JOURNAL OF COMMUNITY SYSTEMS FOR HEALTH
2025, VOL. 2
https://doi.org/10.36368/jcsh.v2i1.1197

ORIGINAL RESEARCH

From policy to practice: Access to sexual and reproductive health services for adolescent girls and young women through the Integrated School Health Policy in KwaZulu-Natal, South Africa

Phiwe Babalo Nota[1,2*], Tamaryn Crankshaw[1], Gavin George[1, 3]

[1]Health Economics and HIV and AIDS Research Division (HEARD), School of Accounting, Economics and Finance, University of KwaZulu-Natal, Durban, South Africa
[2]Children's Institute, Department of Paediatrics and Child Health, University of Cape Town, South Africa
[3]Division of Social Medicine and Global Health, Lund University, Lund, Sweden

***Corresponding author:** phiwe.nota@uct.ac.za

Received 17 April 2025; Accepted 28 August 2025; Published 5 September 2025

ABSTRACT

Introduction: Adolescent girls and young women (AGYW) in South Africa continue to experience poor sexual and reproductive health (SRH) outcomes, such as early and unintended pregnancies, and sexually transmitted infections. The Integrated School Health Policy (ISHP) aims to enhance the health and well-being of school-going AGYW by promoting SRH and providing services. This study examined the implementation of SRH services for school-going adolescent girls within KwaZulu-Natal, South Africa.

Methods: A qualitative research design was employed, gathering triangulated data from six focus group discussions (FGDs) with school-going AGYW (n=54), key informant interviews (KIIs) with learner support agents (n=3), a school-based support team member, district-based support team members (N=8), and provincial-level ISHP stakeholders (n=2). All FGDs and KIIs were audio-recorded, transcribed, and thematically analysed.

Results: Our findings highlight several upstream challenges in providing SRH services for school-going AGYW. Gatekeeping from school governing bodies and difficulties in obtaining parental consent were identified as key obstacles for promoting SRH and providing contraceptive services. Additionally, cultural norms that supported early adolescent pregnancies among learners were reported to be a key challenge. Psychosocial support remains inadequate, particularly for young women who have experienced sexual violence and/or are adolescent mothers. Delivering age-appropriate sexuality education remains a challenge in South African schools because of the age disparities within the same school grades.

Conclusions: Policies and the provision of SRH services need to be responsive to cultural norms, which may be at odds with a rights-based approach to the provision of SRH services. Parents and school governing bodies need to be meaningfully engaged through awareness-raising efforts and education on the short and long-term benefits of SRH support for learners.

Keywords: Sexual and reproductive, school, policy, adolescents, girls, young, women, KwaZulu-Natal, South Africa.

Abstract in Español at the end of the article

INTRODUCTION

Adolescent girls and young women (AGYW) aged 10 to 24 years face significant challenges related to their sexual and reproductive health (SRH), which are exacerbated by a combination of socio-economic, cultural, and structural factors [1-5]. High rates of early and unintended pregnancies [2], coupled with sustained high rates of new HIV infections [6] pose serious adverse health consequences for AGYW and their children. Early and unintended pregnancy (EUP) is a public health and social challenge and also plays a key role in deepening lifetime vulnerability for adolescent girls by interrupting educational trajectories and thus limiting their future productive potential [7, 8]. This is because EUP and early motherhood fundamentally disrupts adolescent health and development and schooling trajectories and perpetuates intergenerational cycles of ill-health and poverty. In South Africa, 54% of all births between 2012 and 2016 were unintended, with the rate being even higher among adolescent girls aged 15–19 years and unmarried women [9]. Research from clinics in some parts of South Africa found the prevalence of unintended pregnancy to be around 59.24% among women accessing antenatal services [10].

Beyond the health risks, the SRH challenges facing AGYW in South Africa are deeply embedded in gendered power relations and broader human rights concerns [11]. Gender norms that prioritise early motherhood, parental gatekeeping over contraceptive access, and the pervasive threat of sexual violence illustrate how structural inequalities shape adolescent girls' capacity to exercise agency over their sexual and reproductive lives. As such, a gender lens is essential, not only to illuminate the unequal burdens borne by AGYW, but also to recognise how the denial of sexual and reproductive health rights (SRHR) constitutes a violation of their fundamental rights to health, education, and bodily autonomy [12, 13]. Framing SRH access as both a gender justice and rights-based issue foregrounds the obligation of states and institutions to create enabling environments where adolescents can make informed choices free from coercion, stigma, and discrimination.

In response to the unique barriers that adolescent girls face in accessing SRH services, the World Health Organization (WHO) published guidelines on Making Health Services Adolescent-friendly [14] on how to make healthcare for adolescents, including SRH services, more accessible. South Africa has developed several progressive policies in response to the barriers in access to care for adolescents between the ages of 10 to 24 years [15-17]. These policies include, National Policy on HIV, STIs, and TB for Learners, Educators, School Support Staff, and Officials in all Primary and Secondary Schools in the Basic Education Sector (National HIV Policy) [18], and the Integrated School Health Policy (ISHP) 2012 [19], which had the goal of addressing health barriers to learning to improve both health and educational outcomes . To augment the ISHP, the Department of Basic Education (DBE) launched the Standard Operating Procedures (SOP) for the Provision of Sexual and Reproductive Health, Rights (SRHR) and Social Services in Secondary Schools in 2019 to further guide the provision of SRH services for learners [20].

The ISHP (2012) SRH package covers the provision of age-appropriate health education to learners from the Foundation phase (grade R-3) to the Further Education and Training phase (Grades 10-12), covering age-appropriate topics such as sexual abuse, menstruation, contraceptive use, sexually transmitted infection (STIs) and choice of termination of pregnancy [19]. The ISHP delivers health education topics primarily through integration within existing school subjects, such as the Life Orientation curriculum, which is a formal subject in South African schools covering personal development, health, and social issues. Health promotion is supported by the provision of condoms in schools; however, this is subject to approval from the school governing body (SGB) [21, 22]. The SGB is a statutory body of parents, educators, non-teaching staff and learners who seek to work together to promote the well-being and effectiveness of the school community. The ISHP SRH package further includes counselling and the provision of and referral to appropriate health and social services [19]. Additionally, through the ISHP, the Human papillomavirus (HPV) vaccination is provided to Grade 5 girls aged 9 years and above [23].

