

# SCHOOL-BASED REPRODUCTIVE HEALTH EDUCATION

*“Children are sexual, and it is up to us to take responsibility for their real education. They have been exploited and betrayed long enough by our silence” Jane Rule, The Body Politic*

*“All children have the right to education on issues such as sexuality, AIDS, human rights...” The Children’s’ Charter of South Africa, 1992*

*“...[P]romoting health through schools is one of the most efficient and effective ways to improve our children’s lives....” WHO, 1996b*

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## **1. Background of this Work**

The Health Systems Trust (HST) funds and provides technical support for research which aims to influence policy and planning which will improve quality of health service delivery in South Africa. In 1996, the Health Systems Trust launched a Reproductive Health Fund (RHF). One of the defined fund priorities is adolescent sexuality-related issues. In keeping with this mandate, one specified concern within adolescent sexuality is promotion of reproductive health within schools.

Since the start of the RHF, several proposals have been submitted to HST focused on various aspects of school-based reproductive health promotion. Given the tremendous response, need for a coordinated research agenda in this regard became increasingly apparent. As a beginning, in May of this year a one-day HST workshop brought together researchers and government officials with interest in school-based reproductive health research from throughout South Africa.

In the course of the workshop it was decided to broaden the scope of research efforts to include not only school-based initiatives but also those focused on adolescent reproductive health education outside the school context. Group discussions also revealed that many school-based initiatives have been tried or are currently being developed. Thus, one concern voiced by the group was the risk of duplication of existing work. To address this problem, it was agreed that a rapid appraisal of current work in the form of situation analysis should be undertaken.

This document is the result of HST's interest in facilitating adolescent reproductive health, and the need for clarity on the state of sexuality and reproductive health education<sup>1</sup> among South Africa's youth. While we hope this information will go far in describing current trends and fostering ideas for future research, it is not without its limitations. The project was commissioned for a period of three months, largely due to the urgency with which the information is needed. However, the content is confined by what we were able to accomplish in that period with regard to both school-based initiatives and those outside the school context. In addition, due to time constraints we have limited most of our coverage to the KwaZulu/Natal region, though we have tried to include information on various efforts countrywide. We hope that KwaZulu/Natal will serve as a case study from which those involved in reproductive health education throughout South Africa may learn and benefit. Though it is a regional focus, it is likely that workers in other parts of the country have encountered similar issues and problems in adolescent reproductive health education initiatives.

## **2. Promoting Youths' Reproductive Health Through Schools**

When considering the connection between youths' reproductive health and education, a flurry of questions come to mind regard:

- where, when and how such efforts should take place?

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<sup>1</sup> The terms "sexuality education" and "reproductive health education" will be used interchangeably from this point forward.

- who should be charged with implementing them?
- are schools the best place for reproductive health promotion and education?
- who should take responsibility for school-based sexuality and reproductive health education efforts on a national, provincial and local level?
- what roles can teachers, parents and community play in providing and fostering youths' reproductive health?
- among which age-groups should it begin?
- what should be the content of sexuality and reproductive health education efforts?

These are only a few of the mind-boggling issues to be addressed regarding the relationship between reproductive health and schools. In this section we examine both international and regional perspectives on this issue.

## ***2.1 International Perspective***

Recently, the World Health Organization (WHO) undertook a detailed 5-year study of ways to improve health promotion through schools. The study touched on barriers to school-based health promotion which cut across local, district/county, state/province, national, and international levels. In addition, a list of recommendations for improvement of school health programs was drafted (WHO 1996a, 1996b). Though the work examined the relationship between schools and health promotion in a broad sense, its findings and recommendations can be of tremendous assistance in the reproductive health forum. As a starting point for examination of these issues in the South African context, we briefly summarize the main findings of the WHO Expert Committee on Comprehensive School Health Education and Promotion.

### ***2.1.1 Barriers***

#### ***At Local Level***

- school health programs not perceived as important by communities
- poor school infrastructure due to political and economic changes
- community and school officials' lack of knowledge about program implementation.

#### ***At District/County Level***

- vague delegation or assumption of authority, responsibility, resources  
⇒ education vs. health departments
- vague jurisdictional boundaries  
⇒ differing boundaries for education and health departments

#### ***At. State/Provincial Level***

- poor capacity to aid district and local program development and implementation
- poor staff management, organization and skills ability  
⇒ responsibilities relegated to junior staff  
⇒ bureaucratic red tape delays

### ***At National Level***

- awareness by education and health officials of importance and mutual reinforcement of education and health
  - ⇒ education level correlates with health and health-seeking behavior
  - ⇒ good health fosters increased learning ability
- implementation of policies and allocation of resources to support school health
- coordination among relevant agencies addressing school health issues
- knowledgeable, motivated, trained staff to plan and manage school health initiatives

In addition to these level-specific barriers, the working committee also described three general, common, and inter-related problems “of overriding importance and priority for action because they cross all levels”(WHO 1996a:5). These were:

- Inadequate understanding and acceptance of school health programs
- Inadequate collaboration between relevant agencies in designing and implementing effective school health programs
- Inadequate foresight and strategic planning concerning the potential for achievement in school health programs

### ***2.1.2 Recommendations***

The committee also provided 10 recommendations as responses to the question “What Can We Do to Help Create More Health Promoting Schools” (WHO 1996b:5). We have selected and adapted seven of these recommendations which appear most pertinent to southern African concerns.

#### ***A.. Schools Must Provide Safe Learning & Workplace Environment for Students and Staff***

- provide safe water and sanitary facilities
- protect from infectious diseases
- protect from harassment, physical and sexual abuse, discrimination, violence
- reject use of tobacco, alcohol, illicit drugs

#### ***B. Schools Must Enable Youth at all Levels to Learn Critical Health and Life Skills***

- focused, developmentally appropriate, skills-based education
  - ⇒ stressing topics like reproductive health and preventive health
- comprehensive, integrated life skills education
  - ⇒ to enable children to make healthy choices and adopt healthy behavior
  - ⇒ to assume responsibilities of adulthood

#### ***C. Schools Must Serve as an Effective Entry Point for Health Promotion and Intervention***

- strive to act as an efficient, cost-effective part of community health care system

***D. Development of School Health Supporting Policies, Legislation, Guidelines***

- identification, allocation, mobilization, coordination of resources at all levels

***E. Teachers and School Staff Must be Valued and Supported in Health Promotion Efforts***

- resources and training to address students' health and education needs
- involvement of tertiary education institutions in training new teachers and staff
- involvement of non-governmental organizations at all levels of health promotion
- providing staff and teachers opportunities to improve their own health and life skills

***F. Cooperation of Community and School in Supporting Health Promotion and Education***

- community advocacy groups
- family involvement in children's health promotion and education
- community outreach by schools

***G. Well-Designed, Monitored and Evaluated School Health Programs***

- ensures successful implementation, outcomes and sustainability
- development of appropriate, affordable rapid analysis methods
- development of appropriate affordable dissemination methods
- involvement of local community members in research and evaluation

***2.2 Regional Perspective***

In the southern Africa region, there is a growing body of research addressing the connection between reproductive health, knowledge, and school-based education efforts (Schoeman 1990, Flisher et al. 1993, Matthews et al. 1995, Mbizvo et al. 1995, Ratsaka & Hirschowitz 1995, Buga et al. 1996, Crewe 1996, Mbizvo 1996, Fuglesang 1997, Rusakaniko et al. 1997). These studies provide important conclusions regarding the connection between school-based sexuality education and adolescent reproductive health promotion in the African context. Common themes include:

- Call for monitoring and evaluation of school-based programs
- Need for basic research on factors affecting adolescent sexuality, behavior and knowledge
- Need for holistic approach to understanding adolescent sexuality & behavior determinants
- Recognition of many school-children's inadequate reproductive health knowledge
- Recognition of significant reproductive health problems among adolescents
- Conflict between adolescents' sexuality-related attitudes, beliefs, and practices
- Need for construction of culturally sensitive educational materials

- Need for partnership between schools, communities and education/intervention efforts
- Need for inter-disciplinary, holistic approach in designing sexuality education programs
- Need for early school-based reproductive health education programs
- Need for links between government & NGO sectors in providing sexuality education

### **3. Historical Trends in Sexuality and Reproductive Health Education**

A historical focus is vital in understanding contemporary situations. Such a perspective is particularly important for South Africa, a country in the midst of struggling with the social, economic, and political legacy of nearly half a century of extreme apartheid policies. In this section, we provide a brief historical overview of trends in sexuality and reproductive health education in the KwaZulu/Natal region. Most of the information included here is drawn from interviews with individuals involved in governmental and non-governmental education and health sectors prior to 1994. Our review illustrates the fact that many contemporary problems - practical, organizational, and philosophical - facing education initiatives in youth sexuality and reproductive health promotion can be directly traced to events occurring before the 1994 national election and subsequent amalgamation of government agencies. We hope that in describing past events we will assist the formation of future policy and practice; and help create a stronger, more informed approach to sexuality and reproductive health education both in schools and the community.

For nearly forty years, government-provided education was racially segregated in South Africa<sup>2</sup>. Prior to 1994, there were five departments of education in what is now KwaZulu-Natal Province<sup>34</sup>. These were:

- Natal Education Department (NED) for White students
- House of Delegates (HOD) for Indians
- House of Representatives (HOR) for Coloured students
- Department of Education and Training (DET) and KwaZulu Department of Education (KZ) for black African students. The former managed schools for black African children in non-”homeland” areas, and the latter was responsible for “homeland” schools.

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<sup>2</sup> In 1953, under the Bantu Education Act the central government took control of public education for Black Africans, and in the process made it nearly impossible for non-governmental schools (such as mission schools) to continue. During the 1960's similar moves were made to assume control of Coloured and Asian education (Thompson 1990).

<sup>3</sup> The same divisions would have applied to other provinces and homeland areas in South Africa.

<sup>4</sup> In real terms, the segregated nature of education began to ease in the early 1990's. By 1991, many private and government schools nationwide had begun to admit students from different ethnic groups, and in 1992 the Education and Training Amendment Act further eased restrictions by providing local school councils and government boards with the power to admit students from previously segregated communities (Official Yearbook of South Africa 1992, SAIRR 1992/93).

There were marked discrepancies in funding and resources between these departments. For example, in 1983/84, state expenditure on education per head for Black Africans was in real terms one-tenth that of White students (Wilson & Ramphele 1989). Such discrepancies were still very apparent until quite recently. In 1991/92, per capita expenditure on pupils by ethnicity was: Black Africans R1,248<sup>5</sup>, Coloured pupils R2,701, Whites R4,448 (SAIRR 1992/93)<sup>6</sup>. This led to obvious - and in many cases quite extreme - disparities in the quality of education provided regarding staffing, resources, management and maintenance of facilities (Wilson & Ramphele 1989). Given this state of affairs, what was taking place in these divisions with regard to reproductive health and sexuality education?

