The Sexual Health Needs of Learners in Makapanstad, Hammanskraal

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ABSTRACT

The aim of this article is to inductively explore and describe the sexual health needs of learners in Makapanstad, Hammanskraal, using a phenomenological qualitative research design. Three themes and eight sub-themes were revealed during data analysis. The identified main themes were: The sexual health needs of learners, contributory factors towards teenage pregnancy and the strategies to address the identified sexual health needs. It is concluded that teenage pregnancy is a serious health concern due to inadequate parental guidance, and poverty. Parental involvement in sexual health issues, free condom distribution, sex education in schools, homes and churches, use of technology and the use of stepping stones were suggested as strategies to reduce the rate of teenage pregnancy. Further research should be conducted in order to explore other strategies that will possibly promote sexual health of learners in other South African schools.

INTRODUCTION

Pre-marital and unprotected sexual activities amongst adolescents in primary, secondary and tertiary education institutions are becoming a serious health concern worldwide, more especially in Sub-Saharan countries. According to Hindin and Fatusi (2009); Mothiba & Maputle (2012), there is evidence of an increasing rate of early marriage and premarital sexual activities amongst the adolescents in Sub-Saharan countries. Consequently there is higher prevalence of HIV and AIDS as compared to other parts of the world. Recent evidence from the Demographic and Health Survey and the AIDS Indicator Surveys shows that the median ages of the first sexual encounter amongst 20-24 year old women ranges from under 16 years in Cha, Mali and Mozambique to 19.6 years in Senegal. Overall, the median age in the rest of Sub-Saharan Africa is 18.5 years. This age pattern at sexual debut in Sub-Saharan Africa, contrasts with that in other parts of the developing world. In the Caribbean and Latin American countries, half of young women were

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between 18 and 19 years during their first sexual encounter. In Bolivia, Guyana and the Dominican Republic men were younger than women during their first sexual experience, according to Hindin and Fatusi (2009). In the Phakunong village in India, children get married as early as at the age of 12 years and as late as 34 years (Devi, Nabakumar & Singh, 2013). In South Africa, the median age of sexual debut is 15 years for males and 16 years for females which also includes children who are less than 11 years of age (Richter, Mabaso, Ramijith & Norris, 2015). South Africa,therefore, seems to have the lowest median age of early sexual debut as compared to other Sub-Saharan countries.

South Africa has policies which support the provision of sexual and reproductive health services from an early age, with the intention to promote the health of adolescents by reducing the rates of unwanted pregnancies, risks related to teenage births, sexually transmitted infections (STIs), HIV and AIDS which contribute to morbidity and mortality amongst the youth (Department of Health, DoH, 2015). Under the Choice of Termination of Pregnancy (CTOP) Act, 92 of 1996, only a 10 year old minor's consent is needed subject to advising such a minor to consult with the parents (DoH, 2012). According to the Children's Act, 38 of 2005 as amended, children from the age of 12 may consent to being treated for HIV, may have access to contraception and should be provided with condoms (DoH, 2012). This is supported by the National Adolescent Sexual and Reproductive Health and Rights (NASRHR) framework strategy, which states that a sexual and reproductive healthright (SRH) is considered to be a basic human right for everyone and is fundamental to developmental conditions of any population. It further states that the youth have the right to exercise sexuality which is free of violence and the right to choose whether and when to have children (DoH, 2015).

The Stepping Stones, training manual has also been used as one of the strategies to promote the sexual and reproductive health of adolescents. Stepping Stones has been described as a workshop series designed as a tool to help promote sexual health, improve psychological well-being and prevent sexually transmitted infections, HIV and unplanned pregnancies. The first edition of Stepping Stones manual was compiled by Wenbourn in 1995.The first South African manual was prepared and adapted from the original Stepping Stones to the South African context by Jeweks and Cornwall (1998), the second South African edition was prepared by Jeweks, Nduna and Jama (2002) and the third South African edition was prepared by Jewkes, Nduna and Jama (2010) and published by the Medical Research Council of South Africa.

