth get caught up in the emotions of their young relationships:

“Others do because a boy says ‘If you say that you do not want to have sex with me, it means that you do not love me’.” (Urban female learners)

“… dating is the cause [of sex] in most cases because the time, because once you start having feelings with your partners, you love him right and there is nothing that you disagree with what he says because you love him.” (Rural female learners)

Male versus female
Urban educators and learners noted that females were more likely to initiate sex at a younger age than males, as female learners are “attracted […] to the boys in higher classes” (Urban educators), and “boys mature late and girls mature early.” (Urban male learners)

Environment/community
Educators, parents and female learners noted that the environment in which you are raised, including parental involvement, influences sexual initiation:

“Maybe it is the way they have been brought up. They have never been taught that you should behave if you are a girl.” (Urban female learners)
Both groups of educators and rural parents described more specifically how early exposure to sex influences initiation of sex, and that poorer living conditions and sexual abuse impacted this:

“Those children who are living in small houses, like two room house, there is one bedroom, and the kitchen, they see their parents doing the job and [...] they want to experience that, and all those things.” (Urban educators)

“And they may be, one had been abused.” (Rural educators)

**Peers**

Peer pressure was discussed as a factor influencing initiation of sex by almost all groups (except male learners and rural parents):

“[I]t happens that they’ve been influenced by a friend, maybe a friend will say, ‘hai I have started having sex so you can also start’, you know. [...] That is how they influence each other like that.” (Rural female learners)

**Media**

Media, including television, movies, cell phones and social networking, were seen as drivers of early sexual initiation by rural and urban educators, rural community members and urban female learners:

“I think young people watch things and, or hear people talking about it. Then from there they would want to experience that thing and say, oh they also doing it let me also try it, so that’s what drives them.” (Rural community members)

**Money/Finances and age-disparate relationships**

Poverty was seen as one of the factors resulting in early sexual initiation, with all urban groups and the rural community members discussing age-disparate and transactional sex. Both male and female learners discussed the issue of age-disparate sex with young females and older males, and felt that it was common in their communities. Age-disparate sex was described as a factor contributing to early initiation of sex as well as to teenage pregnancies. Although some girls described loving relationships with older boyfriends, poverty was described as the major factor driving intergenerational/age disparate sex.
Some young females reportedly had sex with older men “because they want to provide for their family”, and “[t]hey want to feed their parents or to do something at home.” (Urban male learners). Others reportedly had sex with older men out of choice and to support a lifestyle:

“[P]eople like to wear expensive clothes now and they love fashion. Now they see that they are behind fashion then ended up dating sugar daddy.” (Urban male learners)

Educators also described poverty as a reason for young females initiating sex with older males. They described why young females will have sex with older males, for money:

“[A] grade 8 learner, she’s 14. She will meet a sugar daddy or a person that is older than herself, and that person will sometimes give her money, or do something, buy a cell phone, or do something that is pleasing to a child. And because she cannot get that from the parents, then she falls into a gap, falls pregnant.” (Urban educators)

Urban and rural community members described age-disparate sex with ‘sugar daddies’, as a risky way for young girls to access material things:

“She will find a good old person maybe who has a car and who will propose love to her, you see what I am saying. He will explain his misery and will deceive her and want to have sex with her, you see. He will do such things for her, you see. Maybe he will leave her with a disease and then leave her like that. He will leave her with a disease and that Cavella [type of shoes] will get old. It is over but the disease will not end.” (Urban community members)

Parents (urban) knew that intergenerational sex was happening, but did not think that it was happening in their area:

“[W]e have not seen it in this area but what we have seen is that these young people like older guys like maybe those who are working because they want money.” (Urban parents)

### iii) Risky sexual behaviour

A variety of factors were discussed that contribute to risky sex behaviour in youth, placing them at increased risk of pregnancy, HIV and other STIs. Poverty as a cause of (high risk) transactional sex was discussed in detail (as described above). Many respondents described the attitudes and behaviour of youth as being influenced by perceived invincibility, which heightens vulnerability:
“They only think about pleasure and proving themselves that they’ve grown and want to be counted with the grown ones.” (Rural community)

Sex (unprotected, or with multiple partners) in the context of alcohol and drug use were raised by urban parents and male learners:

“The girls should not get used to having good times, like going to parties and getting drunk with alcohol because you end up not being able to control yourself, if a boy sleeps with you, you cannot refuse.” (Urban male learners)

Male and female learners and urban parents, as well as rural community members talked about youth engaging in sex without using condoms:

“[I]t is impossible for not being at risk [for HIV] since the girls are getting pregnant in this school which shows that they don’t use protection.” (Urban male learners)

4. Sexual and reproductive health and family planning

i) Understanding and knowledge of family planning

All participants were asked to describe their understanding of FP services. This was most commonly conceptualised as actual contraceptive and HIV/STI prevention methods. Some learners described FP as a set of services, including counselling:

“Family planning is when you use services that you get from the clinic in order to avoid having a child or spreading of HIV disease.” (Rural male learners)

A literal understanding of FP were evident in three of the four learner FGDs:

“Sir I think family planning is whereby you make decisions of ways to plan your family, that you want to have this much family members and live the life that you want to live at the time you like.” (Urban male learners)
Table 8: Contraceptive methods mentioned in each FGD

<table>
<thead>
<tr>
<th>FGD</th>
<th>Condoms</th>
<th>FC*</th>
<th>OCP*</th>
<th>IUD*</th>
<th>Sterilisation</th>
<th>Implant</th>
<th>Injectables</th>
<th>EC*</th>
<th>Abstinence</th>
<th>Thigh sex</th>
<th>Withdrawal</th>
<th>Traditional methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female learners</td>
<td>X</td>
<td></td>
<td>X</td>
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</table>

*FC: Female condom, OCP: Oral contraceptive pill, IUD: Intrauterine Device, EC: Emergency Contraception
All groups demonstrated good overall awareness of contraceptive methods (see Table 8). Most groups identified condoms (in general) as a dual protective method, and four of the ten groups specifically mentioned female condoms (in three cases in response to direct questioning by the FGD facilitator). Personal preference in respect to the indication for condoms was also noted:

“Other people use it for different reasons; others use it so that they don’t contract sexual diseases and others maybe use it to prevent pregnancy with the one they have sex with.”
(Urban male learners)

One community member raised the important point that despite high awareness, learners may not have the knowledge or skills for correct and consistent condom use:

“They need also to be taught on how to use the condom not just only tell them that they must use condoms, and a person will end up saying that they are using a condom and you will find that at the end the child do fall pregnant because most of the times in schools you will find that children are falling pregnant but yet they are using condoms. Which I think the cause of children falling pregnant is that, maybe they do not even know how to use a condoms but they do know what is a condom, and that it should be used and put on, but on how to insert it and put it on, they do not understand.” (Urban community members)

A few parents, community members and educators expressed confusion or concern regarding some more recent additions to the contraceptive method mix, such as IUDs or emergency contraception:

“A person must use it [emergency contraception] in case of emergency. Okay, sometimes when you have used it more often and it get used to your system, and then you end up falling pregnant while you have taken it. And that it confuses your hormones. If you going to take it all the time and you end up having unusual/irregular periods, you’ll just have your periods at any time.” (Rural community members)

One man in particular highlighted the need to improve access to appropriate information for all community members:

“I’ve heard her mentioning what, is this thing, a loop or what, I don’t know what it is, you see... yes if she [female participant] can explain more in Zulu so that we can be able to
developing a community based response to promote family planning and reduce teenage pregnancy:
formative research

Understand because we don’t know these things as males not that we don’t understand English” (Male urban community members)

Discussions around abstinence as a contraceptive method (held within community and male learner FGDs) often referred to this in the context of waiting until marriage for sexual initiation. One rural community member suggested that adolescent girls should seek advice about abstinence from a Sangoma (traditional healer).

Male and female rural learners also discussed more traditional methods of contraception:

“Or maybe it could be a rope given by a traditional doctor (sangoma) ... there is some traditional medicine that they apply on the rope. Then you always have to wear that rope, not remove the rope because once you remove the rope and you have sex with the boy then you fall pregnant. Actually it prevents you from falling pregnant.” (Rural female learners)

ii) Youth family planning practices

Use of family planning methods

Overall opinion was mixed about whether young people did or did not use FP methods, with the majority stating either that they do not use FP methods, or that “others use them and others do not use them” (urban community member). The only participants who asserted that young people commonly do use FP methods were female learners (urban and rural). Learners most commonly cited injectables as the method of choice for young women, followed by oral contraception (‘pills’) and condoms. Rural learners alone cited use of traditional methods:

“You will find that others are able to eat stones, and sand, is the way they protect themselves from pregnancy and they also eat umcako [white or red clay] and all these things but while there is nothing in their bodies but that is what others do ... there’re stones called ukhethe [type of soil], the one which is loose ... It is said those things hinders fertility.” (Rural male learners)

Perceptions that youth do not use FP methods were largely based on the high incidence of adolescent pregnancy and HIV in youth:

“Let me support there that the way in which HIV has spread, it is because these aids, they do not use condoms.” (Urban community members)
“I’ll say no [young people do not use contraception] ... Basically because the teenage pregnancy, especially in our area, this section that we are living in is very high.” (Urban female learners)

“Me too I am saying same thing that they do not use it because if they are using it then there would be not so many young people who have children” (Urban parents)

**Age or life stage at which young people start using family planning**

The estimated age or life stage at which young people start using family planning methods varied between groups. Educators in rural and urban areas suggested that girls who do use contraception do so when they start having periods or when they become sexually active, both of which were estimated at 13 or 14 years. Some learners also cited the time at which young people ‘mature’ or reach puberty. Female learners in both settings most commonly suggested the older age of 15-18 years, around the time at which a girl becomes sexually active (which is in line with reported age of first sex of the sexually active learners in the FGDs). One learner made the point that if a younger girl did mature early and start having sex, then she would likely start using a method at an earlier age:

