

Dynamic Contextual Analysis Of Adolescent Sexual And Reproductive Health In Peddie, Eastern Cape

**PPASA Adolescent Reproductive Health Service, Peddie
CADRE**

Contributors

M.Mantakana, N.Nqinana, N.Makinana (PPASA)

P.Ntlabati, C.Fawcett, K.Kelly (CADRE)

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ACRONYMS AND TERMS

ARHS - Adolescent reproductive health services

SRH - Sexual and reproductive health

STI - Sexually transmitted infection

TOP - Termination of pregnancy

Emergency contraception - Contraceptive methods used after exposure to pregnancy risk situation

PEP - Post exposure prophylaxis

VCT - Voluntary counseling and testing

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EXECUTIVE SUMMARY

PPASA has recently established an Adolescent Reproductive Health Services (ARHS) project in Peddie. This report discusses the results of a baseline study for this project, that was conducted between October 2001 and March 2002.

PPASA staff and CADRE (Grahamstown) collaborated in the design, implementation and write-up of the study.

Objectives of baseline study

- To enquire into how the PPASA ARHS is likely to be received by the Peddie community.
- To understand the level, relevance and diversity of activity in the sexual reproductive health (SRH)-HIV/AIDS field in the area.
- To identify networks and opportunities for collaboration in addressing SRH in the area.
- To identify gaps in adolescent reproductive health service provision in the area.
- To understand youth knowledge, communication, attitudes and behaviour, in relation to SRH and HIV/AIDS prevention.
- To understand the context of youth relationships and sexuality.
- To introduce the project to the area.

Methodology

- An audit of organizations, agencies and key people in the SRH-HIV/AIDS field. This included organizations and establishments with no actual involvement, if it was felt that they could later be incorporated.
- Six focus group discussions with groups of young people ranging from 10-20 years.
- A questionnaire survey was at 4 Peddie schools including grade 4 (n=120; ave. age = 11 yrs.)and grade 11(n=120; ave. age = 18 yrs.) learners from both rural and urban areas.

Audit of organisations

Three types of organizations were identified in the audit:

1. Those that are ready for immediate co-operation and where little structural development is needed, but there is room for development of services to make them more effective as SRH partners. These included Ubuntu (NGO) and Sports Centre (CBO).
2. Those that have little or no SRH infrastructure, but which need to be incorporated into a comprehensive, integrated strategy for SRH services. These include traditional healers/ traditional health services; school health services; businesses; churches; development and welfare agencies. Whilst there have been attempts to address HIV/AIDS issues through various agencies, there is little evidence of systematic and comprehensive framework of action. Only 42% of Grade 11 participants and 18% of Grade 4 participants in the survey report that AIDS has been discussed in their church, although most of the churches involved in the survey express an involvement in HIV/AIDS issues.

3. Those that have special skills that can support the work of PPASA in developing a comprehensive strategy in co-operation with other organizations. These included Masimbambane and Vusisizwe Development Project.

It was found that there were many organisations that in some way were or could be part of providing ASRH in the area. However, at present, there is no formal organisation or network for co-ordinating efforts in this area, which has resulted in unnecessary duplication or gaps in services.

Young people's orientation to HIV/AIDS and SRH issues and services

- TV and radio are the main sources of information about AIDS for both the older and the younger groups.
- Fifty six percent of the grade 11s and 65% of grade 4s report that their parents had spoken to them about HIV/AIDS. Fifty eight percent of the grade 11s and 26% of the grade 4s report that their parents have spoken to them about sex. It should therefore not be assumed, as is often thought, that parents are not doing anything to educate their children in this area. Parents should be thought of as interested partners in the area of SRH education.
- Seventy three percent of Grade 11s report that sex has been discussed in class, whilst only 15% of Grade 4s report this.
- There is much evidence in the survey to suggest that Grade 4s (ave. age = 11 years, but with age as high as 15 years) have access to less information about HIV/AIDS than their older counterparts, poorer knowledge of HIV/AIDS and significantly poorer attitudes to people with HIV/AIDS. There is very little input at school level for the younger group and little evidence that younger people are active in discussing or being concerned about HIV/AIDS.
- Although health educators have visited the grade 11s, they have spoken mostly about AIDS and not other SRH issues like STIs and TOP. Only 20% reported having been spoken to by a health educator or nurse about STIs. The grade 4s have had little exposure to health educators.
- More than half of the youth respondents (53%) thought that a woman is more likely to fall pregnant during her period.
- People are reluctant to talk about STIs as they feel it is a highly intimate and private issue.
- Understanding of termination of pregnancy and emergency contraception is poor.
- Most participants knew that HIV was a disease that developed into AIDS. However, in focus groups it emerged that there is some confusion about the difference between HIV and AIDS, and evidence of beliefs that there are ways to rid the body of HIV to prevent AIDS from developing.
- Although most respondents in both age groups know that HIV is transmitted through unprotected sex, there were still erroneous beliefs about other forms of transmission such as being in close proximity to an HIV positive person. These were notably present in the younger age group. Some myths surrounding prevention were noted, but the overwhelming majority of respondents have a correct understanding of how HIV infection can be prevented. There was a relatively poor understanding of HIV testing and

VCT, which is not surprising as such services are not locally available on a voluntary basis (only medically referred testing available).

- Traditional healers were cited as being a source for STI treatment and TOP and should be regarded as needing to be included in the network of resources that young people use for dealing with SRH issues.
- It is felt that health workers tend to be unfriendly and condescending towards young people who are engaged in sexual activity. There is a perceived lack of privacy in clinics, health workers are believed not to maintain confidentiality, and confidential counselling services are perceived not to be available. It is important that these services be oriented to the concept of adolescent friendly SRH.

Sexual and reproductive health behaviour

- It was found that there was a high level of early sexual experience among young people in Peddie. Seventy-two percent of the grade 11 participants had had sex before, and 60% of those who had had sex before, had their sexual debut before the age of 16. About half (51%) of the grade 11 participants are currently sexually active. It is important to note that previous sexual experience does not imply current sexual activity. These young people tend to be irregularly sexually active.
- Furthermore 75% of those who have had sex before report that they have changed aspects of their sexual behaviour because of HIV/AIDS.
- There were low levels (39%) of reported contraceptive use in first sexual experience, suggesting that first sexual experiences were either not planned for, or not taken seriously as posing a pregnancy risk. There was indication of relatively high current contraception use with 72% of sexually active females and 63% of sexually active males using some form of contraception. The most common forms of contraception are 'the injection' and condoms.
- Although 92% of the grade 11s indicated that they would use a condom with each new partner, there is an unfavourable stance towards sustained condom use and an attitude prevails of stopping to use condoms with regular or steady partners and in loving relationships. This obviously poses a health risk and is based on an implicit myth that one is at less risk of infection in a regular or well established relationship; i.e. there is a discounting of the history of the partner.

Implications for intervention

Four main areas of intervention are identified:

1. Networking with service providers: There needs to be better facilitation between a range of agencies which are involved directly and indirectly in the provision of youth oriented SRH services and input in Peddie and surrounding areas. There is evidence of an erratic health education system that does not cover important SRH issues in a comprehensive way, leading to significant gaps in SRH information. There is a need to mobilise efforts around age appropriate HIV/AIDS education in primary schools where there is little evidence of health education and where there are significant areas of misinformation. There is also a need to mobilise a more youth-friendly approach in the health services and a need to engage with traditional healers who many young people see as a resource in SRH issues.

2. There is awareness of the need to prevent HIV infection and young people's awareness of issues in this area needs to be built upon and endorsed. There is little evidence of attempts to encourage young people to delay first sexual intercourse and the early onset of sexual activity must be seen as a concern. Similarly, the high age differences between young girls and their partners at sexual debut must be regarded as an area which should be addressed. In addition, many young people are still exposing themselves to the risk of pregnancy, especially at first sexual intercourse, and this is especially problematic given the poor misunderstanding which many young people have of pregnancy risk.
3. Parents are concerned about the threat of HIV/AIDS and many are attempting, in their own ways, to address their children about AIDS and sexuality. They need support and guidance in this area and parents should also be regarded as potential partners in adolescent SRH service delivery. This can be encouraged by having workshops with parents exploring ways of communicating with their children at a young age about sexuality, relationships and SRH issues.
4. SRH education needs to go beyond just HIV/AIDS education. There needs to be more focus on other SRH issues, especially STIs. Further SRH education could include many other issues that are not being covered in the existing efforts which young people are currently being exposed to. Comprehensive SRH programmes education might include human physiology, hygiene and health care, puberty/adolescence, morality, reproductive health, pregnancy, contraception, common infections (including STIs and HIV/AIDS) and prevention, sexuality, relationships, negotiation, and gender issues.

INTRODUCTION

PPASA has recently established a project on Adolescent Reproductive Health Service in Peddie. This is the second project of this nature within PPASA in the Eastern Cape Province. The project is funded by DFID for a three-year period and it is envisaged that a partnership will be developed between PPASA and the Department of Health.

Peddie is situated between Grahamstown and King Williams Town along the N2 National route. It incorporates a small town with 114 villages and 14 wards. It is mainly a rural community.

There is a high unemployment rate in Peddie, with many of the families relying on pensions for income. Most of the villages have electricity, and 74 of the 114 villages have running water. There is some pineapple and orange farming in the region. Otherwise, people rely on subsistence farming.