### ***3.1 Natal Education Department (NED)***

In the NED, there were modules developed for schools, primarily for use among secondary school students. These included sex education and life skills, and were developed by the NED in conjunction with Natal Provincial Authority (provincial health authority; NPA) and members of departments of education at local universities such as University of Natal - Pietermaritzburg. The curriculum used was called “family life education”, and included topics surrounding family members’ interactions, family roles and responsibilities, self-esteem and responsibility training, marriage and parenting, conflict resolution, stress management, and sexuality education. The latter was quite

comprehensive its coverage of both biological and social aspects of human reproduction and sexuality. Also included were lessons on potentially sensitive issues such as contraception, sexual abuse and incest, and homosexuality; though it was left to teachers’ discretion as to which topics were covered. The curriculum made use of both lecture format and inter-active participatory teaching methods such as role-plays and drama. The latest version included lessons for primary school children, though these were implemented more rarely than those for older children. The curriculum was widely used, and in some cases adapted for use in other educational systems such as the HOR and some HOD schools. It does not appear to have been formally evaluated while in use.

Periodic teacher training initiatives took place, often run in connection with trainers from NPA. Generally, the school principal and 2 teachers were trained. Training periods were short, lasting from a half-day to 3 days. Several former NED and NPA trainers maintain such training sessions were ineffective for two reasons. First, they were too short to be thorough. Many teachers lacked basic reproductive health knowledge to be able to teach the subject effectively. Second, and perhaps more important, it appears many teachers were themselves uncomfortable with sexuality-related issues, and the training periods did

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<sup>5</sup> Spending was even lower in “homeland” areas. In KwaZulu, per capita expenditure on education was R440; in “independent homelands” it averaged R523 per pupil (SAIRR 1992/93:52).

<sup>6</sup> Expenditure on Indian pupils was unavailable.

not provide them with sufficient time to overcome personal barriers in this regard, muchless be prepared to discuss such topics with students.

Sexuality education was most often conducted during school “guidance periods”. However, as the topic was not an examinable subject, such instruction was often erratic and lax. One former NPA official described the situation, “As the year progressed and things got more harried and time became short, periods which were supposed to be used for sexuality education were neglected in favor of subjects that needed more attention in preparation for examinations. It was impossible to keep it going, because it really was not considered a very important subject. The guidance periods in schools were generally a melting pot of issues, and often sexuality education got pushed to the side when higher priority issues came up”.

Despite limitations, innovations did take place in the NED system. One initiative in particular concerned introduction of sexuality and life skills education to pre/primary school children. Designed and piloted in 1992 by an NED specialist in primary and life skills education, the program, called “Educating for Life”, was based on a holistic model of health and personal functioning. It was aimed at pre/primary school children between the ages of 3 and 6 years, and consisted of five modules: life skills of sexuality, self-esteem and responsibility training, decision-making and problem solving, values clarification, assertiveness training and effective communication (Educating for Life, 1991). According to its founder, the philosophy behind the program was that “life skills [should] offer the ability for the individual to *choose and evaluate* how to live life ...It is an ‘informed’ way of living...[which] allows one to make decisions and take control”.

Teaching approaches reflected this philosophy. They included role plays and drama, artistic interpretation, instructional videos, and school visits by pregnant women who discussed the experience of pregnancy with children. At various points after delivery, mothers were asked to return to classrooms with their babies. In this manner school children could observe aspects of neonatal development. Moreover, teachers and other school staff were asked to participate in life skills development, thereby contributing to the health promoting environment of the school community. Since its inception the Educating for Life program has been modified for culturally diverse classrooms and been adopted by 29 primary schools throughout KwaZulu-Natal. It has not been formally evaluated.

### ***3.2 House of Delegates (HOD)***

After initial discussions with the NED for use of existing family life education materials, a decision was made by HOD officials to create educational materials specifically for use in Indian schools. Such a decision was taken because it was felt certain social and cultural issues concerning sexuality would best be handled internally. However it appears that the curriculum was confined to nutrition and reproductive physiology and did not address broader life skills-related aspects of sexuality. Some have suggested the narrow content and the general ineffectiveness of the material in schools was a reflection of the fact that it

was not designed by educationists, but HOD bureaucrats “who knew nothing about teaching or about how to convey ideas - especially about sensitive issues like sexuality”.

The HOD also had teacher training programs. Training generally consisted of half-day seminars provided by doctors or university lecturers, and was primarily on reproductive health facts. One former HOD teacher who attended such a seminar described the experience, “They had something like 9 speakers during a day that lasted from 8:30 in the morning until 2 in the afternoon. What can you get from such a packed timetable? None of them had experience with children or teaching - lots of theory and no practice...”

One reason sexuality education efforts in former HOD schools have been considered ineffectual concerns which teachers were given the task of teaching sexuality education. According to another former HOD teacher, sexuality education was the responsibility of guidance teachers, junior staff members, or those out of favor with the principal. Guidance teachers were the “dumping ground for all unpopular subjects” and junior staff members often recent training college graduates who were inexperienced. That the task of teaching sexuality education was often assigned as a means of punishment is sad reflection of its perceived lack of importance by school officials, and likely had extremely negative effects on teachers’ attitudes and ability - and thus success - in conveying such information to students.

Choice of teachers engaged in sexuality and health education also illustrates the lack of the school system’s endorsement for such efforts. The predominant sentiment among those interviewed was that even if HOD teachers had been well-trained or supported sexuality or life skills education, they would eventually fail due to the unsupportive atmosphere in the school systems and negative attitudes of their superiors; many of whom were said to consider sexuality and health education wasted time compared to examination subjects.

Many teachers felt overwhelmed by the awareness for the need for sexuality education for students but inadequate resources to provide such information. A former NED official described the “panic” with which HOD teachers asked for help. Without official HOD support, she described the NED’s limited means of responding to such requests, “This put us in a difficult position because it wasn’t our territory, so to speak. We had no jurisdiction to offer help or intervene without permission - or solicitation from the Dept. of Education (House of Delegates). We were helpless and had to keep refusing them and turning them away.”

For these reasons, school-based sexuality education in HOD schools was generally neglected. It became a task left to non-governmental organizations (NGOs) and agencies such as city health departments to give occasional lectures. Such organizations entered schools only at the behest of school officials, and thus sexuality education from these sources was sporadic and of varying quality.

### **3.3 House of Representatives (HOR)**

Sexuality education in HOR schools was generally the domain of school psychologists. Nonetheless, in the late 1980' and early 1990's there were only 2 educational psychologists allocated for all HOR schools in the KwaZulu-Natal region. According to the 1991 South African census, the Coloured community of the Natal region numbered 118, 300, approximately 2.0% of the provincial population (SAIRR, 1992/93). Thus, for obvious reasons, sexuality education within the school system was hampered in part because of inadequate staffing. Teacher training initiatives for sexuality and life skills education did exist, with the school principal and 2 teachers required to attend. Some training programs were administered through the HOR system itself, and others were run by NPA staff. The latter were generally week-long workshops based largely on the NED Family Life Education curriculum. Despite some opposition from teachers on religious grounds, many of the NPA workshops were successful, and met with the approval of school staff, parents, and other community members. Innovative teaching techniques such as drama and role playing became popular approaches, and in some cases peer education groups visited schools which had no sexuality education. In this manner, support for sexuality and reproductive health education in Coloured communities increased dramatically.

Despite such auspicious beginnings, sexuality and reproductive health education initiatives in HOR schools were generally not sustained. One problem teachers encountered in attempting to teach sexuality and life skills was their inability to handle multiple, and often conflicting roles; to be both academic disciplinarians and friendly facilitators for students' life skills enrichment. Teachers reported being ill at ease with such "role reversals" in the school context, and felt students were also confused by such dynamics.

A major obstacle in HOR schools' sexuality education efforts appears to have been lack of infrastructure and resources to address matters arising from the increased awareness wrought through these initiatives. The unmet need for means of solving community problems became overwhelming, and eventually led to the discontinuation of any

systematic school-based sexuality and life skills education efforts. As noted above, the HOR Dept. of Education was extremely under-staffed, and other agencies were also unable to provide resources or support for managing such problems. Moreover, NPA efforts to provide crisis management workshops for school staff and community members were not enough for long-term effectiveness. A former NPA employee involved in HOR teacher training programs described the situation in the following way:

***"...[W]hen people really started thinking about the issues which came up in the sexuality and life skills courses, many more community problems surfaced - incest, rape, abuse... People started talking about these things...and the worst thing about it was that once they had articulated and realized these problems...they also found they had no resources***

*available to solve these problems. There was nowhere to turn except the misery of helplessness. What good was life skills if it only made you more aware of your helpless plight ... and the misery of your community? The community just couldn't cope with the workload and was completely unresourced, unable to deal with such responsibilities and problems and their need to be solved."*

### **3.4 Department of Education and Training (DET) and KwaZulu Schools (KZ)**

As described above, compared to others DET and "homeland" education systems were poorly funded and resourced. The host of problems faced by these school systems is described in stark detail by Wilson & Ramphele (1989; see also UNICEF 1993), and includes barriers such as:

- vast rural/urban differentials in accessibility to primary and particularly secondary school education
- shortage of and decrepit physical state of school buildings
- poor access to teaching materials
- high teacher pupil ratios
- poorly trained teachers<sup>7</sup>
- low morale and subsequent lax and abusive behavior of teaching staff
- hunger and malnutrition among students.

Perhaps it is partially for these reasons that DET and "homeland" school systems relied almost exclusively on government health services and NGOs to provide sexuality and reproductive health education.

Generally, in DET and KZ school systems sexuality education was considered the domain of school nurses and in some instances local clinic staff<sup>8</sup>. There appears to have been no set curriculum or materials used for sexuality education. Moreover, visits by school nurses were hampered by many of the barriers the education system itself faced. Such obstacles included lack of adequate staffing and funding, bureaucratic and systems-level inefficiency, and transportation problems (KwaZulu Health Dept. Annual Report 1993, UNICEF 1993, Memela & Jinabhai 1996, Taylor et al. 1996). With these limitations, school health teams urged greater participation of teachers in health education efforts, and the need for expansion of "interdepartmental liaison" between KwaZulu Government Departments of

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<sup>7</sup> Two figures illustrate the poor qualification of teachers in Black African schools. In 1982, two-thirds of all African teachers in KZ schools had not matriculated (Wilson & Ramphele 1989). Moreover, in 1991 16% of all teachers employed by DET and "homeland" education departments in the country had not matriculated (SAIRR 1992/93:608-609).