“Ja, that person at the age of thirteen can also start using family planning to protect herself.”
(Rural female learners)

Several parents, educators and community members expressed the view that many young girls only start using contraception after a first pregnancy, when the “damage has already been done” (urban parents):

“In most cases children are using family planning when they’ve already have a baby. If she doesn’t have a baby, she won’t use family planning.... Eeh, there are these things eeh that they say that, if you don’t have a baby... or if you are using family planning, your body becomes full of water and you gain weight, you see. So then when she already has a baby, that’s when she will say, hai i really don’t want a second baby, I will rather have that water or become wet/watery.” (Rural community members)
Points of access

By far the most commonly mentioned point of access for FP methods was the public health clinic. This is seen as a place where one can obtain information, free condoms and other methods:

“In my knowledge people obtain these when they go to the clinics so as to gain information about that and be informed about them as well.” (Rural male learners)

“Yes because at the clinic it is where you can get everything when you state your problem” (Urban parents)

Other points of access included chemists (although it was acknowledged condoms here come at a price), hospital (mentioned by rural participants only) and private doctors (rural female learners only). Only rural parents suggested that condoms were available at schools. Urban learners in particular cited a range of non-traditional condom outlets:

“You even access condoms at the taverns as well as at the stores most of the time; you also get them at the telephone booth, you do get condoms.” (Urban male learners)

Cultural pluralism again played a role in rural learners’ discussions regarding access to FP services:

“I think according to the Department of Health, things to prevent you from having a baby can be obtained from the clinic, it is to obtain condoms and pills, the ones you are getting, and then traditionally they usually go to the traditional healers and use certain herbs to prevent themselves from falling pregnant.” (Rural male learners)

iii) Factors influencing family planning choices

Peers

Very few participants stated that they thought that young people made such choices independently. Educators, community members and learners in half the FGDs felt that a young person’s FP choices were primarily influenced by their peers. Although some suggested that young people simply do as each other, other participants alluded to a peer interaction process that facilitated more informed decision making:
“Some children are open, who would go to the clinic and ask about these things that if I use this, what would happen, and if I use this, what would happen also, then after that they will tell their friends too.” (Rural community members)

**Parents**

Although many parents expressed difficulty in discussing sexuality with their children, one educator felt that those who take a more active role are able to influence their child’s FP choices:

“I can also say, maybe the parents. Due to the activeness of the child towards a relationship. So in order to prevent that child to get kids unnecessarily, then they decide to sit down with them and talk to them, then start it.” (Urban educators)

**iv) Barriers and facilitators to accessing family planning services and contraceptive use**

In general it was felt that FP services were relatively accessible to youth, especially clinic-based services, which are reportedly located within walking distance of both communities:

“In my opinion, I think it’s fine to access them at the clinic... It’s because the clinic... it is where you know exactly that it’s where everybody gets helped and the help that you need you do receive it.” (Rural female learners)

However, several barriers to accessing services and actual use of contraception were discussed at length, namely clinic hours, actual and perceived attitudes and behaviours of community, educators, health care providers and parents, substance abuse and relationship power dynamics.

**Clinic hours**

Community members, educators and parents expressed concern that clinics in both rural and urban settings offer FP services only during school hours:

“The time for the clinics is bad. They open late and they close early. Let me say that a child who leaves school here... who can leave here and go to change and show up no longer wearing a uniform, to do family planning, she will find the clinic to be closed.” (Urban community members)

“[A]nother barrier is their time. Cos during the course of the week they are at school. And if it’s Saturdays, some clinics are closed” (Urban educators)
Educators

Because of limited opening hours, girls often must request permission to miss classes in order to attend FP clinic, causing a great deal of anxiety over the educator’s potential or actual response:

“You will be afraid; like you will be afraid of how you are going to approach the teacher to say that ‘Teacher, I’m going for family planning’. What will the teacher think of you?” (Urban female learners)

Indeed, educators themselves recognised this limitation:

“Teachers who are stereotyped just like myself [act as a barrier to family planning access]. We cannot understand them, to try it. We cannot discuss that. We cannot discuss it with a child. And as parents, the only thing they can tell them is to abstain from sex.” (Rural educators)

Health care providers

Community members, educators and learners all commented on negative treatment of young people by clinic staff (professional and administrative), impacting both re-attendance and the likelihood of their peers accessing the same services:

“Nurses are also not the same. They shout at children. ‘Hayibo! You have come for prevention when you are so young?’ you see that. Other children are afraid because they know them as they are from the area. The children are also abused.” (Urban community members)

“And they are so many, when they get to the clinic they make them do a queue and you can see that they are here to do this, and they say when they go inside the sister shouts at them and say ‘why are you using family planning, as young as this you are having sex’ you see, and there will be that thing. So one, it is a word of mouth, one will tell someone that they shouted at me at the clinic and that one will also say I’m not going to go to the clinic because they shouted at her. And that one will continue telling someone else that they shouted at her at the clinic, so that’s how that rumour will be spread that we will not go to the clinic because they will shout at us.” (Rural community members)
Community members

Attitudes and behaviours of community members negatively impacts young people’s experience or perceptions of accessing family planning in the context of certain culturally specific moral constructs, even if they are not recognised:

“Most people get judged at the clinics, especially when they are going to prevent from getting pregnant, it appears as if she likes sex and not falling pregnant, they are taken as people who are not serious with life.” (Urban male learners)

“I think that children should be quick to start but their problem is that they are afraid when they are still under 18 years of age to go to the clinic to do family planning publicly with people watching. I sometimes see even boys; they are afraid of taking condoms in front of people watching.” (Urban community members)

“Sometimes when you buy something at the shop and then you see condoms and then when I take them and then you would find someone asking, what am I going to do with them because I am young and they ask me if I engage in sex and then I will end up not taking condoms.” (Urban male learners)

Moreover, clinics appear to do little to promote young people’s confidentiality, which increases young people’s anxiety, particularly where close community ties exist:

“Most of the time privacy is very important...because there at the clinic when young people come to the clinic, I usually see when I go to the clinic, the nurses do not treat them properly, so when there are many people and the child is going there only to find there is a neighbour and is hearing everything then they are scared of just taking condoms in front of many people, so they need to have privacy because they deserve it and they also have rights.” (Urban parents)

“You are afraid because there is this community care-giver that you know who is from your neighbourhood, that he/she will talk about you saying, ‘Oh it means that this one is like this; it means that this one is like this’.” (Urban community members)
Side effects of hormonal contraceptives

Several rural female learners and one rural community member cited the effect of hormonal contraceptives on body shape and sexuality as a major barrier to use:

“What someone, them they don’t use them, because some of them say if you are using injectable they don’t like the fact that you will gain weight and some say you become wet in your private part and some say your partner doesn’t, your partner doesn’t feel you when you are having sex.” (Rural female learners)

Substance abuse

Participants in four of the ten FGDs perceived intoxication with alcohol/drugs as a key cause of lack of condomisation:

“And yes we can say the thing that makes them not to use family planning methods eeh is that, like number 6 have said that sometimes they end up having alcohol drinks… On that time they end up doing quick things… Now at that time you find that there is nothing for protection… in your pocket… Then that is how it is happening and the female ends up being pregnant.” (Urban parents)

The invincibility of youth

Both adult participants and learners cited a certain recklessness of some adolescents, despite knowing the risks, as a barrier to contraceptive use:

“[They don’t use family planning] because the youth only think of enjoyment, only enjoyment, after that when a girl is pregnant the boy would run away and that has happened a lot here at (place name). Those are the things that happen every day.” (Urban male learners)

Conversely, ignorance was also cited as a barrier by a number of parents and educators:

“It is because they are not aware, they do things according to their stage or when they are together drinking alcohol and not starting from elder people to get more information about what is happening when you have sex with a man.” (Urban parents)
**Relationship power dynamics**

Discussions around relationship power dynamics and use or non-use of FP methods featured in community, learner and parent FGDs. For some young women, sex without a condom is an important perceived or actual factor in maintaining status quo in a relationship:

> “Most of them say that when I use a condom my partner will leave me and go to someone else who does not use it because the way in which the disease has spread, it is as if most of the children do not use it.” (Urban community members)

This appears to be the case particularly in age-disparate and transactional sexual relationships:

> “No I would say they can’t [use family planning] because…most of the time people from nowadays are used by these other people who are grown ups and working who promise them money so that they will sleep and have sex and the thing that is a problem is that they don’t use things like condoms because they see that this person is working so he can manage to support a child that they can have.” (Rural male learners)

> “[T]hey are unable to use protection […] because they get into relationships with people who are older than them. They fall in love with taxi men; the people who say they want flesh on flesh. They are unable to use a condom. And the way they enjoy love, they do not want a condom.” (Rural parents)

**Risk awareness**

In contrast to barriers, facilitators of FP access and use of contraceptive methods were not extensively discussed. The main factor identified by learners and adult participants was awareness of the risks of unprotected sex, both in terms of risk to self and to others:

> “It is because they do not want to be pregnant; and maybe being infected with diseases.”

(Urban community members)

> “The other thing is that when another one goes to deliver a baby then find herself having a bad luck finding that she is infected with HIV… So she will see that from there if I continue having unprotected sex I will be reducing my days of living then start using a condom.”