There are 71 Primary Schools, 35 High Schools and no tertiary institutions in the area. The area is serviced by one hospital and twelve clinics.

A baseline study was seen as a good starting point to provide a foundation and a focus for the intervention. This has the advantage of enabling the service providers to anticipate how the venture is likely to be received, to identify gaps in service provision and to introduce the project to the district. It was also felt that the exercise would serve to empower the staff with research and networking skills in the area they are going to service.

PPASA Peddie staff and CADRE (Centre for AIDS Development Research and Evaluation) Grahamstown collaborated in carrying out the study with CADRE assisting with the process of setting up instruments and overseeing/monitoring the running of the baseline study.

Objectives of the PPASA Sexual Reproductive Health Project

- To contribute to the positive and long-term impact on the sexual and reproductive health status of young people in the Peddie area.
- To provide young people with access to comprehensive sexual and reproductive health information and services including life skills, to bring about positive behavioral change.

Study aims

The broad aim of the study is to develop a detailed understanding of the context of SRH of young people in the Peddie area and thereby to establish a knowledge base for appropriate planning and prioritization.

Specific aims of the study are:

- To enquire into how the PPASA ARHS is likely received by the Peddie community.
- To understand the level, relevance and diversity of services and social activity in the sexual reproductive health (SRH)-HIV/AIDS field in the area.
- To identify networks and opportunities for collaboration in addressing SRH in the area.
- To identify gaps in adolescent reproductive health service provision in the area.
- To understand youth knowledge, communication, attitudes and behaviour, in relation to SRH and HIV/AIDS prevention.
- To understand the context of youth relationships and sexuality.

- To introduce the project to the area.

Study Design

A Dynamic Contextual Analysis¹ approach was used in order to gain contextually based information about young people's sexual and reproductive lives. Dynamic contextual analyses not only explore individual sexual reproductive behaviour, but also take into account the social context in which this behaviour occurs. By engaging in a dynamic contextual analysis, the situational understanding of beliefs, attitudes and behaviour can contribute to the identification of gaps in knowledge and services around sexual health issues and focus future interventions on addressing these shortfalls.

Methodology

A dynamic contextual analysis integrates a number of different research methodologies with the overall aim of collecting context rich information. All data was gathered in Xhosa and was then translated into English for the purposes of analysis and report writing.

1. *Key informant interviews*² were conducted in order to provide a framework for further in-depth investigation. Youth and SRH service providers and key stakeholders were identified in the Peddie area and their involvement in sexual health issues was outlined
2. Six *focus groups* explored the identified areas and issues in more depth and provided information for the subsequent survey³. Focus group participants included: Rural mixed group, 15-18 years old; Urban mixed group, 15-20 years old; Rural male group, 10-14 years old; Urban male group, 10-14 years old; Rural female group, 10-14 years old; Urban female group, 10-14 years old
3. A *questionnaire survey*⁴ was conducted at 4 schools in the Peddie area, incorporating grade 4 and grade 11 students in both urban and rural areas. Survey samples included: 60 rural grade 4 students; 60 urban grade 4 students; 60 rural grade 11 students; 60 urban grade 11 students. There were equal numbers of male and female participants.
4. All the information gathered in the 3 research processes were combined and *analysed* in order to form a context-rich picture of SRH in Peddie and its surrounds and to identify foci for further service development.

FINDINGS

Peddie and the surrounding areas incorporates a broad range of different organizations and community agencies which have the capacity to contribute meaningfully and positively towards ASRH. The current lack of co-ordination between these partners is the main challenge in addressing the issue of SRH in the area.

Organisations and key informants

The table on the next page represents the missions, barriers, opportunities and possibilities for action of key organizations that have the possibility of contributing to development of SRH in the area.

¹ Chalmers, H.; Stone, N. & Ingham, R. (2001). Dynamic Contextual Analysis of Young People's Sexual Health. United Kingdom: Safe Passages to Adulthood (DfID).

² Appendix 1

³ Appendix 2

⁴ Appendix 3 and 4

Key informant interviews: results

Domain	Projects	Mission	Major barriers	Major opportunities	Possibilities for action
NGOs and CBOs	Ubuntu	HIV training on home based care, STIs, Lifeskills, Child abuse Family planning	No phone or fax Mostly volunteer base	All ages Variety of activities (HIV, disabled, youth, lifeskills etc.)	Lifeskills Support programmes Education Collaboration on programs running, including HIV/AIDS
	Masimanyane (Peddie Women's Support Centre)	Supporting women (violence and rape); supporting men (rape and domestic violence); HIV education	Under resourced No phone or fax Security No funding	Men and women All ages HIV activities Have transport Counselling and training	HIV issues, especially in school outreach Education on SRH rights
	Masimbambane	Legal advice and human rights; HIV education	Small staff HIV trained coordinator	Support from Rhodes legal Aid Funding	HIV and rights Lifeskills and guidance (parents too) Termination of pregnancy
	Vusisizwe Development Project	Career Guidance; Computer training	No telephone or fax	Computers Funding Counselling Career guidance	Collaboration on HIV/AIDS issues
	Sport and Culture	Sports center, youth games, condom distribution	No HIV issues	Department of Sport and Culture Youth Have administrator and board	Continue condom promotion Education on rights (e.g. policy - enforced disclosure for players) HIV prevention
Health facilities and services	Hospital	Condom distribution, Family planning, STIs, VCT, Health promotion activities		Referrals from satellite clinics and mobile clinics	Education and training (outreach) Collaboration and referrals
	Primary Health Care	Condom distribution, Family planning, STIs, Health promotion activities		Clinics and mobile clinics	Education and training Collaboration and referrals
	School Health Services	PHC	No Health Promoting Schools Initiative	In collaboration with Department of Education	Education and training Health Promoting Schools
	Traditional healers/ services	STI and HIV symptomatic treatment; condom distribution; counselling; TOP; referrals to formal health care sector	No association	Willing to work with health sector Promotes condom use Refers to doctor/clinic	Education and training Collaboration and setting up referral system

Domain	Projects	Mission	Major barriers	Major opportunities	Possibilities for action
Education Dept.		Co-ordination of AIDS committee	Low levels of activities Irregular condom distribution Nothing at Primary Schools Problems with implementation of Lifeskills	Office in town Provincial DOE AIDS co-coordinator District AIDS co-coordinator 2 people trained per school Lifeskills program	Structure whole HIV programme in schools under Lifeskills Deal directly with children Health promoting schools initiative
Social Dev. / Welfare		Implement provincial programmes		Deal with referrals Foster care Counselling Invited to schools	multifaceted
Municipal Govt.		Support projects at political level	low levels of activity	AIDS co-coordinator Has had training	Work with future plans e.g. HIV/AIDS committee; health desk; local activity co-coordinator AIDS support centre
Traditional leaders		National HIV/AIDS program (encourage prevention of HIV/AIDS)	No clearly defined role No clear mission from CONTRALESA Often opposed to Govt. legislation (e.g. circumcision) Not a united group, split according to political affiliation Taken over by Councillors, Chiefs feel threatened Traditional educators not really organized – no rules No traditional education for young girls	Recognise that CONTRALESA has role to play Meet regularly Work with TLC Traditional schooling for the boys when they get to the bush Look into traditional disputes/apply customary law Paid by government	Mobilisation around health issues Work together with health sector, especially with initiation Need to implement the National policy on HIV/AIDS (see Mission)
Business community		Condom distribution	Not well organised Rivalry Lack of cohesion	Contact with hospital Reach majority of community	Possible award for best practice on HIV/AIDS related issues

Domain	Projects	Mission	Major barriers	Major opportunities	Possibilities for action
Churches	General		Churches divided over family planning issues No cohesiveness as a group	Regular meeting place for youth	Uniting youth from all churches
	Apostolic		No HIV/AIDS programme (feel there is no need) AIDS not discussed in lifeskills	Support group for sick Clinic referrals Youth lifeskills education	Working with youth Ensure HIV/AIDS program in place Values clarification
	Methodist		No ongoing programmes	AIDS education offered occasionally Condom week activities, experts invited to talk Guilders (youth group) Interest in HIV issues	Working with youth
	Anglican	National HIV/AIDS policy	Problems with AIDS programme at district level	HIV issues a priority	Working with youth
	Zionist			Interest from parents	Working with youth
	Seventh Day Adventist			Ongoing HIV programme	Working with youth
Transport	Taxi Association		No plan around AIDS Some disinterest	Posters on taxis Condom distribution Have administrator See need to be involved in AIDS issues	Play prevention/promotion tapes in taxis Posters Promotion of 'Men as partners' and Women Wellness

Summary

Possibilities for partnerships and action

It was found that there were many organisations that in some way were or could be part of providing ASRH in the area. However, at present, there is no formal organisation or network for co-ordinating efforts in this area, which has resulted in unnecessary duplication or gaps in services.

Three groups of organizations were identified:

1. The first group is those organizations that are ready for immediate co-operation and where little structural development is needed, but there is room for development of services to make them more effective as SRH partners. These include Ubuntu (NGO) and the Sports Centre (CBO). These two organisations have well-developed infrastructures that deal with young people's SRH issues. The key area of co-operation with Ubuntu would be with their lifeskills programme. Development of this could include supporting the staff and

volunteers of Ubuntu through knowledge-based capacity building (providing accurate and up-to-date information on SRH issues to be incorporated into lifeskills programmes). Organisations like the East London- based ATICC (AIDS Training, Information and Counselling Centre) could be involved in providing Lifeskills/peer education training.