<sup>8</sup> In the 1993 KwaZulu Health Department's Annual Report, besides their required medical duties, clinic nurses were "encouraged to become actively involved in local projects such as gardening, sewing, handicrafts... and health education on AIDS and other [aspects of health education]" (p. 36). This illustrates not only the multiple (overburdened) roles the community nurse was expected to fulfill, but perhaps also the perceived lack of importance of HIV/AIDS education - as a sideline community activity to be done in one's spare time.

Health and Education were stressed (*ibid*, p. 36). This was particularly the case as HIV/AIDS became a major health concern in the KwaZulu/Natal region in the early 1990's (KwaZulu Health Dept. 1993:28). However, even recently, many teachers who did cover health education in class confined such instruction to nutrition and personal and environmental hygiene (Taylor et al. 1996).

In some cases DET and KZ teachers themselves sought out training in sexuality and life skills from agencies such as the NPA. Such efforts seem to have been hampered by obstacles such as racial tension, gender issues, conflicting attitudes and beliefs regarding the appropriateness and content of sexuality education in schools, and lack of administrative support. For example, a former NPA trainer described the entire first day of a training session in northern Zululand spent arguing with male teachers over the inappropriateness of a Zulu-speaking female trainer who wore trousers and make-up. Eventually, like many other education systems in the country, the DET and "homeland" education departments came to depend on NGO programs for the majority of school-based sexuality and reproductive health education.

Particularly relevant to the Black African population - as well as to many Coloured communities - was the issue of reaching children living in informal settlements, attending rural farm schools, or not in school. Concerning those in informal settlements, problems associated with school attendance were magnified due to even greater deficits in resourcing and access. Particularly problematic was the fact that preference for secondary school admission was given to children from local feeder primary schools. Thus, due to lack of residential stability, children in squatter communities were often at a distinct disadvantage in access to secondary school education (UNICEF 1993). In 1991 there were an estimated 864 informal settlements in South Africa, with between 3.5 and 7 million inhabitants (SAIRR 1992/93).

It has been estimated that as many as 1.5 million children and youth were resident on White-owned farms in the late 1980's and early 1990's SAIRR 1992/93). Traditionally, education of Black African and Coloured children living under such conditions was state subsidized, but largely under the control of farmers themselves. Therefore, "the establishment and maintenance of schools was dependent on the farmers' goodwill" (UNICEF 1993:68). It was generally thought that farm schools were among the worst in all education systems (*ibid*).

Unlike the other educational systems in the country, where schooling between the ages of 7 and 16 years was required by law, school attendance was not compulsory for Black African children as late as the early 1990's (Thompson 1990, UNICEF 1993, SAIRR 1992/93). Compounding this problem was the fact that school attendance was not especially high in many Black African communities. A 1988 study of school attendance in Nkandla (rural northern Zululand) cited by Wilson and Ramphela (1989: 142) found that the proportion of school-aged children attending school was 47.0%, substantially less than

official figures for the district. In 1992, nationwide nearly 40% of Black African primary school-aged children and approximately half of secondary school-aged youth were not receiving formal education. This translates into nearly 2 million children out of school (Official Yearbook of South Africa 1992:165, SAIRR 1992/93:600)<sup>9</sup>.

Given these barriers to education, it is unlikely that school-going - much less out of school - Black African youth were provided with adequate knowledge or skills to promote reproductive health.

### ***3.5 Why Have Sexuality Education Efforts Failed?***

In sum the reasons that school-based reproductive health and life skills education efforts have historically failed in the KwaZulu/Natal region include:

- ***Division and Unequal Resource Allocation between Education Departments***
  - ⇒ per capita spending and poor staffing
  - ⇒ poor teaching materials
  - ⇒ inability to share resources between systems
  - ⇒ tensions between systems
- ***Lack of Systems-level Support for School-based Sexuality Education***
  - ⇒ viewed as unimportant; not an “examination subject”
  - ⇒ not perceived as school system’s responsibility
  - ⇒ poor timetable allocation for sexuality education
  - ⇒ stigmatization by school officials
- ***Inadequate Preparation and Training of Teachers***
  - ⇒ poor knowledge of facts
  - ⇒ low self-awareness of life skills and sexuality issues
  - ⇒ short training periods
  - ⇒ inappropriate choice of trainers and teacher participants
  - ⇒ inappropriate teaching materials
  - ⇒ conflicting teacher roles in school community
  - ⇒ overburdening of teacher responsibilities
- ***Lack of Community and Systems-level Resources for Education Aftermath***
  - ⇒ HOR experience
  - ⇒ no complementary community-based counseling and welfare services
- ***Reliance on NGOs and Other External Agencies***
  - ⇒ sporadic instruction
  - ⇒ varying quality of instruction
- ***Lack of Programmatic Evaluation***
  - ⇒ inability to assess effectiveness of existing programs

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<sup>9</sup> As a result of such neglect, it was estimated that in 1993 less than half the Black African population aged 20 years or more could be considered literate. The same study estimated that Black Africans had an average of 5 years of total schooling (NEPI 1993).

### ***3.6 Nearing 1994 and Beyond***

Leading up to the 1994 election and in the three years since, there have been considerable efforts to restructure education policy and action. Supported by Nelson Mandela, March 1992 witnessed the National Education Conference in which delegates from diverse organizations such as the African National Congress (ANC), AZAPO, COSATU, the National Education Crisis Committee (NECC), the South African Democratic Teachers' Union (SADTU), came together for a weekend meeting in Broederstroom. On the agenda was formulation of means to revise South African education (see Report on the Proceedings of the National Education Conference, 6-8 March 1992)<sup>10</sup>. The result was the drafting of 11 key principles which included:

- calls for national government to take greater responsibility for providing equal education to all South Africans
- parents to become more actively involved in children's education
- campaigns aimed at a democratic education system
- creation of an apolitical "culture of learning"
- consensus around a fundamental set of educational principles to be adopted nationwide.

This meeting was one of the first unified, non-racial, a-political attempts to place education on the national agenda and begin the process of restructuring and amalgamation. Also in that year, restrictions on segregated schooling were considerably eased, and the government pledged increased funding to assist in improving the state of DET and "homeland" schools.

More recently, the (national) Department of Education adopted a new policy, the outcomes based education/assessment (OBE) paradigm, as the basis for its program Curriculum 2005. OBE stresses the process of learning in a broad sense of accruing knowledge and experience, and evaluation through students' achievement of specified levels of functioning or "outcomes". It is a concerted effort to move away from the present model of education which stresses memorization of facts and evaluation through examination performance. Curriculum 2005 contains 8 learning areas, each of which contains a set of outcomes students in each grade strive toward<sup>11</sup>. Though the current emphasis is on restructuring secondary school curricula, Curriculum 2005 applies to both primary and secondary education levels. As the name suggests, the aim is complete educational transformation and curriculum evaluation by the year 2005.

Such changes have had a tremendous impact on sexuality and reproductive health education and promotion. Recent trends in South Africa have led these topics to be subsumed under a broader subject area known as "life skills". In general, life skills are

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<sup>10</sup> The conference was partially a response to the disastrous 1990 matriculation results among Black African students; in that year the DET announced a 36.4% pass rate (Official Yearbook of South Africa 1992).

<sup>11</sup> See as an example Appendix A, where the 13 outcomes used for the HIV/STD component of life orientation are listed.

composed of a range of “coping mechanisms” including both issues exerting a direct influence over sexuality and reproductive health - like sexual negotiation - as well as those with indirect effects - like assertiveness training. The content of life skills training varies<sup>12</sup>, but nearly always addresses some aspects of sexual health. Life skills is not a new paradigm, having been used in some schools for nearly a decade (Meyer-Weitz & Steyn 1992, Craig 1991 & 1996, see also NED 1990).

Since 1994 the life skills approach has received special emphasis in terms of how sexuality and reproductive health issues are addressed both in school-based and community programs aimed at youth. In KwaZulu/Natal, there have been several efforts to provide secondary school teachers with life skills training. Through workshops run by NGOs such as Dramaide, MacMillan-Boleswa, Planned Parenthood Association, and the AIDS Training and Information Center (ATICC), an estimated 1800 to 2000 KwaZulu/Natal teachers have received some aspect of life skills training since 1994 (Bowman, 1997).

The life skills approach has also received attention through its adoption by groups involved specifically in HIV/AIDS education and intervention programs. In KwaZulu/Natal, the life skills approach to HIV/AIDS gained widespread recognition in 1994 when the provincial branch of the National AIDS Coordinating Committee (NACOSA) established a working sub-committee called the Life Skills Forum. The Forum was created especially for the purpose of networking between organizations involved promotion of HIV-related life skills education and intervention activities.

Curriculum 2005 has also fostered reproductive health education and promotion. This has happened in several ways. First, it is a major focus of “life orientation, one of the specified eight learning areas in the new school curriculum. In addition, attempts will be made to teach life skills through other learning areas, to achieve a holistic approach to life “coping” skills and sexuality education. Finally, earlier this year the (national) Department of Education launched a nation-wide life skills teacher training program. The goal is to provide two teachers in every secondary schools in South Africa with life skills training.

The curriculum used varies between provinces, but includes a strong focus on sexuality and reproductive health issues. Currently, most provinces are at the stage of selecting and training individuals who will serve as teacher trainers; though the level of progress in the program varies widely between provinces. Importantly, this training effort is expected to foster cooperation and coordination among local and national Departments of Education and Health. Traditionally, relations between these bodies have often been strained for bureaucratic and organizational reasons and due to disagreement over the content of school-based sexuality and reproductive health education and promotion.

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<sup>12</sup> This is particularly true of the extent to which reproductive knowledge (anatomy and physiology) is covered. Some programs stress it a great deal, others assume youth have prior knowledge and focus primarily on active attitudinal and behavioral skills which influence sexuality and reproductive health.

However, both government and NGO initiatives have been hampered by the difficult legacy of equalizing school resources and services. As one Education Department official stated, “Before it was skewed to one side, unbalanced toward White schools. Now we are trying to spread resources and are getting toward equilibrium, but we have a long way to go. The scales are still not equal.” This situation often leads to tightly stretched funds which leave little room for developing new initiatives or expansion beyond programs which cover what is perceived to be the essentials of school-based education. Because of this, progress in reproductive health education and promotion - an issue often considered irrelevant and superfluous by education officials - has been slow; government education agencies on both national and provincial levels continue to rely on NGOs to fill existing gaps (Ntshakala 1997).

