Policy Brief:

Sexual and reproductive health of adolescents in Free State schools

1. Introduction

Unplanned adolescent pregnancies can hamper learning and career paths. Unprotected sex can increase the risk of sexually transmitted infections (STIs), including HIV/AIDS. These risks are especially high for girls. To counter these risks, loveLife and various government departments actively play a role in sex education in schools and communities. The idea is to provide information, facilitate communication and integrate sexual health services from various departments.

Despite these efforts, we need more evidence about adolescents' current perceptions and behaviours and the efficiency of prevention programmes. This policy brief reopens policy discussions.

2. Methods

The research stems from a collaborative project between loveLife and the Centre for Development Support at the UFS, involving researchers from the University of Cincinnati, Purdue University, the University of Houston, and Emory University. The Huffman Foundation funded the project, building on a prior project funded by the Bill and Melinda Gates Foundation. The originally planned project entailed a survey and an implementation phase to review the existing materials used for sex education. The second phase had to be abandoned because of the Covid-19 lockdown. The research team has, in the meantime, accessed funds for the second phase. This policy brief only reflects the survey results.

The loveLife programme focuses on communities and several schools in the Free State Province, all in deprived townships. The research team sampled five schools from a list of loveLife schools and ten schools from a list of all schools in township areas in similar-sized towns. The overall sample is representative of each of the province's four districts and Mangaung (the metropolitan area). We compare the data for the schools where loveLife was actively involved with the schools where loveLife did not have a direct footprint. The results are in the context of the Covid-19 lockdown, which severely limited social activities, free and organised recreation, and classroom learning.

The Free State Provincial Department of Education helped in the recruitment process. Each school had a coordinator who recruited learners aged 14 to 17. We obtained parental consent and the assent of participating pupils, who each received an incentive of R100. Data collection took place at the schools under the guidance of the project manager. The survey consisted of a self-administered questionnaire; the results in this policy brief are self-reported.

We recruited 1487 girls and 779 boys. (A further 58 answered 'other' to the question related to biological sex.) Although we aimed to have 50/50 gender representation, this did not materialise in practice.

We recruited 1487 girls and 779 boys aged 14 to 17.

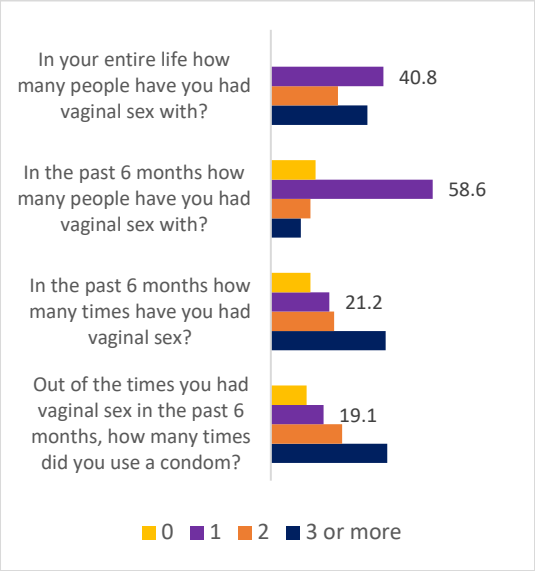
3. Main findings

We provide the results in a non-judgmental manner. Simply put, we are profiling existing behaviours to reveal the patterns. These patterns will form the foundation for the second phase of the project.

3.1 Sexual behaviour

Just over one-third (34.7%) of the respondents reported being sexually active. Figure 1 refers to this group.

Figure 1: Behaviours of sexually active respondents



The breakdown of the number of partners of this sexually active group is as follows: 41% reported having vaginal sex with only one partner in their entire life, 60% with only one partner in the past six months, 21% ever with more than one partner, and 9% with more than one partner in the past six months. (More boys than girls reported having multiple partners.)

3.2 Pregnancy history

Of the sexually active boys, 9.4% said their partner had fallen pregnant, while 12.6% of the girls said they had been pregnant. The percentage for the girls is lower than two decades ago and lower than the current average for South Africa. It is also fairly similar to national data that shows 7% of adolescents lose schooling because of pregnancy. The decrease points to the effectiveness of pregnancy prevention measures. Of those who had been pregnant, about 25% had had abortions.

3.3 Contraceptive use

Levels of condom use were high. Of the sexually active respondents, 76% said they had used condoms. Only 13% of respondents who said they had had sex in the past six months had not used condoms. Contraceptive injections (22%) and pills (12%) were the girls' main contraceptive methods.

The results point to high levels of condom use.

