

ORIGINAL RESEARCH ARTICLE

How do school-going adolescents in KwaZulu-Natal perceive sexual and reproductive health and rights? A qualitative study

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Abstract

Adolescents' risky sexual behaviour and increased teenage pregnancies have become a concern in sub-Saharan Africa, including KwaZulu-Natal province. This study explored school-going adolescents' perceptions of sexual reproductive health and rights in KwaZulu-Natal, South Africa. An exploratory, descriptive qualitative design was used to select 20 school-going adolescents in grades 10 to 12 using non-probability quota sampling. Individual, face-to-face, semi-structured interviews were conducted to collect data, which were thematically analysed using Braun and Clarke's six steps. The findings revealed that school-going adolescents received inadequate sexual education and information from teachers, parents, and churches, and the classroom environment was too noisy and uncontrollable to promote learning. The study recommended strategies for multi-disciplinary teams to improve the quality of sexual health information available to adolescents. This contributed to addressing the concerning issue of risky sexual behaviour and teenage pregnancies in sub-Saharan Africa, specifically within the KwaZulu-Natal province of South Africa. (*Afr J Reprod Health* 2025; 29 [8]:51-59).

Keywords: Perceptions; Qualitative; School-going adolescents; Sexual and Reproductive Health; and Sexual and Reproductive Health Rights

Résumé

Les comportements sexuels à risque et l'augmentation des grossesses précoces sont devenus une préoccupation en Afrique subsaharienne, notamment dans la province du KwaZulu-Natal. Cette étude a exploré les perceptions des adolescents scolarisés en matière de santé et de droits sexuels et reproductifs au KwaZulu-Natal, en Afrique du Sud. Un plan d'étude qualitatif exploratoire et descriptif a été utilisé pour sélectionner 20 adolescents scolarisés de la 10^e à la 12^e année, par échantillonnage non probabiliste par quotas. Des entretiens individuels, en face à face et semi-structurés ont été menés pour recueillir des données, qui ont été analysées thématiquement selon les six étapes de Braun et Clarke. Les résultats ont révélé que les adolescents scolarisés recevaient une éducation et des informations sexuelles inadéquates de la part des enseignants, des parents et des Églises, et que l'environnement scolaire était trop bruyant et incontrôlable pour favoriser l'apprentissage. L'étude a recommandé des stratégies pour les équipes multidisciplinaires afin d'améliorer la qualité des informations sur la santé sexuelle mises à la disposition des adolescents. Cela a contribué à aborder la problématique préoccupante des comportements sexuels à risque et des grossesses précoces en Afrique subsaharienne, notamment dans la province du KwaZulu-Natal en Afrique du Sud. (*Afr J Reprod Health* 2025; 29 [8]: 51-59).

Mots-clés: Perceptions, Qualitatif, Adolescents scolarisés, Santé sexuelle et reproductive, et Droits en matière de santé sexuelle et reproductive

Introduction

Access to sexual and reproductive health and (SRH) and sexual and reproductive health rights (SRHRs) information during adolescence has become a global concern¹. SRHR empowers sexually active individuals to have safe and satisfying sexual relationships by dealing with obstacles such as gender discrimination, gender-based violence, and inaccessibility to health

services, restrictive laws, sex coercion, and exploitation². SRHR may be seen as a person's right to health, autonomy, sexuality education, sexual preference, and avoidance of sexually transmitted infections (STIs) and unplanned pregnancies³. Additionally, SRHR focuses on physical, emotional, mental, and social well-being, concerning all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity².

According to the WHO, adolescence is a developmental stage that occurs immediately after childhood and before the onset of adulthood; it is accompanied by a series of developments that occur between ages 10 and 19⁴. During this time, personal autonomy and responsibility are required to address adolescents' health and sexuality, characterised by risky behaviours that make adolescents vulnerable to SRHR issues⁵.

Adolescents in sub-Saharan Africa experience difficulties related to SRHR, such as restricted access to youth-friendly services and physical development information. They face unsafe abortions, gender-based violence, and a lack of family planning skills⁶. This results in adolescents making rash sexual decisions, exposing them to STIs and increasing their risk of pregnancy-related morbidity and mortality; an estimated 21 000 pregnancies were recorded among girls under 15 years in KwaZulu-Natal (KZN) during the COVID-19 period in 2021⁷.

