

Delivery of school-based interventions to promoting adolescent health and well-being: Lessons from a multilevel HIV-prevention intervention through DREAMS in rural KwaZulu-Natal, South Africa



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1. Background

- HIV incidence remains high among adolescent girls and young women (AGYW) in South Africa, as well as teenage pregnancy, and other sexually transmitted infections
- Schools present an opportunity to promote and deliver health and wellness interventions in a safe and sustainable infrastructure to promote adoption of positive behaviour and resilience
- School attendance is high in SA and being in school has been found to be protective of acquiring HIV
- The WHO Health Promoting Schools (HPS) framework, an ecologic model, uses a whole-school approach to create a positive health environment to support health promotion
- Aim: To inform whole-school intervention development, we examined the implementation of the school-based component of the DREAMS partnership, a multi-level HIV-prevention intervention in rural KwaZulu-Natal, South Africa**

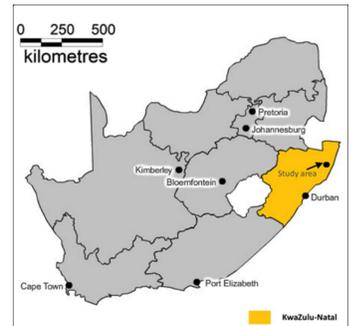
2. Methods

Study site

- Africa Health Research Institute (AHRI) is situated in uMkhanyakude district, KwaZulu-Natal, SA
- Site is mostly rural and poor, with high unemployment (>80% of those aged >18)
- High HIV prevalence ~24% (15-49 years)
- District was selected for DREAMS investment, with few targeted HIV prevention interventions for adolescents and youth prior to DREAMS

Data collection

- Mixed-method process-evaluation approach in AHRI surveillance area
- Rapid ethnographic landscaping of four areas (1 semi-urban, 2 rural and 1 deep-rural) in 2017-18 to purposively recruit participants:
 - In-depth interviews (n=58) with adolescents and youth (10-35 years)
 - Group discussions (n=13) with adolescents and youth
 - Interviews with intervention providers (n=17) and
 - Interviews with life orientation teachers (n=3)
 - Participatory observations.
- All interviews were audio-recorded, transcribed, and analysed using thematic content analysis using Nvivo 12.



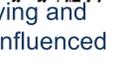
3. Findings

Context prior to DREAMS

High teen pregnancies leading to school drop-outs 

Low condom use – undesirable for boys and poor negotiation skills for girls  

Common alcohol and drug use – peer pressure, perceived as transition to adulthood, unstable/broken family backgrounds 

High violence – both within and out of school, bullying and harassment, and violence towards teaching staff influenced by drugs and alcohol 

Transactional sex common among girls – Blesser-blessee relationships for money and material things, social media influence, and for survival 

Opportunities offered in school

Schools were seen as safe spaces for health education

Health education mostly delivered through Life Orientation (LO) and biology lessons

Teachers were perceived as trusted confidants and sources of health information

“I found out at the end because I communicate a lot with boys at school. So, in classroom during an LO period I asked the teacher about ‘being stuck’, what it was, and he told me what it is. I then noted every time when a person says they were ‘stuck’ they meant that they had drop [STI]” IDI Male learner

Schools were acceptable platforms by learners, school teachers and implementers to deliver health talks and interventions

Books were also mentioned by learners as sources of health education

School-based programs delivery in uMkhanyakude

- Delivered by two community-based organisations with previous history working in the study area
- Program targeted in-school AGYW (10-19 years)
- Consisted of 16 scripted participatory sessions aimed at changing gender norms; peer and educational support to remain in school
- Used trained facilitators (not teachers) to deliver intervention
- Recruitment mostly at schools, orphans and vulnerable children databases and community
- Delivery was done in schools, community halls, creches, churches and homes

Challenges setting up and delivering interventions

- Unable to work in some schools for lack of memorandum of understanding with the Department of Education
- Unable to integrate DREAMS health interventions within the existing school curriculum or health programmes
- Unable to provide biomedical services such condoms and contraception within the school premises, due to school management and education policies
- Limited to using schools as recruitment and delivery venues
- Insufficient educational subsidies for learners needs to remain in school due to funding cuts leading to drop-outs
- AGYW competing priorities – not able to complete all sessions
- Challenges with referrals between DREAMS partners and government departments for provision of further care and other services lack of transport money for participants



Opportunities/success of intervention

- Most adolescents participated in DREAMS school-based interventions
- School interventions found beneficial – increased HIV knowledge and status
- Parents/guardians of participants welcomed the intervention and their children's involvement
- “...Is to work in collaboration with the community, ward councillors and those mothers who are testing young girls for virginity, yes...They accept us and give us their children.”* Implementing partner
- Traditional/political leaders buy-in and support of the implementers and program facilitated intervention roll-out
- Home-visits allowed for follow-up of cases identified in school
- Home-visits and parental/guardian involvement facilitated intervention delivery and effectiveness

4. Conclusion

As learning-positive spaces with trusted adults, schools in rural South Africa provide a favourable setting to promote health and well-being

However, failure to integrate interventions into the school environment and limited access to biomedical services alongside health promotion, limited their effectiveness in practice