The Sports Centre has the advantage of being a non-health/ non-educational setting that attracts young people. Although it is not fundamentally oriented around SRH issues, the healthy lifestyle approach fits well within a comprehensive HIV prevention framework and could be a useful vehicle for SRH education, in partnership with PPASA.

2. The second group is those organizations that have little or no dedicated infrastructure for sustained SRH activity, but which could be utilized as important elements of a comprehensive and integrated strategy of SRH development. This includes traditional healers/ traditional health services; schools; businesses; churches; and welfare or social development agencies. Whilst there have been attempts to address HIV/AIDS issues by various of these agencies, there is little evidence of a systematic and comprehensive framework of action. Efforts are erratic and not very far reaching. Some of the churches have ongoing HIV/AIDS initiatives although only 42% of Grade 11 participants and 18% of Grade 4 participants in the survey report that AIDS has been discussed in their church, although most of the churches involved in the survey express an involvement in HIV/AIDS issues. Similarly as will be seen later, input on SRH in schools is erratic rather than systematic and does not cover important areas.

The above five domains have some opportunities for the provision of SRH services, but their full potential is not being reached. Each of these social institutions could be activated to contribute much more in this area. The churches and businesses, as well established and respected social institutions, could develop more proactive plans for addressing HIV/AIDS in Peddie and surrounding areas. The ultimate goal would be getting them to work together with NGOs, CBOs and the health sector. PPASA can act as a facilitator for this process and coordinate efforts to bring together all the skills and resources available in Peddie under a multi-sectoral umbrella body/committee. Churches have the advantage of having buildings that can be used for youth-based activities, and businesses (including taxi services) have the advantage of engaging with a large number of young people that patronise them. But commitment and innovation appear to be lacking.

Schools need to have clear programmes where age-appropriate sex/health education is incorporated into lifeskills education. This should ideally start at senior primary school level and, following expectations of a comprehensive approach, should include human physiology, hygiene and health care, puberty/adolescence, morality, reproductive health, pregnancy, common infections (including STIs and HIV/AIDS) and prevention and self-care. Links between the schools, the health sector and NGO programs towards collaborative integration could be facilitated by PPASA.

The education sector and the health sector need to be linked so that there are open channels of communication between the two to promote maximum use of referral systems and use of health education resources. It is unclear which agency is responsible for ensuring that all schools are systematically covered with an adequate curriculum and what forms of support there are for school based initiatives. Schools provide an ideal opportunity to gather young people together to address issues as critical to their lives and health as SRH, and it is important that PPASA take a proactive stance in advocating for development of school

HIV/AIDS education and SRH. PPASA could assist in closing of the gap between health and education sectors where responsibilities seem to need to be more clearly defined.

Although the school health services attempt to deliver SRH education, there is only one nurse available to visit all the schools in the area. It seems that the orientation includes little discussion and teaching around SRH issues such as contraception, STIs and non-health issues such as sexuality and relationships. As the survey and focus group findings later point out, this service has done little to promote SRH although it has the highest potential to do so. A key area to develop is this link between the education and health sectors.

Local leadership organisations, the local municipality and CONTRALESA, need to be included, at a policy and planning level, in any decisions and programme plans. The local council has a trained HIV co-coordinator who is in a position to become more involved in supervising the links between the various sectors, especially the health and education sectors. PPASA could work closely with this HIV/AIDS co-coordinator who has the capacity to contribute towards the logistical and practical arrangements of getting various sectors to meet.

3. The third group is those that have special skills that can support the work of PPASA in developing a comprehensive strategy in co-operation with other organizations. This includes Masimbambane and Vusisizwe Development Project.

The advantage of a collaborative effort will not only be in learning from each other but in sharing the load of information dissemination to youth. Masimbambane can be used as a source of information on TOP and other legal issues related to SRH. As is pointed out later in the report, little is known by young people about TOP and its legalities and is an area that needs addressing. Vusisizwe has potential capacity to support PPASA materially with computer skills and place for counseling if needed.

Focus group and survey findings

Six focus groups were conducted with participants from urban and rural areas and this included young people between the ages of 10-14 and 15-20. In addition, a survey including 240 participants from grade 4 and grade 11 classes, at both rural and urban schools, was conducted.

The average age of grade 4 survey participants was 10.6 years, the minimum age being 8 and the maximum 15. Fifty-nine of the grade fours were male, and 61 female. The grade 11 survey participants had an average age of 17.8, ranging from 15 to 23 years. There were 57 male and 63 female participants. Notable in both groups is the broad age range of participants. SRH, perhaps more than other forms of health education, needs to be done in age appropriate ways. Young people of a certain age are ready to discuss particular issues only when they reach particular milestones of physical and psychological maturity. The age mixing in class makes this problematic. This is a problem in many South African schools and one that makes school-based SRH education problematic.

Sexual and reproductive health status

It was found that there was generally a high level of early sexual experience in Peddie, with almost 60% of grade 11s having had intercourse before the age of 16. After this early sexual activity, however, participants did not necessarily continue to be sexually active and the number of participants currently having sex is lower than the number of participants who have had sex before.

There are differences between males and females in terms of social expectations relating to sexual behaviour. For example, boys and girls report expectations that girls remain virgins until they are married, but the same is not expected of boys. There is also social expectation that young people should only start having sex between the ages of 18 and 20. Both of these expectations, held by young people themselves, are not reflected in reality. There is evidence that young people's behaviour is not consistent with the framework of social expectations and this reflects an uncertain and changing socio-cultural terrain where new behavioural norms are not part of the social fabric of group interaction and expectations. Young people are in uncertain terrain with respect to what they expect of themselves and other people in the areas of relationships and sexuality. This is also very much in evidence in gender relations, where a changing gender environment sits somewhat uncertainly with young people. There is clearly much need amongst these young people to discuss these issues and to renegotiate what to expect of each other in an open and permissive world which is coupled with the threat of AIDS.

Sexual debut⁵

- 72% (79) of the grade 11 participants had had sexual intercourse before even though there was a general attitude that sex should only be engaged in when married.
- The median age for first sexual intercourse (age by which half the respondents who have had intercourse had had it already) was 15 years, with the males' median being 15 and the females' 16.
- On average, females were 3 years younger than their partners the first time they had intercourse. This is a large age difference for young people aged less than 16 years and opens strong possibilities for manipulation and coercion.
- More than half of the participants (54%) did not use any form of contraception in their first sexual intercourse.
- Reasons given for engaging in sexual practice included: peer influence, wanting to experiment and "copying parents' behaviour" (especially if young people slept in the same room as their parents). Female participants said that they were more likely to engage in sexual practice if they had an older boyfriend.

Relationships and sexual activity⁶

- 94% (111) of the youth respondents had had a boyfriend or girlfriend before.
"It is said that if you don't have a boyfriend you will end up being mad".
- People chose partners according to physical appearance and behaviour.
- Generally, males initiated relationships, although some females initiated relationships "indirectly".
"Girls don't come directly they will rather communicate this to other girls who will then go and tell the boy that so-and-so loves you"
"Females will entice the male, the male will see that this one is in love with me"

⁵ Youth (grade 11) only

⁶ Youth (grade 11) only

- Although most had had sex before, only 51% of the grade 11's had a current partner. Sixteen percent said that they had more than one current sex partner.
- Thirty five percent of the participants had had more than 1 sex partner in the last 6 months and the average number of days that the participants had had sex in the last 4 weeks (1.7) shows relatively low levels of current sexual activity. Thus, whilst young people are sexually active, it must not be imagined that they are regularly or frequently sexually active. For young people opportunities for sexual intercourse do not present themselves easily and young people may be sexually active on a very intermittent basis only. It must also not be supposed that young people in the area are highly promiscuous. Whereas one respondent reported 12 partners in the last 6 months this is clearly an exception and most young people that are sexually active are fairly hesitatingly engaged in sexual relations with one only partner. Young peoples' sexuality should be spoken about with recognition of the uncertainty they experience in sexual relations.
- There is only a slight difference between the participants' current ages and the age of their last sex partner (approximately 1 year). On average, males were 2 years and 7 months older than their partners, and females only 6 months younger than their partners. Therefore, although there was quite a large age differential at sexual debut, female participants seem *currently* to be having sex with peers rather than vastly older boys.
- Very few (3%) of the participants had ever had sex with someone more than 10 years older than themselves.
- A number of respondents reported having been forced to have sex (8%). Although this may be a small percentage it is almost one in 10 that have experienced this and it is cause for concern, and certainly an area which needs to be addressed. Most (76%) of those who had had sex before felt that they would be able to say "No" to sex if they didn't want it, but again the minority (24%) who are unable to say "No" need to be reached and assisted to be more assertive of their needs and rights.
- In general, participants did not engage in anal or oral sex. There was also little knowledge of people engaged in same sex relationships.
- There are a number of myths and beliefs around increasing sexual pleasure including the prevalent practice of 'drying the vagina' by inserting beef stock cubes and vinegar into it.

"Boys take big pills to enlarge their penises and to make their erection last longer"

- Only 3% (3) of the participants had had sex for money before, although the focus group participants suggested that there was a high level of sex for commercial gain. By this is meant the association of sex with gifts or material favours; i.e. material transaction for sex. This is a gender issue and one that would be important to discuss amongst young people, for it is an important factor making the poorer members of the community more vulnerable to sexual exploitation.
- Six percent of the participants had ever knowingly had an STI.