Life orientation (LO) is a mandatory subject from grades 10 to 12 in South Africa as part of the National Senior Certificate curriculum, addressing sexuality, among other topics. It aims to provide learners with the knowledge, skills, attitudes, and values necessary to make informed decisions about their health and sexuality. The South African Government also implemented policies and strategies aligned with constitutional rights, guaranteeing access to healthcare, including reproductive health. However, despite these strategies, many adolescents still lack comprehensive information on this topic, and statistics show that morbidities and mortalities related to SRHR among school-going adolescents remain a challenge⁸. It is also stated that sub-Saharan regions account for the highest number of adolescents with HIV globally and that girls are mostly affected. Moreover, there is a prevalence of child marriage, adolescent pregnancy, unsafe abortions, sexual and gender-based violence and female genital mutilation⁸. Additionally, there is evidence that in most traditional African societies, SRHR topics are seldom discussed in family settings. Speaking openly about sexuality is considered taboo in many cultures.

This prompted a study aimed at understanding adolescents' perceptions of SRHR, their difficulties in accessing information, and their preferred methods of receiving sexuality education.

The research focused on school-going adolescents in KZN, South Africa.

Methods

Study setting

The research was conducted in Richards Bay, uMhlathuze municipality, KZN, South Africa. Richards Bay is popular due to its large harbour, beachfront, and diverse wildlife. Its appeal to residents and foreign tourists makes it a hub for entertainment. This popularity poses a risk to the youth, exposing them to the increased likelihood of contracting STIs and unplanned pregnancies.

Study design

An exploratory, descriptive qualitative design was used because it is a holistic approach to collecting rich narrative data and yields in-depth insight when studying human experiences. This approach allowed the researcher to explore the topic and discover school-going adolescents' perspectives on SRHR.

Study population and sampling procedure

The study included learners aged 14 to 19 from a high school in Richards Bay, comprising 182 boys and 220 girls. Non-probability quota sampling was used, dividing learners into subgroups based on grades (10 to 12) and some racial categories like Blacks and Coloureds. Participants were easily selected within each subgroup, with quotas of four for grade 10, seven for grade 11, and nine for grade 12. The quota increased with higher grades as older participants were more open to discussing sexuality and had begun using SRHR services.

Data collection

Interviews were conducted in October 2022 at the participants' school and boarding houses. The deputy principal and landlord served as gatekeepers. Pre-testing involved four adolescents who met the criteria but were not included in the study. Adjustments were made after the pilot interviews, favouring grade 12 participants due to grade 10's limited exposure to SRHR services and sexuality topics. Quota sampling ensured diversity across grades (10 to 12), races, and genders. Individual, face-to-face, semi-structured interviews were chosen over group discussions to

ease participants' potential discomfort in sharing personal experiences.

An interview guide addressing the study's objectives with open and closed-ended questions was used, and interviews were conducted in English without any language barriers. Twenty participants were selected, and data saturation was reached with the 17th participant.

Data analysis

In-depth, individual, face-to-face, semi-structured interviews were audio recorded and transcribed verbatim. Data were thematically analysed using Braun and Clarke's six steps:

1. Familiarisation and immersion
2. Development of codes
3. Development of themes – generating themes
4. Development of themes – reviewing themes
5. Development of themes – naming themes
6. Data interpretation – write-up

Five themes and seven sub-themes emerged after analysis (see Table 2).

Ethical consideration

Ethical approval was secured from the College of Human Sciences Research Ethics Review Committee (Reference Number 48460273_CRECHS_2021), the Department of Basic Education, and the relevant high school. Both parents and participants were informed about the study's objectives, procedures, and rights, ensuring confidentiality during interviews. Participants over 18 years provided consent, while parents signed assent forms for those under 18. Participant selection was based on specific inclusion and exclusion criteria.

Results

Theme 1: School-going adolescents' perceptions of SRHR

Two sub-themes merged under this theme.

Sub-theme 1: Perceptions of SRHR

A majority of participants understood that they had the right to say no to unprotected sex. However, participants only knew one or two sexual rights; none of them knew about their right to sexuality education and access to health centres.

"No, I don't know I have a right to know about sexual issues" (P20).

Theme 2: Factors influencing SRHR issues

Three sub-themes emerged under this theme.

Sub-theme 1: Peer-related influence

All the participants acknowledged that they discussed sexuality issues with their friends, which influenced some participants' sexual behaviours.

"Yes, our peers do influence us... Even like us as teenagers we do it to fit in..." (P1).

Other participants said they were not influenced by friends and made their own decisions:

"Yeah, they influence me, but I don't listen to them because what I learn at home is different from what I learn from my friends." (P2).

