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EXAMINING THE IMPLEMENTATION OF SEXUALITY AND REPRODUCTIVE HEALTH EDUCATION AMONG ADOLESCENTS IN SELECTED PRIMARY SCHOOLS OF ZAMBIA

BY

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Dedication Page

This publication is dedicated to my dear wife Angela K. Mukonka, my children Chipego and Joshua and my nieces for their continued support and encouragement rendered to me during my study for this PhD. Further, I dedicate this work to my late elder brother Mr. Chrispin Mukonka who was a major inspiration in helping me attain such a level of education.

Declaration

I declare that this is my own original work and that it has not been submitted elsewhere for publication or examination purposes. Further, all work from other sources have been duly acknowledged.

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Disclaimer

The researcher is an employee of the United Nations Scientific and Cultural Organization (UNESCO). However, findings of the research are not in any way bearing the influence of being a UNESCO staff member. The study is for academic purposes only. The information in the report does not in any way reflect UNESCO's views on Comprehensive Sexuality Education and Sexual Reproductive Health among Adolescents. To ensure that the disclaimer was adhered to, the researcher worked with a competent research assistant of reputable knowledge in ASRH and CSE to help balance any issues relating to bias during the course of the study.

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Acronyms

A/YFRHS	Adolescent/Youth Friendly Reproductive Health Services
AIDS	Acquired Immunodeficiency Syndrome
APHA	American Public Health Association
ARFH	Association for Reproductive and Family Health
ASRH	Adolescent Sexual Reproductive Health
BZgA	German Federal Office for Health Education
CDC	Center for Disease Control
CEDAW	Committee on the Elimination of Discrimination against Women
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
DHS	Demographic Health Survey
EGVS	End Gender Violence in Schools
ESA	Eastern and Southern Africa
FAWEZA	Forum for African Women Educationalists of Zambia
FLE	Family Life Education
FLHE	Family Life and HIV/AIDS Education
FMoE	Federal Ministry of Education
GBV	Gender-Based Violence
GPE	Global Partnership for Education
HECAT	Health Education Curriculum Analysis Tool
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information-Education-Communication
IIPS	International Institute for Population Sciences
IPPF	International Planned Parenthood Federation
IWHC	International Women's Health Coalition
M&E	Monitoring and Evaluation
MCDSS	Ministry of Community Development and Social Services
MNGRA	Ministry of National Guidance and Religious Affairs
MoCTA	Ministry of Chiefs and Traditional Affairs

MoE	Ministries of Education
MoES	Ministry of Education and Sports
MoG	Ministry of Gender
MoGE	Ministry of General Education
MoH	Ministry of Health
MYSCD	Ministry of Youth, Sport and Child Development
NGOs	Non-Governmental Organisations
PCC	Project Coordinating Committee
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Programme Implementation Technical Committee
PSHE	Personal, Social, Health and Economic
SHARE	Sexual Health and Relationships: Safe, Happy and Responsible
SHR	Sexual Reproductive Health
SIDA	Swedish International Development Agency
SIECUS	Sexuality Information and Education Council of the United States
SRE	Sex and Relationship
SRGBV	School Related Gender-Based Violence
SRHR	Sexual and Reproductive Health Rights
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
USA	United States of America
UNAIDS	United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGEI	United Nations Gender Education Initiative
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFRHS	Youth Friendly Reproductive Health Services
YRBSS	Youth Risk Behavior Surveillance System
YWCA	Young Women Christian Association
ZDHS	Zambia Demographic and Health Survey

Abstract

Despite the full-scale implementation of Comprehensive Sexuality Education (CSE), behavioural related health problems among adolescents persist and these include early and unprotected sex, sexual abuse, early marriages and teenage pregnancies among others. The study aimed at examining the implementation of sexuality and reproductive health among adolescents in selected primary schools in Zambia. The objectives of the study were to establish the *implementation* of Comprehensive Sexuality Education (CSE) and reviewing the *relationship* between culture and CSE; to examine the *effect* of CSE on the social-emotional development of adolescents and analyzing how implementation of CSE *addresses* School Related Gender-Based Violence (SRGBV); and to *identify* sources of gender-transformative adolescent sexual reproductive health services for young people in primary schools.

The research employed a mixed method design that integrated the qualitative and quantitative approaches. The study was undertaken in Lusaka, Kabwe, and Choma districts, targeting 700 adolescents aged 12 – 17 years; 15 school key informants who included school headteachers, class teachers, guidance and counseling teachers as well as teachers trained in CSE and other relevant stakeholders such as guidance and counseling teachers in the selected districts as well as Ministry of Education and health senior officials. Simple Random sampling was used to select the learners in the schools and purposive sampling was employed to choose the key informants. Questionnaires and focus group discussions were employed to collect statistical and narrative data. Data was analysed using the Statistical Package for Social Sciences (SPSS) to generate charts, tables and conducting chi-square test. Thematic analysis was utilised for qualitative data.

Major findings demonstrate statistical evidence of CSE implementation in schools with the support of the trained teachers, and to a certain extent, the number of learners dropping out of school due to teenage pregnancy is reducing. Between 2016 and 2017, there was a reduction in teen pregnancy from 15, 240 in 2016 to 13, 640 in 2017 giving a total of 1,600 reduced cases. Findings further indicate that CSE is included in national examinations, but evidence shows that a lot of teachers especially those not yet trained do not integrate CSE in their teaching. There are several challenges that include lack of proper guidelines to effectively implement CSE; lack of learning and teaching materials and insufficiently trained teachers. The study further demonstrates that key components like School Related Gender-Based Violence (SRGBV) do not receive adequate attention, yet it is one of the key pillars of CSE implementation. The study found varying relationships between the influence played by culture and religion to the expected function of CSE trained teachers and there is no standard training manual to guide the training of teachers and consequently, this does not guarantee the quality of teachers trained and their effectiveness to deliver at classroom level. This study has demonstrated that the implementation of CSE is taking place in schools although there are challenges that suggest need for effective implementation in Zambia based on sustainable financing to support both teacher training and enhanced materials production which are currently inadequate in schools.

The study recommends that effective integration of CSE should be coordinated within the Ministry of Education in collaboration with the Ministry of Health.

Key-words: *Comprehensive Sexuality Education, Sexual Reproductive Health, Institutionalisation, Social-Emotional Development, Adolescents, Sexual Health*

Chapter One: Introduction

1.0 Introduction

Adolescent sexual behaviour has been an area of global concern. The Sexuality Information and Education Council of the United States (SIECUS) (2005) indicate that risky sexual behaviour of adolescents has not only been perceived to jeopardize the social order in society but is also a threat to expected health outcomes of young people. In Zambia, the National Acquired Immunodeficiency Syndrome (AIDS) Strategic Plan of 2017-2010 states that early sexual debut among adolescents results in Sexually Transmitted Infections (STIs) which includes Human Immunodeficiency Virus (HIV) which causes Acquired Immunodeficiency Syndrome (AIDS), teenage pregnancies, abortion, school dropouts and early maternal deaths. The strategy further indicates that a healthy adaptive adolescent sexuality would promote not only survival but also adolescent wellbeing. SIECUS (2005) reveals that various parts of the world continue to show that the number of sexually active young people is on the increase and the consequences that accompany early sexual debut are clearly evident.

Since the introduction of Comprehensive Sexuality Education (CSE) in schools in Zambia in 2014, the United Nations Educational, Scientific and Cultural Organization (UNESCO) report (2017) indicates that 65,000 teachers have been trained to deliver CSE at classroom level; over 1, 900,000 learners have been reached with CSE messages; about 5,000 head teachers have been reached with training on the management of CSE at school level and about 6,000,000 parents and young people at community level through mass media have been reached with messages on CSE and Sexual Reproductive Health Rights (SRHR). A further pertinent point to note is the intended outcome in this effort, because the aim of the project was to improve sexual and reproductive health, gender, and education outcomes for adolescents and young people in Zambia through sustained reductions in new HIV and other sexually transmitted infections, early and unintended pregnancy (EUP), and gender-based violence (GBV).

However, despite this high number of trained teachers and clarity of thought in the goal and resource investment into the programme, this does not seem to translate into the desired improved health outcomes among young people in Zambia as school dropouts due to teenage pregnancies, early marriages and HIV and STIs remain high among the

adolescents NASF (2017-2021) It is against this background that this study aimed at establishing what the gaps were between the time the interventions were put in place and the possible results of these interventions. Consequently, the study would make recommendations for public policy and practice necessary for action.

This research is grounded in the Critical Discourse Analysis (CDA), Social Learning and the Institutional Theories. It uses an exploratory phenomenological study using the mixed method design to examine the implementation of sexuality and reproductive health among adolescents in selected primary schools in Zambia.

This chapter is focused on introducing the research. The introductory chapter provides the background to the study and the statement of the problem. Furthermore, the chapter presents the research objectives and research questions that guided the study on examining the implementation of sexuality and reproductive health among adolescents in selected primary schools in Zambia. The significance of the study, delimitations of the study and operational definition of terms are also provided. The chapter also discusses the independent variables that include human rights values, cultural sensitivities, gender equality, gender transformative, age appropriateness, professional coordinators, participatory approaches, training of teachers and team-teaching alongside the dependent variable which is CSE in this case. A summary is then presented at the end of the chapter.

