USAID SOUTH AFRICA SCHOOL-BASED SEXUALITY AND HIV PREVENTION EDUCATION ACTIVITY

SGB SENSITIZATION WORKSHOP ASSESSMENT REPORT, BOHLABELA

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Rapid assessment of CSE sensitization workshops with SGB representatives

Bohlabela, JHB North, JHB Central and JHB West
(August and September 2016)

HEALTH ECONOMICS AND HIV AND AIDS RESEARCH DIVISION

Working to advance health equity in Africa

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1. Introduction

The South Africa School-Based Sexuality and HIV Prevention Education Activity is a PEPFAR-Funded USAID Activity aimed at reducing new HIV infections in learners and educators by assisting the Department of Basic Education (DBE) to implement high quality, evidence-informed sexuality and HIV prevention education programmes. The project's activities are specifically designed to strengthen, link and consolidate South African Government (SAG) efforts to link education sector initiatives and health sector initiatives that share a common purpose: a reduction in the incidence of new HIV and TB infections among young people and improved linkages to HIV care and SRH services for learners. The Health Economics and HIV and AIDS Research Divisions (HEARD), Society for Family Health (SFH) and MOTT McDonald are providing technical support to EDC SLP development and implementation, as well as other complementary, supporting activities.

SFH are leading the complementary activities which involve engaging with the broader school community (school governing bodies (SGB) and senior management teams (SMT)) to advocate for CSE in schools as well as ensuring that the necessary linkages between schools and health services are in place. In order to achieve this, SFH are conducting workshops in the districts where EDC is working to train SGBs on advocacy skills for CSE, including SGBV and the Integrated School Health Policy (ISHP). These workshops consist of 2-day trainings which cover information on the comprehensive sexuality education package that is offered in schools, as well as aim to equip SGBs and SMTs with skills to advocate for schools based comprehensive sexuality and HIV education activity amongst parents in the community. These workshops are being assessed to determine the receptivity of SGBs and SMTs to comprehensive sexuality education and the extent to which an enabling environment for the roll out of comprehensive sexuality education exists.

This rapid assessment presents the key results of the pilot workshop conducted by SFH facilitators with SGBs and SMTs in Mpumalanga in South Africa in terms of changes to participants' knowledge of and attitudes towards comprehensive sexuality education. The training workshop falls under objective three in the overall scope of work: "Improved quality of school-based sexuality and HIV education programs – evidence informed and effective to reduce risky behaviours amongst school-going youth; improved learner knowledge and achievement in targeted areas of the life skills program"; Task 3.1 "Implement sexuality and HIV education activity in target schools". This report relates to Activity 3.1.3 which aims to improve the knowledge and attitudes of SMT and SGBs towards comprehensive sexuality education in schools.

The purpose of this rapid assessment report is to provide EDC and partners with a snapshot of the research findings to guide internal planning processes.

2. Methodology

A total of 80 SGB representatives took part in four training workshops that are included in this analysis. The workshops took place on the 23rd of August, the 5th of September and on the 17th of September in the districts Johannesburg North, Johannesburg Central and Johannesburg West, and in the district Bohlabela on 22 September. The workshops in Johannesburg were part of the DREAMS expansion of the Activity. The participants represented the SGBs in 40 schools in the districts.

Of the 80 participants in the training, a majority (60%) were female. The age of participants varied from 26 to 71 years, with the average age of participants being 44.5 years. A majority (64%) of participants had only been at the school for one (28%) or two (36%) years.

The information was collected from the participants through a self-administered paper-based structured questionnaire administered pre and post training. Respondents were asked to respond questions along four themes:

1. the degree of parental involvement in their respective schools;
2. sexuality education at school;
3. knowledge about HIV & AIDS and sexuality and;
4. HIV stigma.

The questionnaire asked participants to respond to statements of value or opinion by indicating whether they *strongly agree*, *agree*, *neutral*, *disagree* or *strongly disagree* with the statement. The section on parental involvement asked respondents to indicate whether the statements were *true* or *false*.

The questionnaires were anonymous, but each participant entered their dates of birth into the questionnaire in order to allow for the pre- and post-training questionnaires to be linked so as to test the statistical significance of any changes in responses between the two questionnaires.[1]

The data was entered into the SPSS statistical software (version 24) and analyzed by means of descriptive statistics and paired sample t-tests to determine the statistical significance of any change in answers between the first and second round of responses.

Since this rapid assessment report is intended as a 'diagnostic' tool for EDC and the partners involved in the training, we suggest that attention is paid to the changes even if they are not statistically significant. While such changes could not be relied upon to draw any general conclusions, they may still hold important information to those who conducted the training.

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[1] Since there was a small number of respondents, a change of opinion or attitude by one single participant resulted in a shift of 1,7 percentage points. For this reason, as we are only interested in more general shifts as a result of the training, we will only pay attention to larger shifts in the data. It is, in any case, only such major shifts that may be statistically significant. As a rule-of-thumb we will note relevant changes by 7 or more percentage points, as this would mean that 5 or more respondents had shifted their answer.

3. Results

3.1 Parental involvement in schools

The following are the main results relating to parental involvement:

1. **SGB activity**. A large majority of respondents (91%) said that their school has an active SGB, with 74% of participants saying that the SGB in their school meets either once a month or once ever quarter.
2. **Parental and community support**. A large majority (86%) say that their school has strong support from the parents in the community, and 90% say that parents actively encourage learners to take their education seriously.
3. **School communication**. Again, a large majority (90%) say that their school keeps the community informed of activities and events at the school, and the same-size majority say that their school communicates well with the family of a learner who is not doing well in school in order to find solutions that will help the learner.