(Urban parents)
**Parity**

Another commonly discussed theme was the influence of an existing (unintended) pregnancy and birth on FP choices, often in order to avoid making the same mistakes again:

“I think it’s the people who have had sex and had made mistakes before and to prevent having many children.” (Urban male learners)

One female learner alluded to a shift in the social contract between FP providers and young women after their first pregnancy, facilitating their inclusion in FP service provision:

“You’ve realised that at first you didn’t use any family planning method and you fell pregnant and got a child, then you go knowing exactly that even at home they know that I’m having sex nobody will shout at me even the nurses knows that I have a child, I have to use family planning method so I won’t have another child.” (Rural female learners)

**Peers**

The positive impact of peer relationships on more widespread contraceptive uptake was also acknowledged:

“It is also possible for some to see that their friend started a long time ago to jol [party, have sex] but she does not fall pregnant. ‘Ey let me do as my friend does’. “ (Urban community members)

External influences could also positively impact access to FP:

“That loveLife campaign if you have spoken to one of their members maybe [can be a facilitator of family planning uptake]. Like obviously they do not have their centre... where you can go to them, so they come here in our school. You speak to them and they can arrange for you on what you want so they can be able to talk to the nurses that they are working closely with at the clinic... So that you can be able to access them because it’s so difficult sometimes for you to go to the clinic.” (Rural female learners)
Support from schools

Finally, appropriate support from educators and schools may play an important role for some school-going youth:

“Our mistress in our class said that when you know that you are sexually active, she does not have a problem of coming and signing a permission slip so that you go and get an injection. There is nothing that she can do because you have already started. She cannot do anything about you. She will give you the right to go and get an injection.” (Urban female learners)

v) Communication around family planning use by youth

Attitudes towards family planning use by youth

With the exception of those who understood FP literally, most learners saw FP access as “the right thing” to do (urban male learner). One male learner framed access to FP services as a life-saving commodity:

“I think they are saving their lives by doing that because others do not get advice in their homes … it’s difficult for them to know about life and when they go to the clinic for family planning, they get knowledge and all that, and when one wants to have a good time they should be protected.” (Urban male learners)

A majority of parents and educators saw benefit in young people accessing FP, recognising that while they cannot prevent sexual initiation at this age, adolescents have a right to be protected from disease acquisition and unintended pregnancy:

“I think I agree that they access… Because we cannot prevent them from falling pregnant. And we also see learners from grade 8 falling pregnant.” (Urban educators)

“I think it would be a great idea, eeh because it shows that the rate of people who repeat the same mistakes will drop…Mistakes like pregnancy and getting infected with HIV and also getting infected with diseases such as HIV.” (Urban parents)

One participant, although supportive of the concept, recognised that others may judge young girls when attending clinic:
“Ja, I think it is right if they go to clinics but the problem will be with them personally that a person is getting humiliated in the community because you can see, we black people as I have said earlier that it is not normal to find a learner go for prevention.” (Urban parents)

Parents occasionally expressed negative attitudes towards young people accessing FP, something that should be regarded “as a disgrace or something embarrassing” (Urban parents). Interestingly, several rural educators indicated that although policy dictated that they must allow learners to attend FP clinic appointments during school hours, learners who openly seek permission for this should feel shameful, stating that “it’s better for him or her to lie at least”, in order to avoid humiliation.

**Family planning and relationships**

When asked whose responsibility it is to obtain or use FP methods, a minority of male and female learners stated that since the women had a higher risk of disease acquisition and “is the one who falls pregnant” (urban female learners), she should take responsibility. However, learners generally indicated that this responsibility should be shared:

“I think that both partners are responsible because they have sex together [...] [therefore] the outcome of that sex should be faced by both of them.” (Urban female learners)

“One should take the responsibility... the one to make decisions to use family planning services, it is both of them who actually engage in sex, of course, it is just that the woman.... it’s possible that they are taking contraceptive pills even the male should use condoms if they are not prepared to have a baby.” (Rural male learners)

Indeed many expressed a somewhat mature attitude, suggesting that FP is something that should be discussed and agreed upon in the relationship:

“Ja, I would also say that starting to use family planning methods starts from the time when you are in love and also depends on how you discuss. If there are things and if you have secrets at the end you experience problems as you continue with your relationship and then you end up having a child and the child not getting proper care because before you were not able to discuss.” (Rural male learner)
The role of parents

A relatively large portion of time was dedicated to the role of parents in youth SRH and FP in all FGDs, during which the majority of respondents indicated that parents’ (and grandparents’) main role should be to support, educate and advise their children:

“They should be open, and the child will then decide. If they, the parent feels, she cannot talk about prevention with her child, she needs to get a person that she trusts, to speak to the child. But the parents should be open about the issue of... prevention.” (Urban educators)

“Parents should teach us and advise us, especially girls in a family. They should tell us about how to behave if you are a girl. And they should be always there. Like... there are parents with whom you end up being afraid to say ‘Ma, there is this boy who has asked me out’. You are afraid of even telling your parent. Your parent should be open with you. If you have problems ‘Ma, there is such and such a problem’. Your parent must be always there and not judge you. Parents should be involved in children’s lives. I think so.” (Urban female learners)

Some respondents expressed the opinion that whilst it is important for parents to advise against having sex this advice should not be given conditionally:

“Is to tell their children about diseases that are contracted through unprotected sex. They should advise their children and tell them that sex is not good, but they should also tell them that when it’s done, they should go and prevent.” (Urban male learners)

Some parents in urban settings suggested that it was their duty to take a more active role in youth SRH:

“In my opinion, I don’t know if, but with my own thinking right now each parent should fetch condoms for their children. Sit down with a child and when she is about to reach 12 years when she is about to date a boy, then give it to him and say my boy I know and I am not saying you must do it but that you will and once you started it you must carry this then go for it because there is no other alternative.” (Urban parents)

Parents and learners in rural settings often expressed a more conservative attitude towards the parent-child relationship:
“It is the mother’s responsibility as the child is still growing up, to have advices to tell to the child as of course the way forward has to be asked from her.” (Rural male learners)

“Yes a child can get into a relationship; get into a relationship while being watched. She should have a guard to guard her in the sense that this boy that she is in love with should be known to us, if we are guarding her. The boy who is in love with this girl; how is he treating her? We can be able to follow that up.” (Rural parents)

A girl grows up undressing in front of you and doing everything in front of you. When she starts changing, hiding and disappearing when she is undressing or dressing, she disappears, that is when you have to notice that, ‘with this one, there is a story’. Now look for an examiner for her. Even if it is not the one who examines the virgins; let me say maybe here is a granny. I will talk to the granny and say ‘Granny, please be the one who examines my child’ so that she is afraid.” (Rural parents)

One parent however recognised the limitations of this approach:

“Sometimes we are the cause [of unsafe sex]. The child will say ‘How will I start with my mother; to say that I have started having sex with a boy? When she finds the things that I prevent with; she will say that indeed I started a long time ago’. She will hide it and hide until she ends up not knowing. Sometimes she will find herself going to have sex without using them. Then things are messed up.” (Rural parents)

**Barriers to parents discussing SRH with their children**

Many educators, community members and parents cited frustration in their limited ability to discuss sex and relationships with their children, perceiving the generation gap too wide:

“Being quiet makes it worse such that she goes out to be taught by others outside who will teach her wrongly; but if she was taught by me as a parent maybe it would have been better. The troubling thing is that we are elderly people. These things come at this present time. We did not live at this time. With us it is now difficult for our mind to change and be at this time, such that we agree that this is another time.” (Urban community members)
“They just say ‘Mother, we will no longer get the virus; we are circumcised’. Like girls when they are on family planning, they say ‘I will not have anything, I… yes I am on family planning’. I do not know exactly what we should really do. Really I do not see the solution except to catch them and gather them and educate them according to the olden days.”

(Rural parents)

Learners themselves also acknowledged this difficulty:

“What I want to say is that parents are afraid of us because they do not tell us the truth. They do not often tell us the truth. We end up being told here at school. Some of them; not all of them.” (Urban female learners)

Some parents also expressed concern about advising their children about SRH, on the grounds that this would be perceived as them condoning sexual activity:

“[Y]ou will find that a parent do[es] want to tell his or her child what to do but then the parent think she or he will undermine him or her thinking the parent thinks she or he must go and have sex now but must use a condom or use other methods of family planning.” (Urban parents)

SRH and FP and schools

Most participants were aware of some level of SRH teaching in schools from the level of grade eight onwards, usually in ‘Life Orientation’ classes. Both learners and parents expressed ambivalence about the quality and relevance of this teaching:

“Hai they never told us anything. They only tell us that we must use condoms.” (Rural female learners)

“Even if the subject is there but it happens that the teacher sits in front of his/her class and talk about life that is going on; advising children besides whether the subject about a person’s life is learned. But he/she will sit as an elderly person and just advise children; but it remains the same.” (Rural parents)

Rural participants in particular felt that schools should do more to promote abstinence:
“I think, according to my opinion, that when they discuss they do not discuss so that the children would stay away from sex. They do it so that they know that sex is there and it is done; without telling them about the risks, that its risks are this and this and this.” (Rural parents)

Some learners however valued input from external organisations such as loveLife, who provide more practical information:

“Even though teachers sometimes do not teach us but people from loveLife teaches us that you mustn’t have sex with a person without looking at them because most girls have sex with boys, [laughs]... It’s either that person has sores and you didn’t see him and he will come and just insert his thing in you, they say you must look and check him, and make sure that you use a condom. You mustn’t close your eyes when having sex with him, how do you sleep with someone that you scared of.” (Rural female learners)

Most participants appeared to be aware of community-based organisations but were unsure about the extent of their current role in schools:

“Ja hhay no. There was, some time ago but now they have resigned because I came here long time and saw those things that you are talking about... but now they are no longer here and there is no one now who is doing that.” (Urban parents)

Further attitudes towards the role of schools in SRH education will be discussed in section nine on deliverability of SRH information in results.