1.1 Background to the Study

1.1.1 Lack of Sexuality Content in Curriculum Development in Zambia

In the 1970s, Mwanakatwe (1974) profiled the development of education in Zambia in its entirety from the early days of Zambia's independence to 1974 and none of his writings, which mostly, focused on content brings out information on adolescent sexual reproductive health. This, to a certain extent, confirms that issues to do with sexuality education were shrouded in silence yet young people needed the adolescent sexual health services (ASRHS) even as far back as 1974. Unfortunately, even in later years, the *Educating our Future Policy* review of 1996, has little mention of sexuality education in Zambia's education curriculum. Given this background, Comprehensive Sexuality Education is seen as a new concept and therefore still contested in Zambia.

However, the *Educating Our Future Policy* (1996) recognizes the need for sexuality education although it did not provide specific steps needed to be taken to ensure that learners had access to sexuality knowledge particularly in the face of the growing concern for HIV and AIDS at the time between 1982 and 1996.

1.1.2 Sexuality as a traditional taboo

Traditionally, in most African societies, including Zambia, issues of sexuality are still considered a taboo and can never be discussed openly between adolescents and their parents. Kapungwe (2003) affirms this by stating that in Zambia, it has long been a taboo to discuss sexual matters with somebody of the opposite sex and with one's own child. As a result, parents including teachers feel uncomfortable talking about sexuality issues with young people and adolescents. Therefore, an assumption exists that traditional customs contribute to challenges of teaching CSE in schools among learners.

1.1.3 Inclusion of Life Skills in Zambia's Curriculum

To address risky sexual behaviours that include early and unintended pregnancies, the Zambian government in conjunction with pressure groups and Civil Society Organisations (CSOs) that included the Forum For African Women Educationalists (FAWEZA), the Civic Education Organization supported by development partners like UNICEF and World Bank, supported the Ministry of Education to introduce the school re-entry policy in October 2007 with the aim of ensuring that girls who become pregnant while in school can return and continue their education after giving birth. In addition, the Ministry of Community Development, Mother and Child Health (2012), as part of Zambia's Education Policy on "Educating Our Future", recognized that life skills are one of the main components of the school curriculum. Thus, the policy was formulated to provide types of skills that should be offered to both formal and non-formal learners regardless of sex. The policy framework re-defined the purpose of learning with an emphasis that the learner should be equipped with necessary lifelong core skills which enable them to translate skills learnt into decisions leading to sustainable development.

1.1.4 National Priority on Adolescent Health (ADH) - Broad context

The United Nations Population Fund (UNFPA) (2018) defines adolescents as young people between the ages of 10 and 19 and further states that Zambia recognizes the importance and significant impact that adolescents have on the overall health status of the country, including the attainment of the national health objectives and Sustainable Development Goals (SDGs) and especially SGD 4 on education. In view of the foregoing, the Ministry of Health (MOH) has identified the need to strengthen Adolescent Health (ADH) by developing and implementing a national strategy, aimed at providing a comprehensive and coordinated response to ADH problems and needs in the country. The *Zambia Strategic Framework* (2017-2021) states that Zambia currently has the largest population of young people in its history, with 82% aged 35 years and below and 35% aged 15-35 years. Adolescents account for 25% of the total population and have a significant influence on its overall health status, given that adolescence represents a vulnerable period of transformation from childhood to adulthood and, if not well managed, could lead to huge health and socio-economic consequences. The *Zambia Demographic and Health Survey* (ZDHS) (2018) further indicates that about 32% of adolescents aged 15-17 years and 60% of those aged 18-19 years are sexually active, and therefore face risks of acquiring HIV and other Sexually Transmitted Infections (STIs) and only 40% use condoms regularly. The ZDHS (2018) further states that adolescents experience mental health issues, trauma, and physical and sexual violence. In addition, there are substantial gender differences related to risk and vulnerability among Zambian adolescents: almost one in five adolescent girls are already married compared to only one in 100 adolescent boys aged 15-19; and one in four girls aged 17 and six in 10 girls aged 19 have already started childbearing.

1.1.5 Life Skills Education Framework of 2011

In order to deal with the problem of adolescent sexual behaviour risks, Zambia developed a *Life Skills Education Framework* in 2011 that adopted the World Health Organization (WHO) definition of life skills as "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". The framework provided guidelines to direct service providers on minimum content to be taught at different levels of education in order to standardize the

life skills offered to learners. An evaluation conducted by the United Nations Children's Fund (UNICEF) in 2009 reveals that the programme did not achieve its desired outcomes such as resilient young people who are able to effectively communicate, make goals, assertive and are able to make responsible decisions for their lives.

1.1.6 Curriculum Amendment-introducing CSE

In 2011, the Ministry of Education in Zambia enacted the Education Act No. 23. In Section 108 (1) (i), the Act empowered the Minister of Education to amend the curriculum in order to introduce CSE. Thus, in 2014, the Ministry completed the development of the comprehensive sexuality education curriculum, which was rolled out to all schools, targeting children aged 10–24 in grades 5–12. To ensure that CSE is systematically implemented, the curricula was included in teacher-training colleges. Furthermore, in order to make it accessible to adolescents, CSE was integrated into various subjects such as Home Economics, Integrated Sciences, Religious Education, Civic Education, Social Studies, and languages.

The above efforts on the introduction and implementation of CSE have been acknowledged by UNFPA (2018). UNFPA has recognised that CSE is one of the interventions that has been implemented since 2014 aimed at reducing teenage pregnancies in schools; empower young people to delay sexual debut; increase knowledge on Sexual Reproductive Health; and reduce HIV infections. CSE is also one of the pathways through which the Ministry of Education is delivering Adolescent Sexual Reproductive Health (ASRH) information to adolescents which is age appropriate, culturally sensitive, and scientifically accurate and is curriculum based.

Since the introduction of CSE in schools in Zambia, the United Nations Educational, Scientific and Cultural Organization (UNESCO) report (2017) indicates that 65,000 teachers had their capacity built to deliver CSE at classroom level, Over 1, 900,000 learners were reached with CSE messages, about 5,000 head teachers were also reached with training on the management and supervision of CSE at school level and about 6,000,000 parents and young people at community level through mass media campaigns were reached with messages on CSE and Sexual Reproductive Health. It is against this background that this study aimed at assessing the Implementation of Sexuality and

Reproductive Health among Adolescents in selected Primary Schools in Zambia. The Zambian government's target through the National Adolescent Health Strategic Plan (2017-2021) was to increase the knowledge levels on HIV, ASRH and CSE to 75 percent among young people aged 10-24.

Minimal impact of CSE and ASRH - Studies conducted in Zambia reveal that interventions of CSE and ASRH have not resulted in the intended outcomes (UNFPA, 2015; UNESCO, 2017). Further, anecdotal data around the country also reveals that the number of sexually active young people is high as is evidenced by the continued high numbers of teenage pregnancies in successive years. The aforementioned situation points clearly to the fact that young, unmarried girls and boys engage in sexual activities, and this is an issue of concern.

Integration of CSE in the Curriculum - UNFPA report (2015) indicates that, the Ministry of Education's Comprehensive Sexuality Education Framework (2014), shows that CSE is mandatory in carrier subjects or delivered through optional subjects. It further states that, where sexuality education is non-compulsory, extra-curricular or only partially compulsory, a large population of learners would not reap its benefits. As pointed out above, in Zambian schools, teaching of sexuality education has been infused or integrated in Home Economics, Biology, Integrated Science, Religious Education, Civic Education and Languages so referred to as carrier subjects. While this model may reduce pressure on an already overcrowded curriculum, it is difficult to monitor or evaluate, and may limit teaching pedagogies or methodologies to traditional approaches (UNFPA, 2015). Thus, this study aims to assess the implementation of sexuality education among adolescents in selected schools in Central, Lusaka and Southern provinces of Zambia.

Historical Context of CSE introduction in the Curriculum - In order to provide a critical historical context on the development of CSE in the Zambian educational system, it is necessary to review Zambia's Educational Reforms, the Education Act of 1966 and the Educational Reform of 1977. These documents provides a premise for discussing the introduction of CSE into the Zambian curriculum.

The Ministry of Education, Science, Vocational Training and Early Education (MESVTEE) (2013) reveals that based on the National Policy on education, *Educating Our Future* of 1996, the Teacher Education Department in 2000 reformed the Zambia Basic Education Teacher's Course to Zambia Teacher Education Course (ZATEC) which resulted in a change of the teacher education curriculum.

MESVTEE (2013) (now Ministry of Education) indicated that the Zambia Basic Education Teacher's Course consisted of a large number of separate subjects among which there were only few links. MESVTEE (2013) reports that the subjects competed amongst each other creating both superficiality and overcrowding. ZATEC assumed that children do not view their life and their experience in neatly compartmentalised segments but rather holistic with no boundaries. In view of this idea, ZATEC adopted a concept of Study Areas in which the subjects were grouped according to clearly definable relationships among them (MESVTEE 2013). MESVTEE (2013) explains that from twelve (12) traditional subjects that Zambia Basic Education Course (ZBEC) offered; English, Mathematics, Science, Home Economics and Hospitality, Physical Education, Music, Creative Activities, Industrial Arts, Social Studies, Spiritual and Moral Education, Zambian Languages, ZATEC integrated the subjects into Six (6) Study Areas: Literacy and Languages; Education, Mathematics and Science, Expressive Arts, Technology Studies and Social, Spiritual and Moral Education.