Contraception⁷

⁷ youth (grade 11) only

- Sixty-eight percent of participants who had had sex before are currently using some form of contraception. This opens the possibility that the 32% not using some form of contraception may be at risk of pregnancy.
- Young people seem to be well aware of the need for contraception, although as has been mentioned they frequently take risks, especially in first sexual intercourse experiences. Forms of contraceptives most easily recalled are the condom and injectable contraceptives. Oral contraception is less well known as are intrauterine devices. Very few of the participants had heard of emergency contraception.
- There are a number of misconceptions around contraception and conception. One such belief that seems to be prevalent in the community (as reported by focus group participants) is the belief that drinking a lot of water (about six glasses) before sex is an effective contraceptive.
- Five percent of those who were sexually active had not told their partners about whether they used contraception or not.
- Thirty eight percent of the participants' parents knew of their contraceptive use.

Condom use⁸

- About half of the focus group participants indicated that they had started using condoms as a direct result of knowing about HIV/AIDS which is encouraging evidence that many are responding to HIV prevention messages. It is also of interest in this respect that many young people indicated sticking to one partner and secondary abstinence as behaviour changes due to HIV/AIDS awareness.
- Seventy one percent of the participants had discussed condoms with their partner
- Seventy two percent of the participants who had had sex before, had used a condom at least once.
- However, only 55% of the participants, who had had sex before, had used a condom last time they had sex, indicating that condom use is not necessarily consistent.
- For those who do not use condoms, the main reasons were either the partner refusing to use one or the development of an exclusive relationship between partners. Some reported having used a condom at the start of the relationship, but that they discontinue use once they feel they 'know the partner well'. Other reasons vary from not liking it, forgetting it or being drunk, to the partner being on contraceptives and the fact that a condom is believed to dull sensation.
- Although there was relatively low use of condoms, 92% of the participants stated that they would use a condom with every new partner, but about half of them would stop using condoms with more regular partners. There is a fairly low commitment to consistent condom use, with only 23% of the participants stating that they always use condoms.

⁸ youth (grade 11) only

Sources of information and levels of knowledge

Sources of information about HIV and SRH

- Eighty four percent of all the participants had heard about HIV from television in the last month, 87% from the radio, and there were no differences between youth and children's responses, or differences between rural and urban participants in this respect. There is high access to these sources in the Peddie community with 83% of grade 11s and 81% of grade 4s having televisions, and 98% of grade 11s and 89% of grade 4s having radios in their homes.
- Seventy three percent of the grade 11 participants said that they had discussed HIV/AIDS in class. This was somewhat lower with the grade 4 participants (37%).
- Other important sources of information about HIV/AIDS, for both children and youth, were newspapers and parents.

Although parents were included as a source, some felt that "our parents do not sit down and discuss these things with us".

- Only 26% of the children's parents had spoken to them about sex. Twenty percent of the 26% of the grade 4 children came from the rural sample. Seventy percent of the children stated that they had no one to talk to about sex.
- Fifty-six percent of the grade 11 participants indicated that their parents had spoken to them about AIDS, but only forty-nine percent said that their parents had spoken to them about sex.
- Only 42% of Grade 11 participants and 18% of Grade 4 participants in the survey report that AIDS has been discussed in their church
- Although there is a moderately high level of knowledge around HIV issues, there is an extremely low level of knowledge about STIs. Thirty-nine percent (47) of the grade 11 participants and 12% (14) of the grade 4's said they knew what an STI was. It is apparent that children and youth hear about AIDS, fewer are spoken to about sex, and the issue of STIs is largely ignored.

Knowledge and attitudes: HIV/AIDS

- There is a general understanding of what HIV is, with the majority being able to describe HIV as the virus that develops into AIDS.

"HIV is the virus that causes AIDS"

"HIV is the early stage while AIDS is the advanced stage where one gets sick"

"HIV is the virus that later turns into AIDS"

- A significant number of participants were confused about the difference between HIV and AIDS, with many of them believing that HIV is an initial 'curable' state of the disease, which, when left untreated or not treated timeously, will develop into AIDS.
- Most of the grade 4 participants understood that HIV was contracted through sex and that wearing a condom would prevent transmission.
- However, there are still beliefs that "drinking medicine" will prevent HIV.
- A few believe that you can get AIDS by for example, opening a window, 'drinking water with cholera' or standing close to someone with the disease.

- In general, the youth seem to have a higher tolerance of HIV positive people than do the children. Negative attitudes towards people with HIV seem to be prevalent in the community although there is an awareness that one should not discriminate towards people who are HIV positive or have AIDS.

“Our parents would say we mustn’t go to that person’s house because (s)he will infect us with AIDS”

“Some don’t like them, they have their own spoons and buckets. They are afraid of being infected with AIDS”

“Some people are teasing them but we are told to take care of them and to support them. We can eat with their spoons”

- The grade 4 participants felt very strongly (82%) that if a teacher was HIV positive, they should not be allowed to carry on teaching. More than half (68%) of the grade 11’s, on the other hand, said that they should carry on teaching.
- There is the belief that if a pupil is HIV positive (72% of youth, 70% of children), they should not be allowed to continue at school.
- Very few of the children had knowingly been in contact with someone who was HIV positive. Coupled with little teaching from parents or teachers, their level of knowledge of HIV issues, besides that HIV/AIDS involves a disease process, is very low.
- The majority of participants were able to identify the Red Ribbon as an AIDS symbol. Many of the responses indicate that it is regarded as a warning, while quite a number indicate that it signifies ‘support for PWAs’, or ‘unity in the fight against AIDS’. The rest regard it generally as symbolic of AIDS awareness.
- Most participants believed that you could tell if someone had AIDS by looking at them. Signs included thinness, skin rashes, sores, peeling lips and hair falling out.

Knowledge and attitudes: sexual reproductive health

- More than half of the youth respondents (53%) thought that a woman is more likely to fall pregnant during her period.
- People are reluctant to talk about STIs as they feel it is a highly intimate and private issue.
- The most widely known STIs were HIV, syphilis, pubic lice and ‘drop’
- Eighty percent of the respondents did not know whether STIs could cause infertility or not.
- According to some of the focus group participants, STIs are believed to come from “dirty blood”
- More than half (57%) of the respondents were unsure if one could only get an STI from a woman. Sixteen percent thought this was true.
- Seventy percent were unsure whether you could only get ‘the drop’ from sex.

“I once phoned the Toll free number and I was told that you get these diseases by sleeping with someone without using a condom”

“When you get pubic lice you go to the traditional healer”

“I know that when you have ‘drop’ you go to the clinic”

- Thirty percent believed that if a woman used injectable contraception, she would become sterile. There was no difference between the number of males and females who believed this.
- Generally, teen pregnancy is viewed negatively by the community and that if a young girl is pregnant, it is believed that she has been neglectful and is blameworthy.
- There is a high level of ignorance about TOP with most of the participants being ignorant of legal TOP. Traditional healers were cited as a place to have an abortion.

Facilitator: What do traditional healers use to do abortion?

Response: I just heard that they are using steel wool, I don't know how they are using it. I also understand that they are using Esto⁹, I don't know whether they mix it with water or they just drink it as it is.

Gaps in SRH knowledge

The questions raised by the respondents in questionnaires seem to indicate fairly high levels of ignorance regarding SRH issues. For instance, a myriad of questions were asked regarding 'drop', with various myths emerging regarding how this is contracted. There seem to be similar myths regarding abstinence and its supposed effect on those who practice it. There seems also to be poor knowledge of STIs, and there seems to be confusion not only over what constitutes an STI and types of STIs, but also about how these are transmitted. These are areas that would greatly benefit from further educational input, perhaps more so than HIV/AIDS issues.

Provision of services

In-school health education

- Seventeen percent of the grade 4 respondents said that a health educator had been to their school to talk about AIDS. On the other hand, 64% of the grade 11's had had exposure to one.
- Only 20% of the grade 11 participants had had exposure to a health educator talking about STIs.

Knowledge of services

- In Peddie, there is one youth-friendly health care worker who is known to the youth, and they go to her. But when she is not working, there is no one else that they want to go to. Reasons for this include the negative attitudes that health care workers have towards young people who are sexually active, a lack of confidentiality and a prescriptive rather than participatory manner of dealing with clients.
- Only 31% of the children and 65% of the youth participants indicated that they had heard about youth friendly services.

⁹ Esto is a concentrated cool drink powder mix.

- The clinic seems to be the most widely known and used service for SRH issues. It is almost exclusively cited as a service provider for contraceptives, with the hospital far less so.
- Most of the grade 11 participants knew where to get contraception (84%), STI treatment (74%) and information about sex (70%). However, only 54% knew where to go for a termination of pregnancy.
- The predominantly identified place to go for STI treatment was the traditional healer.

“At the hospital there is no privacy and those nurses when you go there with such a problem (STD) they make a joke out of your problem, that is, talking to you about it loudly so that everyone can hear, whereas when you go to the traditional healers there is privacy and they won’t go around talking about your problem”

- Little is known about VCT and VCT services.
- Eighty eight percent of the grade 11’s had never had an HIV test. Thirty-six percent believed that you could get a confidential HIV test in Peddie, 26% believed that you could not and 38% did not know if it was possible to get a confidential HIV test. The fact is that there are no VCT facilities in Peddie which can be accessed through self-referral or on a purely voluntary basis.
- Sixty two percent of the youth respondents said that there was no place for them to go and have confidential counselling.
- Half (50%) of the grade 11’s said that there was no place that you could get condoms without others knowing.
- Eighty seven percent of the children did not know how they could become involved in helping with HIV/AIDS in the community.