Despite the above strategies that are in place to promote the sexual and reproductive health of adolescents, the rate of teenage pregnancies remains a serious global health challenge, more especially in developing countries. In Nigeria, the birth rate of adolescents is one of the highest in the world, and the prevalence of sexually transmitted infections, including HIV among female adolescents, is rapidly increasing. Therefore pregnancy and

motherhood in Nigeria marks the end of school attendance and by the age of 16 years, 21% of female adolescents are either pregnant or have given birth (Slap, Lot, Huang, Daniyam, Zink & Succop, 2003). According to Ekefre, Ekanem and Ekpenyong (2014), it is estimated that about 16 million Nigerian adolescent girls give birth every year mostly in low and middle income areas. In addition, an estimated three million girls aged between 15 and 19 engage in unsafe abortions every year (Ekefre *et al*., 2014). In Ghana, the statistics of teenage pregnancy indicate that about 750 thousand teenagers between the ages of 15 and 19 became pregnant in 2014, with the central region recording the highest numbers (Buabeng, 2015).

In contrast, data that were published by the office of the National Statistics in England, as a developed country, show that the under 18 conception rate has decreased to an all-time low, with a reduction of 41% between 1998 and 2012 (Hadley, 2014). Furthermore, the findings of a study conducted in the United States of America (USA) have shown that in 2008, 51 % of pregnancies were unwanted, and the unintended pregnancy rate was 54 % per 1000 women of ages 15 to 44 (Finer & Zolna, 2013). Between 2001 and 2008, the intended pregnancies decreased and the unintended pregnancies increased; a shift which was previously unobserved. The percentage of unintended pregnancies ending in abortion decreased, and the rate of unintended pregnancies ending in birth increased; reaching 27 per 1000 women (Finer & Zolna, 2013).

According to the 2013 Statistics South Africa's General Household survey which focuses on schools, the prevalence of teenage pregnancy is "alarming and unheard of" (Makiwane, & Udjo, , 2015). The statistics shows that 5.4% of females in the age group of 14-19 years were pregnant during the 12 months before they were surveyed. The prevalence of pregnancy has increased with age, rising from 0.7% for females between the ages of 14 -19 years, to 12, 1%, (DoH, 2015). The rate of school girls who fall pregnant in South Africa has increased from 68,000 in 2011, 81 000 in 2012 to 99,000 in 2013 (Masondo, 2015). The most affected provinces in South Africa are Kwazulu-Natal which is at 26,468, followed by the Eastern Cape which is at 20,698, then Limpopo at 13,941 (Masondo, 2015).

Unwanted pregnancies are accompanied by sexually transmitted infections, HIV and AIDS and dropping out of school before completion of grade 12 and thus resulting in the inability to secure employment (Mothiba & Maputle, 2012). Teenagers who get married at an early age are regarded as high risk because of the physical immaturity in readiness to childbirth (Devi, Nabakumar & Singh, 2013). These consequences have a negative impact not only on the learner who is affected but on society as a whole. The priority problem of teenage pregnancy was identified in one of the selected schools in Hammanskraal within the Gauteng Province, which had 9,428 school girls who fell pregnant in 2013 (Masondo, 2015). Therefore, the School of Health Care Sciences, University of Pretoria, initiated a research study focusing on the wellness of adolescents.

The aim of the wellness project is to promote the sexual and reproductive health of learners in order to prevent their morbidity and mortality as a result of pregnancy and birth related complications. The birth related complications result from the body's immaturity which places the pregnant adolescent at risk of obstetric complications, the unmet need to access timely obstetric care and the prevalence of unsafe abortions (Dunn, 2014). The contributory factors towards teenage pregnancy are multi-dimensional and have not been addressed in a systematic comprehensive manner, despite sex education programmes which are offered in schools as part of the life orientation curriculum (Mushwana, Monareng, Richter, & Muller, 2015). Therefore the purpose of this article is to report the findings of a study which explored and described the sexual health needs of learners at a selected high school in Hammanskraal, with the intention to promote their sexual and reproductive health.