In the year 2000, the Curriculum Development Centre (CDC) embarked on the school curriculum review starting with the Lower and Middle Basic Education (Grades 1 – 7) (MESVTEE 2013). The purpose of the review was to link the school curriculum to teacher education. The review that commenced in 2000 was meant to: re-define the desired learner, the teacher-educator/instructor and the teaching/learning outcomes so as to make education relevant and responsive to the individual and society (MESVTEE, 2013). The MESVTEE (2013) observes that while the primary school curriculum was reviewed in 2000, the secondary school curriculum was last comprehensively reviewed in the early 1970s. The curriculum consists of a small number of core subjects but a wide range of optional subjects (MESVTEE, 2013).

Mulenga and Kabombwe (2019) report that in 2013 the Zambian education was revised from knowledge-based, which had been used since political independence from the British in 1964, to a competency-based or outcome-based curriculum. The Zambian curriculum was reformed in a bid to prepare learners for future challenges in the rapidly changing world (Ministry of General Education, 2013).

The aims of the 2013 revised Zambian curriculum were to produce self-motivated, life-long learners, confident and productive individuals, holistic, independent learners with the values, skills and knowledge to enable them to succeed in school and in life (Zulu, 2015). Mulenga and Kabombwe (2019) further point out that the vision of the Zambian education sector is to ensure that through the competency-based curriculum, learners will be expected to acquire three critical educational elements namely, worthwhile skills, appropriate attitudes and applicable knowledge which make up competences. Through this background, there has been a maintained silence on what culture says around sexuality issues especially around what learners know and should learn from home. Therefore, the curriculum was very much child centered and learning in the classroom was the most important thing.

The 2013 revised curriculum incorporated several cross-cutting concerns, prominent among these being: Comprehensive Sexuality, Life Skills, Financial management, Anti-Corruption, Drug and Substance Abuse, Environmental and road safety education (Mulenga and Kabombwe, 2019).

1.2 Statement of the Problem

- The curriculum review of 2013 that focused on creating relationships among subjects as reflected in the lived experience of learners did not explicitly handle sexuality education as envisioned by stakeholders engaged in Adolescent Health (ADH). There was a growing concern at this period of a lack of a comprehensive content scheme in the curriculum that should address adolescent health arising from sexual vices. Sexual vices among adolescents, who in the majority were in school as learners, had a negative impact on school completion rates as well as academic performance especially among female learners.

- To address this gap in content, in the subsequent year (2014) of the release of new curriculum, the Ministry of Education introduced a new content termed Comprehensive Sexuality Education (CSE) to alleviate challenges of ADH and in effect curb the negative impact on learning arising from sexual vices. The implementation of the teaching of CSE was thus done through integrating its content in carrier subjects in all schools in Zambia.
- After a four-year period since CSE integration in the curriculum, a national survey conducted by the Zambia Demographic and Health Survey (ZDHS) in 2018 focusing on adolescents' statistics, critical challenges in relation to adolescent health were revealed. Statistics indicated that adolescents and young adults form 40% of Zambia's population of both in-school and out of school persons. The survey revealed health challenges that mostly affected the female cohort among this population which included poor access to health information, unsafe abortions, Sexually Transmitted Infections (STIs), HIV, early sexual debut and early marriages. In addition, a total of 9% of adolescent girls became pregnant by the age of 19 years and over half of those who became pregnant while at school did not return to school after giving birth (ZDHS, 2018).
- The statistics present existing critical challenges of adolescent health arising from sexual vices among both in-school and out of school adolescents. Therefore, it begs the question as to the manner of implementation of CSE since its incorporation into curriculum in 2014. To put it as a question: Is the implementation of CSE being hindered by cultural and religious undertones embedded in the Zambian society?

- This further begs the question as to whether CSE introduced and implemented by the Ministry of Education has had any impact at all on adolescents' health. In addition, it can be queried whether there has been any significant notable progress since the implementation of CSE. What challenges could have resulted in statistics on adolescent health remaining stagnant over this given period (2014 - 2018)? This study, therefore, sought to examine CSE's implementation in selected primary schools by the Ministry of Education.

1.3 Research Objectives

1.3.1 General Objective

The general objective of the study was to examine the implementation of Sexuality and Reproductive Health (SRH) education among adolescents in selected primary schools in Zambia.

1.3.2 Specific Objectives

The study sought to achieve the following specific objectives:

i. To establish the *implementation* of CSE in selected primary schools in Zambia;
ii. To review the relationship between *Culture* and CSE in selected primary schools in Zambia;
iii. To examine the effect of CSE on the *social-emotional* development of adolescents in the selected primary schools in Zambia;
iv. To analyse how implementation of CSE addresses School Related Gender-Based Violence (*SRGBV*) in selected primary schools in Zambia; and
v. To identify *sources* of gender-transformative Adolescent Sexual Reproductive Health Services (ASRHS) for young people in selected primary schools in Zambia.

1.4 Research Questions

The study sought to answer the following research objectives:

i. How is CSE being *implemented* in selected primary schools in Zambia?
ii. What is the relationship between *Culture* and CSE in selected primary schools in Zambia?
iii. What is the effect of CSE on the *social-emotional* development of adolescents in the selected primary schools in Zambia?
iv. How does implementation of CSE address School Related Gender-Based Violence (*SRGBV*) in selected primary schools in Zambia?
v. What are the *sources* of gender-transformative adolescent sexual reproductive health services for young people in primary schools?

1.5 Significance of the Study

ADH is a critical element in the success of educational attainment of young people. The disruption that occurs in learning caused by sexual vices creates retardation of enhancing the welfare of young people in their future careers. With high statistics pointing to the negative impact of sexual vices on young people in 2014, the implementation of CSE was envisioned to mitigate this negative trend and promote a positive adolescent growth that would translate into effective educational attainment. Therefore, this study which makes an examination on the implementation of CSE in schools is significant in pin-pointing or identifying challenges that have been encountered in the implementation process over the given period. Identifying these challenges will enable programme implementers to modify aspects that create these challenges. The study is therefore significant in three ways:

Policy – The study might contribute in streamlining the programme and enable new strategic approaches to be adopted by the programme implementers.

Practice – The study may address the challenges that have been encountered in the implementation of CSE over the given period of time. Further, identifying these bottle necks may enable programme implementers to modify aspects that create the challenges of implementation of CSE

Community -The review of the programme might benefit young people and encourage the educational attainments and their future careers.

1.6 Scope of the study

The study focused on the implementation of CSE in selected primary schools in Zambia. Therefore, the study limited itself in examining components of implementation of the programme which included curriculum integration of CSE, pedagogical approaches utilised, training capacities of teachers implementing CSE and learner response to this implementation process. This means that the study was confined to challenges encountered in the implementation process of CSE in the selected primary schools.

1.7 Delimitation of the study

Dusick (2011) describes delimitations as being those characteristics selected by the researcher to define the boundaries of the study. The implementation of CSE between 2014 and 2018 had been done in six Provinces namely, Lusaka, Southern, Eastern, Copperbelt, North-Western and Central Provinces. This study selected three districts from three provinces namely, Lusaka Province (Lusaka District), Central Province (Kabwe District) and Southern Province (Choma district) based on the evidence of CSE implementation and training of teachers, criterion which include urban, peri-urban and rural demographic patterns and socio-economic factors among such geographical localities creating particular influences on adolescents' social and psychological conducts.

1.8 Operational Definitions of terms

Comprehensive Sexuality Education: According to UNESCO (2018) CSE is a curriculum-based process of teaching and learning about cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to; realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others and understand and ensure the protection of their rights throughout their lives.

Social-Emotional Development: This is the stage when adolescence is characterized by the development of emotional and acquisition of social competencies. It is during this process that adolescents become more aware of being able to identify and label their own feelings and the feelings of others (Sanders, 2013)

Adolescents: The Ministry of Health (2011) defines adolescents as young people between the ages of 10 and 19.

Institutionalisation: Refers to a process by which a practice or organization becomes well established and widely known, if not universally accepted. Actors develop expectations, orientations and behavior based on the premise that this practice or organization will prevail into the foreseeable future. In politics, institutionalisation

means that actors have clear and stable expectations about the behavior of other actors. (Mainwaring and Torcal 2006: 206).

School Related Gender-Based Violence: This refers to acts of sexual, physical and or psychological violence inflicted on children in and around schools because of stereotypes and roles or norms attributed to or expected of them because of their sex or gendered identity.

Sexual Health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons should be respected, protected and fulfilled (World Health Organisation, 2006).

Sexual Rights: Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life (World Health Organisation, 2006)

1.9 The organization of the thesis

The thesis is organized in seven chapters and each section contains the introduction. The first chapter presents the introduction; the background to the study; the statement of the problem. The chapter also includes the research questions and research objectives of the study. The scope of the study with its delimitations and the significance of the study are also incorporated in the first chapter. Chapter two of the proposal contains the literature review.

The background and an overview of Comprehensive Sexuality Education is highlighted as well as an analysis of the policy framework for implementing Sexuality Education among adolescents in schools. Chapter two also examines the effect of Comprehensive Sexuality Education on the social-emotional development of adolescents; examines the measures put in place to protect adolescents in schools against School Related Gender-Based Violence (SRGBV); identifying where and how adolescents access high quality gender-transformative sexual reproductive health services and examine the coordination among relevant ministries involved in the implementation of Sexual and Reproductive Health in schools.

Chapter three of the report contains the theoretical and conceptual frameworks which are also highlighted in chapter two. The research methodology is presented in chapter four of the proposal. This includes the research design; study sites and population; sampling design and sample size; data collection; data analysis and ethical considerations. The philosophical approach is also discussed. Chapter five is the presentation of the findings, chapter six is the discussion of findings and chapter seven is the conclusion, recommendations, contribution to the body of knowledge and direction for future research among other components.