Many educational NGOs are dogged by funding crises, and as a result have been forced to scale back dramatically on outreach activities (Ntshakala 1997). Moreover, no well-coordinated effort exists in the educational system to provide youth with necessary reproductive health education and life skills (NPPHCN 1996, Taylor et al. 1996). One KwaZulu-Natal Department of Education social worker described the current situation:

*“Right now there is no standard life skills [including reproductive health or sexuality education] curriculum in provincial schools. If you had a child who was of school age, there would be no way to predict whether he or she would receive life skills education or not, or in what form. It is completely dependent on the particular school in question regarding what is done on this level. It depends on the specific school and staff as to what happens and what is taught in that regard. Those schools with guidance counselors tend to have life skills. But this is such a small minority. And there is some sexuality education in classes like biology, but it is not uniform.”*

It is still too early to assess the impact of large-scale efforts such as Curriculum 2005 and the national life skills teacher training program. These may well make significant strides in instating life skills in school curricula and promoting reproductive health in schools. Besides the efforts mentioned here, there are many other initiatives currently taking place focused on improvement of reproductive health and knowledge both in schools and among those youth out of school. In the next section, we review current approaches and programs aimed at adolescent sexuality education and reproductive health promotion.

#### **4. Recent/Current Trends or Models of Sexuality Education**

In this section, focus will be put on school-based and non-school-based reproductive health education initiatives. Most organizations and activities described below are in KwaZulu Natal but in some cases those organizations that operate both on a broader (national ) and provincial ( apart from KZN ) level will also be tackled.

##### **4.1 School-based**

#### ***4.1.1 Who is involved in school-based sexuality education?***

The following organizations are some / examples of the organizations involved in Sexuality education in schools. These are: Durban City Health ( local government ), MacMillan Boleswa ( a company of publishers ), School Nursing Services ( provincial government ), Peoples AIDS Action Group ( NGO ), KwaZulu-Natal Department of Health, Hillcrest AIDS Center ( NGO ), Sibikwa Community Theater Project ( NGO ), Planned Parenthood Association of South Africa (PPASA - NGO ), Durban Child Welfare ( local government ), Dramaide ( NGO ), Chatsworth Teachers' Center, Department of Community Health University of Natal Durban, NICHE ( NGO ), and Independent Educational Psychologist Consultants. A description of some of the organizations listed above will be given in the next section.

##### ***4.1.1.1 Description of some organizations***

###### ***PPASA***

This is one of the largest non-governmental organizations offering education and training in the reproductive health issues. In 1996 PPASA was awarded a tender for teacher training in Lifeskills in HIV/AIDS education in 5 of the 9 South African Provinces. In the remaining provinces it is part of a consortium of NGOs. Government and independent consultants organizing training of teachers. Apart from the teacher training program, PPASA has been involved in giving sexuality education to school and out of school youth all over the country. This organization is involved in both supply distribution and providing education services. PPASA has three central programs which are:

- the community-based distribution of contraceptives
- adolescent reproductive health services
- lifeskills and sexuality education training for teachers and parents.

PPASA's initiatives have been formally evaluated.

###### ***Durban City Health***

The Durban City Health ( DCH ) is a municipal department. It provides services and support programs, education classes to secondary schools that cannot cope with giving sex education themselves. DCH gets calls from all over Durban to come and give lessons and they do so on an ad hoc basis. It is not involved in the distribution of supplies.

The Durban City Health Department also train STD 8 pupils around the metropolis region. They randomly select schools and then train 5-8 pupils from each school. The pupils are trained to become AIDS peer educators. They are given basic information on AIDS and they in turn give back that information to their peers.

This departments activities have not been formally evaluated although the DCH agents conduct some informal evaluations by giving questionnaires to pupils before and after they have given them information to test their knowledge.

###### ***MacMillan Boleswa***

This is a publishing company which ran an AIDS awareness Program for schools in KwaZulu - Natal during 1995/1996. Teachers were trained in HIV/AIDS education so that they could be

able to teach this to their pupils. The necessity for HIV/AIDS education in KwaZulu-Natal was recognized by the Minister of Education who then initiated the full trial implementation of the Macmillan Boleswa AIDS Awareness Program during 1995/1996. The evaluation of the implementation of this program was undertaken by an independent evaluator assisted by an Evaluation Working Group made up of representatives from both the Department of Education and Macmillan Boleswa. The evaluation was conducted in two phases:

- a qualitative evaluation based on interviews and discussions
- a quantitative evaluation based on questionnaire

#### *School Nursing Services*

Nurses from the School Nursing Services visit schools in the province mostly for health inspections. While doing this they also provide education on reproductive health. During school holidays they also organize pupils into youth groups and use libraries, community halls and even schools if they are available for education programs / workshops. Sometimes schools approach them and ask for a special talk on a particular topic such as prevention. They also do home visits if there is a need and involve parents as much as possible.

#### *AIDS Action Group/ATICC*

This is a non-government organization that is coordinating the teacher training program in KwaZulu-Natal. They also provide education to school pupils and engage in training independently of the Life Skills Initiative.

#### *Hillcrest AIDS Center*

This center opened in 1991 and has been working from an office in the Anglican Methodist Church Center. They network with all the major players in the fight against AIDS in South Africa. They give AIDS education and counseling to church groups, employers, businesses, school pupils of all ages, domestic workers and gardeners and service clubs.

#### *Sibikwa Community Theater Project*

This project was formed in 1988 by a group of parents from the East Rand township of Davetown. The main aim of the project is to “redress the imbalances of the past by providing marginalized youth with marketable skills and encourage a culture of learning through the creative arts. In 1996 they successfully presented two programs on the HIV/AIDS epidemic which reached more than 2000 high school pupils.

#### *Durban Child Welfare*

This large municipal government body houses many and varied departments which are: Social Work, Educare ( facilities for education, stimulation and community and home-based education ), Crisis Center, Street Kids Shelters etc. They work with communities with the main aim of making them self-sufficient. They also offer community and school-based lifeskills programs and education.

### *Dramaide*

This organization teaches life skills using drama. Dramaide is involved in peer education, forming self-sustaining clubs that are responsible for sexuality education to youth, training teachers, working closely with school so that they eventually become “health promoting schools” ( after training pupils in reproductive health education, the school receives a certificate stating that the trained pupils can now train other pupils in other schools around the area. ), and now they have moved into teacher training colleges. Dramaide started as a pilot program in 1991 and started on a large scale in 1992. This organization is KZN - specific. The organizations activities have been formally evaluated.

### *FAMSA*

This is a Family and Marriage Association of South Africa. It is a non-governmental organization dealing mainly with issues concerning family relationships. It also covers family planing. Its activities have not been formally evaluated.

### *Department of Health (KZN)*

An individual from the department of Health (KZN) has a project where she works with two groups of peer educators in Durban. One group is in Sydenham ( with 15 kids ) and the other is in Newlands East ( with about 40 kids ). Three schools are involved and two social workers from Durban Child Welfare help in the project. After receiving training, these kids get certain periods and rooms in their schools to do their education activities (training other students / peers in life skills and sexual education ) and they also act as peer counselors.

#### ***4.1.1.2 Who is targeted?***

Most of the role-players mentioned above feel that reproductive health education should start very early, as early as preschool. Organizations such as City Health and Durban Child Welfare are already targeting preschool pupils where they talk about basic things like, the process of growing up, physical developments, the difference between boys and girls. Durban City Health go as far as targeting students in tertiary institutions and Dramaide has started with training in teacher training colleges. School Health Services target only primary schools and go to secondary schools only on invitation. Other organizations deal mainly with the youth in secondary school ( 12-21 ). Organizations basically give age related education.

There is a general concern from role-players that:

- in some classes the age gap between pupils is very big ( pupils are at completely different levels of sexual maturity ).
- 12years is already too late because some pupils are already sexually active.

#### ***4.1.1.3 What is taught?***

The role players put different emphasis on different aspects of reproductive health. But all of them seem to put more of their effort in teaching HIV/AIDS. They also teach about relationships, STDs, family planning, sexual abuse including rape, communication skills, intimacy and relationships, drug/substance abuse, self esteem, decision making, teenage pregnancy, attitudes/values clarification, human development, assertiveness, peer pressure etc.

### *HIV/AIDS*

Although there is a feeling from some role-players that there is over-emphasis on HIV/AIDS, all of them argue that there is a need to include it in all reproductive health lessons. All NGOs, Community Based Organizations (CBOs), private/independent bodies, Health departments, Education Departments in all regions, AIDS Action Groups include this aspect of reproductive health in their lessons. They all say that due to high HIV infection rates in this country especially among the youth and the fact that AIDS has no cure at the moment, there is a need for it to be openly discussed with the youth. All their effort is a response to the epidemic. Dramaide goes to the extent of using drama when teaching about AIDS to make sure that the subject is interesting to pupils and that they never forget what they have been taught. They relate more to subjects that depict real life. Obviously all role-players feel that there is a need for the youth to know:

- what HIV/AIDS is.
- HIV and the immune system
- how HIV is transmitted from one person to another.
- dangerous behavior that may lead to HIV spread.
- how to prevent AIDS / safer sex
- how to relate to a person who is HIV positive.
- what happens to people who get infected with HIV.
- HIV testing.
- places to go to for counseling.
- myths and facts about AIDS

### *STDs/STIs*

Sexually Transmitted Diseases or Sexually Transmitted Infections is another aspect that all role-players touch on in their lessons. In general, education programs emphasize the following themes:

- transmission
- relationship between STDs and AIDS
- the need to treat STDs as soon as possible
- consequences if left untreated
- dangerous behavior that lead to the spread of STDs
- the availability of STD clinics

### *Sexual abuse*

The National Institution for Crime and Rehabilitation of Offenders ( NICRO ) violent crime including sexual abuse and rape. They also teach about date rape ( e.g. what t expect from a date, dating does not necessarily mean sleeping together, it is OK to say NO! even on a date ). Other agencies like PPASA also touch on date rape when they talk about relationships. They also include child abuse. The pupils are taught:

- when to say NO!

- it is your right to say NO!
- unacceptable behavior especially from adults.
- what is a right / wrong touch.
- counseling places for rape victims.
- acceptable behavior during a date.

All role-players feel that this type of education should start a very early stage ( pre-school), especially with the escalating incidences of child abuse.