5. HIV

1) Knowledge/understanding of HIV

Participants appeared to have a good understanding of HIV and how it is transmitted:

“[I]f you like to help someone who is bleeding; maybe there is somewhere where the blood is coming out and maybe you also have a sore; you have to wear gloves so that you can help them because it is transmitted through blood if the other person has the virus. And that...you
see, when you have sex without protection, you are able to get the virus.” (Urban female learners)

Although participants knew about HIV, their day-to-day concerns about HIV varied:

“The rate of HIV/AIDS rises every day and mostly the people who die are young people; people who are in high school. When...the more the HIV increases; the more South Africa will not have leaders for tomorrow because we know that the young people are the leaders for tomorrow. If the HIV rises, the more young people die, the more South Africa does not have a future.” (Urban female learners)

“Looks like they don’t care. They don’t care [about HIV infection]. [...] They are clued up about this thing. Ja. They know everything.” (Rural educators)

“I would say it [HIV] does concern me and on the other hand it doesn’t. Because, it concerns because I can have that thing that ‘ey I’m HIV positive’ for the rest of my life. But that won’t hurt me most because there is something you can use to reduce it and you can live for forty years.” (Rural female learners)

ii) HIV risk and youth

Low condom use

The most commonly mentioned factor that put youth at high risk for HIV infection (mainly by urban groups) was that the youth don’t use condoms, which can be observed through high rates of pregnancy.

“There is a risk [of HIV] because if there was no risk, the pregnancy rate wouldn’t be so high, which shows that they are not protecting themselves when they are having sex.” (Urban male learners)

Substance abuse

Urban community members and male learners also described alcohol and drug use as a factor contributing to loss of self-control, high-risk sexual behaviour and HIV infection:

“School children most of the times drink so much alcohol. They drink it like adults. And as you can see how much AIDS is, it is due to alcohol because people leave for school and you
see them putting the clothes into school bags; and you will see them getting into taverns, having taken off the uniform because they know that they will be refused entry if they are wearing uniform. They have bought alcohol and walking with boys. They will go to that place where they will sit, you see. They will drink alcohol and have sex in that way, you see. I can see that you think about a condom afterwards if you are drunk, you see. It is something that happens because it is known that diseases have spread so much because of alcohol.” (Urban community members)

**Poverty**

Poverty, age-disparate sex, sexual exploitation and abuse were also linked to HIV risk:

“[W]e are in a poverty-stricken area which can cause our learners to fall in love with elderly people, and don’t use condoms, and that’s how they are gonna be infected.” (Urban educators)

**Lack of knowledge**

Urban educators and male learners, as well as rural community members felt that youth did not always have knowledge about the details of HIV, which put them risk. Both male learners and rural community members suggested that what they were taught about HIV may be inadequate:

“Just because they [the youth] are not educated [about HIV], even parents, some parents aren’t able to teach their children straight about protection and how to be protected, even children also... there is a lack of information to everyone actually, we are talking about it but actually we are not getting it properly.” (Rural community)

**Vulnerability of youth**

Male and female learners from the urban area and educators from both rural and urban areas discussed issues related to the vulnerability directly associated with adolescence, which would put them a risk for HIV:

“Because we basically, as the youth, do not know ourselves. We are just lost. We do not know what we want. Regardless of the home you come from...like, let’s say you come from a decent home, a good one. You have advices and everything but when you come to school you definitely forget everything.” (Urban female learners)
“Sometimes when you buy something at the shop and then you see condoms and then when I take them and then you would find someone asking, what am I going to do with them because I am young and they ask me if I engage in sex and then I will end up not taking condoms because of them asking me what am I going to do with them because I am very young.”
(Urban male learners)

iii) HIV testing behaviour

Testing frequency
FGD participants gave varied responses when asked about frequency of HIV testing of youth, possibly indicating that there is no ‘typical’ youth behaviour when it comes to HCT. Urban learners and parents noted that some young people test every three months; parents and female learners noted that some young people test twice a year. Some female learners felt that youth may only test for HIV once a year. Rural and urban community members felt that young people only go for one-time testing.

Some rural community members said female youth only test for HIV during pregnancy. They also felt that males might not test for HIV, and use their female partner status to determine their own status:

“As the female is getting tested she will [tell] the male partner that “I’ve tested and I’m positive or negative”. Then the male will think that he is also okay not infected and don’t get tested on his own.” (Rural community members)

Participants in almost all groups reported that some youth never test for HIV:

“[Y]oung people do not get tested.” (Rural community members)

Where youth access HIV testing services
The most frequently cited place for youth to test for HIV was at clinics – including mobile clinics, government health care clinics and NGOs. The rural community members also discussed testing at ANC clinics during pregnancy, and at MMC clinics prior to circumcision. The urban female learners spoke about being offered incentives for testing at mobile clinics (possibly from an NGO):

“You used to get R50.” (Urban female learners)
“They bring cake, when you are done with testing they cut a piece of cake for you.” (Urban female learners)

The rural female learners mentioned that some youth “would buy [an HIV testing kit] at the chemist and test themselves”.

*iv) Barriers and facilitators to HIV testing*

**Fear**

Fear was described as the major barrier to youth accessing HIV testing services. The immediate fears of finding out one’s HIV status, of living with HIV and of possible suicidal thoughts in the event of HIV positive status were commonly discussed:

“I would say they don’t normally test because some are scared to know their status [...] Because they just think how are they going to cope knowing their status, ‘okay now I’m HIV positive the only thing haibo, the only thing I must do is to take’, sometimes some say to eat pills, some they say pills are not okay because they say some it makes their body shapeless, some develop big stomach, things like that.” (Rural female learners)

Fear of the attitudes of others was another barrier to accessing HIV testing services. Parents and urban community members felt that youth might be concerned that they would be seen accessing HCT, by neighbours and friends respectively. Male learners explained what they were afraid of:

“[W]hen you are standing there waiting for testing and when you look at people that came to the clinic who came to other departments, they look at you in a different eye and when you go to school, you would be asked “what were you doing there?” because some have rooms and others don’t have, it’s much better if there are mobiles that go to different places because it is widely known that it for testing only, whereas at the clinic, the nearby clinic where many things are done, you get scared because people talk badly and it ends up seeming like it is something that you are doing.” (Urban male learners)

Rural educators felt that youth were afraid to test because of attitudes of parents and educators:

“But teachers and parents we can be barriers, because I’m going to ask you why are you going there? Because you have had sex with someone.” (Rural educators)
Health care providers

Health care workers’ attitudes and behaviours were also seen to be a barrier to youth HIV testing, by both urban parents and learners:

“I think that there is something that stops them [testing] because the nurses...when you go to test, others say ‘Ha, you are so young and you are having sex. You have come to test when you are so young’. They are scared of how they will look at them.” (Urban female learners)

Facilitators

Few facilitators to testing were mentioned. Urban male learners and rural community members described how friends/peers could influence each other to test for HIV:

“They go for testing, and they also tell each other to go together for testing, that will help and decrease the number of people with HIV.” (Urban male learners)

Rural educators felt that awareness campaigns would facilitate HIV testing practices in youth. Rural parents felt that youth were treated well at clinics, “they are welcome, in other words they are treated well, they are treated well and it is confidential” and that the barriers to testing rested within the individual youth.

v) HIV communication

The role of parents

Overall opinion in the majority of groups in relation to HIV and youth was that parents should advise and support their children, whether or not they have had sex, and that the advice should be linked to this (i.e. if they are sexually active their parents should provide information on contraception and HIV prevention, and if they are not sexually active, their parents could promote abstinence and support them not to have sex). Parents should ensure that they give children full, accurate information, and rural female learners felt this should include information on abstinence, protection during sex, monogamy and testing with partners. Urban female learners felt that this should be given before they are sexually active:

“I was saying that parents should support us. Basically they should be with us through thick and thin. That is why they are referred to as our parents, because they have to guide us.” (Urban female learners)
“My child, do not have sex with a male without a condom. You have to use a condom because there is death. There are diseases out there. Even if it is not HIV there are many diseases.”
(Urban community members)

In the rural parents group there was divided discussion about the parents’ role in providing advice and support about HIV and HIV testing:

“Brethren, if we can talk about a virgin and threaten our children. Then the one who wants to be like that, they can be... she can be what she wants to be. But we should threaten a girl by saying ‘Please watch your reputation so that you can be a virgin until you get into marriage’.”
(Rural parents)

“I say we have talked about the cures and put all the medicines and everything; this will not help us. There is only one cure. At the age of 12, you should take her there to the person who will examine her [virginity testing]. She should grow up fearing that ‘If I ever go to a man, it will be seen that this is messed up’.”
(Rural parents)

“They have to be taught about virginity, firstly. When she has lost it, then she can be involved in the education about how she should protect herself; because you have done so, rather than losing the virginity.”
(Rural parents)

“We parents should talk to children and encourage them that if they have had sex, even if he/she has had it once but he/she should go to test. We parents should talk to children; that ‘If you know sex, go and test so that you will know where you stand’.”
(Rural parents)

**Barriers to parents discussing HIV with their children**

Rural community members felt that parents did not have enough information to discuss HIV with their children. Urban educators and female learners however described parents’ fear of discussing HIV with their children:

“[C]ulturally, I might say, or traditionally, some of the parents are afraid to talk about these things to their kids, so that we make them fear to tell the kids what it’s all about, HIV.”
(Urban educator)
“Parents are afraid of us because they do not tell us the truth [...] Maybe I think it is because they see on television that children beat their own parents and they stab them. Maybe they are scared that we would also do the same.” (Urban female learners)

Rural parents described the attitudes of their children as a barrier when telling them about HIV.

“[My daughter] said ‘Hey Ma please excuse us. I was not there when you were young’.” (Rural parents)

**HIV and schools**

Urban educators and male learners said HIV was discussed with learners, largely during “Life Orientation” classes, although educators said it was also discussed on an *ad hoc* basis by other subject teachers.

Urban educators specified that the following topics are covered in HIV education in schools:

“Like if you have a boyfriend, use protection first. Use condoms. Go to the clinics and get help. Have enough information.” (Urban educators)

Female urban learners said that “we are taught about everything”, including how it is transmitted and how to protect themselves against transmission.

Female rural learners said they “are taught about protecting ourselves and [...] to have sex with one partner not just [sleep] around with anyone.”