The ISHP is a multi-sectoral initiative led by the Department of Health (DOH), Department of Basic Education (DBE), and the Department of Social Development (DSD) to provide comprehensive health services to school-going children and adolescents. The DOH is responsible for delivering school-based health services, while the DBE facilitates programme implementation within schools and integrates health education into the curriculum, and although the role of DSD is not well articulated in the policy, they provide psychosocial support through social workers. The School-Based Support Team (SBST) is responsible for determining the support needs of the school, teachers and learners and coordinating support, including school health services. Learner Support Agents (LSAs) work with the SBST and are contracted by provincial education departments to assist vulnerable learners through care and support activities [24]. However, not all public schools have LSAs in South Africa, their placement in schools are dependent on available resources.

Literature on school health implementation in South Africa and sub-Saharan African countries reveals common challenges and some region-specific experiences, with a focus on resource constraints, weak intersectoral collaboration, and lack of training. In Ghana, school health staff have reported that school health policy implementation faces several challenges because of limited government support and weak intersectoral collaborations [25]. In Nigeria, the national school health policy has also been critiqued for a lack of effective coordina-

tion among stakeholders, which negatively affects school health services [26]. School health implementation in Nigeria has also been reported to be weak due to a lack of resources, inadequate health facilities, and limited awareness of the national school health policy [26]. Similarly, South African studies have also suggested that there is a lack of coordination between the Department of Health and the Department of Basic Education in implementing school health activities, as well as limited consultation and involvement of key stakeholders such as school managers and healthcare facility managers, resulting in poor implementation of school health services [27]. However, there are limited studies that have explored access to SRH services through the ISHP in South Africa.

While access to healthcare, especially for adolescents, is a high-priority policy objective in South Africa, SRH challenges persist among AGYW [28-31]. These challenges underscore potential gaps in service appropriateness and accessibility. This research aimed to examine the implementation of SRH services for school-going AGYW in South Africa.

METHODS

Study design

The study utilised a qualitative research design to better understand the specific contexts in which the services are delivered and the challenges around implementation.

Study setting

The study included three secondary schools in the King Cetshwayo District (KCD) which is one of twelve districts in KwaZulu-Natal (KZN), South Africa. KZN is one of South Africa's nine provinces, located along the country's eastern coast. The schools in this area mostly fall within the quintile 1-3 categories [32]. The quintile system in education is a ranking method that categorizes public schools into five groups (quintiles) based on the socioeconomic status of the community where the school is located. The primary objective is to promote equity by directing more public funding and support to schools serving the poorest learners. Quintile 1 schools represent the most disadvantaged, and Quintile 5 schools represent the least disadvantaged [33]. Two of the participating schools were situated in rural areas and are categorized as quintile three (non-fee paying) schools. The third school was based in an urban area and classified as a quintile four (fee-paying) school. The selection of these schools was informed by the ISHP district coordinator, and the range of schools offer a broad overview of the educational ecosystem in the KCD district.

Sampling

Key informants (18 years and older) were recruited using purposive sampling to gather insights from different support personnel involved in the provision of SRH services in schools within the KCD. Recruitment began with initial contact with the ISHP district coordinator, who played an oversight role in the delivery of school health in the KCD, and who facilitated contact with key stakeholders from the various departments; Education, Health and Social Development. Purposive sampling followed by snowball sampling was particularly useful in this context as it facilitated access to a network of support personnel who might not have been easily identifiable through other sampling methods. Key informants included LSAs, a SBST member; and district-based support team (DBST) members.

School-going AGYW who were 16 years and older and currently in grades 10, 11 or 12 were recruited. While most participants were under the age of 19 and enrolled in their final year of school (Grade 12), female learners up to 27 years were included in the sample. These participants had temporarily left school, primarily due to early motherhood, and later returned to complete their education. Despite the age variation in the study sample, all were school-going at the time of the study. This group of older girls provided valuable insights, particularly as they represented a subset of learners who had experienced extended and often more complex trajectories shaped by early motherhood, interrupted education, and re-engagement with both schooling and SRH services.

In the selected schools, key personnel were identified by a district-based stakeholder to facilitate the recruitment of school-going adolescent girls for participation in the FGDs. In one school, the Life Orientation (LO) educator initially extended the invitations, while in another, the LSA undertook this role. In the third school, the principal invited the interested learners to participate in the study.

Data collection

Two focus group discussions FGDs were conducted per school (n=3), making a total of six FGDs, with approximately nine participants in each group. FGDs were facilitated in a closed and private space on the school premises where learners could engage in discussions without interruptions from peers or being heard by others. An open-ended FGD guide was used for adolescent girls, and an open-ended interview guide for the KIIs. The KIIs were conducted in both English and Zulu. FGDs and KIIs were conducted by the first author, who is trained in facilitating FGDs and conducting KIIs. The FGD guide and KII guide were developed through an iterative process that involved the first and third author working together to develop the research tools [34]. The FGD guide examined various topics, including the challenges faced by adolescent girls, their SRH and psychosocial support needs, and their specific experiences with SRH services. The interview guides were developed using a similar approach. The questions for stakeholders concentrated on identifying the structural barriers and facilitators in providing school health and SRH ser-

vices to learners. KIIs were conducted in stakeholders' workspace, depending on the nature of stakeholders' work environments, with the privacy of KIIs considered. FGD lasted approximately 60 minutes and KIIs lasted 45 to 60 minutes. All FGDs and KIIs were audio recorded and transcribed.

Data analysis

Inductive thematic analysis [35] was used to analyse the data. Inductive thematic analysis is a systematic, yet flexible, approach to analysing qualitative data, involving identifying, analysing, and reporting patterns (themes) within the data, to capture pertinent issues in the data in relation to the research question. To strengthen trustworthiness, all three authors engaged in the thematic analysis process and held consistent discussions during and after data collection. The second and third authors, both senior researchers with expertise in SRH and health systems strengthening, provided additional perspectives that enriched the analytical process and helped ensure a balanced interpretation of the data. Data saturation was achieved when no new themes emerged during later interviews, and existing codes became repetitive across participants and sites. Transferability was supported through descriptions of the study context and participant quotes, which provided readers with sufficient detail to assess the relevance of the findings to other settings.