1.10 Summary of the chapter

Chapter one provides a foundation and basis for the study in order to create a clear picture of the source of the problem. The contextual background also gives a strong basis to argue that the implementation of CSE has had its challenges as there has been no in-depth research providing reasons why the problems persist despite the CSE/SRH interventions. The background also profiles the chronological development of the education system over the years since 1966 right through to 1996 and more recently, the introduction CSE in 2013. It is clear from the detailed account of this background that sexuality education has remained a challenge for the education system to embrace until now. However, it is also clear that the problems of poorly managed adolescent sexual behaviour come with consequences that include both communicable and non-communicable diseases (NCDs), particularly: Sexually Transmitted Infections (STIs), including HIV and AIDS.

Other behavioural related health problems among adolescents involve early and unprotected sex, sexual abuse, early marriages and underage pregnancies, unsafe abortions, substance and alcohol abuse, accidents and violence, mental health, and unsafe cultural practices. Both health and behavioural related problems often lead to severe short term and long-term consequences on the health and development of the adolescents. The chapter also covered the objectives and research questions which are key in guiding the research. Operational definitions were also covered to guide readers on what are agreed working or operational definitions around issues of ASRH and CSE. This, to a certain extent, provided a firm background to help problematise the research and inform its focus and direction.

Chapter Two: Literature Review

2.0 Introduction

Through the study topic on examining the Implementation of Sexuality and Reproductive Health Among Adolescents in Selected Primary Schools in Zambia, this chapter reviews the literature on the pedagogical approaches in delivering CSE; the relationship between culture and CSE; the effect of CSE on the social emotional development of adolescents; how school related gender-based violence is addressed and sources of sexual reproductive and health services among the adolescents in schools. The Chapter outlines the themed sections as stated above based on the objectives in reviewing the literature using the funnel model which starts with global literature and narrows down to the continental, regional and subsequently, Zambia as a context for the study. The Chapter also presents a critical review of the empirical studies, contradictions, and inconsistencies. Finally, the chapter concludes with a summary of the literature reviewed.

2.1 Principles of Comprehensive Sexuality Education in Schools

Bonjour and Vlugt (2018) reveals that sexuality education has a long history in most of the Western European countries, the United States of America (USA) and the Global South. Sexuality education has been developed by responding to emerging issues in society. The attention to sexuality education is constantly being influenced by norms and values on sexuality and young people and the current political climate in a country. Bonjour and Vlugt (2018) adds that globally, in the 20th century, sexuality education started as "Education, Information and Communication" (IEC) with names such as Family Life Education, Population Education, Life Skills Education. Stimulated by institutions such as the United Nations Populations Fund (UNFPA), international NGOs developed interventions, mostly based on temporary mass media campaigns on specific topics, but sometimes also developing courses for schools as well. These interventions were mostly aimed at behaviour change regarding reproduction.

Bonjour and Vlugt (2018 reveal that there was an increased attention for adolescent health with the rise of HIV/AIDS in the '80s where educational programmes in schools focusing on health-related behaviour change increased rapidly in number. They note

that in the ’90s, a broader vision on sexual reproduction and health rights gave rise to sexuality education and the attention for adolescents and young women in particular, increased further. They argue that this resulted in the formulation of more progressive and comprehensive international declarations around sexuality, reproduction, and gender, at events like the International Conference on Population and Development in Cairo in 1994. This was picked up by (inter)national NGOs and donors, and more comprehensive and rights-based sexuality education programmes started to be developed. However, it was only in 2009 that UNESCO published its Technical Guidance on Sexuality Education, providing a first elaborate international standard for sexuality education.

Furthermore, the American College of Obstetricians and Gynecologist (2016) states that sexuality education programs vary widely in the accuracy of content, emphasis, and effectiveness. Data have shown that not all programs are equally effective for all ages, races and ethnicities, socioeconomic groups, and geographic areas. The United Nations Populations Fund (UNFPA) (2014) adds that the right of access to CSE is grounded in fundamental human rights and is a means to empower young people to protect their health, well-being, and dignity.

In addition, the American College Obstetricians and Gynecologist (2016) states that CSE should put emphasis on human rights values of all individuals, including gender equality, healthy relationships, participatory and culturally sensitive teaching approaches that are appropriate to the student’s age as well as identification with distinct sub-populations including adolescents with intellectual and physical disabilities. Other components include the component of knowledge about specific consequences of sexual activities during adolescence as well as benefits and pitfalls of information and misinformation on sexuality.

Bogota (2010) also adds that the core principles of sexuality education include advancing human rights, gender equality and improved sexual and reproductive health. UNFPA (2014) expands the concept and adds that sexuality education should be included in the education programmes and curricula and should include respect for human rights and diversity with sexuality education affirmed as a right; critical thinking

skills, promotion of young people's participation in decision making and strengthening of their capabilities for citizenship; fostering of norms and attitudes that promote gender equality and inclusion; addressing vulnerabilities and exclusions; local ownership and cultural relevance and a positive life cycle approach to sexuality.

UNFPA states that when CSE is started early, provided over time and involves all of the necessary elements, young people are more empowered to make informed decisions about their sexuality, including their sexual and reproductive health. These can help them develop the life skills necessary to protect themselves while respecting the rights of others. The American Public Health Association (2014) supports the delivery of CSE in schools and argues that it helps young people with knowledge, skills and attitudes to avoid sexually transmitted infections including HIV and unintended pregnancies so that they become sexually healthy adults.

The UNFPA argument above is supported by the Ministry of Education's justification for CSE in schools that if provided early, would contribute to delayed sexual debut, increasing retention in school, and improving educational health outcomes. However, the problem statement is not in sync with this assumption as the opposite is what is happening. For example, statistics show that there are more learners dropping out of school due to teenage pregnancies, high STIs including HIV infections. This is despite heavy investments that have gone into ensuring that young people's lives are protected and supported to stay in school longer through a project aimed at strengthening the implementation of CSE in school settings in Zambia (2014-2018).

In adding to the debate on CSE, Ketting and Ivanova (2018) observes that the delivery of CSE differs widely between and even within countries. However, they argue, despite the differences, the assessment in sexuality education in Europe and Central Asia reveals that sexuality education has become the norm in most countries. They further point out that remarkable progress has been made in the European region in developing and integrating sexuality education curricula in formal school settings. Bonjour and Vlugt (2018) explains that formal CSE occurs in an education or training institution, and provides structure in terms of learning objectives, learning time/support and delivery

which can, but doesn't have to, lead to a recognized qualification. In school, this can be implemented as part of school curriculum or other activities within the school timetable.

Clearly, a good comprehensive sexuality education is one that links young people to adolescent sexual reproductive health services and increases knowledge to help act on decisions which help young people take responsibility for their lives and realise their human rights while acting in the appropriateness and sensitivities of their culture.

2.2 Implementation of Comprehensive Sexuality Education in Schools

Age-appropriate primary and middle school pedagogies based on learning and teaching were analysed and evaluated by Goldman (2009) in a study on *sexuality education for young people in Australia*. Goldman (2009) indicated that key considerations were the early maturing of girls and boys, findings from relevant literature about children and young people's cognitive capacities, as well as the relevance of curriculum content for upper primary and middle school students, and the concomitant need for better and earlier sexuality education.

Goldman (2010) contends that compared with other school subjects, such as English and Mathematics, many schools give very little emphasis to sexuality education. Although sexuality starts from conception to death, other school subjects, such as the arts may or may not be emphasising in their content. In Australia, for example, education about puberty, sexuality, relationships and reproductive health and safety is generally located in the Health and Physical Education (HPE) curriculum of the education authority of each state or territory (Goldman, 2010).

Goldman (2010) further observes that though very little formal or classroom-based information is actually delivered to students during the compulsory school years (5–7), in the United States, there is inadequate sexuality education in schools, and that which does exist leaves much to be desired. Goldman also points out that in the United Kingdom, sexuality education is only part of a crowded curriculum of Personal, Social and Health Education and Citizenship.

Goldman and Bradley (2001) reports that in Australia, knowledge/information on sex, puberty, and sexuality, although included in the compulsory HPE curriculum in each State or Territory, is delivered in a sporadic, 'ad hoc and somewhat discretionary' manner. They observe that many students are not taught an accurate vocabulary for body parts and systems. In Queensland, each principal is responsible for instigating a sexuality education program after negotiations with the School Community Consultative Committee about timetabling, funding and content. Orlich et al. (2001) states that relatively few elementary/primary teachers are confident of the level of workplace and parental support necessary to implement even simple, explicit and relevant pedagogies, let alone discussions on body image, sexual values or gender issues. Goldman (2010) reports that schools in Australia choose to employ external providers to deliver an annual lesson to the middle school Grades 4 to 8, for students aged about 8–13 years, but many children and adolescents are left to garner a 'playground education from sexual banter, boasting and bullying.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Population Fund (UNFPA) Fact Sheet (2013) reveals that, while there are a range of views on what should be included in sexuality education, and what the term encompasses, there has been a strong international commitment to promoting the provision of CSE among young people. These include the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (UNESCO, 2009). UNESCO (2009) further points out that the international agreements over the past decades such as the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 have extended the scope of the Convention on the Rights of the Child (CRC), by affirming the right of all children and adolescents to receive sexual and reproductive health (SRH) information, education and services in accordance with their specific needs.

The International Planned Parenthood Federation (IPPF) (2016) reports that there are a limited number of impact assessments of CSE in a range of outcome areas. Even though

some countries have scaled up CSE programmes in schools, implementation is often nowhere near good enough. IPPF (2016) contends that delivery is often outdated and non-participatory, teaching staff are not adequately trained and content focuses exclusively on health outcomes, rather than the recognition of rights. Sometimes the information is scientifically inaccurate.