**6. Adolescent pregnancy**

All groups stressed that teenage pregnancy was “very common in this area of ours” (Urban community) and there was a high level of concern regarding the very young age at which some girls become pregnant:

“[F]rom 12 years upwards because with the other child, when you are still expecting them to have periods you find that they are pregnant [...] before she does [even have her period].” (Rural parent)
i) Factors influencing pregnancy

It was felt that in some instances teenage pregnancy was planned (or desired) by young girls, for various reasons. Urban educators and parents as well as rural male learners all said that poverty led to young girls falling pregnant, since they were motivated to access the government childcare grant. In some cases they saw how easy it was for their peers to do this and therefore decided to do it too:

“[T]here is a grant here aside and the other one ends up liking it and will say ‘hay no why [do] I keep on using a condom, hay me too let me do this [fall pregnant] because I will get money’.” (Urban parent)

Urban male learners felt that some young women become pregnant “because they have seen others” do so, so were therefore no longer afraid of the consequences if it happened to them. Finally, urban educators felt that some young girls intend to become pregnant to maintain their relationships:

“Sometimes there is a competition, maybe they are in love with one, it’s a boy, it’s got about 2 or 3 girlfriends. The other one will fall pregnant, and the other one will feel, he doesn’t take care of me anymore. Let me fall pregnant, so that he’s attracted again, even to myself. So that’s one of the reasons, is that they want attention from their boyfriends.” (Urban educators)

However, most adolescent pregnancies were reported to be unplanned – either because youth had limited knowledge of the risks of unprotected sex – “they are not educated, they do not have information” (Rural community member) – or, as discussed by urban female learners and rural educators and community members, because youth have, to some degree, a “sense of invincibility”, which leads them to practice high risk behaviour without thinking of the consequences.

“They just do it [have sex] for fun.” (Rural educators)

ii) Pregnant learners

School policies on pregnancy

Urban community members and learners as well as rural educators and community members all felt strongly that learners had a constitutional right to education and that they should be able to continue schooling until they were ready to give birth. However, neither of the schools within which
FGDs were conducted had an explicit policy on how to manage pregnant learners; rather participants reported on the ‘usual’ management of pregnant learners. Urban learners specified that they were expected to take “retirement” for four months, and the time of retirement varied from when the pregnancy was visible until around the due date. If however, exams fell within the “retirement” period, the pregnant learner should come to school with a parent who should care for her in case of complications; in addition, the learners would not be allowed to wear a uniform. These measures were seen as important barriers to help reduce the rate of pregnancy in the school:

“[T]eachers have passed a law that says when the child’s stomach is showing, she has to come with her parent all the time. Otherwise... She should also not wear school uniform but wear a dress so that she will be seen by all. That is the discipline that is existing now because of the way the number of pregnancies has increased.” (Urban community members)

“So as teachers they came out and said that the solution to help decrease the rate of pregnancy was that when a person gets pregnant, she should take retirement for that period of time until the delivery date comes; and then they will go back to school. And basically that thing helped because teenage pregnancy has decreased a little bit.” (Urban female learners)

“When a girl is pregnant and the stomach is starting to show, she is stopped for four months and it is time of exams, she is told to come with her parent so that she can guard her should she have a problem.” (Urban male learners)

Despite supporting the education of pregnant learners in theory, rural educators and community members stressed that the school’s primary role is to teach, and that educators do not have the expertise to manage pregnant learners:

“[T]here was this thing that teachers used to say that, they are not nurses they are our teachers.” (Rural community members)

“Although we are not midwives.” (Rural educators)

**Attitudes towards pregnant learners**

Community attitudes to pregnant learners were explored. Rural and urban community members did not think that it was acceptable for learners to become pregnant:
“I think that [it] is not acceptable because a person who is at school is a child. A person who is pregnant is a person who has gotten to a stage of being a mother. So mothers are at home and children are at school.” (Urban community members)

Notwithstanding this opinion, rural community members also felt that the pregnant learners had a right to be in school.

Further discussions around community acceptability in some FGDs (urban female learners, urban community members and rural parents) revealed how pregnant learners are often singled out as a focus of community gossip, making it hard for the learners to disclose their pregnancy in good time:

“She will be afraid of that; that she will go to the clinic and find a mother from the neighbour and she will look at her. Then she will spread the news that she is pregnant. She will end up hiding the stomach; hiding the stomach. Sometimes she will be found delivering when they have not seen at home that she is pregnant.” (Rural parents)

Educators’ attitudes to pregnant learners were also explored. Urban parents and female learners agreed that although educators were not qualified to care for pregnant learners (provide ANC), in general they did accept them. Learners did note however that educators often expressed disappointment around pregnancy in school-going youth:

“They are really hurt because they even tell us that it is also their disappointment because the ones that have just fallen pregnant are part of [school’s name]. I would say that they really get hurt.” (Urban female learners)

The rural educators described how they try to help and support pregnant learners to attend school, despite the fact that they don’t necessarily agree with/support it:

“Deep down in our hearts, we don’t like it, but it is, we have, we have to accept it. We do accept it.” (Rural educators)

One rural educator said she would deal with pregnant learners as a parent would do:
“‘How can you do this?’ I’ll ask you. ‘How, my daughter, how can you do this? You’re still in grade 11, you’re supposed to go to grade 12 next year. Now you are pregnant. How can you do this?’ I will talk as a parent.” (Rural educator)

Both urban and rural parents had negative attitudes towards pregnant learners. Rural parents felt that it impacted negatively on the reputation for the school – “it destroys the school” – and felt strongly that a “school is a place for children to go and learn”, not a place to become a parent. Urban parents were concerned that pregnant learners create an additional burden for them as parents:

“[S]he will be bringing us responsibilities because she will be not working, and to find that even the father of the baby will not be working or maybe they might even not knowing who the father is.” (Urban parents)

Educators on the other hand felt that parents’ concern about the rights of pregnant learners would negatively impact the school:

“Parents will open [a] case against [the] school who chases [a] child away.” (Urban educators)

Urban female learners described the attitudes of health care workers to pregnant learners:

“When you fall pregnant at a young age, nurses talk. They talk mistress. You can end up being hurt because when you come in to ask for help, they will talk before helping you. [...] They say ‘you are pregnant at such a young age! Today’s children are this and this’. They talk as they please.” (Urban female learners)

Learners also expressed negative attitudes to pregnant learners and the impact this had on the reputation of the school. As one urban female learner stated “it is not nice when you wear a uniform with the stomach”.
Impact of pregnancy on schooling

Male and female learners from the urban area, and parents from the rural area all discussed how pregnant learners negatively impact the reputation of the school and how “a pregnant learner degrades the name of the school that she is attending” (Urban male learners).

“Before I started studying at this school they used to say that ‘Ey, this school is rotten. The girls get pregnant. It is like the teachers are not doing anything. Instead they are teaching the children how to fall pregnant’. Like on the outside, our school was looking bad because its girls often fell pregnant. As I have said that from 2010 the rate has been high. We have been leading with pregnant girls. And people on the outside, on the street, were saying ‘This school gets pregnant. It is as if the teachers are not educating. It is like they teach children how to fall pregnant’.” (Urban female learners)

There was an overwhelming sense from FGD participants (urban community, urban female learners, rural female learners and rural parents) that pregnant learners affected other learners by “making them sleepy”, therefore impacting levels of concentration in their classes:

“Like when studying sometimes she can’t, others can’t concentrate in class. [...] Some will get tired, sleepy, and can’t hear what the teacher is teaching. [...] They say when someone is pregnant... they say it affects others.” (Rural female learners)

Urban male learners felt that seeing pregnant learners created a safe space/norm for other young females to fall pregnant, (which was not viewed positively).

Although urban educators specified that pregnant learners were allowed to attend school and therefore being pregnant did not impact school attendance, male and female learners and urban parents stated otherwise, explaining that pregnant learners had to “retire” for three or four months, although they were allowed to return for exams. Urban female learners also mentioned that some pregnant learners do drop out of school more permanently.

“It depends on whether they have someone to look after the baby at home. If they do not have anyone, others do not come back; they end up not coming back to school.” (Urban female learners)
There were varied reports on the impact of pregnancy on school attendance in the rural FGDs. Educators noted that pregnant learners stay in school until their due dates, whilst female learners reported that “sometimes the child gets expelled from the school or she gets distracted from her studies”. Some rural parents noted that in some instances it can be difficult for pregnant learners to return to school once their child has been born, as they need to care for it. Other rural parents felt that they return to school straight after delivery. These varied responses may indicate that learner pregnancy affects individuals in different ways, depending on their personal circumstances.