Identified gaps in services

There is reported need for supportive services like counselling, education on sexuality/ health issues, being supportive and helpful to clients, providing support, for example for rape survivors, and other similar services at clinics. In particular, factors like the following were mentioned as some of the features that could enhance the value of the service:

- good/ caring doctors
- social workers working full-time at the clinic
- ambulance services
- sufficient resources (e.g. sufficient number of staff, materials for education, an adequate number of condoms/femidoms, spaces for counseling, emergency contraception)
- bringing the services closer to users (e.g. visiting schools and communities)
- educating youth around sexuality issues in a supportive environment
- increased confidentiality

CONCLUSIONS AND KEY RECOMMENDATIONS

1. Networking to provide integrated SRH services

It is apparent that there are many structures, institutions and organisations in Peddie that in some way are, or can be, involved in SRH issues with young people. They need to be linked in some way in the interest of providing a more comprehensive and integrated service and context for ARSH. In this way, gaps in services can be identified, as well as overlaps and problem areas addressed. A disorganized system intimidates young people and makes services difficult to use.

Bridging the gap between the health and education sectors

Issues

- It was found that very few students, especially in the primary schools, had ever had a health worker visit their school.
- Even if a health worker had visited their school, students were generally only spoken to about HIV/AIDS.
- Few young people had heard of youth friendly health services
- Pupils have voiced interest in having someone come to their school to address their questions and to have discussions with them.
- There is an educationist in Peddie trained in the Health Promoting Schools approach and support for such an initiative may be a fruitful way of generating further interest in the interface between health and education.

Actions

- Be instrumental in connecting the health and education sectors by setting up planning meetings.
- Encourage them to draw up a roster of visits, where at least one health care worker visits a school once a term. The aim will be to advertise youth friendly services by informing learners of their choices.

Improving the quality of services available

Issues

- Youth had not heard about youth friendly services.
- Only one health care workers is known to the young people in Peddie as being friendly and working in a confidential manner.
- Young people do not know where to go to obtain confidential counseling or VCT.
- For TOP and STIs, traditional healers are preferred.

Actions

- Information on help seeking patterns and social networks of help seeking should be made available to various relevant organisations. PPASA can gain this information through ongoing information gathering and monitoring, and getting young people involved in the planning and implementation of interventions.
- Accurate information on STIs, VCT and TOP, and locations for these services, must be made available to youth, possibly through pamphlets and increased communication with health care workers through schools.
- Confidentiality is a major issue with the youth and special attention needs to be paid to addressing staff attitudes and the quality of the services

rendered. Young people's involvement in saying what types of services they need may address this.

- The health and education sectors need to work hand-in-hand with traditional healers and a protocol drawn up for how TOPs and STIs are treated.

Rapid responses to promote safer sexual activity

Issues

- Some interventions and programmes may take time to have an effect on the sexual behaviour of young people. In order to gain rapid results, there needs to be an immediate improvement in the access of condoms and information (such as leaflets and posters) that can be instigated as an initial visible intervention. Visibility creates awareness, laying the foundation for future interventions.
- By starting off with a relatively easy intervention with quick, visible results, PPASA has the chance to encourage organisations to work together. This exercise can be used to assess what future issues will be when local organisations work together.

Actions

- Setting up a meeting with key stakeholders (from all organisations, sectors, including youth representatives) where an intensive condom campaign is planned. Address issues such as appropriate places for distribution, and confidentiality. How the campaign is going to be advertised should also be planned.
- Attainment of pamphlets and other educational materials, and condoms from Department of Health and other organisations.
- Monitor the number of condoms distributed and the locations from where large amounts were taken.

Drawing on National resources

Issue

- Peddie has neither a Health Promoting Schools programme or a National Adolescent Friendly Clinic Initiative, which are rapidly expanding programmes in other areas of South Africa. It has already been mentioned that there is a teacher in the Peddie area trained in the Health Promoting Schools approach, who might be encouraged to explore the possibility of linking with other initiatives, for instance in Grahamstown.

Action

- PPASA (Peddie) is in the position to draw on National PPASA (and international IPPF) resources that can be adapted to the local situation. Other possibilities for broader networking can be found in appendix 5.

2. Age appropriate SRH education

At present, any form of SRH education is done at secondary level. There is little, or no, primary level education that would address pre-adolescent SRH questions and needs. Although many people believe that primary school children should not be taught about SRH, the fact that very young people are engaging in sex illustrates the need to start education younger. However, this needs to be "age appropriate". In other settings, where SRH education has been addressed to younger children, there has been a delay in age of sexual debut, people have had fewer sex partners, and more have used

contraception¹⁰. If SRH issues are addressed at a level that the individual can understand, they can begin to make *their own* decisions regarding *their own* SRH. However, they need to be empowered to make their own informed decisions, take charge of their bodies and be responsible for their own health.

Setting up programs towards meeting youth SRH needs

Issues

- There is evidence that young people are having sex at an earlier age than the age where sex is usually discussed with them at school, if it is discussed at all.
- Very few young people have been spoken to about sex and related issues at school, even though some HIV/AIDS education has been done
- Young people, especially children, feel that they have no-one to talk to about sex
- Although most young people know what HIV and AIDS are, there are still some myths and misconceptions surrounding treatment and transmission
- There are high levels of ignorance around most other SRH issues such as pregnancy, menstruating, STIs, contraception and abortion at both primary and secondary school level.

Actions

- Age-appropriate programmes need to be put in place for educational institutions (schools, home, health care centers) to provide SRH education for both the older and the younger groups.
- PPASA can include key local stakeholders in the planning and implementation of locally relevant programmes. Networking with National organisations (see above) can help with creating the framework for such programmes.

Promoting individual involvement and responsibility in SRH

Issues

- There are high levels of ignorance around most other SRH issues such as pregnancy, menstruating, STIs, contraception and abortion at both primary and secondary school level.
- Some young people may already have engaged in sex, been pregnant, given birth, terminated pregnancies, had STIs or be HIV positive. It is of great importance that these individuals not be discriminated against by the focus of programmes, or the language used to discuss these issues.

Actions

- It must be ensured that every individual has the chance to empower themselves with the relevant knowledge they need to be able to make safer choices. Therefore, there need to be intensive information dissemination efforts by a variety of organisations. Churches, NGOs, local meeting places, schools and health service locations need to have pamphlets and other

¹⁰ Senderowitz, J. (2000) *A review of program approaches to adolescent reproductive health*. Population Technical Assistance Project, Arlington.

information available. Talks, rallies and public gatherings should be organized to raise the public profile and sense of concern around these issues.

- All people/organisations involved in information dissemination/education need to be sensitized to the fact that education is not about prescription, but empowering individuals to look after themselves better and make safer choices. This should be included as a crucial focus of any training or networking with other organisations that PPASA does.

3. Holistic SRH education

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes....It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. (ICPD, 1994)

SRH need not be in a specific health category on its own. Many programmes have benefited from including a health and wellness programme into their curricula. In this way, SRH is seen as being part of everyday health and hygiene.

Going beyond HIV/AIDS awareness

Issues

- There is some confusion around the difference between HIV and AIDS and there is considerable confusion around most other SRH issues such as pregnancy, menstruating, STIs, contraception and abortion. Whereas some of the basic facts are known, clearly the understanding of the body, of the physiology of the reproductive system, of human development, and such issues is wanting.

Actions

- Age-appropriate education programmes need to include aspects of human physiology, hygiene and health care, puberty/adolescence, morality, reproductive health, pregnancy, contraception, common infections (including STIs and HIV/AIDS) and prevention, sexuality, relationships, negotiation, and gender issues.
- Providers of basic education need to be trained in these other aspects so that the service they deliver can be holistic, and the area of their service can be provided within the context of overall SRH. For example, clinic staff are well-trained to provide information about contraception, how it works and how to use it. However, they might not include how to negotiate contraception use with a partner.

4. Getting parents involved

In order to promote sustainable and worthwhile learning in (pre)adolescents, parents need to be supportive, and endorse, the knowledge that is being presented to their children. Often parents might be offended at the nature of the education, or deem it unnecessary for others to become involved in SRH education of their children. However, the reality is that everywhere, a gap exists in communication between adults/parents and adolescents. Confirmed in this research is the fact that relatively few parents talk to their children about sex, although prevalence of parent to child talk about AIDS is encouraging.

Encouraging openness and communication

Issue

- Young people, especially primary school age, said that their parents rarely speak to them about sex
- Few young people feel that they have someone to talk to about sex
- Parents are more likely to speak to their children about AIDS than sex.

Action

- Run workshops with parents and older community members around adolescent development and sexuality of young people. Often older people need to be assured that sex and sexuality are normal aspects of development and it is better to speak to your children about this development than to ignore it.
- Activities can include how to communicate with young people about sex, and discussing the consequences of NOT talking to children about sex.

5. Programme development

This report describes the results of the first step of what should be an ongoing research process. In order to monitor the progress of certain projects and to assess whether the ASRH programme is meeting the needs of the Peddie youth, PPASA staff need to involve people in the evaluation of SRH activities.