### *Family Planing*

FAMSA, PPASA deal with this aspect of reproductive health more than others. There are also people from family planing clinics who visit schools to talk contraceptive methods. Topics that are covered by most role-players under this section are:

- the need for family planing
- different types of contraceptives and how they work, this includes their side effects as well.
- the condom as the most effective in that it also protects against HIV/STD transmission.
- the availability of family planing clinics, the pupils are encouraged to visit these once they are sexually active

### *Communication*

All role-players blame lack of communication for all the problems experienced by our youth today. They argue that there is lack of communication between parents and the youth, teachers and the youth, the youth and adults concerning reproductive health matters. The youth has been “exploited and betrayed enough by the silence” of the parents, the educators, the nurses, the ministers, the leaders in the communities. Because the adults cannot or are scared to communicate with their children about reproductive health matters, the role-players feel that it is their duty to teach the youth how to open these communication channels and to make them easy to access. They are taught:

- how to communicate with their parents, the language to use, how to make parents feel free to open up to them.
- how to communicate their problems to helpful people e.g. nurses, teachers, ministers etc.
- which channels to follow should they encounter reproductive health problems.
- NEVER to keep silent if there is a problem.
- agencies ( including Child-Line ) that are willing to listen to their problems.

### *Substance abuse*

Quite a few agencies teach this aspect. Some feel that it has no relation to reproductive health while some argue that it has since drugs and alcohol cloud the mind and make it impossible to make clever decisions. One respondent from the PPASA, speaking in support of the inclusion

of this aspect in reproductive health education, asked: “How many times have we heard of rapes where the rapist plead innocence on the basis that he was drunk when committing the crime? How many times have we heard young women crying “I do not know how it happened, I must have forgotten to take the pill because I was drunk.” The agencies which cover substance abuse teach the pupils that:

- abusing drugs or drinking too much alcohol clouds a persons judgment, that may result in violent behavior, leading to disastrous consequences
- drug/substance abuse may have a negative impact on a person’s sexual functioning, and what the negative impact is.

### ***Decision making / peer pressure / assertiveness***

Almost all teenagers have profound fears about being different. That is why they succumb so easily to peer pressure. They let their peers make decisions for them. They sometimes allow their peers to bully them into making decisions they never would have made if their friends were not in the picture. A lot of them engage in sex because their friends are doing it. That is why role-players in school-based reproductive health education find it necessary to teach the youth how to be assertive in order to be able to avoid peer pressure and to make informed decisions. Under this aspect they teach them:

- how to be assertive without being aggressive
- how to make responsible and healthy decisions
- how / when to say NO! to friends
- it is okay to be different

### ***Teenage pregnancy***

Of all live births, 40-50% are attributed to teenaged women ( S.A. Ministry of Welfare & Population Development 1995, Goosen & Klugman 1996; ethnicity not specified). Other studies, however report that teenagers pregnancy among black women ranging between 11.4% and 49.0% ( Roberts & Rip 1984, Boulton & Cunningham 1991, Klugman & Weiner 1992 ). Teenagers engage in unprotected sex which then leads to them falling pregnant before they are ready to be parents. All agencies teach this aspect of reproductive health. They teach pupils:

- consequences of being a parent before one is ready.
- to use contraceptives once you are sexually active.
- what it means to be an unmarried parent, both to the parent and the baby.

#### ***4.1.1.4 How is the teaching done?***

All role-players agree that they have tried to do away with the traditional method of teaching ( where the teachers is the only one talking and all the pupils have to do is to listen and take notes ), or are in the process of developing innovative approaches to teaching these subjects. They all try to get pupils to participate as much as possible and they deal with topics that are relevant to

the pupils every day life experiences. In-order to keep the pupils captivated, they employ the following techniques:

- teaching through drama ( e.g. Dramaide )
- involving pupils in focus group discussions. Through this technique, kids are able to share their experiences in the group.
- encouraging pupils to participate and to draw examples from their life experiences.
- training pupils to educate others ( peer education ).
- being realistic about the fact that some teenagers are already sexually active and taking that into account when educating them..
- using videos. This makes it easier for pupils o understand the subject.
- being culturally sensitive.

#### ***4.1.1.5 When is the teaching done? / How often?***

Organizations receive invitations from schools and then go to educate pupils in response to those invitations. Schools are visited as much as possible as long as the help of the organizations is still wanted. But, because of under-staffing, most organizations find themselves visiting schools once in three to six months. Organizations also do the needs assessment before approaching schools. For example they will sometimes find that in a certain area teenage pregnancy is very rife and then approach schools in that area and then give lessons on teenage pregnancy.

The school nursing services visit each school once a year, although school coverage is not 100% and was found to be much less than 70% (Taylor M., Memela D., Nzimakwe D. 1996). The visit may sometimes go on for five days, depending on how big the school is. During the visit they do screening and health education.

#### ***4.1.2 Advantages of schools as a place for sexuality education***

There is a general feeling from most role-players that teachers are not good conduit of sexuality education because they are too stereotyped and too associated with the establishment to be effective. The point that favors teachers is that they have daily contact with the youth in their schools. But there is a general agreement that targeting just teachers does not work. One respondent from the City Health Department said: “The whole process has to be “a systems-level and community program - a thrust that will include everybody.” Respondents also agree that teachers will require a lot of training to equip them with information and to change their attitudes before they are ready to teach pupils. Some NGO’s like PPASA, Dramaide, MaCmillen, etc. have already started training teachers. Although the school is not the best place according to some respondents, it can be used because pupils are already there ( a captive audience).

#### ***4.1.3 Disadvantages of schools as a place for sexuality education***

***“Schools should not be the starting place for such movements, but the places to reinforce.”***

***A quote from the Department of Health employee***

- teachers are too much part of the school itself to be effective, according to some respondents
- there is no continuity outside of school
- teachers are ill-equipped for sexuality education needs.
- teachers attitudes need to be changed first before they are fit to teach sexuality in school. They need to come to terms with their own sexuality first.
- quite a substantial proportion of kids are not reached by school-based initiatives either because they are not in school or have left the school before they reached classes where this kind of education begins.
- a total number of African pupils enrolled in secondary schools in 1993 was 1972561 a number that is far less that the number of the African youth who should be attending secondary school ( Race Relations Survey 1993/94 ).
- Quite a substantial number of pupils drop out before they can even reach secondary school level ( when sexuality education normally starts ).

#### ***4.2 Outside School***

Organizations that deal with the youth out of school are: PPASA, NPPHCN, Society for Family Health, Dramaide, health Systems Development Unit, Durban Child Welfare, Family Health and Communication and independent individuals/groups.

##### ***4.2.1 Youth centers***

###### ***The NPPHCN's Youth Center***

The National Progressive Primary Health care Network is a “national non government health advocacy organization promoting collaboration, participatory research and policy formulation, appropriate training and organizational development.” This network originated in April 1987 out of a need for a national network to promote Primary Health Care and to develop a national PHC strategy for S.A. It has a number of programs and one of them is the Youth and Sexuality Program. In this program, NPPHCN help the youth to in order to improve communication on sexual issues between them ( the youth ) and their parents. Currently the program is engaged in bringing together health workers and other service providers, youth, adults and community based organizations under the Theme “Talking to each other.”

###### ***The PPASA's Youth Centre***

PPASA has youth centers in 7 provinces which are the Western Cape, Gauteng, KwaZulu-Natal, North-West Province, Northern Province, Free State and Eastern Cape. These are

information centers “set up to provide young people with friendly reproductive health services.” One of these centers is the New Crossroads Project. This project operates over two days (Wednesday and Thursday clinic days ) every week and has two sexuality courses. The aim of the project is to “bring the message of responsible sexual lifestyles to the young people. Twenty five people in the group have been identified as leaders and have received training in peer education.

#### *4.2.1.1 Who is targeted by these centers?*

NPPHCN targets the youth out of school between the ages 10-20. The first sexuality course of the PPASA’s project targets the youth between 11-14, while the second course targets 15-20 year olds.

#### *4.2.1.2 What is taught?*

The topics covered by the NPPHCN’s project include: HIV/AIDS, negotiations, contraceptives, STDs, communication skills, physical development etc. Topics covered by the PPASA’s projects include: puberty and adolescence, physical and emotional changes, heterosexual relationships, sexual decision making, STDs, HIV/AIDS, contraceptives, sexual abuse and teenage pregnancy.

#### *4.2.1.3 How is the teaching done?*

NPPHCN uses the media, participation in meetings, and making presentations to get the message across. After training peer educators, PPASA allows them to present their own workshops in the community. The youth also performs in AIDS awareness plays on World AIDS days. PPASA has also joined forces with the Olympic Bid Committee and Society for Family Health to arrange a memorable day of parades, speakers, music and drama. Otherwise they engage in group discussions with the youth during the teaching sessions.

#### *4.2.1.4 Evaluation*

The PPASA’s project in the New Crossroads has been evaluated by Loren Bremmer of UCT’s Department of Community Psychology. It has been found to be a very good and fruitful project.

#### *4.2.1.5 Advantages of youth centers*

- The youth is free to talk to one another rather than to parents or teachers who are perceived as authority figures.
- Once the youth is involved in youth centers, there is a feeling of ownership and they take pride in them.

### **4.2.2 Youth groups / peer education groups**

#### *The HSDU’s Initiative*

The Health Systems Development ( HSDU ) Unit have started a community project whose goal is to improve reproductive health outcome. The program is based in 4 clinics around Bushbuck Ridge but branches out to include youth groups, schools, community members (including

parents ). All these work together to achieve the project's goal. The aim of the project is to eventually produce peer educators who will be trained in life skills. The youth groups will also be able to sell condoms as small money-making projects as well as provide community education. HSDU hopes that this will lead to peer information programs, peer education and peer counseling. The program is still in the process of being developed. HSDU also did a baseline KAP study with 900 youth to estimate to test basic understanding of youths' knowledge and awareness.

#### *Dramaide community youth clubs.*

Dramaide has three primary programs involving youth clubs. The first one is a four-phase intervention program surrounding community and school-based awareness of HIV/AIDS through setting community youth clubs. These four phases are:

- needs analysis of school and surrounding community
- drama production of needs/problems posing followed by workshops and canvassing for club membership among local school-based youth.
- a community open day where pupils perform for parents and community members.
- a community health festival.

The next program is called ACT ALIVE where Dramaide go to schools to establish clubs in which kids act as peer educators. There is also a move towards implementing activities and programs in schools which will certify them as "health promoting schools" where they will also serve as centers for training teachers and pupils from other schools in the area.

Dramaide's third program involves working with colleges of education.

#### *4.2.2.1 Advantages of peer education*

- peers are able to relate to each other because they have similar experiences.
- there is no authority figure involved when they share experiences and that promotes freedom to speak.

#### *4.2.2.2 Disadvantages of peer education*

- it creates false hopes of those involved ( thinking that involvement will ensure jobs )
- most kids want payment for their services and once that happens, there is going to be regulation on the number of hours spent on activities. It is hard to sustain volunteer commitment.