Ethical considerations

Ethics approval was obtained from the Humanities and Social Sciences Research Ethics Committee, University of KwaZulu-Natal (approval number: HSSREC/00004926/2022). Written informed consent was obtained from all participants, and assent forms were also obtained from learners under the age of 18 years. Furthermore, the consent form outlined that if any participant required psychological support or other forms of assistance, the study team would facilitate access to appropriate services through the SBST. The SBST is the formal structure within schools mandated to respond to learners' psychosocial and support needs.

RESULTS

A total of fifteen stakeholders were interviewed across the Departments of Education, Health, and Social Development, representing different levels of the ISHP. Five participants were based at the school level (including school health nurses, LSAs, SBST members, and a Life Orientation educator). Eight participants were from the district level (including three ISHP district coordinators, LSAs, and a health promoter). Overall, four participants identified as male and eleven as female (Table 1). A total of six FGDs were conducted across three schools (two rural, one urban), with two FGDs held per school. In total, 54 female learners participated, ranging in age from 16 to 27 years (Table 2).

The findings reveal several individual, interpersonal, school, and community-level barriers and facilitators to implementing ISHP and providing SRH services for school-going AGYW. The findings are organised into five themes: (1) Provision of in and out-of-school SRH services for learners; (2) Mixed experiences and gaps in adolescent and youth-friendly services (AYFS); (3) Parental resistance to SRH services for school-going AGYW ; (4) Inadequate resources and referral systems in SRH services for school-going AGYW; and (5) The role of school-based intermediaries in bridging the service gaps.

Table 1. Key informant interview demographics.

Participant ID	Department	Role	Gender
School Level			
P1	DoH	School Nurse	Male
P2	DoH	School Nurse	Female
P3	DoE	LSA (School based)	Female
P4	DoE	SBST (LO Educator)	Female
P5	DoE	LO Educator	Male
District Level			
P6	DoH	ISHP District Coordinator	Male
P7	DoH	District Health Promoter	Male
P8	DoE	ISHP District Coordinator	Female
P9	DoE	LSA (District based)	Female
P10	DoE	LSA (District based)	Female
P11	DSD	ISHP District Coordinator	Female
P12	DSD	District Coordinator	Female
P13	DSD	Social Work Manager	Female
Province Level			
P14	DoH	Provincial Task Team Member	Female
P15	DoE	Provincial Task Team Member	Female

Provision of in- and out-of-school SRH services for learners

Key informants described how both in school and out of school SRH services are being provided to learners in their schools. The ISHP SRH package primarily focuses on health promotion and includes counselling, as well as the provision of and referral to appropriate healthcare facilities and social welfare services:

> *"We give age-appropriate health education to all learners. Yes. And then we also see the referrals*

from the other grades which are not our target grades, if they are referrals from the educators, we also address those needs. Then we also do referrals to other services like social welfare psychologists, clinics, hospital OTs (occupational therapists). That's basically what we are doing in our schools." P2, Female, School nurse

Table 2. Focus group discussion demographics.

School ID	Area	Quintile	No. of learners in school 1	No. of educators 1	Fee paying school 1	No. of participants in FGD	Age range in Focus group
School 1 (UHS)	Urban	Q4	1162	31	No	FGD1: 4	18-19
						FGD2: 13	16-20
School 2 (NHS)	Rural	Q3	601	23	Yes	FGD1: 10	18-22
						FGD2: 10	18-23
School 3 (MHS)	Rural	Q3	644	21	Yes	FGD1:10	18-25
						FGD2: 7	17-27

1 Figures come from the most recent EMIS data(2023) available at: https://www.education.gov.za/Programmes/EMIS/EMISDownloads.aspx

Participants also emphasized accessible SRH services for learners at health facilities. They highlighted that there were designated spaces for young people and the presence of dedicated health providers who provide SRH services to school-going adolescents:

> "*When the children are referred to a clinic, we have the programme that you referred to as AYFS [Adolescent and Youth Friendly Services], Youth friendly services. So, in each and every clinic, there is a focal person who's an AYFS focal person. Who receives the school children. All children coming from school wearing uniforms, they know where to go. We have created space, especially in clinics where there's adequate space.*" P14, Female, DoH Provincial Task Team Member

AFYS are specifically aligned to the school timetable, to ensure that learners can access services after school hours:

> "*Yes, that's why it was changed to Youth Zone so it can be an hour or two that are specifically allocated to cater for young people to engage with health care workers in facilities to access health services and information. So, the nurses at schools promote the Youth Zone that they should go after school to see nurses. At facilities, they are free to engage with the nurses in terms of SRH, HIV and AIDS management, including TB and other services*" P6, Male, District DoH ISHP Coordinator

Mixed experiences and gaps in adolescent and youth friendly services (AYFS)

Participants in schools narrated a different experience with health facilities, with some school-going adolescents stating that they felt services were accessible. However, experiences were different given the variation in facilities and the differing approaches.:

> "*I used to be afraid [to get tested for HIV], but I do it for peace of mind. If I am not busy and I am by the clinic, I walk in and test and the testing section it never full…*" School 2, FGD 2, ages 18-23

> "*The clinic is my friend. I visit it. I am on a 3-month injection, and I am using PrEP [Pre-exposure prophylaxis] as well and practice safe sex as well but not all the time…I am in grade 12, I have to try to do it. I use an injection, I never miss my date at the clinic and my PrEP I take it accordingly, I take blood every month not that I have HIV, but I make sure*" School 3, FGD 2, ages 17-27

The data suggests that school health nurses are aware of and responsive to these SRH needs among AGYW, as one of the school nurses shared:

> "*We say we are giving all the services whilst we know what our target is, either implant [contraceptives] or PrEP [pre-exposure prophylaxis]*" P1, Male, School nurse

However, the same nurse felt that there was a mismatch between the policy regulating the sharing of age-appropriate SRH information and education to learners and the need on the ground:

> "*So now the policy wants us to start talking about serious things to the 15-year-olds but by the time they are fifteen, they already have two children because the policy did not allow us because we need to adhere to the policy. So, we need to review the age for education*" P1, Male, School nurse

Despite implementers' assertions that SRH services are youth-friendly, learners had mixed experiences with accessing these services, given the variation in facilities and the differing approaches of nurses.