Mackay and Barrett (2010) reports that the US has one of the highest teen pregnancy rates in the industrialized world. Each year in the US, more than 750,000 women ages 15–19 become pregnant (Kost, Henshaw and Carlin, 2011) with more than 80 percent of these pregnancies unintended (Finer, LB and Zolna, 2011). Elia and Eliason (2010) states that school-based sexuality education in the U.S began in 1913. However, Weaver, Smith, and Kippax (2005) observes that at both national and international levels, deeply entrenched and ongoing tension exists between those who accept or tolerate sex among young people and those who do not.

Future of Sex Education Initiative (2011) explains that the National Sexuality Education Standards in the United States were developed to address the inconsistent implementation of sexuality education nationwide and the limited time allocated to teaching the topic. Health education, which typically covers a broad range of topics including sexuality education, is given very little time in the school curriculum. Future of Sex Education (2011) expounds that the goal of the National Sexuality Education Standards in the United States is to ensure that the Core Content and Skills, K–12 provides clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is developmentally and age-appropriate for students in grades K–12. In the United States of America, the delivery of CSE is under the National Sexuality Education Standards and it is informed by the work of the Center for Disease Control's (CDC) Health Education Curriculum Analysis Tool (HECAT); existing state and international education standards that include sexual health content; the Guidelines for Comprehensive Sexuality Education: Kindergarten – 12th; and the Common Core State Standards for English Language Arts and Mathematics, adopted by most states.

In Europe, Ketting and Ivanova (2018) reports that in some countries the delivery hinges on laws on CSE, whereas in other countries it is through the national policy or a national strategy. Ketting and Ivanova (2018) indicates that in many cases there is no specific law on how sexuality education can be delivered but only through healthy lifestyle education or a similar teaching subject which may include some references to sexuality education items. Rutgers (2018) reveals that in Europe and the US, sexuality education as a school curriculum subject, has a history of more than half a century. It officially started in Sweden in 1955 followed by many more Western European countries in the 1970s (like the Netherlands) and 1980s and Eastern Europe in between 1990s and 2000s.

Ketting and Ivanova (2018) further expounds that, sexuality education in Finland is mandatory in all primary and secondary schools. It is interpreted into broader subjects that are mandatory. The delivery varies in practice because municipalities and schools have a certain degree of autonomy. In this country, there are national-level core curricula and qualification requirements related to sexuality education which are enacted by Finnish National Board of Education. The core curriculum for primary education includes elements of sexuality education in the subjects; environmental studies which is taught in grades 1-6 for 7-12-year-old pupils. The core curriculum of secondary schools is integrated in Health Education. This is implemented in grades 7 – 9 when pupils are about 13 – 15 years. The main focus on sexuality education lies in grade 8 and 9. Health education is a separate subject with the contents-growth and development, supporting health, factors supporting and harming health and prevention of illness and health, communities, society and culture.

Rutgers (2018) states that it is extremely difficult to examine the extent to which CSE is implemented in some countries. It is often not monitored or evaluated due to lack of qualified and useful methods and a lack of expertise or money to do so. Furthermore, there is often a large variation of CSE programmes and a wide range of quality criteria.

In 1955, Sweden was the first country to introduce mandatory sexuality education in schools. Since then, the subject has gone through a long process of evolution, along with changing conditions, incorporating new elements and reflecting new evolving visions in people and society. Sexuality education is fully integrated in school curricula and

delivered in a variety of teaching subjects. Sweden's teaching of sexuality and relationships is based on the 2010 Education Act on gender equality. This has resulted in two (2) new curricula, the curriculum for the compulsory school and pre-school and the recreation Center 2011 and the curriculum for the upper secondary school, 2011. The subject is generally referred to as 'Sexuality and Relationship Education.' The delivery of CSE is for pupils to develop their knowledge about Sexual Reproductive Health Rights, (SRHR), Sexually Transmitted Infections (STIs), reproduction, the human body, contraceptive methods as well as their voices to question the norms, identity, gender, gender equality, sexual orientation and relationships. Its aim is to help develop respect for diversity among the pupils.

Literature reveals that sexuality education in Switzerland is well developed. Lessons commence early between the ages of 4 and 8 years and continue through secondary school. There are some differences between three (3) lingual regions of the country. The delivery for sexuality education is included in the Education Plan of Romandy adapted in 2009 in the French-speaking cantons or districts; Educational Plan 21 in the Germans-speaking canton and Guidelines for School Sexuality Education in Italian-speaking canton. Sexuality is delivered both as a separate subject and integrated into wider subjects. Table 2.0 below is a summary on the delivery of sexuality education in Switzerland. Sexuality education is mandatory, but with the possibility of opting out. Number of hours is also not defined (Ketting and Ivanova 2018).

Table 2.0: Delivery of Sexuality Education Switzerland

Region	Language	Subjects
West and South-West	French	Nature, Humanity and Society
North	German	Life Science
Southeast	Italian	Health and Well-being Diversity

Source: Ketting and Ivanona (2018)

In the United Kingdom, since 1996 Sex and Relationship (SRE) has been compulsory in public (Local authority-run) schools but not in the private schools. The Education Act of 1996 provides that Sexuality and Relationship Education is compulsory for public (not private schools) from the age 11 onward. In 2000 the Department of Education and

Employment (now the Department of Education) published a 'Guidance on the Delivery of SRE' through the Science, Personal, social, health and economic (PSHE) framework. Its aim is to help schools to plan SRE policy and practice and includes teaching strategies and working with parents and confidentiality. SRE is integrated into other subjects and mainly taught in science, personal, social, health and economic (PSHE) classes. It focuses on the prevention of unwanted pregnancy and STI/HIV (Ketting and Ivanona, 2018). In 2017 after persistent pleas by many organisations, the Government decided to make Sexuality Education 'statutory' and as a result it became mandatory in all public schools in 2019 (Ketting and Ivanona, 2018).

Rutgers (2018) reports that in many countries around the world, amongst others Indonesia, Brazil, Burundi and Uganda, the space for civil society is shrinking and opposition to CSE growing. However, Wakaseh (2019) indicates that most countries in Sub Saharan Africa (SSA) have realized the need to have CSE programs to address young people's negative outcomes in their SRH. Top on the list, is to avert the challenges posed by HIV, including high rates of new infections among young people. As a result, countries in SSA have signed on to a regional and international commitments to address young people's SRH needs, including their need for CSE services. One of these commitments was adopted by the countries of Eastern and Southern Africa (ESA) in 2013. This is referred to as The ESA commitment.

IPPF (2016) emphasizes that, attention should be paid on who delivers CSE, where it is delivered, what is delivered, when it is delivered and how it is delivered. Without paying close attention to pedagogy, countries will not be able to ensure that they reach young people in a considered and participatory way. IPPF (2016) expounds that without training educators to deliver CSE, it is difficult to ensure that information and education is being delivered in a standardized, effective, high-quality manner as well as ensuring that the content of CSE is informed by the lived experiences of young people.

Schiffman et al. (2018) reveals that in Nigeria the creation of the National Guidelines on sexuality education set the stage for the Federal Government's forward movement on sexuality education, including the adoption of the guidelines and their subsequent delivery of CSE in schools. Schiffman et. al., (2018) adds that mention of contraception,

masturbation, abortion, sexual diversity and other contentious topics was removed, as was the word 'sexuality.' In addition, the title was changed from 'Sexuality Education Curriculum' to 'Family Life and HIV/AIDS Education,' (FLHE). Proponents reluctantly agreed to these modifications, realizing these were the only way to get a majority of commissioners to approve the curriculum.

Ford Foundation (2014) reports that the delivery of CSE in Schools varies across the rest of the country. A study by researchers at the University of Ibadan found that the percentage of secondary schools within states providing FLHE ranged from 13.5 to 100%, and most states have no budget line for the program. A study on program delivery of CSE (Esiet, 2012) found multiple challenges, including a limited number of trained teachers, leading to the curriculum being delivered by untrained teachers; crowded classrooms; insufficient learning materials; and inadequate monitoring mechanisms.

In Uganda, the Ministry of Education and Sports (MoES) developed the National Framework on Sexuality Education through wide consultations with a cross section of stakeholders. The framework was intended to create an over-arching national direction for providing young people with sexuality education in the formal education setting (Ministry of Education and Sports, 2018). The Ministry of Education and Sports (2018) indicates that the National Framework on Sexuality Education was developed in line with existing national policies and commitments, Vision 2040, the Presidential Fast Track Initiative to End HIV as a Public Threat by 2030, the National Development Plan, the National HIV Strategic Plan and finally the Education Sector Strategic Plan. The delivery of CSE in Uganda is organized into four key themes, each of which encompasses one essential area of learning for young people (Ibid).

The themes include Human Development, Relationships, Sexual Behaviour and Sexual Health. Each key theme is broken down into a number of specific topic areas i.e. individual subjects that need to be covered in order to sufficiently address each key theme so that the learners may achieve the desired outcomes or life behaviours (Ministry of Educations and Sports, 2018). The framework is particularly targeted at learners in educational institutions, and these are categorized into five separate age-groupings. The

levels are: (1) Early Childhood: - 3 to 5 years; for pre-primary learners in nursery. (2) Lower Primary: - 6 to 9 years; from Primary 1 to 4. 3) Upper Primary: - 10 to 12 years; from Primary 5 to 7. 4) Lower Secondary: - 13 to 16 years; from Senior 1 to 4. 5) A-level/Tertiary Institutions: - 17+ years; senior 5 to 6 students, tertiary institutions of learning i.e. colleges, institutes and universities (Ministry of Education and Sports, 2018). Family Watch International (2018) proposes that Uganda should establish a sex education framework that seeks to ensure that the primary approach to sex education is abstinence based and reflects the strong religious and cultural values and morality of the Ugandan people.