7. Antenatal care

i) Antenatal care knowledge and practices

Most respondents stated that young pregnant girls access ANC at local primary health care clinics. Hospitals were also commonly cited, in one instance by a learner who reasoned that girls under fifteen years of age were not permitted to access clinic-based ANC services. There were mixed opinions about the stage at which one should access services, ranging from three to six months, or when a girl experiences pregnancy symptoms:

“You have symptoms; they start. Like okay you will not notice at first. Firstly you miss your periods. Maybe you will not notice if you have irregular periods because there are others who have it twice a month. So you will think that ‘No, I skipped because I had it twice in a month’. After 3 months you will then realize that ‘No, there is a problem. I have to go to the doctor to check’.” (Urban female learners)

Interestingly, some participants demonstrated a broad understanding of ANC, stating that this could be provided by families, boyfriends, fathers and parents:

“I was going to say that you get it from the clinic. You also, as a child’s parent you are able to treat her in the house and talk to her.” (Urban community members)

Many parents, educators and community members had poor knowledge of PMTCT, whereas female learners in rural and urban settings were best able to describe this:

“It is preventable. If you know as a mother that you have AIDS while you are pregnant; during delivery at the clinic it’s like there is medication that they give you; that will be taken
by the baby for a period of time. Then it will come back after the time that they gave you, to check if the baby was not infected.” (Urban female learners)

ii) Barriers and facilitators to accessing antenatal care

Health of the baby

Only one participant commented on potential motivations for pregnant learners to attend ANC:

“To see how her baby is; and to see whether it’s two babies or one; or whether it is still breathing. It is such things. To also see if it does not have the virus; if it does not have any disease.” (Urban female learner)

Health care providers and community members

The most commonly discussed barrier to young pregnant women accessing ANC, which emerged across all FGDs, was the actual or perceived attitudes and behaviours of adults in the clinic setting, including those of health care providers and community members, who tend to “make an example” of pregnant learners (rural female learner):

“Others are afraid of the nurses. When you fall pregnant at a young age, nurses talk. They talk mistress [facilitator]. You can end up being hurt because when you come in to ask for help, they will talk before helping you [...] They say “You are pregnant at such a young age! Today’s children are this and this”. They talk as they please, mistress.” (Urban female learners)

“Mistress I think that what also stops them are neighbours in their neighbourhood. There are instances whereby neighbours fight over their children, saying “You see, my child is examined and yours...” you see. So she will be afraid that indeed the neighbour’s child will see that I am now pregnant and will tell her mother that I am now this and this. Then the heart breaks.” (Urban female learners)

Rather than maturity alone, young pregnant women are judged on multiple levels. One urban parent commented that some girls who realise that they are pregnant late are scared about the reaction of clinical staff when they present late into their gestation period. Others may find themselves stereotyped in other ways:
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“So I want to do this thing, I want to start by thinking about the way they will throw words and swearing at me and questions about the father of the baby, asking me that, is the father of the baby even in the picture this and this and that.” (Rural community members)

Understandably, this causes some women to present very late for ANC:

“You see, so I will have that thing that, no let me stay and you will find that someone will start and going to the clinic at the gestational of eight months and they will be people pushing her at home to go to the clinic.” (Rural community members)

Parents

The role of parents and educators in access to ANC was more ambiguous. One urban community member commented that the requirement for a parent to accompany pregnant girls under 16 years to clinic may act as a deterrent, more so in the event that she has not yet told her parents. Conversely, it was suggested that parents facilitate access, by encouraging their child to if they are aware of the pregnancy. Interestingly, one male urban community member commented on the conflict that may arise between family-members in the event of adolescent pregnancy, which may further deter a young woman from seeking appropriate care:

“As the father of the house […] You... the child knows that if it can be heard that she is pregnant or that maybe she has gone to the clinic like that, you will throw tantrums at home; you see that that thing, or maybe you will fight with her mother, you see [...] When a child has a baby... when you are a male it makes you angry because it seems as if the mother is together with her in that, you see that thing.” (Urban community members)

Other barriers

Other barriers to ANC access were the fear of being asked to undergo HCT and limited clinic opening hours, particularly if permission from educators must be sought or if other priorities must be sacrificed:

“Yes, maybe you are writing a test on that day, and then you have to go to the clinic. Sometimes a learner may not go, for instance if learner is doing grade 12, you know what is happening in grade 12. It’s too much job, there’s too much work to be done. So you can feel
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that if you are going to the clinic, you will be behind the other learners in class. Because you are going to be allowed to go, but I keep on teaching.” (Rural educators)

8. Circumcision

i) Circumcision knowledge, attitudes and practices
Knowledge of circumcision was high across all groups and participants of every type made a clear distinction between MMC and traditional circumcision. High levels of awareness appear to be closely related to mass media exposure, as one urban community member noted, “we hear it from clinics, on the radios, at hospitals, everywhere.”

The benefits of MMC were acknowledged and clearly defined by a number of participants across the groups:

“It is the removal of the foreskin from a boy’s penis, which decreases the rate of getting HIV and other viruses, and other STIs.” (Urban female learners)

In terms of reasons to circumcise, most participants cited HIV/STI prevention, whereas it was frequently commented that traditional circumcision was a Xhosa rather than a Zulu tradition, and therefore less relevant in the local area. The risk associated with any type of circumcision was commented on by a number of participants, however it is noteworthy that MMC was preferred as a much safer option:

“Those boys are dying [...] The reason being, people that were performing circumcision were not educated. If you go for medical male circumcision now, they do the screening, checking of sugar level, BP, HIV and all that isn’t. [...] So, for traditional way they do not check them, they are being informed that they would go to the mountain [...] So they wouldn’t do all that BP, TB of HIV screening.” (Rural community members)

Importantly, urban learners, rural parents and educators and community members in both settings all acknowledged the partial protective effect of MMC against HIV acquisition:

“You see, there was that thing plus this sixty percent which a person who say, my chances are fewer because I’m circumcised than yours are bigger because you are not circumcised.
(Rural community members)
“[T]hey should also know that once they are circumcised that it is possible for them to contract AIDS, and not that once a person gets circumcised they will not contract AIDS, they should now that once they are circumcised they should use protection when having sex.” (Urban male learners)

Both rural and urban participants commented on the high frequency of MMC in male learners and other young men living in their communities. When asked where men go for MMC, most referred to clinic or hospital-based services or MMC camps, organised through NGOs and the DoH. Learners were often recruited through schools, following which parental consent would be sought and transport arranged to take them to hospital:

“It is really common because the people who circumcise boys sometimes come to schools and explain to them; and they take a list of those who want to go and get circumcised.” (Urban female learners)

9. Deliverability of sexual and reproductive health information and services

i) Preferred sources of sexual and reproductive health information

Discussions around the advantages and disadvantages of various sources of SRH information and advice occurred throughout the FGDs. The preferred role of parents in SRH education has been discussed in some detail above; other potential sources of information discussed were clinics, community organisations, peers, schools, and community-based NGOs.

In some cases, preferred channels of information were gauged against the limitations of others:

“In my opinion I think it is better for them to go to the clinics because other parents fail to advise their children.” (Rural male learners)

Community

In response to the perceived failure of schools to prevent HIV and adolescent pregnancy, rural parents cited the need for collective community action, going back to the ‘traditional way’ in order that girls are “threatened with the disgrace of losing their virginity”: 
“The teachers there try very hard to teach children about the risks of sex but now here in the community we do not have an organization that is able to gather children, to meet teachers halfway.” (Rural parents)

Peers

The potential advantages of both formal and informal peer education were raised by a minority of learners and community members, often in relation to learning from each others’ mistakes:

“Ja, I say, it is a bad thing but I say, what could happen is that, that particular person who is going to be teaching those children about that should be learners who teach one another because children are shy about talking about sex.” (Rural male learners)

“(H)is peers are growing fast, so I like the point that they must use the ones that already experienced this so they could be the ones now who help to build these groups that we are talking about.” (Rural community members)

Schools: Who and what should be taught about SRH?

With the notable exception of rural parents, the majority of participants across all FGDs supported comprehensive SRH teaching in schools. For example, rural and urban community members and educators in particular felt strongly that HIV should be discussed with learners in schools, whilst male urban learners mentioned specifically that schools should cover information on MMC for HIV prevention. Condoms, ‘safe sex’, FP, the ‘dangers of sex’ and benefits of abstinence, STIs, circumcision, ANC and PMTCT were also cited as key topics that should be included in a schools-based SRH curriculum:

“They must teach us that once you started having sex with a male you must condomise or you use prevention so that you won’t fall pregnant. The trust must be told.....and not that the baby comes from the aeroplane.” (Rural female learners)

“(E)eh I think there is a huge need that it should be discussed this thing of family planning [...] Because we are seeing eeh...we are seeing children concentrating more into adult things without understanding them.” (Rural community members)
“[T]here should once in a while be programs like this one, which will educate at schools directly; teaching the children at school about how to behave in terms of pregnancy and HIV infection. It should be taught right here at school.” (Urban community members)

“Okay what I wanted to hear in this school we are taught about HIV/AIDS that how it is contracted, ways of contracting it and also how to protect yourself against it, and that you are still a human being even if you have it, how you should live when you have it and not to lose hope.” (Urban male learner)

Rural parents however questioned the effectiveness of such a broad approach:

“It is important that the children are first taught about the risks of sex. If you have sex you will get pregnant and you will get HIV, you see. The risk... you will lose education. You will no longer be able to study and reach the level that you want to reach. This and this and this. Before you have sex you should know the disadvantages that you will come across. Do not say that you are going there for pleasure.” (Rural parents)

A few urban educators expressed fear that exposing learners to SRH information in schools will lead to promiscuity:

“I think another effect on it is that it encourages these people to do sex. Because they will, they know that they won’t get pregnant, at the end of the day.” (Urban educators)

Some participants also indicated that some topics were relevant only to a minority of learners:

“Okay, firstly I think before anything could be included, we should first discuss about these children who are falling pregnant in schools and then work with them those who are already pregnant.” (Rural community members)

“They have to be taught about virginity, firstly. When she has lost it, then she can be involved in the education about how she should protect herself.” (Rural parents)

Similarly rural parents and a few urban male learners had reservations about the relevance of SRH teaching for some learners:
“It shouldn’t [be taught in schools] sir. Family planning is supposed to be discussed by people who are in a relationship and who are older, who are able to make the right choices that they can make according to their ages.” (Urban male learners)

Conversely, one male learner cited the importance of timely SRH education so that young people are fully informed for the future, even if they are not sexually active as a learner:

“I thought that family planning should be taught in schools so that they could be able to take decisions so that when they are allowed when they have finished school, and know that when starting making a family, I will have it with so and so at a certain time because maybe you would have spent years dating.” (Urban male learners)

Interestingly, several learners who supported teaching abstinence also highlighted the impractical nature of a singular approach:

“Okay, the youth can be taught on how to behave and also wait for the right time […] And if you have already started having sex, maybe use things to protect yourself from getting pregnant, something like that.” (Rural female learners)

**Schools: Why schools?**

Reasons given for the importance of schools-based SRH teaching included the need for schools to face the reality of HIV/STIs and adolescent pregnancy (cited by urban parents and community members in both settings):

“Because it is clear that our children are sexually active they must know that when they are sexually active, they need to know what they must do in order to protect themselves from HIV/AIDS.” (Urban parents)

“They are taught so that when it happens that she gets a baby while in this situation of being HIV positive or HIV what; to be able know when to take the treatment. When does she start to go to the clinic to see doctors, and all that?” (Urban community members)
One participant referred to the ‘fast life’ led by young people and the risks that they are increasingly exposed to, reasoning that SRH teaching should start in schools at an early stage so that “[h]e/she should know everything while he/she is still growing and grow with it” (Urban community members).