> "*It depends on the nurse you encounter; there are those that are friendly and there are those that judge you. You sometimes get there, say for family planning they ask you, 'are you having sex at such a young age, why are you having sex?*" School 3, FGD 2, ages 17-27

> "*Okay, clinics are not the same and the nurses are not the same. With other nurses, if you get to tell her that you are there for family planning, she will say that's fine, she will do the necessary test and check urine. Once you are inside, you are free you can talk to her, I am talking in my instance because I am on contraceptives, I use an implant. Nurses are not the same*" School 2, FGD 1, ages 18-22

While some girls expressed confidence in accessing these services, others reported feeling apprehensive due to stigma or concerns over discrimination:

> "*I have experienced it, I have I was going to get contraceptives. The way they remarked they were rude, they were saying 'wow you love boys, you love sex why are you on family planning at your age' saying rude things… The things they say are hurtful and painful you don't think about going back because they say mean things*" School 3, FGD 1, ages 18-25

While prevention needs were being met, participant accounts highlighted a key gap in psychosocial support services, particularly in cases of sexual violence and in instances of teen pregnancy:

> "*I don't trust social workers. In primary school I moved from [location name removed] to here [location name removed], as a child I was raped by my dad's girlfriend's son every night and when I told my dad and he told his girlfriend bhut she denied the whole thing. I told social workers who made fun of me in front of the whole school. Every time they saw me, they would say 'here is this child who was raped' I never got any support until I came to live with my mother. I always thought about killing myself, but I realized that won't help. That boy is back, I always see him. Now this is taking me back every time I see him because I never got support, I thought I would get it from social workers…To this day I have never received help.*" School 1, FGD 2, ages 16-20

> "*Right now, I am a mother of two. I told myself that being a teen mom is hard because right now I am in school, I am not financially stable, I am struggling with all my issues. Mostly I tell other girls, if they have started having sex, that you can have sex but please make sure that you don't get pregnant, because the struggles are many and some can't cope with the struggles that they face. Some even decide that killing or suicide is the solution, whilst a person is committing suicide you leave a child, some kill the child and, in the process, they die too*" School 3, FGD2, ages 17-27

Parental resistance to SRH services in school

Implementing stakeholders identified a multitude of challenges, including socio-cultural, systemic and practical obstacles that prohibit the provision of SRH services to school-going adolescents.

Our findings highlighted the key role that parents play in access to SRH services in schools. Parents inform what SRH services can be provided to learners in schools through the SGB structure:

> "*In the province they, in terms of sexual reproductive health, they talk about education, sharing the information with the children, giving pamphlets and telling them about the available resources in the clinic. But to actually bring them the methods and offer within the school premises, that is not happening. The school governing bodies are against issuing of condoms on site, not to mention issuing a family planning method*" P14, Female, DoH Provincial Task Team Member

Being unable to bring services into schools, the province has made efforts to ensure that services are still in reach for learners:

> "*We have not started providing them [condoms and contraceptives] for schools. We need to meet SGBs [school governing bodies], still need to sit well with the parents…Condoms and family planning in schools... If we really have a high number who need the service then we provide a mobile clinic, but we park outside the school.*" P1, Male, School nurse

Furthermore, parental consent for providing SRH services was reported as a major barrier. Another school nurse shared some of the difficulties in obtaining parental consent to administer the HPV vaccine to learners in school:

> "*We issue the ISHP consent form, they come back with all notes. I'm talking about the isiZulu consent form, which is in the common language. It all comes back. 'No'. So, what we do is we have to phone every 'no'*" P2, Female, School nurse

Providers also indicated that they dealt with significant resistance in the delivery of SRH services due to prevalent socio-cultural beliefs. A male nurse shared some of the community resistance to the provision of contraception for AGYW who had not yet had a child:

> *"A belief system causes the most damage especially for the teenage pregnancy that we are experiencing. Ya, you will find out that in another community they don't want young girls to get contraception. When you talk about contraceptives it's like you are bringing a monster in the community. They will tell you that a young girl cannot go for contraceptives without having a baby, she must have a baby to prove her fertility, only after that can she get onto a contraceptive"* P6, Male, School nurse

Another school nurse shared her similar experience:

> *"So, it was a high school where there were high teenage pregnancy, even when they've had a big awareness (campaign) on teenage pregnancy. So, we called the parents and then one of the parents stood up and said, 'you know, what, we don't have a problem with teenage pregnancy, because if my child is pregnant, it means that she doesn't have a fertility problem."* P2, Female, School nurse

Inadequate resources and referral systems in SRH services for school-going AGYW:

Participants also highlighted the challenges related to limited resources and weak referral systems in the implementation of the ISHP, which hinder the provision of SRH services to school-going adolescents.

Participants across the provincial, district, and school levels further highlighted the inadequate level of human resources available to address the SRH needs of learners sufficiently:

> *"So the total number of public schools in the province are 5800 and…then they're broken down into the levels where you will have the primary, the primary schools, the combined, the secondary and the high schools…So, if we are looking at the number of school health teams currently, we're having 210. Two hundred and ten school health teams versus 5000 because we don't go up to grade 12 at this stage because we are following the policy... So roughly, if the 210 school health teams to 5000 schools. That's just a tip of an iceberg."* P14, Female, Provincial Provincial Task Team Member

> *"So we are basically three people running 48 schools with 17 200 something learners. The policy says we must see 2 000 a year, which means we need almost eight teams to cover our schools. So that is the main challenge.... In reality we don't do the children justice due to the staff shortage."* P1, Male, School nurse

Finding private spaces for school health services proved challenging for school nurses, and this was coupled with the shortage of social workers:

> *"But then we don't have a social worker, full time on board with our team to provide the counselling... In the schools, we don't have sort of a counselling room for privacy. That's our major challenge…We don't have that privacy."* P2, Female, School nurse

The process of making referrals and ensuring that learners receive the help they needed was identified by participants as crucial but challenging. In particular, the data suggests that while the links between DBE and DOH are being implemented, the relationship with DSD and the other stakeholders needs to be strengthened:

> *"The person who gives us a problem or rather who gave us a problem to work with was DSD (Department of Social Development) in fact you get there and introduce yourself and what you do, and they ask what is an LSA, what do they do?"* P6, Female, LSA

> *"It's been difficult working with them (DSD). They would tell you that they have a big workload…. Another problem we had was the zoning that when you get there, they will tell you that that social worker is not available, or your area does not have a social worker"* P9, Female, LSA

The role of school-based intermediaries in bridging the service gaps

LSAs were found to play an important role in the provision of support and a crucial link to services for adolescent girls. Participants described how they trusted the school LSA and felt comfortable asking for the help they needed, including SRH-related matters:

> *"Many depend on (LSA name). It's not easy to talk in class, but with (LSA name) you sit with her and then you are able to talk to her about everything that is making you unhappy. And if your problems are too big, she refers you to get help from other social workers …She is resourceful because she helps us with sanitary pads"* School 2, FGD1, ages 18-22

The LSAs perceived their role as extending beyond facilitating access to psychosocial support for vulnerable learners. They emphasized that a central focus of their work was addressing the issue of EUP among school-going girls:

> *"For LSAs, teenage pregnancy is their main job. If there is an LSA at a school, teenage pregnancy needs to be reduced, they need to do campaigns. The campaigns that talk about teenage pregnancy."* P10, Female, LSA

Sexual violence as cited by participants in this study was an SRH issue that posed challenges, particularly in reporting and managing cases. However, our data showed that LSAs can also provide a vital link between learners who have experienced sexual violence and their access to the necessary care:

> *"In rape cases we fill Form 22. So, for me Thuthuzela [sexual assault "one stop" crisis centre] is not far from the school. It's easy, so if a child reported a rape case, I ask a teacher to accompany me to Thuthuzela. From 22, I send to DSD. Then at Thuthuzela they open a rape case, there are police there, social workers and counselling the child accesses. Then they schedule follow up sessions. Since I need to be at the school most of the time, I'd pass that responsibility on to the parents and communicate with the parents about their appointments, that they will miss school and I also report to their teacher, so I follow up on those cases."* P3, Female, LSA

Participants in our study also confirmed that when implementing ISHP, they worked closely with implementation partners to provide SRH services and health promotion for school-going adolescents. At the provincial level a stakeholder stated:

> *"We have partners with the NGOs that are supporting us. One of them is working very closely with the school going children. So again, those partners will then drive the health trucks, and then they will park outside the school premises…And only when the school is out that the kids are able to access the services from the truck and that is how we are doing it."* P14, Female

DISCUSSION

The findings of this study highlight several key challenges and opportunities for strengthening the implementation of the ISHP and the provision of SRH services for school-going AGYW. While schools are considered important sites to address the SRH needs of learners [36, 37], our findings reveal that the community context in which these schools are located need to be considered as part of implementation strategies to ensure local norms and practices are addressed in a way that is supportive of the services being provided.

The findings offer useful insights into systemic gaps and opportunities for improving the implementation and responsiveness of SRH services targeting school-going AGYW. Findings highlight a mismatch between the ISHP guidelines that limit the topics covered in SRH education and the reality on the ground, suggesting that the ISHP requires regular review, ensuring contextual relevance and earlier and more comprehensive engagement with learners on topics such as contraception, pregnancy, and reporting sexual violence. Furthermore, the age variation among learners within the same grade, as observed in this study, underscores a critical challenge for the delivery of school-based SRH services. The large gaps in different developmental stages and SRH needs confirm the concerns of the school nurses about the appropriateness and timing of SRH information and services. For some learners, SRH content may be timely and relevant, while for others, it may be delivered too late, after they have already faced significant SRH-related challenges. Another South African study amongst AGYW in Gauteng schools highlighted a wide age range of learners in the same grade, with up to a six-year age gap between the youngest and oldest learner in each grade [38]. The authors of this study suggest that SRH education may need to be targeted to the age of the learner rather than the grade level of the class.

The findings reveal a clear gap between the psychosocial needs among AGYW and the support provided, and perhaps is, in part, the consequence of the role of DSD not being well articulated in the ISHP. South Africa is home to high rates of teenage pregnancy and sexual violence amongst AGYW [39, 40], and more needs to be done in identifying and supporting young people. Although the ISHP includes mental health screening undertaken through the administration of the Strengths and Difficulties Questionnaire (SDQ), this screening is limited to grade eight learners. According to the Strategy for the Implementation of the Integrated School Health Programme (2014), each school health team should be supported by social work services, an educational or clinical psychologist, and a network of relevant and well-functioning referral services, however, our findings that the lack of human resources, including the unavailability of social workers and psychologists, compromised the delivery of psychosocial services in schools. Similar findings have been reported in another South African study, highlighting the need for enhanced collaboration between schools, social workers, health services, and community organizations to create a comprehensive support network for learners in need of psychosocial support in schools [41]. Furthermore, other research conducted in South Africa has also highlighted barriers to successful referral completion for school learners needing health services, including a lack of available specialty services such as psychosocial support, optometry, and dentistry, distance to clinics, and transportation costs, particularly for children from low-income families [42, 43]. Another key challenge in the provision of psychosocial support services and other health services to learners is that nurse visits to school are too infrequent, sometimes once a year, or less, limiting early detection and effective referrals.

However, one important bridge between learners and the services they require is highlighted by the presence of the LSAs in schools, which represents a positive step toward addressing the needs of vulnerable learners. AGYW in our study identified LSAs as key people whom they felt they could approach within schools who could assist them in accessing SRH-related information and services they required. This support could include assisting learners with their menstrual-related challenges. LSAs have a critical role to play in the identification of vulnerable learners and acting as a bridge between a

learner and the services they require, including access to healthcare and social welfare services. According to DBE [24], the role of an LSA is to support schools to render care, support and protection to vulnerable learners in line with the implementation of the HIV and AIDS Life Skills Education Programme as well as the Care and Support for Teaching, and Learning and Peer Education Programmes. Therefore, with the relevant training and clear referral pathways, LSAs are well placed to play an effective role in the support of vulnerable learners, including ensuring vital links to health care, social protection and justice following sexual violence.