UNESCO and UNAIDS (2013) reports that the ESA-CSE commitment gave new impetus to deliver CSE in the region. Since the commitment was made, most ESA countries subject to it have registered significant progress, especially in establishing relevant structures to enhance CSE uptake and scale-up. Wekesah (2019) indicates that most ESA countries have developed CSE curricula and have integrated them (or are in the process of integrating them) into the main education curricula. Different countries have integrated the agreed CSE-ESA commitments into their programs through line ministries—among them ministries of health (MoH) and ministries of education (MoE) (Ibid). Wekesah (2014) observes that Zambia took a multi-sectoral approach to involve other ministries, such as those focused on gender, youth, culture, sports, and development. However, these responses have not been without challenges; sociocultural norms remain a major obstacle to the delivery of CSE.

Kalembo, Zgambo, and Yukai (2013) states that CSE programs in SSA are predominantly school based, both in primary and secondary schools. Teachers deliver CSE as part of the school curriculum and in a classroom setting. In a few cases, CSE is taught as a stand-alone subject (or alongside other life skills-based subjects) but is usually integrated into relevant "carrier subjects." UNESCO (2015) adds that the delivery of CSE requires a specially trained teacher to teach CSE as a stand-alone subject. Stand-alone CSE classes are taught in South Africa, Namibia, and Zimbabwe. Various authors report that integration of CSE to carrier subjects is preferred by most implementers. CSE is integrated into one or more carrier subjects in Madagascar, Mauritius, Mozambique, Rwanda, and Zambia (UNESCO 2015, UNESCO HIV and

Health Education Clearing House, 2016). Wekesah (2019) points out that, in the carrier - subject's scenario, specific CSE topics are covered in related classes on subjects already taught in the curriculum—for instance, topics around pubertal changes and reproduction are covered in classes focused on biological subjects, whereas values and norms are covered in classes focused on religious education.

Sani et al., (2018) reports that CSE programs in SSA cover such topics as STIs, safer sex, and prevention of STIs and unwanted pregnancies. CSE also focuses on abstinence, promoted as the only method of contraception, or the main method (Browes 2015; Vanwesenbeeck et al., 2016). Topics touching on gender and power relations and culture are the least frequently addressed among CSE programs (Kalembo, Zgambo, and Yukai 2013; UNFPA 2015).

According Wekesah (2019) the integrated CSE curriculum in Zambia was officially rolled out in 2014. Considerations made when settling for integrating CSE into various subject areas and at different education levels (e.g., social studies, biology, home economics, civic education, integrated science and religious education).

Table 2.1: How CSE is integrated in different subjects per grade level

PRIMARY LEVEL	SECONDARY LEVEL JUNIOR	SENIOR SECONDARY LEVEL
Integrated Science	Integrated Science	Biology
Social Studies	Social Studies	Civics/Civic Education
Home Economics	Religious Education	Religious Education
	Home Economics	Home Economics

Source: Wakesah (2019)

2.2.1 Content of CSE in the Education Curriculum of Zambia

CSE is covered in Zambia under six topics distributed across six carrier subjects *(Table 3).* Of note, Home Economics—a carrier subject into which CSE has been integrated - is elective/optional and learners who choose not to take it are likely to miss out on its content (UNESCO 2016).

Table 2.2: Summary of CSE curriculum framework in Zambia

TOPIC	CSE SUBTOPICS	CARRIER SUBJECT
Relationships	Families Friendship, love, and relationships Tolerance and respect Long-term commitments Marriage and parenting	Religious education Home economics Social studies
Values, attitudes, and skills	Values, attitudes, sources of sexual learning Norms and peer influence on sexual behavior Decision-making Communication, refusal, negotiation skills Finding help and support	Religious education
Culture, society, and human rights	Sexuality, culture, and law Sexuality and the media The social construction of gender Gender-based violence, sexual abuse, and harmful practices	Religious education Social studies
Reproduction	Sexual and reproductive anatomy and physiology Reproduction Puberty Body image Privacy and bodily integrity	Integrated science Home economics
Sexual behavior	Sex, sexuality, the sexual life cycle Sexual behaviors, sexual response	Integrated science Home economics
Sexual and reproductive health	Pregnancy prevention Understanding, recognizing, and reducing risk for HIV and other STIs HIV/AIDS stigma, treatment, care, support	Integrated science Social studies Home economics

Source: Wakesah (2019)

2.2.2 Teacher Training on CSE in Zambia

Moate and Cox (2015) expound that both pre-service and in-service teachers are trained to deliver CSE in the country. Training for CSE is largely supported by UNESCO with funding from the Sweden's government agency for development cooperation (Sida), Sweden and Airish Aid. Teacher training is focused on amplifying CSE content in the curriculum, emphasizing a learner-centered approach in teaching and helping teachers

to reconcile their own values and attitudes and to feel confident delivering CSE as expected. Wakesah (2019) reveals that, to reach many in-service teachers faster with limited resources, a cascade model of training was used.

A national training team trained the trainers in six (6) provinces in Zambia; the provincial trainers trained trainers in districts and in turn, trained at zonal level; with the intention of the schools training teachers at school level. Wakesah (2019) adds that, at school level, one teacher was in charge of CSE (in most cases, the School In-service Provider), supported by the head teacher and these teachers together made sure that all teachers in the school were trained on CSE and how to deliver lessons at classroom level. It is reported that approximately 60 percent of the nation's over 100,000 teachers at the time of the research, (or about 66,600 teachers) were trained in this way.

Wakesah also observes that due to the sheer number of teachers trained, the cascade model proved expensive, and the content and quality of the training was compromised at every stage as it went down, such that the first teachers to receive CSE training were more likely to receive comprehensive training than those down the line in the cascade UNESCO (2017).

2.3 Relationship between Culture and Comprehensive Sexuality Education

Roudsari al et., (2013) states that, despite clear reasons for necessity of sexuality education for adolescents, CSE is still a contested issue and faces challenges in most cultures. There are several pieces of evidence from Africa and Asia showing cultural resistance to adolescents' sexual education (Mbugua 2007). Even in more liberal cultures, discussing sexuality for adolescents has not been without challenges; at least at the family level, parents-adolescents sexual communication has faced some difficulties (Turnbulla, et al., 2008). Roudsari et al., (2013) adds that common concerns are associated with providing sexuality education for adolescents; for example, many parents, teachers and policymakers believe that it can result in early sexual activity and privation of childhood innocence. In policy making and curriculum designing processes, there are some controversies about appropriate age and contents that should be taught (Helleve et al., 2011).

As gatekeepers of sexual health information for adolescents, adults define content of information that adolescents receive, whereas there is a gap between what they perceive adolescents need and what adolescents themselves really need (Avusabo-Asare, Bankole, Kumi-kyereme, 2008). Sexual education is a form of value-based education and due to political, cultural, religious and ethnical diversities, agreement on values especially in controversial areas of sexuality remains challenging (Halstead and Reiss, 2003). Asian cultures share disapproval of non-marital sex and taboos surrounding sexuality (Kim and Ward, 2007). This is the case in Muslim countries particularly in relation to girls, because their chastity is denoting their families' honor (Orgocka, 2004; Sanjakdar, 2005; Smerecnik et al., 2010). Roudsari et al., (2013) indicates that in Iran and most other Muslim countries, denial of non-marital sex is an important barrier to combating HIV/AIDS. Sexuality education programs are limited or are skipped over by the teachers. Because of addressing many reproductive health issues in accordance with Islamic values, Iran is a successful model for other Muslim countries in some issues, but not regarding sexual health education for adolescents (DeJong, 2005).

A few studies have examined social attitudes towards sex education for adolescents in Iran, with contradictory findings. Iranian parents' attitude towards SHE for teenagers is not positive but there is some contrary evidence indicating that both adolescents and parents agree with it (Azizzadeh, et al., 2007). Educating sexual health through websites seems difficult in Iran, especially in Persian language, and those programs targeting adolescents are scarce (Rahnavardi et. al., 2008)[1]. Rabenoro (2004) in a study conducted in Bestimisaraka region of Madagascar where culturally, 'sex' is a taboo subject, shows that culture affected the sexuality education offered in schools which was widely considered "useless" partly because many dropped out before joining the upper classes where it was taught. According to teachers in such a cultural background are likely to be unwilling to cover sexuality topics within the classroom freely.

One major taboo, so strong in all the regions of Madagascar that it could be described as the 'mother' of all taboos, at least in this specific area, is that sexual intercourse – or even mere mention of it – between relatives of opposite sexes, is strictly forbidden

[1] *Although this is an outdated literature together with others, this researcher used it as it was relevant to the study.*

(Mulama, 2006). Boler et al., (2003) found that in both India and Kenya, though teachers played a major role in giving young people information on HIV/AIDS and sexuality they were constrained by social and cultural factors. The result of this is that teachers resulted to 'selective' teaching where they restricted teaching only the biological aspects and left out those that have to do with sex and relationships.