#### **4.2.3 Other**

##### *PPASA's CBD Project*

In PPASA's Community Based Distribution of Contraceptives Project community-based distribution agents offer reproductive health education and contraceptives to communities. They do this through home to home visits. Now there are six CBDs in six provinces. PPASA is now

exploring the possibility of CBD agents “administering antibiotics, based on client histories, for sexually transmitted diseases. These projects help to relieve family planning clinics.

#### *Family Health and Communication*

What people from the Family Health and Communication organization do is to consult with youth leaders asking them to organize groups. Then they come to address those groups. Topics they cover include: physical and sexual development, human anatomy, how to cope with peer pressure, STDs, HIV/AIDS.

##### *4.2.3.1 Advantages of CBDs*

- They relieve family planning clinics.
- they are accessible and affordable for the community
- they are money savers.

##### *4.2.3.2 Disadvantages of CBDs*

- hard to sustain volunteer commitment
- people expect payment

##### *4.2.3.3 How is education given?*

Through group talks and discussions

## **5. Issues and Questions Raised**

This is a section based on interviews and our analysis of the interviews and discussions with respondents. Respondents raised some very interesting issues and concerns and these are discussed in detail below.

### ***5.1 Curriculum Content and Organization***

#### ***5.1.1 Cultural Diversity and Reproductive Health***

Although the curriculum content of most organizations' programs tries to encompass as much as possible on reproductive health, it is not comprehensive enough in S.A. There is very little on society and culture. Different cultures and societies perceive reproductive health differently (e.g. in most African Cultures, it the man who normally makes reproductive health decisions -whether the wife/girlfriend should use contraceptives or not) These cultural differences are not adequately catered for in the reproductive health education given to the school youth.

***When teaching sexuality education, one must take into account the sexual culture, especially the social and cultural context of sexual decision-making.***

***Reproductive Health Matters, 2, Nov. 1995***

There is also very little said on abortion. When one respondent was asked why they do not teach about abortion, she said: "We cannot just confidently talk about abortion to the youth, because it is still an emotive and controversial topic in this country." There is an over emphasis on HIV/AIDS. Many respondents feel that there is a need to teach more about AIDS because it is unique to all other reproductive health issues, mostly because at the moment it has no cure.

The good with many schools in this country is that classes have pupils from different cultural background. This is good in that they are then able to learn about as many cultures as there are in this country. Although this is an advantage, it becomes a problem when it comes to sexuality education. Because of this cultural diversity, the teacher becomes confused as to how different cultures approach sexuality. This may then result in the teacher using his cultural background as the basis of his teaching thereby confusing kids who are not familiar with that culture. Again, in most schools ( especially African schools ) there is a problem of age mixed classrooms. One sometimes finds that there is a pupil who is 12 years old and an 18 year old people in one class. This makes it difficult for a teacher to teach sexuality education because these pupils are at totally different levels of sexual maturity.

### *5.1.2. Curriculum Content*

For sexuality education to be effective, it should be as comprehensive as possible. It should cover all the following key concepts:

- human development
- relationships
- personal skills
- sexual behavior
- sexual health
- society and culture

The above guidelines need to be then adapted for country-specific requirements.

### *5.1.3. Teaching Modes - Traditional vs Alternative*

In a sexuality education lesson, there should be a lot of interaction between the learners. The teacher should only act as a facilitator. Learners should be able to talk to each other and share their life experiences. The teacher should encourage them to do this and he/she in turn should make it easy for learners to approach him/her should they have problems or queries. At no stage should the teacher assume the role of a disciplinarian. This traditional method does not go well with sexuality education.

### *5.1.4. Place ( or lack thereof ) on life skills/sexuality education in syllabus.*

At the moment sexuality education is not an examinable subjects in schools. Because of this, it tends not to be taken seriously. Almost each and every school has a guidance periods. During this period, teachers are supposed to teach sexuality education amongst many things. This period is rarely used. In most schools it just becomes a free period where pupils catch up with their homework or if there is a teacher who is behind with his subject, he then uses this period to catch up.

At the moment there is a limited and inappropriate approach to sexual health education in schools.

## **5.2 Acceptability / accessibility: Age Groups and Geography**

At the moment, life skills sexuality education is mainly given to the youth between the ages 12-19. A number of respondents have commented that this is starting too late. At 12, a number of pupils are already sexually active. One respondent from PPASA said that sexuality education should start before puberty because at that stage kids are already starting to ask sexuality-related questions.

Although sexuality education is taught in many schools in this country, the under-resourced schools ( most of them in rural areas and informal settlements ) receive very little attention if any at all. Reproductive health agencies tend to focus on urban schools. With the Life Skills Initiative where two teachers per school will receive training in life skills education, schools all

over the province are all going to eventually receive the training. The schools that will receive first preference are the least resourced schools which have no teachers trained as sexuality and HIV / AIDS educators.

### ***5.3 Role of parents and community members.***

***“open communication  
should start at home.”  
A quote from a department of  
education employee***

All role-players agree that parents should be primary sources of reproductive health information. There is a general concern though that some parents never talk to their children about such matters, either because they are scared or they are not well informed themselves. This has prompted some organizations like PPASA, Family Health and Communication, the School Health Services etc. to involve parents in reproductive health education. The School Health Services people hold meetings with parents to educate them as well because parents have expressed to them that what is taught to their children in school is above them. PPASA have an education program at Isithebe ( KZN ) where they teach parents about sexuality. People from the Family Health and Communication organization also have talks with parents where they include topics like: communication skills, the difficult stage of adolescence and how to handle a child who has reached that stage, openness, straight talking without hiding facts etc.

Life skills initiatives will be most successful if they are done in a coordinated way, where every sector in the society is involved, this includes community members, parents, teachers, priests, health providers, community leaders etc. In that way, each would be able to learn lessons from the other’s experiences. “Communication with the government structures is also important, to ensure a coordinated approach, and prevent the fragmentation of services” ( S.A. Health Review 1996 ).

### ***5.4 Are Teachers Appropriate Conduits of Knowledge?***

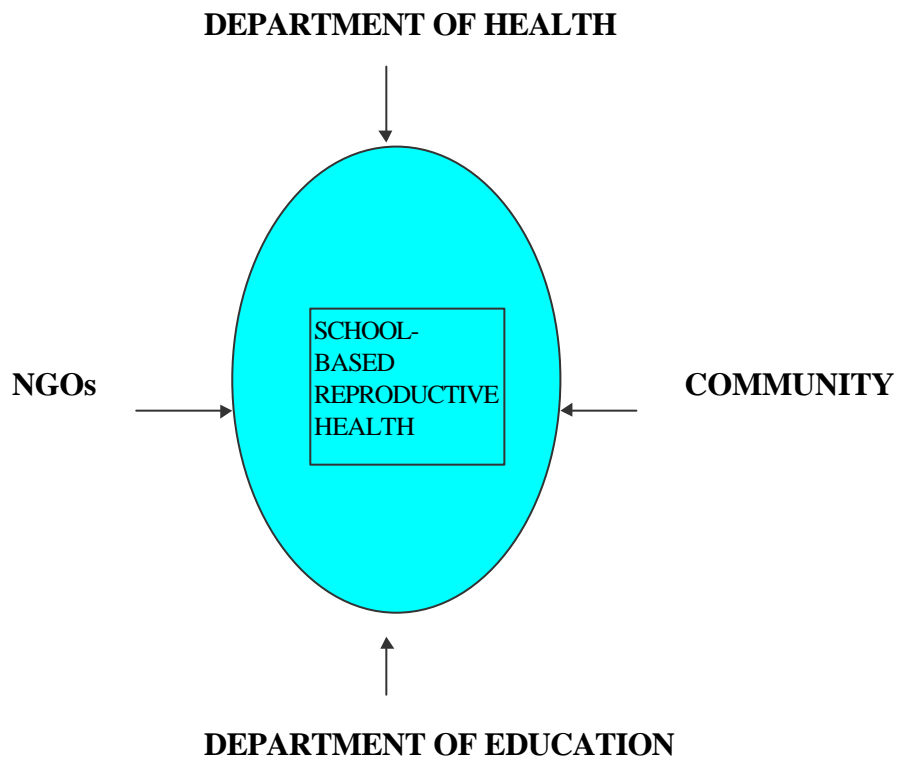
All respondents agreed that for teachers to be effective in their teaching of sexuality education, they need to follow the following guidelines:

- shed off their disciplinarian role.
- become counselors / facilitators rather than teachers.
- be comfortable with their sexuality.
- seek as much information on sexuality education as possible.
- be willing to take such a responsibility.

In schools there is too much vertical instruction and top-down education. Pupils at school are used to being lectured at, while sexuality education and life skills are interactive, participatory matters.

There was a general concern though from respondents that teachers do not have much training and therefore will need it. Also the pupils themselves are not comfortable with talking to teachers about sexuality issues because to them teachers are like parents. Some teachers do not want to take on such a responsibility because they are already overworked.

### ***5.5 Long-term Sustainability of Current Initiatives.***



*All the above role-players need to cooperate more effectively in order to sustain sexuality education programs.*

For sexuality education to be effective the following needs to be done:

- involve every sector of society. This includes parents and community members
- coordination between school-based youth programs and out of school youth programs
- sexuality education should not be confined to a particular place but needs to be everywhere and be reinforced everywhere



***Sexuality has to be a team approach for it to be sustainable***

### ***5.6 Role of NGOs in Sexuality Education***

NGOs might be successful in giving sexual health education to school pupils since they are not school-based authority figures. Another advantage of NGOs is that they have greater accessibility to communities and have worked with disadvantaged communities. This then brings credibility. If NGOs are to work successfully in schools, they:

- should not be foreign.
- should have local knowledge.
- should have the ability to collaborate with others players.
- should fit into the school environment.
- should have a complementary relationship with government.


At the moment there is no coordination between various NGOs, the government, health workers and other role-players in sexuality education. There is just a lot of disorganization. Role-players need to come together and work out a plan on how to approach things. This has already started with the training of teachers. All role-players have come together to put together a curriculum design. Each role-player cannot do this on its own. This needs to be a joint effort. At the end of it all, role-players need to equip communities to be able to run the programs on their own and therefore take ownership of these programs.

### ***5.7 Role of Health and Education Departments***

Before these two Departments made an effort to work together, both had their own life skills programs. The Health Department's program was geared more specifically toward reproductive health and sexuality while the Department of Education's program was much broader, and focused on many aspects of life skills - in terms of social development and social skills; including sexuality issues as just one part of the broader focus. With the help of NGOs, both departments have managed to reconcile and strike a balance between their differing foci. The government's White Paper on Health emphasizes the need for cooperation between the Departments of Health and Education

Respondents are happy that there is now a commitment from these departments to work together. One respondent from the Department of Education stresses that:

***For sexuality education to be successful, it needs to be supported from within the government system, not just by NGOs on the outside.***



These two departments ( especially the Department of Health ) need not only focus on the youth in school but need to target the youth out of school as well. The directorates within the Department of Health, that have been responsible for in sexuality education are; The Health Promotion Directorate and the STD / AIDS Directorate and they should continue with their responsibility.