Urban male learners and community members, and parents from both settings highlighted the role of schools in providing information to young people that may not be accessible through clinics, or at home, either if parents are “not open enough to talk about sex with their children” (Urban parents), or as a result of other factors:

“I think it is important to talk about it in schools because there are other girls especially who are used to that they have to live with their boyfriends, meanwhile staying with a boyfriend is not acceptable because making a family is different and making a family grow is difficult, some grew up under difficult families who are really poor.” (Urban male learners)

In some cases schools were perceived as a more objective and therefore more accessible source of information for young people:

“When he/she leaves home for school he/she knows that he/she is going to build a future at school. Those things can help him/her if they are discussed at school because he/she knows that all those things are things that help him/her in planning his/her future or to build his/her future.” (Urban community members)

“It is important to teach children because when they start having sex they do not ask permission from their parents, they find themselves involved into sex and get infected with sexual diseases especially AIDS eeh, just because they do not have knowledge.” (Rural community members)

One rural community member mentioned that normalising SRH discussions in schools might also help young people to access clinical services:

“Eeh, but if they would understand ... they can be able to access family planning and have children at a right time and when she has finished her studies.” (Rural community members)
Schools: Limitations

Despite overall support for SRH teaching in schools, it was also recognised that much needs to be done to improve the quality of SRH teaching through better training or subject specialisation:

“I feel the department should train more teachers on the subject, like on pregnancy, HIV, they should train, should have full time teachers that are doing that, and that are paid for that. Maybe the, the risk of pregnancy can be reduced. Cos, I think even the LO [life orientation] teachers, they were not trained to do LO, cos it’s a new subject. They have the information because they go to the libraries, and get the information. But if they can be, let’s say take a year, train them. Give them enough information, enough resources. Then I think we can, can reduce the risk of pregnancy in our schools.” (Urban educators)

One rural parent and one urban community member specifically cited the need to better educate male students:

“But even when there is education, you see the educator, the family planning and everything pointed at girls. There is nothing that is directed... there are not many things that are directed to the ones who cause problems, boys, who are really the ones who cause the problem.” (Rural parents)

Although educators themselves generally acknowledged schools’ responsibility to provide SRH education, many expressed a reluctance to tackle some topics, particularly ANC and PMTCT. Where some felt they lacked training, others simply felt that this was not their role or that learners did not respect them in this role, citing the need for external assistance:

“In connection with this. We do what we are employed for, we just go to classes and teach what you are supposed to teach. But when it comes to these things it needs you.” (Rural educators)

“Cos as much as the females are there at school, but, we, we cannot do that. So it should be people that have enough information, they can care of it. So there should be a relationship between the schools and the department of health. Or between the department of health and the department of education. So that whatever that we are unable to do, we are helped by the health workers.” (Urban educators)
Rural community members also supported the idea of external assistance, in the form of specialised youth NGOs who may be better placed to gain the trust of young people:

“What would they do because they are scared to talk eeh, and schools are closed and they are scared of nurses, if government could work with NGOs these things will always be available in the offices of the NGOs and NGOs also have clubs where young people get together and do something, where young people are free, there are those things which we are able to talk with young people and participate on things that we do” (Rural community member)

ii) A coordinated response between parents and schools
The relationship between parents and schools, in the context of high incidence of adolescent pregnancy and HIV, was explored in six of the ten FGDs (urban male learners, rural parents, educators and community members in both settings), with a number of participants citing a lack of coordination as a key problem:

“The school fails. Cos you know, most of the time the meetings are called, the parent don’t turn up. You just find the, er, maybe 10% of the parents will come to school, that is why we have these problems of, of these children getting pregnant while in school. Because their parents, they don’t take initiative concerning their child. In this community.” (Urban educators)

Both parents and educators felt that parents should proactively engage with their child’s school life:

“[T]he school must be able to contact the parents, and know what is going on at school, and they must know more about their learners in the school environment. And we must know more about their kids. In their, in their environment, at home environment. So it is a very important [...] They will come here when there is a problem done by the teacher. But they won’t come if you call them without any problem.” (Urban educators)

“Even if nothing has gone wrong... before anything goes wrong, a parent should appear “No I am so and so’s father. I have come here because we are working together in bringing up the child. How is it going because at home I discovered that this and this is not going well? I just came to find out what you have discovered in the child.” (Rural parents)
Many rural educators felt ill equipped to extend their responsibilities outside of their immediate environment:

“In fact we are not dealing with parents, we are dealing with learners [...] That’s what we are trained for.” (Rural educators)

However, male urban learners, urban educators and rural parents called for a more proactive response from schools, to ensure greater communication with parents and a coordinated response to adolescent problems. Suggestions included educator-led “leadership” sessions for parents (urban male learners), more regular general parent-educator meetings (rural parents), a “school programme of parents and teachers” to formalize parent input into teaching (rural parents), and coordination through an NGO third party (urban educators):

“We should have meetings every Friday with parents, so that they can be educated on how to rear their children and they should stop being scared of them, parents are scared to talk to us about these things especially sex related things.” (Urban male learners)

“I think that teachers should have meetings where they will call parents. May we have... as we are all parents working together in raising children, may we do this job like this. May we handle it together like this so that we are one? I should not say one thing and you say something else at home. I should not say something here and you do not talk about it, you see. You teach this to a child and I am teaching this and it clashes. Let us do one thing and cooperate. Let us discuss.” (Rural parents)

iii) Improving youth access to public sexual and reproductive health services

In discussions around improving access to SRH services for young people, the most frequently explored idea was to expand mobile clinic services for young people. Importantly, parents, community members and learners felt that the additional anonymity that this would provide would encourage young people to access particularly HCT and FP services:
“They do not want to be known in the community for what they do because most of the times, they do these things of theirs in the corners, and they are discreet [...] I think that if a mobile can be organized to go to school; maybe during lunch times so that they are able to go there.” (Rural parents)

“[W]hen you are standing there waiting for testing and when you look at people that came to the clinic who came to other departments, they look at you in a different eye and when you go to school, you would be asked ‘what were you doing there?’ because some have rooms and others don’t have, it’s much better if there are mobiles that go to different places because it is widely known that it for testing only, whereas at the clinic, the nearby clinic where many things are done, you get scared because people talk badly and it ends up seeming like it is something that you are doing.” (Urban male learners)

Educators and community members in both settings suggested that adapting clinic hours to meet learners’ availability was an important first step to increasing access. Many also felt that introducing specialised training in order to provide dedicated youth services within public clinics would further encourage more young people to attend:

“I think the nurses need education mostly. That when you get to the clinic you must feel free in any way, they are responsible for people’s lives.” (Rural community member)

In order to achieve such changes, one community member highlighted the need to engage with health service managers:

“There can be a discussion. If the health manager could come here, for instance... It is like here at school [...] We should be able to explain everything to them. They should call us regarding the clinic because at the clinic there is so much that can be rectified if their manager could come and hear from us about our grievances.” (Urban community members)

iv) Accessing sexual and reproductive health services through schools

**Family planning and condoms**

Participants in all FGDs were asked what they thought about a system of accessing FP methods (including condoms) through schools. In general responses were positive. With the notable
exception of rural female learners, participants in every group supported the notion as a viable and necessary option for learners who have limited access to public health clinics:

“I think there should be a programme that will be suitable for learners inside schools, to find that there will be a small room that will be private for girls or sometimes say from this time to time, boy will be able to go there and talk to someone or girls also. At that particular time all the preventions will be available so that after the talk then will receive the service or if it is a condom then they will take it from there.” (Urban parents)

Several learners spoke of the advantages of confidential access to condoms through schools-based distribution, suggesting this may increase the number of protected sex acts:

“At schools we would like to have access to condoms because basically there are these discussions about putting condoms at school. I agree; we should put condoms at school because already the teenagers are having sex without...with or without condoms. So basically if they have condoms we will get access to it.” (Urban female learners)

“It would be a good idea because we could even have free condoms here in the girls toilet as well as in the boys toilet whereby you can just grab them with being seeing by anyone and put it in your pocket.” (Urban male learners)

“It is a good idea because it does not mean encouraging it to happen in school, but it’s raising awareness.” (Rural male learner)

One male learner also mentioned a potential positive impact on peer influence over FP choices:

“I think that would be good because it would be difficult for them to just go alone and go to the clinic for family planning but here in school it’s possible because most of the time, now children do things because they see their friends doing it. Maybe if it was done here in school, they would also go because their friends also go, there is no problem.” (Rural male learners)

Moreover, male learners in both settings, urban female learners and rural educators all felt that providing FP methods in schools would have a direct effect, reducing adolescent pregnancy and HIV:
In this school since there was a high rate of pregnancy maybe the rate would decrease when family planning is accessed through schools.” (Urban male learners)

Rural community members and parents however added a caveat that increased access to contraception must be supported by appropriate education:

“Hmm I think that it is a good thing for children at school to be given prevention things these days but before children are given, they should go through certain education because they will take these things as if they are taking packets of chips.” (Rural parents)

Interestingly, the most frequent objections to a system of accessing FP methods in schools came from learners themselves; participants in all four learner groups expressed a concern that this would encourage sex:

“I think that would be a bad idea to access family planning methods here in school because that would spread the fact that since family methods are available in school that means we are now allowed to have sex, because now things are available at school, to prevent pregnancy, which is totally wrong.” (Rural male learners)

“I think if family planning was accessed through schools the rate would increase because maybe other learners would be encouraged to have sex knowing that there is this thing.” (Urban male learners)

“It’s easy, maybe let’s say your boyfriend asks you maybe to go into the corner and do our thing, and have sex there in the corner [...] it’s easy for them to go and access condoms because condoms will be close and available in school now. They will just take them here in school and have sex here in school maybe behind the school maybe.” (Rural female learner)

Confidentiality was the second most common concern, highlighted by urban female learners, both groups of rural learners and rural community members, demonstrating that stigma is common amongst educators and learners alike when it comes to youth sexuality:
“Students and teachers, you will be scared that the teacher trusted you and now she will have to see you going to that room and for sure she knows that a person that goes to that room is a person that is using family planning.” (Rural female learners)

“Okay I’m supporting number two because here in school if I would to go to the room where you access family planning methods and maybe number six [another student] will see me going there and then she will go maybe and tell number eight that, you know what I saw so and so going there to access family planning that means she is having sex mean while I was doing something without anybody knowing, it was my secret and didn’t want people to know about.” (Rural female learners)

For this reason it would be imperative to ensure a supportive environment alongside service provision:

“Students will be afraid to go there but we will need to be encouraged by the teachers to be able to go there.” (Urban female learners)

Other learners simply felt that schools are a place for learning, “not a place for family planning” (Rural male learners).