Our Study findings highlight the important role of SGBs in shaping the implementation of SRH services in schools. Therefore, it is critical to actively engage parents and SGBs through awareness-raising efforts and education on the risks associated with inadequate SRH support for learners.

Our findings add to the evidence that parental resistance toward the implementation of comprehensive sexuality education (CSE) is a significant challenge for school health programmes [44] and highlight the need for policies like the ISHP to be more contextually adaptable, particularly in settings where cultural norms are at odds with a rights-based approach to the provision of SRH services. Our findings that early pregnancy is not only accepted but some encouraged by parents is consistent with another research in the region [45-47]. Recent studies conducted in Zambia and Ghana have also shown that cultural narratives often encourage young girls to engage in sexual activity while simultaneously perpetuating stigma around contraceptive use [47, 48]. Conversely, and as our findings suggest, parents may also be concerned that SRH interventions will encourage sexual activity among adolescents. This dynamic has been documented in earlier research in the South Africa school setting, which highlights how educators themselves encounter pushback from parents who view condom provision in schools as contradictory to efforts to promote abstinence [49]. These tensions underscore the importance of engaging parents, guardians and caregivers as key stakeholders in the design and communication of school-based SRH programmes.

Our study showed that obtaining parental consent for certain school health services, such as the HPV vaccination, can be an obstacle when implementing school health and is consistent with another research in South Africa [50, 51]. A systematic review focusing on barriers confronting parents, providers, and health systems that hinder childhood immunization found that barriers included parents/caregivers' lack of knowledge of immunization, lack of partner support, and distrust in vaccines and immunization programmes [52]. Evidence highlights how the COVID-19 pandemic has significantly influenced public attitudes toward vaccines, leading to a notable rise in vaccine hesitancy worldwide [53, 54]. This hesitancy is characterized by increased skepticism about vaccine safety, efficacy, and necessity. This points to the need for enhanced community engagement efforts to increase awareness among parents and caregivers about the importance of these services and the benefits they bring to their children [55]. Parents require information on the package of school health services provided to their children, and this information should be made available to parents through several varied channels to ensure all parents are reached, understand the objectives of the ISHP, and play a meaningful role in facilitating access to services, including SRH.

Support from external stakeholders, such as implementing partners, remains critical for the effective implementation of the ISHP. Given the numerous challenges in delivering comprehensive health services within resource-constrained environments, collaboration with external stakeholders is crucial. This collaboration often involved partnering with non-governmental organizations (NGOs) and other donors to augment the existing resources allocated to the ISHP.

Limitations

This study has several limitations. First, it was conducted in one education district in KwaZulu-Natal, South Africa, with AGYW participants from only three selected schools, limiting the generalizability of the findings. Another recognised limitation of the study is the age disparity among AGYW participants; however, all were enrolled in school at the time of data collection. Additionally, the use of snowball sampling to select interviewees may have introduced bias, as programme coordinators might have recommended stakeholders likely to speak positively about programme implementation.

Conclusion

Our findings highlight several upstream challenges in providing SRH services for school-going AGYW. Gatekeeping from SGBs and difficulties in obtaining parental consent were identified as key obstacles for promoting SRH and providing contraceptive services. Our study highlights some key areas for the strengthening of the Integrated School Health Policy and the provision of sexual and reproductive health services. The need for context responsive SRH information and education for both learners and parents is urgently required. This will require a refocusing on the content and timing of delivery of sexuality education for learners or considering a more nuanced and targeted approach to older learners in the same grade. Widespread awareness-raising campaigns within communities, utilising community-based partners, can support and be complementary to school efforts. Lastly, the psychosocial needs of learners cannot be detached from their SRH needs and LSAs, as a promising practice, should be expanded and carefully tracked to determine their impacts.

DECLARATIONS

Publication consent

Not applicable.

Competing interests
The authors declare no conflict of interest in relation to this study. All authors have contributed to the research, analysis, and manuscript preparation impartially.

Funding
This work was supported by the International Paediatric HIV Symposium in Africa (IPHASA) grant from the International AIDS Society (IAS). The views expressed in this publication do not necessarily reflect the official policies of the IAS. IPHASA Grant ID: 0131.

Author contributions
Conceptualisation, P.B.N.; methodology, P.B.N. and G.G.; formal analysis, P.B.N, T.C., and G.G.; investigation, P.B.N; resources, P.B., and G.G.; data curation, P.B.N.; writing—original draft preparation, P.B.N.; writing—review and editing, P.B.N, T.C, G.G.; visualisation, P.B.N, T.C, and G.G.; supervision, G.G.; project administration, P.B.N. All authors have read and agreed to the published version of the manuscript.

Data availability
Not applicable.

Acknowledgements
None.

ORCIDs
Phiwe Babalo Nota 0000-0003-4393-077X
Tamaryn Crankshaw 0000-0001-6974-1593
Gavin George 0000-0001-7258-8470

De la política a la práctica: acceso de las adolescentes y mujeres jóvenes a los servicios de salud sexual y reproductiva mediante la Política Integrada de Salud Escolar en KwaZulu-Natal, Sudáfrica

RESUMEN

Introducción: Las adolescentes y mujeres jóvenes (AMJ) de Sudáfrica siguen enfrentando resultados desfavorables en salud sexual y reproductiva (SSR), como embarazos tempranos y no intencionados e infecciones de transmisión sexual. La Política Integrada de Salud Escolar (PISE) busca mejorar la salud y el bienestar de las AMJ escolarizadas promoviendo la SSR y ofreciendo servicios. Este estudio examinó la implementación de servicios de SSR para adolescentes escolarizadas en KwaZulu-Natal, Sudáfrica.
Métodos: Se empleó un diseño cualitativo, recopilando datos triangulados de seis grupos focales (GFs) con AMJ escolarizadas (n=54); entrevistas a informantes clave (EIC) con agentes de apoyo al alumnado (n=3); un miembro del equipo de apoyo escolar; miembros de equipos de apoyo distrital (N=8); y actores del ISHP a nivel provincial (n=2). Todos los GFs y EIC fueron grabadas en audio, transcritas y analizadas temáticamente.
Resultados: Identificamos varios desafíos "aguas arriba" en la provisión de servicios de SSR para AMJ escolarizadas. El control del acceso por parte de los órganos de gobierno escolar y las dificultades para obtener consentimiento parental fueron obstáculos clave para promover la SSR y brindar anticoncepción. Además, se reportaron normas culturales que favorecen los embarazos tempranos como un reto central. El apoyo psicosocial sigue siendo insuficiente, especialmente para jóvenes que han sufrido violencia sexual y/o son madres adolescentes. Impartir educación sexual adecuada a la edad sigue siendo un desafío por las disparidades de edad dentro de un mismo grado.
Conclusiones: Las políticas y la provisión de servicios de SSR deben ser sensibles a normas culturales que pueden entrar en tensión con un enfoque de derechos. Es necesario involucrar de forma significativa a padres/madres y los órganos de gobierno escolar mediante sensibilización y educación sobre los beneficios, a corto y largo plazo, del apoyo en SSR para las y los estudiantes.