Sub-theme 2: Influence of educator and class environment

Most participants felt teachers provided inadequate information and noisy classrooms hindered learning.

"In Life orientation class, my teacher would just read something for us without explanation..." (P3).

"In the classroom learners and make side jokes and you cannot hear because people are making noise." (P2).

One participant complained that the teacher used Zulu in an English-speaking class:

"I'm not a person who understands Zulu perfectly well, the School I go to is an English School but most of the time Teachers teach in Zulu." (P15).

Another comment was that neither learners nor teachers took the lessons seriously because they bunked classes.

"To be quite honest, L.O are usually a missed period, the teacher and learners do not usually come to class..." (P8).

Conversely, some learners said they were afraid to raise their hands in class to ask questions for fear of being judged as being sexually active:

Table 1: Sample demographic profile (N=20)

<i>Criterion</i>	<i>Characteristics</i>	<i>Frequency</i>	<i>Percentage</i>
Gender	Female	9	45%
	Male	11	55%
Age	14 years	3	15%
	16 years	6	30%
	17 years	2	10%
	18 years	4	20%
	19 years	5	25%
Race	Black	14	70%
	Coloureds	6	30%
Number of adolescents per grade	Grade 10 – 4	4	20%
	Grade 11 - 7	7	35%
	Grade 12 – 9	9	45%
	Grade 9		

“Aah in class we are afraid to lift up our hands and ask questions because our peers will think that we are already having sex” (P11).

A complaint was also raised that family planning issues were not discussed in class:

“It’s kind of weird, our teachers do not tell us about Family Planning but only tell us about using condoms.” (P17).

Sub-theme 3: Culture and parent-related influence

Most participants said discussions with their parents about sexual topics were infrequent, and they lacked the comprehensive understanding to make informed decisions. Topics typically centred on abstinence, girls’ virginity, and boys’ circumcision.

“Also, when parents discuss these issues, they don’t go into details...” (P12).

“Aah... In our culture, it is only the girls who go to the reed dance to check if they are still virgins. For boys, it is just to get circumcised to prevent getting diseases” (P18).

Some participants said it was difficult to discuss sexual matters with their parents due to fear of being judged:

“What makes us not to have all this information sometimes is our parents, because when you start talking about sex, they think you are doing it.” (P10).

Sub-theme 4: Religion-related influence

Most participants said that the information they received from church was superficial and did not help them to make informed decisions:

“Yes, we are taught but we do not discuss in depth. At church, they never discuss such issues” (P8).

Theme 3: Accessibility and quality of SRHR services

Two sub-themes merged:

Sub-theme 1: Availability of SRHR services

Participants mentioned clinics were available in their areas but under-used due to a lack of service awareness and dissatisfying clinic hours that coincided with school hours. Participants explained:

“There are clinics but I’m not sure if they offer sexual reproductive health services” (P17).

“It is difficult to attend the clinic because it closes at certain time, and we find it closed when we knock off from school” (P15).

Sub-theme 2: Health personnel’s attitudes toward adolescents

Most participants found health personnel friendly and helpful; they provided condoms, pre-exposure prophylaxis (PrEP), and sexuality information. However, a few participants noted instances where nurses were unfriendly or too busy to offer information:

“When we went to the clinic, we were given pills (PrEP) and condoms to protect ourselves from getting HIV and the nurses were friendly.” (P20).

“They are usually busy, so they give you the condoms and you go, and they do not give you any SRH-related education” (P17).

“I went there with my cousin... The Nurse started asking her how old she was, and when she told her, the nurse started asking her if she was a Christian and if she was not going to wait for marriage and my cousin felt very bad” (P3).

Table 2: Themes and sub-themes

Themes	Sub-themes
School-going adolescents' perceptions of SRH/SRHRs	<ul style="list-style-type: none"> • Perceptions of SRHRs
Factors influencing SRH/SRHRs issues	<ul style="list-style-type: none"> • Peer-related influence • Educator and class environment influence • Culture and parent-related influence • Religion-related influence
Accessibility and quality of SRH/SRHRs services	<ul style="list-style-type: none"> • Availability of SRH/SRHRs services • Health personnel's attitudes toward adolescents
Preferred method of receiving SRH information	
Breaking taboos	

Theme 4: Preferred method of receiving SRHR information

Participants primarily favoured comprehensive education at school, and they also proposed various alternatives: segregated groups by sex or age for a more comfortable learning environment, one-on-one teaching for open questioning, professionals like social workers or medical personnel, and options like clinics, community programmes, social media, individual research, pamphlets, Google, and parental guidance based on their own experiences.