- Involve young people in the planning, implementation and evaluation of projects
- Get continuous feedback

A major impediment to their work was the lack of transport. This was a huge limitation in that they were only able to work with the town and the immediate surroundings. They feel that for them to be most effective they have to reach out to the far-lying villages, which have limited access to information and services. This would have to be addressed with urgency for their efforts to have optimal impact.

6. Reflections on the process

The DCA conducted in the Peddie area was both a means to the end of systematically and comprehensively getting to know the context of SRH in the area, and an introduction of the PPASA programme to the area. The act of enquiry served to open discussion in the area on ASRH issues, and to get different constituencies and networks within the community to examine their stance on these issues.

Importantly by asking questions and conducting an audit of organizations in the area, the team were able to establish a firm foundation without intruding upon the territory of other organisations and interested parties. A firm collaborative foundation was established.

This process of enquiry proved to be an excellent and credible base for a programme on adolescent SRH and introduced the programme to young people and service providers of the area in a way that made it evident that the programme is to be based on an understanding of the context and on the basis of broad consultation.

The DCA framework proved to be a useful approach to the task at hand. The outcome is a contextually sensitive understanding which also contains sufficient quantitative data to be of value as a follow-up survey after the project has run for a few years.

The comprehensivity of the approach adopted meant that the PPASA team were able to gain insight into areas of importance at the outset, which may have otherwise taken

them a much longer time to accomplish. Through this process the team feels that it now knows where to start, what to do, who to work with and how to work with them.

Finally, the process of laying the foundation on the basis of a sound initial analysis has established a culture within the project team of basing action upon contextual understanding and evidence. If this same culture is maintained it will provide an excellent foundation for systematic programme development, monitoring and evaluation.

Appendix 1: Guideline questions for key-informant interviews

A: The Health Services		
What services are available?		
Health management system (local governance)	<ul style="list-style-type: none"> Where is this situated? (regional/district?) How does the health system work? Where are decisions made? What training do health staff have and offer? 	<i>This is probably a good place to start. This way you will be able to introduce yourselves to health office and find out what information is available to answer the other questions below.</i>
Testing	<ul style="list-style-type: none"> Is testing available? Under what conditions does testing occur (i.e. how do you go about being tested?)? How long do tests and results take? Is there pre- and post-test counselling? What happens when someone is HIV+? Are they referred anywhere? 	<i>It might be better to send a young person to a clinic to gather this information through the experience of being tested. What the staff tell you happens might not happen in practice.</i>
Condoms	<ul style="list-style-type: none"> Are condoms distributed? Where can you get condoms? How are they dispensed? How many condoms are distributed? Can you get condoms anonymously? Are condoms available all the time, or do they sometimes run out? 	<i>Different sites might have different ways of dispensing condoms and some places dispense more than others. It might be useful to indicate this on the map.</i>
Syndromic management (STIs and other)	<ul style="list-style-type: none"> Is syndromic management available? What is the protocol? What are the STI stats? 	<i>This type of information should be available at the district office.</i>
Educational information	<ul style="list-style-type: none"> What type of information is offered at various health service sites? E.g. posters, pamphlets What topics are covered? 	<i>It might be important to complete all the questions in A for each of the clinics / sites where health services are provided.</i>
Family planning services	<ul style="list-style-type: none"> Are they available? How is the service provided? What options are given to clients? How many people use this service? How many people under the age of 20? 	<i>Once again, this type of information should be available at the district office, but HOW this service is provided might differ from site to site.</i>
Termination of pregnancy services	<ul style="list-style-type: none"> Where are TOP services available? What information is provided to the client? What is the attitude of nurses towards TOP? Are TOP clients referred anywhere? 	<i>This service, for example, might have a link with the welfare services. It is important to note these links.</i>
Health service committees (including HAST)	<ul style="list-style-type: none"> What committees exist? Who is represented in each committee? What issues are discussed? Do they discuss 	<i>HAST stands for HIV AIDS STIs and TB. All districts have HAST committees that co-ordinate interdisciplinary activities and promote collaboration</i>

	<p>SRH issues?</p> <ul style="list-style-type: none"> • Are any of the committees specialised in HIV/Aids issues? • What are the current and future plans/activities of the committee? • When/how often do they meet? 	<p>between departments and services.</p> <p><i>There may also be other smaller committees.</i></p>
Other health-related programmes	<ul style="list-style-type: none"> • Are there any other programmes? • Details 	<p><i>There may be one-off projects that have occurred or are being planned as well as annual events that are related to SRH and HIV/AIDS.</i></p>

B: The Education System		
<i>Its structure and function in SRH</i>		
Schools	<ul style="list-style-type: none"> • How many • No. learners • No. educators • Location of schools 	<p><i>It would be useful to plot this information on a map as above. This may be available at the district education office.</i></p>
Education Management Structure (local governance)	<ul style="list-style-type: none"> • Where is this situated? (regional/district?) • How does the education system work? • Where are decisions made? • What training do educators have in terms of life-skills/ life orientation? Is this type of training available? 	<p><i>Often you will be able to identify a few key people who will be able to provide this information for you. It is a good chance to introduce yourself to the local education leaders and tell them what you are doing. Gaining their support will be very beneficial to your project.</i></p>
AIDS committees	<ul style="list-style-type: none"> • Are there? • How many people? • Who is represented? • When do they meet? • What is their emphasis? • What have they done and what are their future plans? • What kinds of programmes do they implement? 	<p><i>If a number of schools have these committees, collect the information for each of the schools.</i></p>
AIDS/SRH education	<ul style="list-style-type: none"> • Is there? • When is it done? • Content • How often? • At what levels? 	<p><i>This may also differ between schools. Collect this information for each one.</i></p>

	<ul style="list-style-type: none"> • Attitude of the educators when talking about these issues? 	
Life-skills/ life orientation	<ul style="list-style-type: none"> • Is this done in schools? Which schools? • Who is responsible for this? • At what levels is it done? • Is there an allocated 'guidance' period? • Syllabus/ content • Problems • Attitude of learners and educators towards life skills/ life orientation 	<i>Although SRH education may be incorporated into this section, it is important to identify how much SRH education is done and what other life-skills such as career guidance are offered.</i>

C: Welfare/ Social Development		
What is their involvement?		
SRH issues	<ul style="list-style-type: none"> • Are they involved? • How are they involved? • What communication do they have with the health services? • Do they have programmes for HIV+ people? 	<i>You may have answered these questions already.</i>

D: Community Organisations		
Who else has an interest?		
NGOs	<ul style="list-style-type: none"> • What NGOs are involved in SRH issues? • What NGOs deal mainly with young people? • Do they have special HIV programmes? Details of programmes. 	<i>It is also important to find out about the structure and function of these NGOs and how they are funded.</i>
Local Government	<ul style="list-style-type: none"> • Are they involved? How? • What are their plans? 	<i>Once again, a good opportunity to introduce yourselves.</i>
Stakeholders	<ul style="list-style-type: none"> • Who are they? • How are they involved in SRH issues and young people? 	<i>A stakeholder is a person or organisation that has a vested interest in certain aspects of a project. These might include funders, programme</i>

	<ul style="list-style-type: none"> • Do they have special programmes targeted towards young people and SRH including HIV/AIDS? • What are their plans? • Problems 	<p><i>might include funders, programme planners and implementers, participants/users and other organisations that provide services. For example: places where condoms are dispensed or pamphlets are available.</i></p>
Churches	<ul style="list-style-type: none"> • Which churches are involved with SRH issues and young people? • What is their attitude towards SRH? • Are there special programmes? • Who runs them? • What is their emphasis/content? • Problems 	<p><i>Different churches have different views about young people, sex and birth control including barrier methods. It is important to have a detailed understanding of these principles. Also important is how congregations view or adhere to these principles. Congregation size and characteristics (such as age) are also important to note. These may be related to the church's principles.</i></p>

Appendix 2: Focus Group Issues

Sexual information

Where do you get your information about sexuality?

Where do you get information about contraceptives?

Where do you get information about HIV/AIDS?

Where do you get information about STIs?

Communication

With whom do you discuss sex?

What are your parents' expectations about sex?

Sexual practices

At what age did you first encounter sex?

At what age are you expected to engage in sex?

What makes some people start having sex earlier than other people?

What is your attitude towards sex?

Is sexual abstinence practiced in your community?

Are there gay/lesbian relationships in your community?

What is the impact of alcohol and drugs on sexual practices?

Do people use condoms?

Relationships

What do you look for in a partner?

Who initiates relationships?

In a relationship, who has to be faithful?

What role do friends play in the faithfulness of a couple?

Do you get gifts/money from partners?

What meaning do these gifts have?

Are there commercialized relationships in your community?

Do they get paid?

Marriage

At what age are you expected to marry?

Are marriages voluntary or forced?

STIs

What do you know about sexually transmitted infections?

If you have an STI, where do you get it treated?

Pregnancy / contraception

Are the majority of pregnancies in your community planned or unplanned?

Are you using any form of contraception?

Were you given information about contraception to make your own choice, or was the choice made for you?

Do you know anything about emergency contraception?

Termination of pregnancy

What do you know about abortion?

Is abortion done at the local clinic?

How prevalent is abortion in your community?

What are the possible reasons for making a person have an abortion?

HIV/AIDS

How prevalent is HIV/AIDS in the community?

Are you personally at risk of contracting HIV/AIDS?

In your relationship, do you think about HIV/AIDS?

How does one determine one's HIV status?