Palabras clave: Sexual y reproductiva, escuela, política, adolescentes, niñas, jóvenes, mujeres, KwaZulu-Natal, Sudáfrica.

REFERENCES

[1] McClinton Appollis T, Mathews C, Lombard C, Jonas K. School dropout, absenteeism and coverage of sexual and reproductive health services in South Africa: Are those most at risk reached? AIDS Behav. 2024;28(10):3525-42.

[2] Tolla T, Bergh K, Duby Z, Gana N, Mathews C, Jonas K. Adolescent girls and young women's (AGYW) access to and use of contraception services in Cape Town: perspectives from AGYW and health care providers. BMC Health Serv Res. 2024;24(1):787.

[3] Moolman B, Tolla T, Essop R, Isaacs N, Makoae M. "I felt

like I was going to cause conflict. So, I kept quiet…"(Female child rape victim, 15 years). Child Abuse Negl. 2023;144:106355.
[4] Duby Z, Bergh K, Jonas K, Reddy T, Bunce B, Fowler C, et al. "Men rule… this is the normal thing. We normalise it and it's wrong": Gendered power in decision-making around sex and condom use in heterosexual relationships amongst adolescents and young people in South Africa. AIDS Behav. 2023;27(6):2015-29.
[5] Duby Z, McClinton Appollis T, Jonas K, Maruping K, Dietrich J, LoVette A, et al. "As a young pregnant girl… the challenges you face": exploring the intersection between mental health and sexual and reproductive health amongst adolescent girls and young women in South Africa. AIDS Behav. 2021;25:344-53.
[6] UNAIDS. In Danger: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/AIDS 2022 [Available from: https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update.
[7] Jochim J, Groves A, Cluver L. When do adolescent mothers return to school? Timing across rural and urban South Africa. S Afr Med J. 2020;110(9):850-4.
[8] Steventon Roberts K, Smith C, Toska E, Cluver L, Haag K, Wittesaele C, et al. Risk factors for poor mental health among adolescent mothers in South Africa. Psychol Health Med. 2022;27(sup1):67-84.
[9] Woldesenbet S, Kufa T, Lombard C, Manda S, Morof D, Cheyip M, et al. The prevalence of unintended pregnancy and its association with HIV status among pregnant women in South Africa, a national antenatal survey, 2019. Sci Rep. 2021;11(1):23740.
[10] Baloyi T, Rammopo M, Fernandes L. Prevalence and factors associated with unintended pregnancies: A study from a clinic in Tshwane district, South Africa. Afr J Phys Act Health Sci. 2023;29(3):252-65.
[11] Jewkes R, Morrell R. Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises. Soc Sci Med. 2012;74(11):1729-37.
[12] CEDAW. Convention on the elimination of all forms of discrimination against women. Office of the United Nations High Commissioner for Human Rights; 1979.
[13] UNCRC. Convention on the rights of the child. United Nations. General Assembly Canada. Human Rights Directorate; 1991.
[14] WHO. Making health services adolescent friendly. World Health Organization: Developing national quality standards for adolescent friendly health services. 2012;56.
[15] Strode A, Essack Z. Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience. S Afr Med J. 2017;107(9):741-4.
[16] Ketye TJ, Babatunde GB, Akintola O. How do South African policies address provision of contraception among adolescents? Afr J Prim Health Care Fam Med. 2024;16(1):1-11.
[17] Davids E, Kredo T, Gerritsen A, Mathews C, Slingers N, Nyirenda M, et al. Adolescent girls and young women: Policy-to-implementation gaps for addressing sexual and reproductive health needs in South Africa. S Afr Med J. 2020;110(9):855-7.
[18] DBE. National Policy on HIV, STIs, and TB for Learners, Educators, School Support Staff, and Officials in all Primary and Secondary Schools in the Basic Education Sector. In: Education DoB, editor. Published as Government Gazette No. 41024; 2017.
[19] DBE. Intergrated School Health Policy. Pretoria: Department of Basic Education; 2012.
[20] DBE. Standard Operating Procedures for the Provision of Sexual and Reproductive Health, Rights and Social Services in Secondary Schools. Pretoria: Department of Basic Education; 2019.
[21] Tucker LA, George G, Reardon C, Panday S. Sexuality education in South African schools: The challenge for civil society organisations. Health Educ J. 2017;76(1):77-88.
[22] Junck LD, George G. Giving condoms to school children: educators' views on making condoms available in South African schools. Afr J AIDS Res. 2022;21(1):58-64.
[23] Delany-Moretlwe S, Machalek DA, Travill D, Petoumenos K, Nyemba DC, Mbulawa ZZ, et al. Impact of single-dose HPV vaccination on HPV 16 and 18 prevalence in South African adolescent girls with and without HIV. JNCI Monogr. 2024;2024(67):337-45.
[24] DBE. A Guide for Learner Support Agents and Schools on Providing Psychosocial Support to Learners. Pretoria: Department of Basic Education; 2020.
[25] Opoku JA, Brenyah JK, Mohammed A, Mensah AK. Assessment of school health policy in Ghana: Perspective of teachers in second cycle institutions in the Kwadaso municipal area, Kumasi. Int J Educ Dev Afr. 2023;8(1):24.
[26] Adebayo A, Bella-Awusah T, Adediran K, Omigbodun O. School health and well-being in Nigeria: gaps in policy and design. J Public Health. 2024;32(12):2271-7.
[27] Lenkokile R, Hlongwane P, Clapper V. Implementation of the integrated school health policy in public primary schools in Region C, Gauteng Province. Afr J Public Aff. 2019;11(1):196-211.
[28] Vujovic M, Struthers H, Meyersfeld S, Dlamini K, Mabizela N. Addressing the sexual and reproductive health needs of young adolescents living with HIV in South Africa. Children Youth Serv Rev. 2014;45:122-8.
[29] Smith P, Marcus R, Bennie T, Nkala B, Nchabeleng M, Latka M, et al. What do South African adolescents want in a sexual health service? Evidence from the South African Studies on HIV in Adolescents (SASHA) project. S Afr Med J. 2018;108(8).
[30] Ndlazi BE, Masango T. The sexual and reproductive health needs of young people living with HIV in Gauteng, South Africa. S Afr J HIV Med. 2022;23(1).
[31] James S, Pisa PT, Imrie J, Beery MP, Martin C, Skosana C, et al. Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa. BMC Health Serv Res. 2018;18:1-10.
[32] Hall K, Giese S. Addressing quality through school fees and school funding. [place unknown]: Children's Institute; 2009.
[33] White C, Van Dyk H. Theory and practice of the quintile ranking of schools in South Africa: A financial management perspective. S Afr J Educ. 2019;39(Supplement 1):s1-19.
[34] Kvale S, & Brinkmann, S. . Interviews: Learning the craft of qualitative research interviewing (3rd ed.). SAGE Publications. 2015.
[35] Braun V, Clarke V. Using thematic analysis in psychology.