Browes (2015) states that comprehensive sexuality is recognised as an effective method of sexual health education, with the school identified as a fitting site for implementation. Its holistic and participatory nature endeavours to develop the knowledge, attitudes and life-skills of students to help them secure their sexual and reproductive health and rights Browes' study aimed to better understand aspects of CSE implementation in one context and focused on the effects of the cultural setting, considering how gender and sexuality norms influence teacher and student implementation strategies.

The qualitative research which was carried out in one secondary school in Ethiopia, which delivered a Dutch-developed programme throughout 2013 (Browes, 2015). Over 50 in-depth interviews were conducted with teachers and students, influential community members and experts in SRHR and data were also gathered through focus group discussions and classroom observations (Ibid). The results show that CSE teachers and students, both male and female, were able to discuss issues of sexuality (Browes, 2015). The cultural context was seen to affect interpretation of programme information, influencing the nature of this discussion (Stevens, 2015).

Stevens (2015) observes that in traditional societies, sexuality is frequently central in myths of cosmogony. This is common in Asian religions, but also in sub-Saharan Africa and elsewhere. Everywhere there are restrictions on contact between men and women and sexuality is at their root (Gilmore 2001).

Dykeman (n.d) states that popular culture has belittled the moral significance of sexual relations among young Americans, and the idea that sex is merely a recreational activity has prevailed. Whether or not this is a respectable mindset, is a debatable but also a separate issue; the existence of this mindset among adolescent Americans is unquestionable.

In addition, Rodgers et al., (2019) states that adolescents in Sub-Saharan Africa encounter high risks associated with sexuality and reproduction. He further adds that the advent of mobile phones provide a unique opportunity to provide youths with this critical sexual and reproductive health information need. To this end, Rodgers et al., (2019) points to the importance of the TuneMe app in reaching the youth. Designed from the United Nations Comprehensive Sexuality Education framework, the mobile-optimized app TuneMe aims to provide adolescents living in eight sub-Saharan African countries—Zambia, Malawi, Zimbabwe, Swaziland, Lesotho, South Africa, Botswana, and Namibia— with sexual and reproductive health information, and to promote uptake and use of sexual and reproductive health services.

To assess the scope and appropriateness of TuneMe's sexuality education content, a directed content analysis of the 299 articles published on the Zambia-specific TuneMe site between October 2015 and June 2017 was conducted. Results from the analysis indicates that the greatest information provided by TuneMe was on sexual and reproductive health and HIV, followed by relationships, sexual rights, and citizenship (Rodgers et al., 2019). There was substantially less information that focused specifically on matters of pleasure, violence, diversity, and gender. Content was situated within relatable and culturally relevant contexts, but gave mixed, and often problematic, depictions of gender norms Rodgers et al., 2019).

2.4 The effect of CSE on Socio-Emotional Development of Adolescents

The American College Obstetricians and Gynecologist (2016) states that Comprehensive Sexuality Education programs reduce the rates of sexual activity, sexual risk behaviors (e.g. number of partners and unprotected sexual intercourse), Sexually Transmitted Infections, and adolescent pregnancy. One key component of an effective program is encouraging community-centered efforts. In addition to counseling and service provision to individual adolescent patients, obstetrician–gynecologists can serve parents and communities by supporting and assisting sexuality education (Gynecologist, 2016).

Rutgers (2018) observes that impact evaluations of CSE are complex as well as very costly and is seldom conducted in a randomized controlled trial (golden standard).

Research on the effectiveness of CSE is not widely available and mostly focused on the reduction of risky behaviour like STIs or unwanted pregnancies due to the predominant focus on public health. Ketting et al., (2016) points out that there is a very limited use of indicators that focuses on positive aspects of sexuality. Even though, indicators such as the ability to communicate about feelings and wishes or self-efficacy are often used, they are usually only considered in respect to the desired behaviour, and not as important on their selves. Indicators measuring the ability to experience pleasurable and satisfying sexual relationships are hardly ever used.

Studies further show that CSE has great potential to provide young people with the necessary information about their bodies and sexuality, to reduce misinformation, shame and anxiety, and to improve their abilities to make safe and informed choices about their sexual and reproductive health (Boonstra 2011; UNFPA, 2015). There is growing evidence that good quality CSE has positive impact on sexual knowledge, attitudes, communication skills and certain sexual behaviours (Kirby et al., 2011; UNESCO 2009). In comparison to less comprehensive programmes, CSE has been shown to contribute more adequately to gains in young peoples' sexual health (Fine and McClelland, 2006; Haberland and Rogow, 2015; Kirby, 2008; McCave et al., 2007; Trenholm et al., 2007; Underhill et al., 2007; Santelli et al., 2017).

Fonner et al., (2014) reveals that one major study carried out 17 reviews or meta-analyses of sexuality education programs and STI/HIV education, conducted in the United States of America and in some other countries between 2000 and 2014. 15 of these 17 reviews reported statistically significant positive behavioural outcomes for CSE or abstinence plus programs. Fonner et al., (2014) points out that the review states that there is clear evidence that CSE has a positive impact on Sexual and Reproductive Health (SRH), notably contributing towards reducing Sexually Transmitted Infections (STIs), the Human Immunodeficiency Virus (HIV) and unintended pregnancy. CSE has demonstrated impact in terms of improving knowledge and self-esteem, changing attitudes and gender and social norms, and building self-efficacy (Fonner et al., (2014). Sexuality education does not hasten sexual activity but has a positive impact on safer sexual behaviours and can delay sexual debut and increase condom use' (UNFPA, 2010; 2015). However, the challenge remains. For as long as the number of teenage girls

continue to remain high as provided for by the Ministry of Education Statistical Bulletin (2019), it is still very difficult to see and appreciate tangible benefits of CSE at personal level in a life of a young person or indeed a family. This is the very core of the statement of the problem in this study. The assumption is that there is insignificant progress made in terms of benefits in the life of young people who should see better health outcomes.

Rutgers (2018) reports that several West European countries have already a long tradition with national comprehensive sexuality education in schools. Looking at the teenage birth rate in European countries, there tends to be a relationship between comprehensive sexuality education and a low rate of teenage pregnancies. The teenage rate tends to be very high in central Asian countries (such as Georgian, Russian Federation, Tajikistan) where sexuality education programs are still in an early stage of development (IPPF & BZgA, 2018). Beyond medical health outcomes, sexuality education can lead also to happier relationships by increasing confidence and strengthening skills. It also has an impact on positive attitudes and values and it evens out the power dynamics in intimate relationships resulting in mutually respectful and consensual partnerships (UNESCO, 2018). Also, in schools, learners and teachers feel more at their ease to talk about sexuality. There tends to be a more open atmosphere for young learners to pose questions or ask for help regarding sexuality and relationships (Bachus et al., 2012 and Schutte, 2016).

The American Academy of Pediatrics (2001)[2] reveals that there has been a decline in sexual activity among adolescents 15 to 19 years of age in the United States. However, initiation of sexual intercourse during adolescence remains the norm for American youth. The report further reveals that rates of hormonal contraception and condom use have risen and adolescent birth rates have been decreasing, yet the percentage of births to unmarried women of all ages, including adolescents, remains high (the American Academy of Pediatrics, 2001). Among women 15 to 19 years of age, most pregnancies are unintended and approximately 1 in 3 results in abortion.

[2] *Although the literature is dated, the researcher found it very useful in helping to shape a global view of the perspectives argued in the document*

The American Academy of Pediatrics (2001) adds that overall rates of Sexually Transmitted Infections (STIs) in the United States are among the highest in the industrialized world. Every year, an estimated 1 in 4 (approximately 3 million) sexually active adolescents acquire an STI. Additionally, only 57% of the 1 in 3 adolescents who reported having been sexually active in the past 3 months reported that they had used barrier contraception the last time they had intercourse. Advocates for Youths (2015) reveals that a 2012 study that examined 66 comprehensive sexual risk reduction programs found them to be an effective public health strategy to reduce adolescent pregnancy, HIV, and STIs in the United States of America. Although this is categorically stated for the United States, it is not clear why the results are not the same in the Sub Saharan African.

The International Women's Health Coalition (IWHC) (2015) reveals that programs that address issues of gender and power (and were thus closest to true CSE) are markedly more likely to demonstrate significant positive effects on health outcomes—such as reductions in STIs and unintended pregnancy— than programs that ignore gender and power. For example, the Horizons Project conducted with African American adolescent girls in the United States emphasized ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships (The International Women's Health Coalition, 2015). The Horizon Project resulted in a 35 percent lower risk of acquiring chlamydia. In Kenya, a simple, targeted intervention in schools used interactive and critical thinking methods to increase girls' understanding of the significantly higher rates of HIV infection amongst adolescents and of the consequences of "sugar daddy" relationships. It saw a 28 percent reduction in teenage pregnancy, indicating a significant drop in unprotected sex. The Steppingstones curriculum used in South Africa, which relies on gender equality and empowerment, resulted in a 33 percent reduction in the incidence of herpes simplex virus and reduced reports of intimate partner violence.

The impact of CSE was explored on the sexual knowledge and skills in England. Stephenson et al., (2004) conducted a school-based randomised trial of over 8000 pupils aged 13 to14 years to evaluate the long-term effect of pupil-led sex education. The programme showed some positive impact on self-reported knowledge of methods to

prevent STIs and skills in using condoms at age 16. In Scotland, the Sexual Health and Relationships: Safe, Happy and Responsible (SHARE) programme was developed for 13-15-year-olds. Respondents (n=2,689) in the intervention group scored significantly higher on knowledge about sexual health than those in the control group (Wight et al., 2002). Yu (2010) stated that 'Healthy Respect' was part of the SHARE project as implemented in 10 schools in Lothian. Tucker et al., (2007a) reports that among 2,796 pupils in the intervention groups, there was a significant increase in confidence about getting and using condoms, and in believing that 'condom use reduces the chance of contracting (STIs).