METHODOLOGY

A qualitative, descriptive approach which is phenomenological in nature was followed in this study. The selected research approach enabled the researchers to inductively explore and describe the sexual health needs of learners in the selected high school in Hammanskraal. The setting of the study is described by Polit and Beck (2008) as the physical location and conditions in which data collection takes place in a study. Data were collected from a selected high school in Hammanskraal. This is a semi-rural low-resourced area with Setswana as the main language. The high school was the suitable setting for data collection because it was the central venue for the group of participants who were available at the school. The sample consisted of five school teachers and 20 learners. It was convenient to use a large hall that was situated in the middle of the school right behind the staff room. The hall was a quiet environment which enabled focus group interviews to be conducted without any disruptions, because of the distance from the classrooms.

Study population and sampling

The study population comprised of 25 participants, the 20 learners were selected because they had been the best performers in Grade 10. They were selected to represent the rest of the learners because they still had two years in Grade 11 and 12 to implement what they had learned during the research process. The parental consent and the consent from the school principal was obtained as majority of learners are less than 18 years. There were also five school teachers who taught life orientation, life sciences and sexuality education at the selected school. The participants were selected purposively, because only school teachers and learners who were involved in reproductive health issues in one way or another participated in the study. In-depth, unstructured, open-ended focus group interviews were used to collect data (Creswell, 2014).

DATA COLLECTION

Data were collected using in-depth, unstructured, open-ended focus group interviews. The following open-ended research question was used as a guide during focus group interviews: "What are the sexual health needs of learners? Follow-up questions were developed for probing purposes, based on the responses from the participants. The current understanding of the sexual health needs of adolescents were bracketed by the researchers in order to avoid contamination of data through pre-conceived ideas about the phenomena being studied. Five focus group interviews were conducted. For the purpose of phenomenological research approach, which allows three to 10 participants, each focus group consisted of five participants, four groups of five learners and one group of five school teachers. The focus groups enabled learners to express themselves freely and in a non-threatening environment. Each focus group interview lasted between 45 to 60 minutes. A tape recorder was used during focus group interviews to capture all the data, with permission from all the participants. Additionally, observational and field notes were also gathered (Babbie, 2010).

Ethical Considerations

This article reports the findings of the baseline study which was aimed at identifying the sexual health needs of learners, as indicators for the proposed Stepping Stones project prior the approval from the University of Pretoria Ethics Committee. The parental consent for learners who are under the age of 18 years and the school principal,verbal and written consent was obtained from the teachers. During the study, the participants were informed that it was their right to voluntarily decide, according to their own will and understanding, whether to participate in the study or not. The researchers provided a full description to the participants about the nature of the study since it is the participant's right to refuse participation. The participants were treated equally as co-researchers before, during and after the study. In order to ensure fair treatment, the researchers provided a non-prejudicial treatment to those participants who decided to withdraw from the study after agreeing to participate. Participants were treated with respect and dignity, and persons with diminished autonomy were protected (Polit & Beck, 2008). The participants were encouraged to respect each other during the focus group interviews. The researchers ensured that they were free from any harm which could be emotional, physical, psychological or spiritual, since they were discussing sexual health related issues. The participants were made aware that all the personal information that was provided during focus group interviews was kept privately and confidentially (Polit & Beck, 2008).