Qual Res Psychol. 2006;3(2):77-101.
[36] Hsiao C, Richter LM. Early mental development as a predictor of preschool cognitive and behavioral development in South Africa: The moderating role of maternal education in the birth to twenty cohort. Infant Young Child. 2014;27(1):74-87.
[37] Miller-Lewis L, Searle A, Sawyer M, Baghurst P, Hedley D. Predictors of mental health resilience in early childhood: A multi-methods analysis. Child Adolesc Psychiatry Ment Health. 2013;7(6).
[38] Crankshaw TL, Strauss M, Gumede B. Menstrual health management and schooling experience amongst female learners in Gauteng, South Africa: a mixed method study. Reprod Health. 2020;17:1-15.
[39] Yah CS, Ndlovu S, Kutywayo A, Naidoo N, Mahuma T, Mullick S. The prevalence of pregnancy among adolescent girls and young women across the Southern African development community economic hub: A systematic review and meta-analysis. Health Promot Perspect. 2020;10(4):325.
[40] Kuo C, LoVette A, Slingers N, Mathews C. Predictors of resilience among adolescent girls and young women who have experienced intimate partner violence and sexual violence in South Africa. J Interpers Violence. 2022;37(15-16):NP13425-NP45.
[41] Pillay J, Patel L, Setlhare-Kajee R. Teacher awareness of psychosocial support available as per the Integrated School Health Policy in South Africa. S Afr J Child Educ. 2023;13(1):1172.
[42] Ndevu S-M, Mahomed O. Professional nurses perceptions of Integrated School Health Team performance in the Eastern Cape Province of South Africa in 2018. Open Public Health J. 2022;15(1).
[43] Reddy M, Singh S. The promotion of oral health in health-promoting schools in KwaZulu-Natal Province, South Africa. S Afr J Child Health. 2017;11(1):16-20.
[44] Koch R, Wehmeyer W. A systematic review of comprehensive sexuality education for South African adolescents. J Transdiscipl Res S Afr. 2021;17(1).
[45] Horn B. Cultural beliefs and teenage pregnancy. Nurse Pract. 1983;8(8):35-42.
[46] Saftner MA, Martyn KK, Momper SL, Loveland-Cherry CJ, Low LK. Urban American Indian adolescent girls: Framing sexual risk behavior. J Transcult Nurs. 2015;26(4):365-75.
[47] Amoadu M, Ansah EW, Assopiah P, Acquah P, Ansah JE, Berchie E, et al. Socio-cultural factors influencing adolescent pregnancy in Ghana: a scoping review. BMC Pregnancy Childbirth. 2022;22(1):834.
[48] Menda dM, Zimba RK, Mulikita CM, Nawa M, Shamazubaula SF, Musonda H, et al. Socio-cultural factors and experiences of school going teenage mothers in rural Zambia: A phenomenological study. medRxiv. 2023:2023.10.13.23296957.
[49] George G, Beckett S, Reddy T, Govender K, Cawood C, Khanyile D, et al. The role of schooling and comprehensive sexuality education in reducing HIV and pregnancy among adolescents in South Africa. J Acquir Immune Defic Syndr. 2022:10.1097.
[50] Amponsah-Dacosta E, Blose N, Nkwinika VV, Chepkurui V. Human papillomavirus vaccination in South Africa: programmatic challenges and opportunities for integration with other adolescent health services? Front Public Health. 2022;10:799984.
[51] Milondzo T, Meyer JC, Dochez C, Burnett RJ. Misinformation drives low human papillomavirus vaccination coverage in South African girls attending private schools. Front in Public Health. 2021;9:598625.
[52] Bangura JB, Xiao S, Qiu D, Ouyang F, Chen L. Barriers to childhood immunization in sub-Saharan Africa: a systematic review. BMC Public Health. 2020;20:1-15.
[53] de Albuquerque Veloso Machado M, Roberts B, Wong BLH, van Kessel R, Mossialos E. The relationship between the COVID-19 pandemic and vaccine hesitancy: a scoping review of literature until August 2021. Front Public Health. 2021;9:747787.
[54] Anas AL, Salifu M, Zakaria HL. COVID-19 pandemic and vaccination skepticism. Hum Arenas. 2023:1-25.
[55] Tathiah N, Naidoo M, Moodley I. Human papillomavirus (HPV) vaccination of adolescents in the South African private health sector: Lessons from the HPV demonstration project in KwaZulu-Natal. S Afr Med J. 2015;105(11):954.