What happens in an HIV test?

What is the difference between HIV and AIDS?

Can you see when someone is HIV positive?

What are the symptoms of HIV/AIDS?

What are the causes of HIV/AIDS?

VCT

What do you know about VCT?

Condom use

How widespread is the use of condoms in your community?

Are condoms easily accessible?

Who initiates the use of condoms in a relationship?

What is the attitude of the community towards condom use?

Commercial sex

Is commercial sex practiced in the community?

Rape / violence

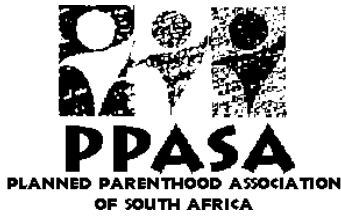
What is rape?

What do you know about child abuse?

Who rapes?

What makes people rape?

Appendix 3: Grade 4 Questionnaire (English translation)



Peddie

Grade 4

Make a tick (✓) in the box next to your choice.

1. Male	<input type="checkbox"/>	0	Female	<input type="checkbox"/>	1
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2. How old are you in years? _____

3 Have you heard about youth friendly health services before?				YES	<input type="checkbox"/>	0	NO	<input type="checkbox"/>						
4. In my home there is: (✓ all of those which are true)														
television	<input type="checkbox"/>	1	radio	<input type="checkbox"/>	3	newspaper	<input type="checkbox"/>	5	magazines	<input type="checkbox"/>	7	telephone	<input type="checkbox"/>	9

5. Where have you heard and seen information about AIDS in the past month (recently)? ✓ all of those which are true											
television	<input type="checkbox"/>	1	leaflets	<input type="checkbox"/>	7	Teacher/lecturer	<input type="checkbox"/>	13	friend	<input type="checkbox"/>	19
radio	<input type="checkbox"/>	2	Painted walls	<input type="checkbox"/>	8	Health educator	<input type="checkbox"/>	14	work	<input type="checkbox"/>	20
newspapers	<input type="checkbox"/>	3	meetings	<input type="checkbox"/>	9	nurse	<input type="checkbox"/>	15	Peer educator	<input type="checkbox"/>	21
magazines	<input type="checkbox"/>	4	plays	<input type="checkbox"/>	10	Priest/minister	<input type="checkbox"/>	16	other	<input type="checkbox"/>	22
Road signs	<input type="checkbox"/>	5	parent	<input type="checkbox"/>	11	AIDS community group	<input type="checkbox"/>	17			
posters	<input type="checkbox"/>	6	doctor	<input type="checkbox"/>	12	relative	<input type="checkbox"/>	18			

6. Have you ever heard of HIV or the disease called AIDS?				YES	<input type="checkbox"/>	0	NO	<input type="checkbox"/>	1
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7. What is the difference between HIV and AIDS? _____

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8. How does one get AIDS?

9. Can HIV/AIDS be prevented? How?	YES	0	N O	1

	1	2	3
	yes	no	Not sure
10. Do you have a relative who you think is <u>sick with AIDS</u> ?			
11. Do you have a relative who you think may have <u>died</u> of AIDS ?			
12. Do you have a <u>friend</u> who <u>is HIV- positive, sick or dead from AIDS</u> ?			
13. Is there anyone in your home that has died of AIDS?			

	yes	no	Don't know
	1	2	3
14. Do you think that a healthy looking person can be infected with HIV (the virus that causes AIDS)?			

	1	2
	yes	no
15. If someone in your family had AIDS, would you be happy for them to eat with your <u>eating utensils</u> ?		
16. Would you buy food from someone who has AIDS?		
17. If a teacher in a school has HIV, should they be allowed to continue working as a teacher?		

18. People with AIDS deserve it, they are to blame. .		
19. Are there people in your community who talk openly about having the AIDS germ?		
20. Are people in your community unkind to people with AIDS?		
21. If a student is HIV+ve, but is not sick, should he/she be allowed to continue attending school?		
22. If a member of your family became ill with HIV (the virus...) would you want it to remain a secret.		
23. Have you ever been in the same room or listened to a talk by a person who you know is HIV infected?		
24. Do you think there are people in your community who have the AIDS virus but do not know it?		

	yes	no	Don't know
25. Is it likely that you can get the HIV virus from kissing?			
	1	2	3
26. Is it likely that you can get the HIV virus from using the same cup?			
	1	2	3
27. Is it likely that you can get the AIDS virus if you touch the skin of an AIDS infected person?			
	1	2	3

	YES	NO
28. Have your parents warned you about AIDS?		
	0	1
29. Has a health educator or nurse ever visited your school to talk about AIDS?		
	0	1
30. Has AIDS ever been spoken about in your church?		
	0	1

	Yes	No	Not sure
31. Do you know what a 'sexually transmitted infection' is?			
	0	1	2

	<u>NOT AT ALL</u>	A LITTLE	QUITE A LOT	VERY MUCH
32. Have you worried before that you might have the HIV germ?				
	1	2	3	4
33. Have you discussed AIDS with your friends?				
	1	2	3	4
34. If you are at school has AIDS been discussed in class or lectures?				
	1	2	3	4

	YES	NO
35. Have your parents spoken to you about sex?		
	0	1
36. Is there someone in your family that you can speak to about sex?		
	0	1

	<u>NOT AT ALL</u>	A LITTLE	QUITE A LOT	VERY MUCH
37. If you are at school has AIDS been discussed in class or lectures?				
	1	2	3	4

38. Have you ever thought you should become involved in helping somehow with the HIV/AIDS problem	yes		0	no		1
39. Do you know of ways in which you could become involved in helping with HIV/AIDS	yes		0	no		2

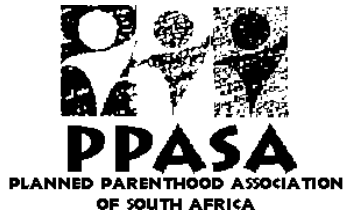
40. List the things which you have done to protect yourself from AIDS

41. How do you know when a person has AIDS?

42. List any questions about AIDS which you need to have answered

43. If something in the past really made you take the problem of AIDS more seriously what was it?

Appendix 4: Grade 11 Questionnaire (English translation)



Peddie

Grade 11

Make a tick (✓) in the box next to your choice.

1. Male	<input type="checkbox"/>	0	Female	<input type="checkbox"/>	1
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2. How old are you in years? _____

3 Have you heard of youth friendly services?	YES	<input type="checkbox"/>	0	NO	<input type="checkbox"/>	1
--	-----	--------------------------	---	----	--------------------------	---

4. In my home there is: (✓ all of those which are true)

television	<input type="checkbox"/>	1	radio	<input type="checkbox"/>	3	newspaper	<input type="checkbox"/>	5	magazines	<input type="checkbox"/>	7	telephone	<input type="checkbox"/>	9
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5. Where have you heard and seen information about sex, including AIDS in the past month (recently)? ✓ all of those which are true

television	<input type="checkbox"/>	1	leaflets	<input type="checkbox"/>	7	Teacher/lecturer	<input type="checkbox"/>	13	friend	<input type="checkbox"/>	19
radio	<input type="checkbox"/>	2	Painted walls	<input type="checkbox"/>	8	Health educator	<input type="checkbox"/>	14	work	<input type="checkbox"/>	20
newspapers	<input type="checkbox"/>	3	meetings	<input type="checkbox"/>	9	nurse	<input type="checkbox"/>	15	Peer educator	<input type="checkbox"/>	21
magazines	<input type="checkbox"/>	4	plays	<input type="checkbox"/>	10	Priest/minister	<input type="checkbox"/>	16	other	<input type="checkbox"/>	22
Road signs	<input type="checkbox"/>	5	parent	<input type="checkbox"/>	11	AIDS community group	<input type="checkbox"/>	17			
posters	<input type="checkbox"/>	6	doctor	<input type="checkbox"/>	12	relative	<input type="checkbox"/>	18			

6. What is the difference between HIV and AIDS?

	1	2	3
	yes	no	Andiqi niseka nga
7. Do you have a friend or relative who is HIV- positive, sick or dead from AIDS?			
8. Do you think that it is true that if you have sex with a virgin, you will be cured of HIV/AIDS?			
9. Have you ever had sexual intercourse?			
10. Do you know what a sexually transmitted disease is?			

11. Have you ever seen this (ⓧ) before?	Yes	No
	1	2
12. What does it mean?		

	1	2
	yes	no
13. If a teacher in a school has HIV, should they be allowed to continue working as a teacher?		
14. Are there people in your community who talk openly about having the AIDS germ?		
15. Are people in your school or community unkind to people with AIDS?		
16. If a student is HIV+ve, but is not sick, should he/she be allowed to continue attending school?		
17. If a member of your family became ill with HIV (the virus...) would you want it to remain a secret.		
18. Has a health educator or nurse ever visited your school to talk about Sexually transmitted infections?		
19. Have you parents spoken to you about sex?		
20. Have you parents spoken to you about AIDS?		
21. Has a health educator or nurse ever visited your school to talk about AIDS?		
22. Has AIDS been discussed in the class?		