Measures to ensure trustworthiness

The following measures were adhered to for ensuring trustworthiness: credibility,

dependability, confirmability and transferability. To achieve credibility of the study findings, three to four meetings were held with the participants to ensure prolonged engagement, establish rapport, and to develop an in-depth understanding of the study (Creswell, 2009). To achieve triangulation, different sources of information were sought from the learners and teachers focus group discussions. The study was critically evaluated by other researchers who were not part of the study. To achieve credibility, other researchers were permitted to ask questions about the study methods, continuous focus group discussions and evaluation of the participatory action research cycles to identify what worked and what did not work in order to re-plan and use other methods that improved on practice and ensured member checks (Creswell, 2009). Dependability was achieved by ensuring that the collected data only reflected the sexual and reproductive health needs that were obtained during focus group discussions and the suggested action plan to address the identified sexual and reproductive health needs of learners (Lincoln & Guba, 1985). To achieve confirmability, data were verified by the researchers and the participants as supported by Polit, D (1996). Transferability of the findings to other settings is not possible for this study because the research was only conducted at one high school (Lincoln & Guba, 1985).

Data analysis

Tesch's (2013) eight steps were used during the coding process. Data were transcribed, organised, prepared for analysis and grouped according to similarities and relationships. The researchers read the organised data and made sense of its meaning. All data were coded by bracketing chunks and writing their categories to reduce the total lists. The most suitable descriptive wording was assigned to the categories. Each category was coded, interpreted and preliminary analysis was done, and then the final codes were tabulated. A report was compiled and the findings were shared with the participants, colleagues and the wider audiences during feedback meetings (Creswell, 2014).

FINDINGS AND DISCUSSIONS

The learners and the teachers who participated in the study were all South African citizens who spoke Setswana as their dominant language because they all lived in the same village. However, the learners selected English as their preferred language during data collection. The age of the learners ranged between 10 and 20 years. About 90% of the learners who participated in the study indicated that they were sexually active. The ages of school teachers ranged between 25 and 55 years while their work experience ranged between 5 and 25 years. Table 1 illustrates the demographic characteristics of learners and Table 2 illustrates the demographic characteristics of teachers. Three themes and eight sub-themes were identified during data analysis and they are illustrated in Table 3.

Demographic characteristics of the participants

Table 1

The demographic characteristics of learners

Learners (Grade 10)		
Characteristics	**Number**	**Percentage**
Gender		
Female	12	60
Male	8	40
Age (years)		
10-15	17	85
15-20	3	15
Related subject		
Life Orientation	20	100
Other subjects	0	0
Sexual behaviour		
Sexually active	18	90
Not sexually active	2	10

Table 2

Illustrate the demographic characteristics of school teachers

School Teachers		
Characteristics	**Number**	**Percentage**
Gender		
Female	4	80
Male	1	20
Age (years)		
25-35	1	20
35-45	3	60
45-55	1	20
Related subject		
Life Orientation	3	60
Other subjects	2	40
Work experience (years)		
5-10	1	60
10-15	3	20
15-25	1	20

Table 3

Illustrates categories, sub-categories and themes

Themes	Sub-themes
Sexual health needs	High rate of teenage pregnancy
Contributory factors towards teenage pregnancies	Lack of parental guidance
	Poverty
Strategies to reduce high rate of pregnancy	Parental involvement
	Sex education in homes, schools and churches.
	Free distribution of condoms in schools.
	Use of technology to promote sexual health.
	Use of Stepping Stones approach.

Sexual healthneeds

- ***High rate of teenage pregnancy***

FINDINGS AND DISCUSSIONS

During discussions, the learner participants pointed out that there was a high rate of teenage pregnancies in the selected school. They also acknowledged the fact that teenage pregnancy was an indication that a child who is pregnant once had sexual intercourse without a condom, which placed learners at risk of contracting sexually transmitted infections and HIV and AIDS. This is evident from the following quotes:

Learner 14, female aged 15 years, sexually active indicated that:

> "*Our school has high number of pregnant teenagers every year; you are able to confirm this by the number of parents who comes to school every day to sit in for their pregnant daughters".*

Learner 9, female aged 17 years indicated that:

> *"This is not the problem of this school only, actually this happens to all the schools in South Africa, there are few girls who never gave births, the rest are teenage mothers who already gave birth to one or two children"*