## **6. Where to Go From Here? Research Needs**

In compiling this analysis, we interviewed over three dozen individuals representing NGOs, government health and education agencies, and independent consultants involved in youth-focused reproductive health education. We undertook literature searches, reviewed program descriptions, syllabi and materials used to educate youth in reproductive health and sexuality-related matters. The preceding pages have tried to provide a description of events and dynamics leading up to the present situation in South Africa, as well as the many and varied current initiatives in sexuality education. However, many issues have not been addressed, and present education and intervention efforts are hampered by problems which seriously jeopardize their effectiveness. Where can we go from here in trying to improve adolescent reproductive health and sexuality education? What are the most pressing issues which need attention? What research needs to be done?

### *6.1 Need for Basic Research*

Despite the wide range of programs in place, it appears there is still need for basic descriptive research on a number of issues concerning reproductive health and sexuality education. Recently, a few studies (Meyer-Weitz & Steyn 1992, NPPHCN 1996, Richter 1996) have begun to advance our understanding of youths' knowledge, attitudes and practices regarding sexuality and reproduction, and the factors - such as drug use, peer pressure, communication networks, family dynamics and violence - which influence them. Based on these works and others (Kau 1988, Ncayiyana & Ter Haar 1989, Nash 1990, Setiloane 1990, Boulton & Cunningham 1991, Frame et al. 1991, Naidoo et al. 1991, Varga & Makubalo 1996, Varga 1997), there is little question about two aspects of adolescent sexuality in South Africa. First, *an unacceptably high proportion of youth engage in high risk sexual activity*. Second, *an unacceptably high proportion of youths' reproductive health knowledge is inadequate and must be improved*.

However, there seems to be considerable disagreement and lack of clarity regarding the “who, what, when, and how” of adolescent sexuality education. Among those interviewed, there was considerable disagreement about many aspects of sexuality education implementation. For example, among the issues which drew conflicting responses were 1) the potential role of parents in sexuality and reproductive health education, 2) the appropriateness of teachers as sexuality educators, and 3) the extent to which ethnic or cultural factors might affect education

efforts both in school-based settings and in out of school programs. Evidence in defense of one argument or another was usually anecdotal, making evaluation difficult. Below are some of the issues which appear to need further descriptive research:

#### *Youths' Perceptions*

- parents' involvement in sexuality education
- most appropriate sexuality educators
  - ⇒ teachers (which ones are the best role models?)
  - ⇒ peers
  - ⇒ health workers
  - ⇒ traditional healers
  - ⇒ church
  - ⇒ community consortiums
- school vs. other environment for sexuality education
- preferred content of education messages
  - ⇒ what youths' priorities in sexuality education?

#### *Parents' Perceptions*

- knowledge of and ability to communicate about sexuality issues
  - ⇒ perceived need for education before approaching youth?
- role in youths' sexuality education
  - ⇒ willingness to actively reinforce education messages at home
- perceived most appropriate sexuality educators
  - ⇒ do parents want school and teacher-based sexuality education?
  - ⇒ other community members, community consortiums, NGOs, etc.
- preferred content of education messages
  - ⇒ what kind of messages are parents willing to support?

#### *Teachers' & School Officials' Perceptions*

- knowledge of and ability to communicate about sexuality issues
  - ⇒ perceived for need education before approaching youth?<sup>13</sup>
- perceived most appropriate sexuality educators
  - ⇒ sexuality education viewed as school's/educator's responsibility?
- perceived role in youths' sexuality education
  - ⇒ willingness to actively reinforce education messages in and out of school
  - ⇒ willingness to prioritize sexuality/life skills in school timetable
  - ⇒ perceived liaison and responsibility-sharing with health services and NGOs
- preferred content of education messages
  - ⇒ what kind of messages are school staff willing to support?
- perceived practical constraints in implementation of sexuality education
  - ⇒ space

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<sup>13</sup> This issue is partially being addressed by the national life skills teacher training initiative.

- ⇒ staffing
- ⇒ materials
- ⇒ matriculation/examination pressure

### *Health Workers' Perceptions*

- knowledge of and ability to communicate about sexuality issues
  - ⇒ perceived need for education/training before approaching youth?
- perceived most appropriate sexuality educators
  - ⇒ sexuality education viewed as health workers' responsibility?
  - ⇒ which health workers: local clinic, community health workers, school nurses?
- perceived role in youths' sexuality education
  - ⇒ willingness to actively reinforce education messages
  - ⇒ liaison and responsibility-sharing with schools, community and NGOs
- preferred content of education messages
  - ⇒ what kind of messages are health workers willing to support?
- perceived practical constraints in implementation of sexuality education
  - ⇒ staffing and morale
  - ⇒ transport
  - ⇒ materials

### *Cultural Values in a Multi-Cultural Society*

- effect of socio-cultural values on content and approach to sexuality education
- reconciling educational material and teacher training with cultural diversity and multi-cultural classrooms
  - ⇒ consideration of both teachers' and students' heritage

Regarding the final point, cultural values and multi-cultural society, we must consider these factors in two ways. First, how can sexuality and reproductive health education initiatives take into consideration the values, mores, and traditions of tightly-knit, relatively homogeneous communities and still convey the necessary messages? This challenge is described by Matthews et al. (1995) when working with a Muslim community in the Western Cape. In addition, now more than ever school classrooms are made up of students from varied social and cultural backgrounds; which dictate different behaviors and values regarding sexuality and reproductive issues. Our challenge is to find approaches and create materials which respect such varied backgrounds and encourage cultural diversity while reinforcing messages important for good reproductive health practices. Some programs, such as Craig's work, have adopted such a multi-cultural approach to life skills education.

Without community-specific in-depth research focused on issues like these, education and intervention efforts risk *a priori* about the most effective means of information dissemination and interventions for long-term lifestyle change. However, as Matthews et al. (1995) point out, with in-depth understanding and community-specific focus comes risk of the inability to generalize to other contexts. In addition, the feasibility of such an approach may be limited in large-scale education efforts; especially those based in schools. Nonetheless, there appear to be many basic issues - both from the perspective of the receiver (youth) and the provider (teacher, educator, counselor, parent) which need clarification regarding the most appropriate ways to

educate youth about sexuality issues. As part of larger education and intervention initiatives, focused descriptive research on issues concerning “who, what, when, and how” of sexuality education will help assure successful, sustainable programs.

### *6.2 Study of Schools as Systems*

Many of those interviewed pointed to characteristics of the school system itself as the most significant barriers to successful reproductive health and life skills education. Given that it is a frequent, logical and practical place for learning and teaching, how can the school itself function most effectively as an available, acceptable, accessible and adaptable system for sexuality/life skills knowledge, attitudes and practices of pupils? This approach is strongly emphasized in the WHO’s recommendations for school health promotion. Its findings suggest that “[e]ven how a school is organized - its policies, physical and social environment, curricula, teaching and learning styles, examinations, and the ways in which students are engaged in their own education - can promote or discourage health” (1996b:3). Systems level problems were also highlighted by Taylor et al. (1996) in an analysis of KwaZulu/Natal School Health Services (SHS) coverage of provincial public schools. The following points may serve as guidelines for studying schools as systems.

- Decision-making
  - ⇒ provincial-level
  - ⇒ district-level
  - ⇒ school-level
  - ⇒ relationship with local health services
  - ⇒ relationship with community
  - ⇒ financial policies and allocation to reproductive health activities
- Organization
  - ⇒ timetable allocation for life skills, health, sexuality education
  - ⇒ formal evaluation of health education and learning (internal & external)
  - ⇒ reinforcement and implementation of health messages in broad school context
  - ⇒ physical space for health education activities
  - ⇒ means to ensure safe learning environment
- Staffing
  - ⇒ choice of life skills teachers
  - ⇒ supports for teachers in life skills/sexuality/reproductive health education
- School Reproductive Health Referral and Supply Practices<sup>14</sup>
  - ⇒ how
  - ⇒ when
  - ⇒ where
  - ⇒ by whom
  - ⇒ feasibility of schools as component of community health care system
    - \* school-based reproductive health supplies distribution

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<sup>14</sup> See work by Taylor et al. (1996) for work on general health referral, not specific to reproductive health

- \* school-based reproductive health services

### *6.3 Staffing and Training*

The examination and monitoring of qualification and training needs for both teachers and health service providers is a significant part in the success of sexuality education and reproductive health promotion. It is estimated that only two-thirds (64%) of South African teachers are qualified to teach; nearly one third (29%) are under-qualified, and a further 7% are unqualified (SAIRR 1996). Moreover, the extent to which current teacher training methods equip teachers to undertake sexuality and life skills education is unclear. While the national life skills teacher training initiative has made inroads in providing teachers with such skills, improvement must be considered at the level of teacher training - before teachers ever enter the classroom. In addition, though national education policy has recently undergone significant reform with the adoption of outcomes based strategies, and increased focus on life skills, it is unclear what - if any - impact this has had on teacher training programs. For health service providers the need for adequate preparation is equally significant.

Several primary health nurses interviewed expressed frustration at not having adequate skills to educate youth about sexuality and reproductive health issues. They also noted the problem of schools' and communities' assumptions that health care providers make good teachers and communicators. Finally, one issue seemingly common issue for both health service personnel and teachers is concern over conflict between personal beliefs and values, and the reproductive health information they are asked to disseminate to young people. Thus, more work needs to be done in the following areas:

- Examination of teacher and health worker training curricula
  - ⇒ ensuring adequate skills to teach and communicate
  - ⇒ life skills training in curricula
  - ⇒ reproductive health facts in curricula
  - ⇒ values clarification workshops
  - ⇒ gender issues in teaching and communicating

### *6.4 Reaching Out of School Youth*

Reaching out of school youth remains one of the greatest challenges faced by those involved in life skills and sexuality/reproductive health education initiatives. A number of programs such as those run by Planned Parenthood Association of South Africa, Dramaide, Durban Child Welfare and the Health Systems Development Unit reach the community and children outside the school context. However, such efforts often incorporate schools as a major focal point and place of contact, and the extent to which children who are not currently enrolled in school benefit from such programs remains unclear. While exact figures are not available, the most recent SAIRR report estimates that 5 million South Africans old enough to attend school have had no formal education (SAIRR 1996). Thus, out of school youth comprise a significant proportion of South Africa's children and young adults.