23. Has AIDS ever been discussed in your church?

	yes	no	Don't know
24. Do you think that a healthy looking person can be infected with HIV (the virus that causes AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3
25. Is it possible in your community for someone to get a confidential test to find out if they're infected with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3
26. Have you ever had an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
	1	2	

	yes	no	Haven't had sex
27. Have you changed your sexual behaviour because of AIDS, even a little?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explain	1	2	3

28. Please list all the forms of contraception you have heard of...

29. What forms (if any) of contraception have YOU used?

30. Where do you get contraceptives in your area?

	YES	NO
31. Have you ever had a disease in your private parts (STD)?	<input type="checkbox"/>	<input type="checkbox"/>
	0	1
32 During the past 12 months did a sexual partner force you to have sex with them even though you didn't want to have sex?	<input type="checkbox"/>	<input type="checkbox"/>
	0	1
33. Have you ever discussed condoms with your partner?	<input type="checkbox"/>	<input type="checkbox"/>
	0	1

	YES	NO
34. I could stay in a relationship without sex		
	0	1
35. I'm scared of being tested for the AIDS germ.		
	0	1

36. If you have had sex before, think of the last time – about how old was your partner? _____

	yes	no	Don't know
37. Is it likely that you can get the HIV virus from kissing?			
	1	2	3
38. Is it likely that you can get the AIDS virus if you touch the skin of an AIDS infected person?			
	1	2	3
39. Washing after sex can protect you from AIDS.			
	1	2	3

	<u>NOT AT ALL</u>	A LITTLE	QUITE A LOT	VERY MUCH
40. Have you worried before that you might have the HIV germ?				
	1	2	3	4
41. Have you discussed sex with your friends?				
	1	2	3	4
42. I can discuss sex with at least one member of my family				
	1	2	3	4

43. Is there a place where you can go for confidential counselling?	yes	<input type="checkbox"/>	0	no	<input type="checkbox"/>	1
44. If yes, write down the name(s) of the place(s) you can go						

	YES	NO	Never had sex
45. Have you ever used a condom?			
	1	2	3

46. Did you use a condom the last time you had sex?			
47. If NO, what were your reasons?			
48. There is a place where I can get condoms privately (without others knowing)			
	1	2	3

	1	2	3
	Yes	no	Never had sex
49. Are you currently using any form of contraception?			
50. If YES, what?			
51. If NO, why not?			

	1	2	3
	Yes	No	Don't use
52. Does your partner know if you use contraception or not?			
53. If YES, are they in favour of you using contraception?			
54. Do your parents know if you are using contraception?			

	1	2
	YES	NO
55. Do you know where you can go to get contraceptives?		
56. Do you know where you can go for termination of pregnancy?		
57. Do you know where to get STD treatment?		
58. Do you know where you can get information about sex?		

	1	2	3
	YES	NO	Don't know
59. Condoms are usually safe as HIV protection			
60. Condoms are easy to get hold of			
61. Condoms protect you from getting sexually transmitted diseases			
62. If I use a condom I / my partner will not get pregnant			
63. If a condom breaks, you can go to the clinic and get emergency contraception			
64. I will use a condom with every new partner			
65. Do you know how to use a condom?			

	1	2
	YES	NO
66. Have you ever had sex for money or other gifts?		
67. If you have had sex for money more than once, do you always use condoms?		
68. Have you ever smoked dagga?		
69. Have you ever smoked dagga and then had unprotected sex?		
70. Have you ever got drunk on alcohol?		
71. Have you ever been drunk and had unprotected sex?		

72. How long would you use a condom for in a new relationship (✓ ONE)

Wouldn't use a condom	<input type="checkbox"/>	
Just the first time	<input type="checkbox"/>	1
For the first week	<input type="checkbox"/>	2
For the first month	<input type="checkbox"/>	3
For the first 6 months	<input type="checkbox"/>	4
Longer than 6 months	<input type="checkbox"/>	5
Would always use a condom	<input type="checkbox"/>	6

73. If you did stop using a condom in a relationship, what would the reason be?

74. Have you ever had a boyfriend/ girlfriend?	yes	<input type="checkbox"/>	0	no	<input type="checkbox"/>	
75. Do you have a steady sex partner at the moment?	YES	<input type="checkbox"/>	0	NO	<input type="checkbox"/>	
76. Do you have more than one sex partner at the moment?	YES	<input type="checkbox"/>	0	NO	<input type="checkbox"/>	

77. How many <u>different</u> sex partners have you had in the last 6 months (this year)?	0	1	2	3	4	5	6	7	8	9	More?
											number?

78. How old were you when you first had sexual intercourse? (age in years)
79. How old was the other person the first time you had sex?
80. Did you use any form of contraception the first time you had sex?

81. Have you discussed the risk of AIDS with your boyfriend, girlfriend or partner?	yes	<input type="checkbox"/>	1	no	<input type="checkbox"/>	2	Not applicable	<input type="checkbox"/>	3
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82. List the things which you have done to protect yourself from AIDS

	1	2	3
	yes	no	Never had sex
83. Have you ever have had sex with someone more than 10 years <u>older</u> than you?.			
84. Have you ever in the past been forced to have sex by a sex partner?			
85. Are you able to say no to sex if you do not want it?.			
86. Did you use a condom the <u>last time</u> you had sex? (answer even if you have a steady partner)			
87. Have you had sex in the last month?			
88. In the last six months have you had sex with someone who refuses to use a condom?			

89. How many days did you have sex in the last four weeks? (if none write 0)	<input type="text"/>
--	----------------------

90. Which of the following is true for you? (✓ only one)		
I am sexually active and <u>always</u> use condoms for HIV protection	<input type="checkbox"/>	1
I am sexually active and <u>sometimes</u> use condoms for HIV protection	<input type="checkbox"/>	2
I am sexually active and <u>never</u> use condoms for HIV protection	<input type="checkbox"/>	3
I am sexually active and <u>plan to</u> use condoms in future, but <u>do not use them yet</u>	<input type="checkbox"/>	4

I am sexually active and do not use condoms because me and my partner are not HIV infected		5
<i>I am not sexually active</i>		6

	1	2	3
	true	false	Don't know
91. A woman is more likely to fall pregnant during her period			
92. Sexually Transmitted Diseases (STD) cause infertility			
93. A woman becomes sterile if she uses injectable contraception?			
94. A woman is allowed to legally terminate her pregnancy up to 20 weeks (5 months)			
95. You can only terminate your pregnancy if you have been raped			
96. You can only get an STD from a woman			
97. You can only get the drop from sex			

98. What do you think happens at a clinic?
99. What do you think <i>should</i> happen at your clinic
100. What things does your clinic need to be able to provide in order to deal with your problems?
101. What difficulties do you have in trying to get health care?

102. List any questions about sex which you need to have answered

Thanks!

Appendix 5: Possibilities for National networking

HEALTH PROMOTING SCHOOLS (HPS)

Definition: A school that is constantly strengthening its capacity for healthy living, learning and working.

Health-promoting schools focus on creating conditions conducive to health and preventing disease. It creates healthy relationships both within the school setting and with the larger community.

This initiative is ideally jointly driven by both the Health and the Education Departments. Other Departments like Agriculture and Welfare have also been incorporated into Health Promoting School activities in the sites where the concept is already being implemented.

Who is involved: students, teachers, parents, community, health and education officials, community leaders etc. in a concerted effort to make the school a healthy place.

What a health-promoting school provides:

Takes a wider view of learning, including all aspects of school life and relationships with the community.

- Use of resources at its disposal towards learning and health (including physical, mental, social and environmental).
- Constantly adds to what it has (e.g. sick-room and providing 1st aid; deworming program; feeding scheme etc.).
- Teaches respect and nurtures a healthy value system (e.g. non-violence etc.) without undermining existing beliefs and attitudes.
- Recognizes good effort, initiative and achievements. Seeks to develop a positive self-image and sense of efficacy.
- Concerned not only with the health of students, but also families and the community as they have to recognize/ understand how they contribute to, or undermine, health and education issues (e.g. food sold, seeing to homework etc.)
- Teaches life skills! e.g.
 - to be health conscious
 - hygiene and sanitation
 - prevent tobacco use
 - nutrition
 - reproductive health (e.g. STDs)
 - physical activity etc.
- Encourages the exemplary role of staff and therefore improves relationships between students and staff.
- Holds open days – to invite even those not in school and to demonstrate what they have or have learnt.
- Encourages co-operative learning : where students help each other, participate in peer screening and disease prevention strategies.
- Constantly strives to improve, e.g. making pupils aware of services available and encouraging them to use them.
- Identifies children with problems (emotional or physical) and deals with these OR refers them.

- Promotes good attitude and peaceful solution to problems.
- Plays a role in helping children with long-term conditions (e.g. epilepsy) and or disabilities.
- Ideally, integrates and co-ordinates activities with other schools.

Though programs for different schools may be similar, there is no common template for action. Each school has to focus on its own unique assets, circumstances and problems, and will therefore come up with its own program of action.

NAFCI [National adolescent friendly clinic initiative]

This is a service geared towards the improvement of the quality of adolescent health services at the primary care level. Services offered here include: providing information, education, counselling and appropriate referral on sexual reproductive health, violence/abuse and mental health problems; providing contraceptive information and counseling; pregnancy testing and counseling; pre and post TOP counseling and referral; STI information (including HIV/AIDS); VCT and referrals. The emphasis is on providing for adolescent needs in a positive/conducive environment.

Stepping Stones

This is a training program for sexual and reproductive health. It addresses questions of gender, sexual health, HIV/AIDS, gender violence, communication and relationship skills. Use of participatory learning methods through peer group learning is made, with knowledge being affirmed through discussion and taking responsibility for own decisions.