School teacher 3, male aged 45 years with 20 years of work experience indicated that:

> *'I wonder, what might be the contributory factor towards the high teenage pregnancy rate, this was not supposed to happen because, in every clinic there are free methods of contraception for everyone, may be people do not know about this."*

These findings implied that there was a high rate of teenage pregnancy at the school where the research was conducted. Findings also showed a need for serious attention, interventions using multidisciplinary team approaches, because it exposed the teenagers to the risk of having sexually transmitted infections, and HIV infection which lead to morbidity and mortality rates. In South Africa, according to the statistics for the 2013 General Household Survey, the prevalence of pregnancy increased with age, rising from 0.7% for females aged 14 years, to 12,1% for females aged 19 years (DoH, 2015). The number of school girls who fall pregnant in South Africa increased from 68 000 in 2011, 81 000 in 2012 to 99 000 in 2013 (Statistic South Africa, 2015). In the North-West Province where the study was conducted, the rate of teenage pregnancy for learners aged between 15 and 19 years was at 10.1% in 2014 (DoH, 2014). Similarly, Nigeria has the highest rate of teenage pregnancy in the world according to Ekefre, Ekanem and Ekpenyong (2014). It is estimated that about 16 million Nigerian adolescent girls give birth every year mostly in low and middle income areas *(ibid*). This could be an indication that teenage pregnancy is a serious health concern in Sub-Saharan Africa.

Contributory factors towards teenage pregnancy

● ***Lack of parental guidance leading to inadequate knowledge about sexual health issues***

The study revealed that some learners engaged in early sexual activities because they did not receive any guidance from their parents on how to protect themselves from unwanted pregnancy, sexually transmitted infections and HIV and AIDS. Learner 18, female aged 15 years old and sexually active indicated that:

> *"My mother never talked to me about teenage pregnancy, I heard about it from my friends".*

Learner 2, female aged 18 years old, with an 18 month old baby boy said:

> *"When my mother realise that Iam pregnant, she was so angry with me and she began to tell me about the dangers of teenage pregnancy… For me it was too late ……..."*

Learner 7, female aged 16 years old, sexually active said:

> "*I started menstruation for the first time when I was in Grade 9, it was during class time, I was so scared……then I reported to my teacher who send me home immediately, I felt that my mom should have warned me about this before…..*

Learner 12, female aged 14 years old, who already started dating suggested that:

> *"Our parents need to be encouraged to talk to us about what happens to our bodies during puberty, and how to protect ourselves from teenage pregnancy, but they don't,……..most of us get information from school teachers during life orientation period……..."*

Learner 20, male aged 15 years old, and sexually active said:

> *'At the age of 10, my father told me about masturbation……and manhood ….by the time it started, I already knew what it means……(sighing).*

There is a connection between parental guidance and knowledge amongst learners regarding the sexual and reproductive health issues. Children who receive guidance from the parents during the adolescent stage regarding sexual health issues are more likely to be able to protect themselves from unwanted pregnancies, sexually transmitted infections and HIV. Mothiba and Maputla, (2012) reveal that some young girls who engage in early sexual activities lack knowledge of access to conventional methods of preventing pregnancy as they may be afraid to seek such information or do not have any one from home to give such information. According to Mushwana *et al*. (2015), the following are contributory factors towards adolescents pregnancies in the Greater Giyani municipality, Limpopo Province, South Africa: unavailability of health services specifically for the adolescents, poor relationship between the nurses and the adolescents, lack of confidentiality from the nurses' side, inadequate knowledge regarding sexual health issues, changing attitudes towards sex and peer pressure. Similarly in Nigeria, findings from a cross sectional survey of secondary school students which focused on sexual behaviour of adolescents, revealed that secondary school students from a polygamous family structure are more likely to have engaged in sexual activity than learners from a monogamous family structure (Slap, Lot, Huang, Daniyam, Zink & Succop, 2003). This could imply that there is a relationship between the family structure and the adolescents' sexual behaviour.