One way to interpret these result would be to say that since communication and support seems to work this well, the views and opinions of the SGB members are more likely than not to represent the views and opinions held by the broader community of parents.

3.2 Sexuality education and HIV and AIDS

In this section and in the table below we will identify what change, if any, occurred in how participants responded to the same question in the pre- as opposed to the post-training questionnaire. In order to conduct this analysis we could only include and match the 58 participants that had stated their date of birth in both questionnaires, as requested. This means that the following analyses are conducted on the basis of 22 fewer questionnaires than the analyses we reported above. While this is unfortunate, it does not invalidate the analysis.

The table below provides the percentage of participants who responded 'correctly' in the pre-training questionnaire in the sense that their response was either factually correct or in line with the values of the sexuality education that is advocated by the Activity.

We will indeed note such changes on some of the statements, but only of these changes were substantial enough be statistically significant, if only just. This is the increase from 50% to 57% of respondents who disagreed with the statement that only parents must talk to their children about sexuality and HIV prevention. Out of the total 34 statements (presented in the table below), there was notable change in 13, and in 11 of those did the change represent a higher percentage of correct answers. These 11 cases are highlighted in green. No change is noted as '—'. The two cases of a negative change are highlighted in orange.

Statement according to themes		Correct answer (%)	
		pre-training	post-training
A	**Sexuality Education**		
1	Teaching young people about sexuality encourages them to have sex at an early age	84	--
2	Teaching young people about HIV prevention encourages them to have sex at a young age	83	90
3	Scripted lesson plans on sexuality education in schools will help LO educators teach HIV/AIDS and sexuality education	91	--
4	Schools should refer children for regular health screenings for STIs	69	84
5	Healthy parent child relationships are based on children who are seen and heard	45	--
6	It is only the responsibility of the parent to talk to their child about sexuality and HIV prevention	50	57*
7	Boys should be encouraged to register for MMC at school	84	--
8	Children should be able to access condoms in schools	38	24
9	It is important for learners to be taught about HIV & AIDS and sexuality within schools	93	--
10	It is important for learners to be taught Life Orientation	97	--
11	I support the roll out of a School Based Sexuality Education and HIV prevention activity	90	98
12	School children should be taught only about abstinence as a form of birth control and prevention of STIs	39	--
13	Learners who have had sexuality education are more likely to get pregnant	58	72
14	Parents need to be equipped in discussing sexuality education and HIV with their children	95	--
B	**Sexuality and HIV/AIDS Literacy**		
1	STIs can be treated easily and effectively if detected early	93	--
2	HIV can be transmitted through oral sex	60	77
3	HIV cannot be transmitted to an unborn child by the mother	55	--
4	HIV cannot be transmitted to a baby who is still breastfeeding	45	64
5	Using condoms correctly and consistently is the only form of HIV prevention	17	--
6	HIV is not curable but it is treatable	93	--
7	STIs cannot be transmitted through anal sex	79	71
8	If someone is engaging in sex they need to be tested for HIV and other STIs	88	--
9	Puberty is a normal process of physical, social, emotional and spiritual growth	91	--
10	HIV positive people need to take ARVs for the rest of their lives	91	--
11	ARVs increases the progression and reproduction of HIV in the body	50	--
C	**HIV Stigma**		
1	HIV is a punishment from God	88	--
2	People with HIV/AIDs are sexually immoral	69	83
3	HIV/AIDS is a punishment for bad behaviour	83	--
4	I would be willing to be friends with someone who is HIV positive	81	90
5	People with HIV/AIDS should be ashamed of themselves	91	--
6	I would be ashamed if I were infected by HIV	65	79
7	I would be ashamed if someone in my family had HIV or AIDS	78	85
8	HIV positive children should be allowed to play with HIV negative children	91	--

It must be noted that only one of the changes were statistically significant. We must therefore not generalise too far on the basis of these results, or take immediate action only on the basis of these results. It is recommended that the results be viewed as indications that may or may not become more cumulatively relevant as we analyse more data from future rounds of training workshops. If all of some of the above findings show up also in our analysis of future trainings, this would provide stronger reasons to take corrective action.

4. Highlighted findings

We wish to highlight the following findings:

1. In 11 of the 34 cases, 85% or more of the respondents gave the 'correct' answer already in the pre-training questionnaire and we found no notable increase in the post-training questionnaire. This should not necessarily be interpreted as a poor result as it will always be more difficult to generate a clear better result among the few participants that make up the remaining 15% or less of respondents.
2. However, in 8 cases, fewer than 85% gave the correct answer in the pre-training questionnaire and we did not see a notable improvement after the training.
3. Two results are particularly concerning since we found the same poor results in the previous report on SGB workshops:
    a. Among these 8 cases, it is a particular concern that some 50% seem to think that ARVs increase the progression of HIV in the body. There was no change in the post-training responses.
    b. Only 38% of SGB members were in support of condom distribution in schools before the training, and this support dropped even further to 24% after the training.

Future and more comprehensive analyses as more data becomes available will indicate whether these findings are robust enough to warrant any revisions of the training workshops.