**HIV counselling and testing**

In response to the question of whether there should be a system of accessing HCT through schools, similar advantages and disadvantages to those stated above were discussed. Urban community members and parents, and rural educators argued that this would increase HIV testing in young people, as a result of greater accessibility and lower stigma in this environment:

“At schools I can be very happy if they can test at schools because it is known that there is no one who will be regarded as not eligible to go there. Everyone will go to this room. It will be his/her secret and the one who has tested him/her; that this one is now like this and that. This one is not yet like this. Everyone gets inside here. It is not important to say “Because you are now like this, go inside there. You are not yet like this; do not get inside there”. It is much better at schools.” (Urban community members)
Male and female urban learners however again raised the issue of confidentiality and HIV-related stigma, reasoning that this would affect uptake of HCT in schools:

“I don’t think that [HCT access in schools] would be a good idea because sometimes other people are unable to hide their shock. One will go to test and discover that they are HIV positive. When they come out, they are shocked. Then they can see. There are people who love stories. Children who love stories; they can see you. Everyone will know about their status whereas the person was not ready to disclose to people.” (Urban female learners)

“I think it would be a bad idea, because you will not feel comfortable going there because everyone knows that they are dealing with AIDS related things there, so people from your class will look at you in a different way, you see, that you are going there.” (Urban male learners)

**Antenatal care and PMTCT**

Discussions about providing ANC and PMTCT in schools were brief. Although some educators expressed a concern that this would “promote pregnancy” (urban educators), others conceded that schools had a duty to provide such services to pregnant learners who have limited access elsewhere:

“But I think they can, they can only service those that need that. They can have a special room, special hours, that is meant for them. Because we cannot run away that our learners fall pregnant. They have kids. There need to be service for them. So we can establish a way of doing it. So that people cannot think we are promoting that. But it’s something that is there, that is happening, and we need to service those children.” (Urban educator)

**Integrated school health clinic**

Finally, in order to tackle all of these problems together, rural community members and educators in both settings suggested the possibility of an integrated school health clinic:

“For instance, there must be office that can be opened in school. Maybe we know that we do have a nurse, maybe who comes to school maybe once a week to talk to the learners about these things as we have said that. We as teachers, we are not able to do this. We do what we are employed for. So, there must be maybe, a nurse or whoever else can be employed by the government. There must be a helpdesk at schools, you know, where a learner can go
whenever she or he is having a problem like this, concerning this thing pregnancy, HIV and everything. There must be someone employed in each and every school, really.” (Rural educators)

Summary and conclusions

The following is a summary of the key findings and outcomes of this study.

SRH issues facing young people and contributing factors:-

- FGDs with learners, parents, educators and community members identified a common set of problems affecting young people in both rural and urban settings in KZN. Major discussion themes were unplanned adolescent pregnancy and HIV/AIDS, which are mediated by poverty, substance abuse, stigma, peer pressure and poor communication with parents.
- Several factors, including poverty, substance abuse, age-disparate relationships and the media contribute towards early sexual initiation and unsafe sexual practices by young people.
- Despite good knowledge of modern FP methods, actual uptake of services and use of condoms and other contraceptive methods by sexually active young people is inconsistent. This is observable in high rates of adolescent pregnancy, which in most cases is unplanned.
- Similarly, young people demonstrated good knowledge of general HIV risk, yet personal risk perception was low and unprotected sex is reportedly common. Reports of youth HIV testing practices varied widely.
- Conversely, knowledge of MMC in relation to HIV risk was high in both settings, with a high proportion of learners reportedly undergoing the procedure.
- Although most agreed that SRH, FP and HIV were currently taught in Life Orientation (LO) in schools, many expressed negative opinions about the quality or relevance of this teaching.
- Negative attitudes towards pregnant learners were widespread. This is likely to be associated with late disclosure of pregnancy and presentation to ANC services, as well as psychological harm resulting from gossip.
- Although many participants acknowledged the constitutional right of pregnant learners to continue their school education, neither school had a relevant policy in this area. Actual treatment of learners appears to be based on precedent, with the majority experiencing reduced school attendance and special treatment that singles them out. Depending on
circumstances, some pregnant learners may not return to school after their baby has been born.

Barriers to accessing existing services:-

- Barriers that prevent young people accessing SRH services, such as FP, HCT and ANC, include inaccessible clinic hours, fear, negative attitudes and behaviours of health care providers, educators, and community members, relationship power dynamics and the perceived invincibility of youth. There was no knowledge of existing youth friendly services at a public health care level.
- Conversely, risk awareness, the positive impact of peers and supportive educational environments can facilitate access to these services and use of contraception.
- Attitudes towards contraceptive use by youth are generally positive, yet some responses also indicate that a high level of stigma around youth sexuality still exists in both the rural and urban community.

Perceived solutions:-

- The vast majority of respondents felt that parents should support, educate and advise their children around SRH, FP and HIV prevention (with rural participants expressing overall a more conservative attitude). Many participants however acknowledge that parents often struggle to fulfil this role due to lack of knowledge or limited communication skills.
- The majority of participants called for comprehensive SRH teaching for school-age youth. Schools are regarded as the preferred medium for this, being at the centre of communities that need to accept the realities of youth sexuality, HIV and adolescent pregnancy. Schools also have the potential to act as an objective source of information, which may not be accessible elsewhere.
- Some participants, however, had reservations that SRH teaching would lead to promiscuity or was simply not relevant to learners.
- The need for support from the departments of health and/or education, as well as external assistance from specialist organisations such as NGOs was also recognised, since many educators are currently poorly placed to provide this type of education.
- Suggestions of ways to improve youth access to SRH services included mobile clinics, more accessible clinic hours, and provider training in youth-friendly services.
- FP and HCT provision in schools was also widely supported as a way to increase access, potentially through an integrated school health clinic. However, many learners expressed
Developing a community based response to promote family planning and reduce teenage pregnancy:
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concern that their confidentiality would not be sufficiently protected in a school environment, and that providing FP methods in school may encourage promiscuity. In particular the concern of being seen by peers was an issue.

- The majority of learners however supported schools-based condom distribution, since this would facilitate anonymous access and may even lead to a higher proportion of protected sex acts. However there were some learners who had conflicting opinions regarding providing support for hormonal FP at schools.

- Lastly, educators and parents called for a proactive, organised and coordinated response to SRH education between schools, parents and the community.

Recommendations

Based on the study findings, the following recommendations can be made:

School level recommendations:

- There is a need for clear school policies on learner pregnancy, addressing constitutional rights and ways to support learners to return to school after giving birth (based on national policies, but taking local circumstances into account). Different groups could be consulted to provide input to this.

- Values clarification could be conducted with all educators. Basic LO education skills could be reinforced. Educators could be familiarised regarding national/local policy on learner pregnancy.

- There may be a need to re-examine LO teaching – who is teaching this, what training is available for these educators and the possibility of greater involvement of external organisations.

- The possibility of peer-led SRH teaching in schools could be investigated, and possible peer leaders identified, with the help of external organisations such as loveLife.

- Condom distribution in schools should be further explored, and the acceptability of this further investigated.

- Substance abuse could be addressed via appropriate programmes in LO classes or through peer support.

- Parent, learner, educator committees (with external membership/mediator) could be set-up to normalise discussions around SRH and identify ways to improve relations between these groups. These could be open to the general community and could include the possibility of running leadership sessions etc. Such committees could serve to bridge the gap between
schools, parents and communities, and facilitate the relationships and develop understandings of roles of these groups.

- Key study findings could be presented to representatives from the schools in a “utilisation of study findings exercise” - and from this they can make a short and long term plan of which recommendations are doable.

Health service level recommendations:

- Communication between health service managers, providers, parents, learners, and educators to identify areas of concern and potential solutions – this could be linked to the integrated school health programme, and form part of the “utilisation of study findings” exercise.

- Values clarification could be conducted with health care providers – and this could include training in youth-friendly service provision.

- The possibility of extending clinic hours, or supporting mobile clinics with extended hours, to improve access for school-age learners could be explored.

- The possibility of a dedicated youth clinic, with particular focus on confidentiality and ensuring relevant/appropriate IEC materials could be explored. This could also be in the form of a mobile clinic. However, the acceptability of this to the youth as well as the sustainability of this would need to be explored.

- Further investigation into the acceptability of schools-based SRH services such as FP and HCT as part of an integrated school health clinic or mobile health service could be explored, especially as part of the integrated school health programme. School principals can work together with parents and school governing bodies to explore their views on this.
References