- ***Poverty***

The learner participants revealed that poverty was one of the contributory factors towards teenage pregnancy. They further indicated that learners from impoverished families were more likely to engage in early sexual activities with elderly people of high socio-economic status, than children from financially stable families. Learner 1, female aged 20 years old, with a 3 year old son expressed that:

> *"If I do not have pocket money at school, I usually get it from the "sugar daddies" or taxi drivers because they always have cash in their pockets."*

Learner 8, male aged 16 years old said

> *"In order for me to get pocket money, I need to sell drugs 'nyaope" at school, I do not have a choice, I have to do it".*

Learner 19, female aged 17 years old, indicated that:

> *Whoever promises to give me money, I do not have any problem of engaging into sexual intercourse with him, as long as he pays at the end".*

These short narratives reveal that poverty might place the sexual and reproductive health of young girls at risk of getting unwanted pregnancies, sexually transmitted infections and HIV infection. This is supported by Mothiba and Maputle (2012) who revealed that in the Limpopo Province, teenage pregnancy was commonly found in youngsters who were less than 19 years of age and who had been disadvantaged and had poor expectations with regard to their education or job market. In addition, they further [1]revealed that 60% of girls started to engage in sexual intercourse between the ages of 13 and 15 years, 48% of teenage partners were 21 years and above, 44% depended on single parents' income, 20% depended on their fathers' income, 165 received social grants and 8% lived on their grandparents' pension fund. This shows that poverty could be one of the contributory factors towards teenage pregnancy. Cook and Cameron (2015) contend that in Western Europe and within the UK, higher rates of teenage pregnancy are found amongst women who live in areas of higher deprivation and other factors such as lower educational achievement or living in state care homes.

Plan of action to address the identified needs

- ***Parents' involvement in sexual and reproductive health issues***

Most participants indicated that in order to reduce the rate of teenage pregnancy, there should be involvement of parents in sexual and reproductive health issues. They raised a concern that many parents were not confident enough to discuss the sexual and reproductive health challenges with their adolescent children. Furthermore, they also indicated that, even those who decided to talk to their daughters and sons about sexual and reproductive health issues, they did not tell them the truth. Others suggested that teachers and parents should communicate regarding sexual and reproductive health issues pertaining learners.

Learner 5, female aged 14 years, who is already sexually active said:

> *"When I ask mom about teenage pregnancy, she do not tell me, the truth, she send me to my aunt who is also not comfortable enough to clarify me about this, so I end up not knowing what is the right thing to do"*

Learner 13, male aged 16 years, sexually active suggested that:

> *"Teachers should talk to parents about teenage pregnancy on a regular basis."*

Learner 4, male aged 15 years, sexually active, also suggested that:

> *"Parents should be encouraged to discuss sexual and reproductive health issues with us."*

These findings reveal that there is a need for parents to communicate with their adolescents regarding the sexual and reproductive health issues. This is supported by Weaver, Byers, Sears, Cohen and Randall (2002) who confirm that parents need more information about the school health education curriculum, about sexuality in general, and about communication strategies to assist them in providing sex education at home. Nielsen, Nielsen, Butler and Lazarus (2012) also argue that the involvement of youth in Albania, men, healthcare providers and the status of parents, can be an effective strategy in the promotion of contraceptive use, which reduces the risk of teenage pregnancy. According to Hadley (2014), the development of strong relationships between the adolescents and other family members and supporting positive sexual health, has shown a significant reduction of the under 18 year old conception rate in England, which has fallen to an all-time low, with a reduction of 41% between 1998 and 2012.

- ***Sex education in homes, schools and churches***

The school teacher participants indicated that the sexual and reproductive health problems amongst the learners should be addressed by providing sex education in different parts of the community such as homes, schools and churches. The intention is to ensure that community members, more especially the adolescents, receive timeous information about the prevention of teenage pregnancy, sexually transmitted infections and HIV infection.