"I prefer the Social Worker more because they deal with these things... unlike teachers because they just go according to the books." (P1).

"In classrooms by teachers if it could be given to us in detail and through awareness and in our community." (P5)

Theme 5: Breaking taboos

None of the participants perceived sexuality issues as being taboo, and they expressed their eagerness to learn more.

"Yes, I feel that it is the right thing to do as we are growing, we are the next generation and I think that

this information can lead the world into a better generation." (P6)

Discussion

Most participants had misconceptions of what SRHR was and related it to sexual intercourse. Some perceived it as parent-child relationships, and others said it was a developmental stage in life. This confirms the findings of research across sub-Saharan Africa that indicate that the knowledge of HIV seems widespread, but knowledge of other dimensions of SRHR is lacking, especially among early adolescents⁹. In a Uganda-Nakivale refugee settlement, a study reported that adolescents had a lack of knowledge on SRHR issues¹⁰. A lack of sexual education leads to poor health outcomes; for example, adolescent girls face challenges such as gender-based violence, early marriages, and limited economic opportunities that affect their SRHR¹¹. A study conducted in Cooks Island, Fiji, Papua New Guinea, and Vanuatu concurred that a lack of accurate SRHR knowledge led to limited access to SRHR services for adolescents¹².

On issues relating to SRHR, most school-going adolescents knew they had the right to say no to unprotected sex. However, none of them knew that they had a right to sexuality information and access to SRHR services. Similar results were reported in a study done in the Pacific that showed adolescents did not know their sexual rights, one-third of adolescents had experienced sexual and gender-based violence, 28% of births were unintended, and half reported an unmet need for modern contraceptives¹³.

Adolescents' inability to define SRHR signals a lack of comprehensive sexual education. Contributing factors include teachers' perceived lack of seriousness in LO sessions due to absenteeism, language barriers, noisy classrooms, and ineffective teaching methods that do not encourage open discussions. Teachers seemed ill-equipped to manage classrooms and engage students adequately. The Department of Basic Education (DBE) in South Africa introduced comprehensive sex education in LO for grades 10 to 12, yet some learners feared peer judgement, hindering their participation in class discussions¹⁴. This view is supported in a study from Zambia, which revealed that adolescents felt shy, embarrassed, or uncomfortable when questions about sexuality issues were posed face-to-face¹⁵.

Literature ultimately reported that the existing LO school education programme still focuses on abstinence and risk-based approaches¹⁶. This calls for the DBE to revise the school curriculum and teachers' training to equip them with adequate teaching skills. This confirms the African Population and Health Research Centre's⁹, view that schools' sexual curriculums fail to sufficiently equip adolescents with information to make knowledgeable decisions regarding sexual matters. Therefore, this study agrees with the recommendation to study LO teachers' experiences in providing sexuality education. It was determined that in secondary schools in Limpopo Province, South Africa, teachers needed to be equipped with knowledge and skills to teach various sexuality topics¹⁷. Since adolescents were unequipped with comprehensive sexuality information from teachers, they sought information from peers, which influenced some participants' decision to become sexually active. This confirms the African Population and Health Research Centre's⁹, statement that people mostly learn about SRHR by associating with the opposite sex, through peers, and friends. Therefore, peer-to-peer education programmes should be considered; a survey conducted in high schools in Rwanda showed a reduction in adolescent pregnancies using this approach¹⁸. Since culture is thought to shape the norms of the community, school-going adolescents reported that it was difficult to discuss SRH/SRHRs issues with their parents due to fear of being misjudged that they were sexually active. The African culture is also known to prohibit open discussions about sexuality¹⁹. Moreover, research findings from rural areas in KZN, South Africa, reported that parents had challenges in providing sex education to school-going adolescents, and, if given, the information was often uncoordinated and chaotic²⁰.

Discussions are thus limited by cultural norms, lack of knowledge among parents and parents' busy work schedules²¹. However, parent-adolescent communication on SRHR is vital to reduce adolescents' risky sexual behaviours. A study conducted in Oman showed that parents rarely discussed sexuality issues, including HIV, with their children, as this led to fear that the adolescents would engage in early sexual debuts²². In this study, the researcher noted parents' primary focus was circumcision for boys and preserving girls'

virginity. The findings highlighted the pivotal role of a strong parent-child relationship in addressing adolescents' lack of knowledge about sexual matters. It was also reported that churches seldom discuss sexuality issues. Most participants perceived that SRHR topics were not discussed in Churches, and if they were, the focus was on abstinence. A study in Iganga, Uganda, determined that religious leaders perceived the promotion of SRHR increased sexual immorality among adolescents²³. Another study from Rwanda regarded the teaching of sexuality topics as a sin and a violation of the Church commandments¹⁹. However, it is critical to discuss sexual issues in detail so that school-going adolescents gain comprehensive knowledge to help them make informed decisions about their sexual lives.