- Where do they Go? Where do they Meet?
  - ⇒ clubs
  - ⇒ churches
  - ⇒ community centers
  - ⇒ clinics
  - ⇒ workplaces
  - ⇒ on the streets
- How Much do They Benefit from and Participate in Community Programs?
  - ⇒ do community efforts reach out of school youth?
- Do Out of School Youth have Special Reproductive Health Needs?
  - ⇒ knowledge, awareness, education
  - ⇒ violence, sexual abuse
  - ⇒ malnutrition
  - ⇒ sexually transmitted infections
  - ⇒ psychological and life skills counseling

#### *6.5 Measuring Cause, Effect, and Sustainability*

One problem common to several initiatives reviewed here was the lack of formal program evaluation and monitoring (see Meyer-Weitz & Steyn 1992). Lack of such measures makes it difficult - if not impossible - to draw conclusions about the effectiveness of such efforts and whether they had an impact on knowledge or health status. For those programs which had been evaluated, it was often unclear as to what factors were being monitored and how these linked with reproductive health.

Finally, many of those we spoke with voiced questions about long-term sustainability of programs. This issue was especially troubling for programs dependent on precarious government funding, NGO involvement and those relying on volunteer support. Each of these components - evaluation, monitoring, sustainability - must be carefully considered in implementing new programs or critiquing existing ones. How can these elements be built into programs? More work needs to focus on:

- Development of Efficient, Effective Means of Identification, Evaluation, Monitoring
  - ⇒ youths' reproductive health status and problems
  - ⇒ youths' reproductive health knowledge
  - ⇒ community and school reproductive health concerns
- Sustainability
  - ⇒ incentives for volunteer and peer educators to remain involved
  - ⇒ sustained community interest
  - ⇒ cost-effectiveness and financial self-dependence

#### *6.6 Developing Information Dissemination Strategies*

Finding ways of sharing information and creating communication networks was a commonly voiced need by many involved in reproductive health education and intervention programs. Feelings of isolation and helplessness were particularly acute among those involved in small-scale programs in isolated rural areas. Despite country-wide efforts such as AIDS Training and Information Centers (ATICCs), NACOSA, PPASA, NPPHCN, and the national life skills teacher training initiative, it seems that there is still a need for improved communication networks. Some of those interviewed felt the need for a “grass roots” network as an alternative to large NGO and government agency committees and task forces. Such efforts were seen as too easily swallowed up by bureaucratic delays and inefficiency. Given financial constraints and limited resources, what are feasible ways of getting timely information out to those who need it as quickly and efficiently as possible? We need to find more efficient means of doing the following things:

- Link and Publicize Existing Programs
  - ⇒ facilitates a coordinated approach to reproductive health education
- Disseminate Results Quickly
  - ⇒ avoids replication
- Facilitate Dialogue and Information Sharing
- Reach Isolated Rural Areas and Small-Scale Projects
- Examine the Feasibility of Alternative Means of Information Transfer
  - ⇒ electronically: e-mail, websites, databases
  - ⇒ grassroots newsletters provincially and nationally

## **7. Other information Sources**

## **1. PPASA**

### **Books**

#### **Straight Talk**

A lively and colourful booklet for teens, giving them the facts they need in order to carry out fulfilling and healthy sexual lives.

#### **Responsible Teenage Sexuality**

A comprehensive book for teachers of Lifeskills and sexuality education

#### **Bodywise**

Sex education, health and advice for South African youth.

#### **Quest for Excellence**

Produced in the USA, this book covers teenage issues ranging from self esteem and alcohol to AIDS and sexual abuse.

#### **Sexual Etiquette**

A little black book for adolescents, covering everything they need to know about health sexual decision making.

#### **The Male Reproductive System**

#### **The Female Reproductive System**

**Life Skills and HIV / AIDS Education.** A Manual and Resource Guide for Secondary School Teachers

### **Journals**

#### **AIDS Scan**

#### **Sexual and Reproductive Health Bulletin**

## **2. NPPHCN**

#### **The Youth Speaks Out**

## **3. Overseas Development Administration**

Promoting Better Reproductive Health: Responding to the Needs of Young People

## **4. The World Health Organization**

#### **Promoting Health Through Schools**

A report of the WHO Expert Committee on Comprehensive School Health Education and Promotion, *Geneva, 18-22 September 1995*

#### **The Status of School Health**

( WHO / HPR / HEP / 96.1 )

#### **Improving School Health Programs**

Barriers and Strategies ( WHO / HPR / HEP / 96.2 )

#### **Research to Improve the Implementation and Effectiveness of School Health**

#### **Programs**

( WHO / HPR / HEP / 96.3 )

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## List of KwaZulu-Natal Lifeskills / Sexuality Education Organizations and Programs

Some organizations are not listed because information on them could not be found ( some not easy to contact ) - a few are discussed in the body of the text

ORGANIZATION	TYPE	PROGRAM	METHOD	AGE
ATICC, Dbn.	Municipal	ATICC Street Children	Peer education (youth)	4-18
ATICC, PMB	Government	ATICC Lifeskills	Variety of participatory methodologies	11-21
ATICC, Zululand	Government/Municipal	Zululand Teacher program/Youth Program	Lectures, Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (youth)	12-25 (youth)
African Enterprise	Para Church (Xian)	Teacher Program / Youth Program	Lectures, Workshops, Games/Role Plays (youth)	4-25 (youth)
Aryan Benevolent Home Council	NGO	Aryan Council Caregiver Program / Youth Program	Lectures, Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (youth)	18 / 4-25
East Griqualand & Usher Memorial Hospital	Government	Annual AIDS Open Day	Parades, question / answer session, Information Talk at Churches / Youth Conferences (Community)	
Edendale Hospital	Government	Teacher Program / Youth Program	Lectures, Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (youth)	4-25 (youth)
Gamalakhe Health Ward	Government	Gamalakhe Youth Program	Games/Role-plays, Drama, Pamphlets/books/posters (youth)	14
Greytown Provincial Hospital	Government	Greytown Hospital Medical Student program	Books, Group Discussions, Question/answer Sessions, Ward Rounds, Theatre/Maternity cases (other)	18-24
Health Promotion	Government	Teacher Program / Youth Program	Lectures, Workshops, Games/Role-plays, Drama, Pamphlets/books/posters (youth)	4-25 (youth)
Hillcrest AIDS Center \$ Molweni AIDS Center	NGO	Hillcrest & Molweni Teacher Program	Workshops, Games/Role-plays, Drama, Pamphlets/books/posters , Sport (youth)	12-25 (youth)
Hlabisa Hospital &	Government &	Community HIV	Small Groups,	

Vusi Impilo	NGO	Education Program / Traditional healers / Church Leaders Ed. Progr.	community-based teaching (Community) / Group-based, interactive teaching (Educators)	
Interdependent Youth Forum	Municipal	Interdependent Youth Forum Youth Group	Lectures, Workshops, Games, Pamphlets/posters, Debates(youth)	12-25
KZN Department of Education	Government	Teacher Program / Youth Program	Lectures, Workshops, Games/Role Plays, Drama, Videos, Pamphlets/books/posters (youth)	4-25 (youth)
KZN Department of Education & Culture	Government	Department of Education Teacher Program	Interactive learning (Educators)	21-55
Kynoch Hospital AECI Operation Services	Private	Kynoch Workers Counseling	Individual Counseling (other)	20-50
Lifeline, Natal Coastal Region	NGO			
Lifeline, PMB	NGO			
Manguzi AIDS Counseling	Government	Teacher Program / Youth Program	Lectures, Workshops, Games/Role Plays, Drama, Videos, Pamphlets/books/posters (educators/youth)	21-55/8-25
Midlands Hospital	Government	Midlands Program for the Mentally Retarded	Lectures, Games/Role Plays, Drama, Videos, posters (other)	16-55
Mseleni Hospital	Government	Teacher Program / Youth Program	Workshops, Games/Role Plays, Videos, Pamphlets/books.posters (Educators/Youth)	21-55/21-18
Murchiston Hospital	Government	Murchiston Hospital Counseling Program	Individual Counsellin (youth)	12-25
Natal Youth Network	NGO & CBO	Natal Youth Network Youth Program	Lectures, Workshops, Videos, Role-pay, Group Work, Problem Solving (youth)	12-25
National Association of traditional healers of S.A.	Government		School visits (youth)	4-25
Nkonjeni Hospital	Government	Nkonjeni Youth Program	Lectures, Workshops, Videos, Role-pay, Pamphlets/books/posters (youth)	4-25
Nolwazi Educational Publishers	Private (Commercial)	Macmillan AIDS Awareness Program	Lectures, Workshops, Games/Role Plays, Videos, Books, Macmillan AIDS readers (Educators)	21-55

Okhahlamba AIDS Action Group	Government	Teacher Program / Youth Program	Workshops, Games/Role Plays, Videos, Pamphlets (youth)	12-25 (youth)
Phoenix Primary Health care Center	Government	AIDS Counseling / AIDS Education Program	Counselling Sessions (other) /Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (other)	14-40
People AIDS Action Group (PAAG)	NGO	Pre-teen Medical Development Program/National Teacher Program/Outreach projects for youth/Outreach Projects for educators/Commercial Sex Workers Project	Workshops, Games/Role Plays, drama, Videos, Pamphlets/books/posters (youth)/Training Courses (educators)/Targets teachers and youth for identified needs (youth)/ Targets teachers and youth for identified needs (educators/Training Course, Zimani support club (youth)	8-12/4-25/15-25
Pinetown Highway Child & family Welfare Society	NGO	Pinetown Youth Program	Workshops, Games/Role Plays, drama, Videos, Pamphlets/books/posters (youth)	4-25
Planned Parenthood Association of S.A.	NGO	Teacher Program / Youth Program	Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (youth)	4-25 (youth)
Project Champs	NGO	Teacher Program / Youth Program	Workshops, Discussions, Role Plays, Lectures, Pamphlets/books/posters (educators/youth)	21-55 / 21-25
School Health Services	Government	School Health Youth Program	Songs, Lectures, Plays (youth)	8-18
Scripture Union	NGO	Teacher Program / Youth Program	Workshops, Games/Role Plays, Videos, Pamphlets/books/posters (youth)	8-18 (youth)
Society for Family Health	NGO	Social marketing Concept	Distribution of condoms for an affordable price (other)	13-49
Spirit of Adventure	Private	Spirit of adventure Youth Program		
The Pietermaritzburg Hospice Association	Welfare	Adjustment to Change and Loss	Lectures, participation, Exercises, group discussions, Art (youth)	4-25