School teacher 5, female, aged 45 years, with 20 years working experience suggested that:

> *"I suggest that the sex education be given everywhere in the community, for an example in homes, school and churches, so that people understand the seriousness of the issue".*

School teacher 1, female, aged 30 years, with 5 years of working experience, said:

> *"More information about the different ways to prevent teenage pregnancies, sexually transmitted infections and HIV infection should be given to adolescents, whereever they are able to make informed decisions regarding their sexual and reproductive health."*

The issue of providing sexual health education in schools and in the homes, is not

new, because it was suggested in 2002 by Weaver, Byers, Sears, Cohen and Randall (2002) in a study of New Brunswick parents which focused on sexual health education at school and at home. The findings confirmed that parents supported the issue of including a broad range of sexual health topics at some point in the curriculum (Weaver *et al*., 2002). This was also supported by Mushwana *et al*. (2015) who indicated that in order to improve the school health services, there should be reproductive health education that focuses on reproductive health, sexuality and guidance for future research. Findings of another study that was conducted in England revealed that in order to further improve the decline of teenage pregnancy, a teenage pregnancy prevention strategy was developed, which made teenage pregnancy to remain a priority, and they planned to work on prevention and support of young parents, which should be integrated into relevant policy and programmes (Hadley, 2015). This is an important strategy, which might bring a significant reduction to the teenage pregnancy rate in developing countries.

- ***Free condom distribution in schools.***

Most participants suggested that the condoms should be distributed freely in schools, most importantly the female condoms so that they are protected from teenage pregnancies, sexually transmitted infections and HIV.

Learner 4, male aged 15 years suggested that:

> *'I suggest that we receive condoms freely from school, rather than going to the clinic where everyone will be looking at you knowing that obviously you are there for the condoms."*

Learner 16, male aged 17 years, expressed that:

> *"I prefer getting the condoms from the school and not the clinic'.*

School teacher 2, female aged 37 years, a life orientation teacher for 12 years said:

> *"Most of our school children like to experience what they learn in life orientation, so they expose themselves to early sexual activities and unprotected sex, as a result they become pregnant as early as 12 years….sexually transmitted infections….HIV and AIDs…. Which is a serious concern…"*

According to the mid-year population estimates of HIV prevalence and the number of peoples living with HIV, 2002-2015, the prevalence of youth living with HIV is at 5.59 million. This indicates that there is a need for the distribution of free condoms in schools as one of the strategies to protect the youth from contracting sexually transmitted infections, including HIV (Statistic South Africa, 2015). Furthermore, the Children's

Act, 38 of 2005 as amended, spells out that children from the age of 12 may also consent to being tested for HIV, may also have access to contraception and should be provided with condoms freely (DoH, 2012). It is evident that there is an urgent need to provide free condoms to the learners at schools with the intention to protect and promote sexual and reproductive health.

- ***The use of technology on sexual and reproductive health promotion.***

The learner participants indicated that they use technology for promotion of the sexual and reproductive health because as the y-generation, they are able to use and understand technology for different activities in their lives.

Learner 10, male, aged 16 years, sexually active, expressed that:

> *"I prefer the use of technology which is easy to understand and it makes my life very easy, so I hope we can use it also in health promotion."*

Learner 17, male, aged 15 years, sexually active said:

> *"The use of technology is the way to go, this is 2016, let us go for it, because it is very quick and it saves time."*