Moreover, despite the availability of clinics in their residential areas, they were under-used. This confirms that sub-Saharan African adolescents face significant SRHR challenges, including limited access to youth-friendly services and information on their development, unsafe abortions, gender-based violence, and family planning²⁴. Only a few participants were concerned that clinic working hours were unsuitable for young people because they were closed when schools closed. This may contribute to limited access to SRH centres and, therefore, lead to morbidities, mortality, and a lack of knowledge. A study conducted in Edmonton, Canada, concurs that clinics' operational hours were challenging as they coincide with work and school hours²⁵. Most participants reported that the health personnel were friendly because they gave them condoms, sexual information, and PrEP during clinic visits. This finding was confirmed by a study conducted in South Africa on PrEP usage, which indicated an uptake of 68.6% in one month²⁶. However, some participants said that nurses were usually very busy, so they did not provide any information on SRH/SRHRs, and sexual awareness campaigns were not held in the community. Findings from Khayelitsha in South Africa and Jordan showed that most health centres were not friendly and judgemental of youths^{27,28}. Furthermore, an online literature review study showed that healthcare personnel were unfriendly, and this inhibited adolescents' access to SRH services²³. Only a few learners in this study complained about the negative attitudes of nurses and said they were too busy to provide them with

sexuality information. Therefore, the Department of Health needs to rectify this problem.

Participants offered different suggestions for acquiring sexuality information. A majority preferred to receive comprehensive information from schools in a conducive environment. In low and middle-income countries, teachers' engagement in teaching was vital for the successful implementation of comprehensive sexual education²⁹. This was contrary to the findings of the study from Uganda's Nakivale settlement, where most participants preferred to receive information from parents or guardians¹⁰. A few preferred to be placed into smaller groups according to their sex or age as they felt the teachers would better control the classroom, and learners would feel free to ask questions in the absence of the opposite sex. Placing learners in smaller groups is useful because it improves their communication skills³⁰. One participant preferred one-on-one teaching as she felt that she would be freer to ask the teacher questions in this context. This confirms the findings of a study among Sudanese refugees in Northern Uganda, stating that family planning knowledge and uptake was poor, and a lack of privacy was a contributing factor³¹. Other participants preferred social workers or medical personnel providing information, as they felt these professionals were more knowledgeable about sexuality issues. A few participants preferred using clinics, community awareness programmes, social media, individual research, pamphlets or Google to gain information. However, others mentioned that they preferred discussions with their parents as they were more knowledgeable and had gone through this same experience.

Most participants viewed SRHR as acceptable rather than taboo, as they expressed an eagerness for information on the topic. The significance of this study lies in the absence of similar research on adolescents' perceptions of SRH/SRHRs in the Richards Bay area. Conducting a more expansive study across multiple high schools with representation from all racial groups could provide deeper insights into the phenomenon.

Strengths and limitations

The study was limited by its sampling from a single high school and the use of English to conduct interviews. However, a notable strength was the willingness of all learners to participate and freely share information. To add on, identified gaps can

guide future research and funding to advance SRHR policies and programmes.

Conclusion

Although the government has policies and strategies to promote SRHR, it was revealed that school-going adolescents in Richards Bay, KZN, had inadequate information on SRHR issues because the information they received at schools, from parents and churches was too superficial for them to make informed decisions about their sexual health. This explains why the rate of teenage pregnancies is high in KZN. This study contributes to SRH research since some of the causes that prevented adolescents from acquiring adequate information were identified, and recommendations were made accordingly. The multi-disciplinary team should ultimately work together to equip adolescents with comprehensive information on sexuality issues to reduce their risky sexual behaviours.

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Competing interests

The authors declare that they have no financial interest that influenced the writing of this article.

Author contributions

BL was the original contributor who conceptualised the study and conducted the literature review, methodology, data collection, analysis, and manuscript writing. RGM contributed to the conceptualisation of the study, methodology, supervision of the research study, and manuscript writing and guarantees the integrity of the study. All authors reviewed and edited the final manuscript.

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