3.4 Communication with partners

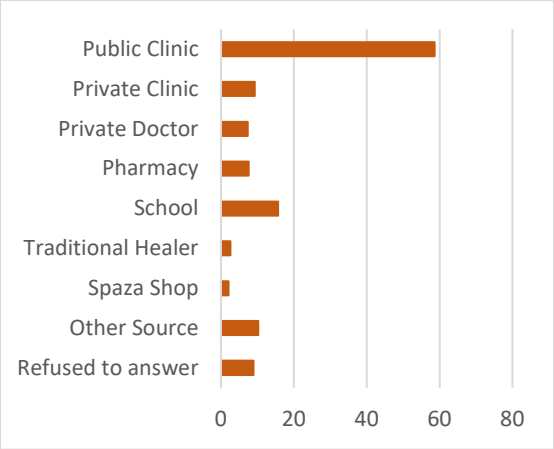
Open communication about sexual matters is important to ensure safe sex. The sexually active respondents said they found it easy to discuss condoms with their partners. It was easy to demand the use of a condom and even to refuse to have sex without a condom, but hard or very hard to discuss the number of partners they had had or to talk about STIs. The girls found it easier than the boys to talk about sex and reproduction. Overall, the results indicate a considerable shift over the past two decades and suggest that communication about sex is easier than we had anticipated.

3.5 Sources of information

We need to know where adolescents get sexual health information and what sources they value. We found that clinics and

schools are the main sources, with 70% of respondents saying this is where they get their information (Figure 2).

Figure 2: Place where sexual health information was obtained



Where loveLife had a presence in the schools, it was responsible for 20% of information the respondents obtained. Public health clinics were the source of information about contraception, STIs and HIV for about 60% of the respondents.

3.6 HIV testing and status

Nearly 60% of the respondents said they had been tested for HIV, and 80% said they knew their HIV status. Testing for STIs was lower at 28%, with 40% of those tested saying a doctor had told them they had an STI in the past six months.

60% of respondents said they had had an HIV test.

3.7 Acceptability of contraceptive methods

The use of contraceptives often depends on how acceptable they are to the users. Condoms had the highest acceptability rating as a contraceptive method (about 85%). The second highest rating (55%) was for the contraceptive injection. Abstinence also had a high rating (45%). Free condoms and clinic services played a big part in acceptability. Not having to pay was of central importance to our respondents.

3.8 loveLife vs non-loveLife schools

In comparing the two types of schools, we found that respondents from loveLife schools were more open and effective communicators about sexual and reproductive matters. They found it more acceptable to know about these things, as they got their information from teachers and elders or older sisters. (These differences between loveLife and non-loveLife schools were statistically significant.) Other things they found more acceptable were receiving information from parents, refusing to have sex, and engaging in sports activities (reflecting the balanced approach to life that loveLife promotes).

They were less likely to have sex or fall pregnant, but they were also less likely to use a variety of contraceptives and STI and HIV prevention methods.

Respondents from loveLife schools were less likely to have sex or fall pregnant.

3.9 Mental health

The results show a substantial decline in socio-emotional well-being. We used the CES-D-10 instrument, which is a good depression screening tool, despite criticism. The data we obtained from this survey

during the Covid-19 lockdown shows a substantial deterioration in the girls' mental health compared with a similar survey of adolescent girls in Mangaung in 2018. The lockdown harmed adolescents by inhibiting learning and socialisation, and in some cases this was exacerbated by shortage of food. In 2018 the screening tool showed that 21.7% of respondents exceeded the cut-off score of 12, indicating a risk of depression. The percentage was 36.9% in the present survey.

Girls' mental health had deteriorated since a similar survey conducted in Mangaung in 2018.

3. Recommendations

The following main recommendations include:

- Since adolescent boys find it more difficult than girls to talk about sexual matters, we suggest that sexual health intervention content could benefit from tailored messaging, though the core content would remain the same for both sexes.

- Interventions should build on the strengths of current prevention messaging systems, such as peer education as done by loveLife, since our results showed lower levels of pregnancy at the loveLife schools in our sample.

- Sexual health interventions should emphasise STI and HIV testing and treatment, coupled with practices to reduce these infections (such as consistent condom use).

Interventions should build on the strengths of current prevention messaging systems, such as peer education as done by loveLife

- Sexual health interventions should focus on clinics and schools as the sources of sexual and reproductive health information, as these sources were found to be the most acceptable to our respondents.

- The messaging content and approach should be reviewed every four to seven years by soliciting the input of adolescents.

The messaging content and approach should be reviewed every four to seven years by soliciting the input of adolescents.

- Ongoing mental health screening and monitoring is essential, along with additional mental health services and support.

- The effectiveness of loveLife and other behaviour change programmes should be recognised in providing sexual health messages to adolescents.

Enquiries:
mmokoene@lovelife.org.za
MaraisJGL@ufs.ac.za