These findings reveal that there is a need for the adolescents to use technology for sexual and reproductive health promotion. According to Guse, Levine, Martins, Lira, Gaarde, Westmorland and Gillian (2012), the use of new digital media showed a significant delay in the initiation of sex for school children. One was successful in encouraging users of SNS to remove sex references from their public profiles. They further indicated that seven interventions significantly influenced psychosocial outcomes such as condom self-efficacy and abstinence attitudes, but at times the results were in directions which were not expected by the study. Six studies increased knowledge of HIV, sexually transmitted infections, or pregnancy (Guse *et al*., 2012). In addition, Shepherd, Harden, Barnett-Page, Kavanagh, Picot, Frampton, Cooper, Hartwell and Clegg (2014) also reveal that the implementation, engagement and acceptability of processed data included good quality teacher training, involvement and motivation of key school stakeholders, relevance and appeal to young people. On the other hand, the study findings indicate the factors which have a negative impact of the use of the processed data such as failure of teachers to comprehend the theoretical basis for behaviour change, school logistical problems and omission of topics that were considered to be more important by young people. It is evident that even though the use of technology is more effective in the promotion of sexual health amongst learners because of its relevance and acceptability by the younger generation, it also has some negative factors when used by teachers who were born before the technology age. Thus there

should be continuous training of teachers to ensure the effective use of technology in order to meet the sexual [2] and reproductive health needs of learners (Shepherd *et al*., 2014).

● ***The use of "Stepping Stones" training of trainers approach, Training on sexual health issues.***

Many learners requested the use of "Stepping Stones" to address the sexual and reproductive health problems which lead to teenage pregnancy and exposes learners to sexually transmitted infections including HIV infection.

Learner 15, male aged 16 years, sexually active suggested that:

> *"How about using the Stepping into the right future, to address the increasing rate of teenage pregnancy?*

School teacher 4, female aged 55 years with 30 years of teaching experience expressed that:

> *"I heard that stepping stones is a very good strategy which can be used to change the sexual behaviours of adolescents and the rest of the community, let us try it"……*

Learner 12, female, aged 15 years, who is not sexually active said:

> *"I attended a Stepping Stones workshop, and we were trained about sexual behaviours and sexual relationships, so it empowered me to understand my sexuality…….learned to say no…..focusing on my school work….."*

Learner 3, female, aged 14, sexually active, said:

> *I read about it (Stepping Stones)….. It is so interesting…I need to know more…….*

The Stepping Stones approach was discussed during the Association for Cooperative Operations Research and Development (ACORD) conference in London (Hadjipateras, 2006). Jeweks, Nduna, Levin, Jama, Dunkle, Puren and Duvvury (2008), reveal that participation in the Stepping Stones programme in South Africa did not reduce the incidence of HIV infection amongst young women and men aged between 15 and 26, but was associated with a reduced incidence of herpes simplex type 2 (HSV-2). According to Jackson, Geddes, Haw and Frank (2012) there is some albeit limited evidence that programmes aimed at reducing multiple risk behaviours among school children could be effective unless the programmes focuses on addressing multiple domains of influence on risk behaviours. They recommend that further research is needed on the effectiveness of programmes such as the reduction of teenage pregnancy, sexually transmitted infections and HIV amongst learners. It is evident that the Stepping Stones programme

in South Africa does not yield positive outcomes when used with the intention to reduce the rate of HIV infections.

CONCLUSION

The aim of the study was to explore and describe the sexual health needs of learners in a selected high school in Hammanskraal. Three themes were revealed during data analysis which were sexual and reproductive health needs, contributory factors towards teenage pregnancy and strategies to address the identified needs. All learners agreed that the teenage pregnancy rate was high at their school. Teenage pregnancy is a serious health concern among learners as it leads to complications related to childbirth because of their physical immaturity. The increasing rate of teenage pregnancy has also been supported by other studies in other South African provinces, Nigeria and the United Kingdom. We recommended that the suggested intervention be implemented as a matter of urgency in order to promote learners' sexual and reproductive health. The results of this study can be used to inform the integrated school health policy, and the policy makers to consider the involvement and active participation of parents in preventing teenage pregnancies. Further studies should be conducted in other high schools around South Africa in order to explore more strategies to prevent the increasing rate of teenage pregnancy.

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This was the baseline study done before the ethical approvals from the University and Department of Health but with the permission of the School Principal, Parents, Teachers and the Learners.

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