Yu (2010) concludes that it may be difficult to draw conclusions from these studies, as interventions with diverse aims were utilised in dissimilar groups. The school was seen as an important element in the provision of sexuality information. Even then, it was not the sole influential factor to teenage sexual behaviour. Yu (2010) further reveals that sexually active respondents were also found to be more likely to use birth control if taught at home about delaying sexual activity and contraception. Similarly, a study of 894 pupils in Ghana showed that family communication about HIV/AIDS was significantly associated with condom use although it did not result in sexual abstinence (Adu-Mireku 2003).

The impact of family communication appeared to depend on what parents talked about. A longitudinal study by Romo et al., (2002)[3] documented matters of talking about dating and sex among 55 Latino mothers and their children. Dialogue about values and beliefs was found to have a positive impact on attitudes to premarital sex and sexual initiation; however, talking about everyday activities had no effect (Yu, 2010). The generalisability of this longitudinal study is limited due to its small, non-randomised sample, yet it did show the importance of parental values and support findings reported by others (McNeely et al., 2002; Somers and Gleason 2001; Somers and Paulson 2000).

[3] *Although this is a dated literature, the researcher found it useful in addressing issues of dating and sex among Latino young mothers and their children and this compares with the challenge of young people in Zambia.*

A large survey of 14,287 adolescents in nine European countries showed that in fact, family was a key protective factor for early sexual engagement, while close parent-adolescent relationships and high levels of parental monitoring were less protective (Lenciauskiene and Zaborskis 2008). Yu (2010) points out that, studies conducted in various countries confirmed these findings. In England, Bonell et al., (2006) followed 8,766 pupils for two and half years (29 months), reporting that respondents from lone parent families were more likely to report having had sex in the subsequent two and half years. In the US, analysing a subset of sample from a longitudinal survey (n=497), Upchurch et al., (2001) found that Hispanic adolescents who lived with one sole parent or non-biological parents held more permissive sexual attitudes and lost virginity at a younger age. A longitudinal study of 567 Swedish girls revealed a similar pattern (Magnusson 2001). In addition, Moore and Chase-Lansdale (2001) found that living in any type of married family protected African American females from getting pregnant.

Yu (2010) reports that CSE has positive impact of religious commitment and participation of religious activities. In a New Zealand longitudinal study of a cohort of 1,020 participants, Paul et al., (2000) found that religious beliefs/practices were an important factor enabling them to sustain sexual abstinence to age 21. A study of 1,153 adolescents in Nigeria by Odimegwu's (2005) revealed its positive effect on both sexual attitudes and initiation. In addition, its positive impact on condom use was reported in a US study of 230 first year students at a Catholic university (Zaleski and Schiaffino 2000). Yu (2007) in a qualitative study of Chinese-British teenagers and parents in Scotland reported that religious practice reinforced the quantity and quality of parent-child interactions and may have made the young people more willing to share parental values. Religious practices also offered the teenagers more opportunities to make friends who hold similar sexual values. Christian parents highlighted the value of providing sex education within a moral and religious context by teaching young people the option of sexual abstinence (Yu 2007).

Friends were also seen as the major source of information about sex and relationships (Chung et al., 2005; Currie et al., 2008; Yu 2008). The effect of dialogue about sex with friends appeared to depend on the content of such communication. In a small US study of 157 school teenagers, Somers and Gleason (2001) found that gaining more

information about sexual intercourse from friends was related to more liberal sexual attitudes in respondents. A US survey by Lefkowitz and Espinosa Hernandez (2007) explored sex-related communication with mothers and close friends among 182 first-year college students aged 17-19 years. More frequent discussion about behaviours and feelings and more open and comfortable communication with friends correlated with respondents being non-virgins. Similarly, Amoran, Onadeko and Adeniyi (2004) in a community-based study (n=274) in Nigeria found that significantly more respondents who sought sexual information from peers had sex compared to those who sought information from parents, teachers and other sources (43.2%, 25.2%, 14.4%, 17.1%). On the other hand, Potard, et al., (2008) in a French study found that respondents (n=1000) who perceived a high prevalence of sexual initiations of peers tended to have greater intentions to have sex. Such perception was also related to earlier sexual debut, as reported by Babalola (2004) in a survey of 1,327 youth in Rwanda, Africa.

A review on the impact of CSE worldwide show somewhat different regional trends (Santhya and Jejeebhoy, 2015). In South and South East Asia, there have been declines in early marriage and early childbearing (6–7% and 6–10% points, respectively); in Sub-Saharan Africa, there has been a small decline in multiple partner relations (4% points) and a substantial increase in condom use (18% points); and in Eastern and Southern Europe there has been a corresponding increase in condom use (15% points). Santhya and Jejeebhoy (2015) further report that, Latin America and the Caribbean, changes are observed in the opposite direction: for example, pre-marital sex increased considerably (14% points), but condom use and multiple partner relations remained unchanged and unintended pregnancy increased substantially. In other regions, trends did not suggest notable changes.

This is linked to the Institutional Learning Theory espoused in this study which emphasises that young people learn better when the learning is institutionalised, detaching it completely from individual biases which affect the way human beings think and feel at each given point (Wekesa 2019). The Institutional theory is supported by the Social Learning Theory in that most of the changes at personal level are socially constructed. The social construct is usually determined by the social setting and a school in this regard is a perfect example for such learning.

2.5 School Related Gender-Based Violence (SRGBV) in Schools

Gender-Based Violence (GBV) knows no boundaries (UNESCO, 2013). This global phenomenon does not discriminate on the basis of geography, culture, ethnicity, or economy, and is often tolerated and sustained by the very social institutions – such as schools – where children are expected to be safe and protected (UNESCO 2013). UNESCO further adds that violence that occurs in and around schools (also known as School-Related Gender-Based Violence -SRGBV) continues to be a serious barrier in realising the right to education (2013). Girls are most at risk of GBV in and around schools, but boys may also be targeted. The experience, or even the threat, of SRGBV often results in poor performance, irregular attendance, dropout, truancy and low self-esteem. Violence can also have serious health and psychological implications that can have long lasting effects (UNESCO, 2013).

UNESCO (2012) reports that sexual violence by boys or men (teachers and learners) against girls has received increased attention as a major concern. Emerging research is also highlighting the more complex nature of violence in schools and has shifted the usual authority/age hierarchy to address violence by students (usually male) against teachers (usually young and female), as well as female teachers perpetrating violence against male students. Increasingly recognized issues are homophobic bullying, bullying based on real or perceived sexual orientation and gender-identity, cyber bullying and the fear of violence itself.

Incidences of SRGBV can occur in the classroom, in teacher residences, toilets, dormitories, and the roads and areas near schools, among others (UNESCO, 2012). This type of violence is made up of a variety of actions that include, but are not limited to: (i) Bullying, including verbal and/or physical harassment; (ii) Sexual harassment, also referred to as 'teasing' or insinuation; (iii) Sexual acts in exchange for good grades or for the paying of school fees; (iv) Non-consensual touching or sexual assault; (v) Seduction or sexual harassment of learners by a teacher; and (vi) Tolerance (or encouragement) of male dominance or aggression within the school environment.

UNESCO (2012) further reports that prevailing gender norms legitimize violent behaviours toward girls, thereby rendering these acts invisible and reinforcing gender

identities that subordinate girls. Boys may also be targets if they do not conform to prevailing norms of masculinity. Social structures and institutions, including families, schools and communities, support these norms. Schools, in their role of guiding the 'socialization' of children may implicitly legitimize and reinforce harmful gender norms through tacit or rather explicit approval of the status quo. Educational institutions, as respected centres in a community, can unwittingly feed a wider enabling environment in which GBV flourishes (UNESCO, 2012). Forms of SRGBV have been documented in all countries around the globe, though inflected differently within and between countries (Leach et al., 2014). Patterns of violence are related to the varying histories, political economies, socio-cultural conditions and institutional frameworks (Johnson Ross et al., 2017; Parkes et al., 2017c; Parkes et al., 2017b; Westerveld et al., 2017)

The Irish Consortium (2019) indicates that, schools and education systems are fundamental in any programme for transformation. A number of promising interventions and programmes have been made to date by International Non-Governmental Organizations (INGOs) and other actors which have transformed schools into safer places. Parkes et al., (2017) expounds that Côte d'Ivoire, Togo, Zambia and Ethiopia have strengthened legislation and policy linked to SRGBV, with their frameworks including adoption of international conventions, national constitutions, laws spanning sectors including education, gender equality, health and justice, and policies and plans at national, mid and local levels. Reviews of laws, policies and education sector plans should ensure that they address the multidimensional features of SRGBV and include indicators on SRGBV within the monitoring frameworks. Parkes at al., (2017) further states that, legal and policy frameworks need to be comprehensive and cross-sectoral, while avoiding duplication and overlap. The studies found frequent disjunctures between what is written into legal and policy frameworks, and the understanding and enactment of these at national, district and local levels (Parkes et al., 2017.

Parkes et al., (2017) reports that Côte d'Ivoire, Togo, Zambia and Ethiopia administrative structures at national, mid and local levels have been created to enable effective implementation of laws and policies through, for example, mainstreamed gender units and focal points at all levels. There are also national cross-sectoral and

thematic working groups on SRGBV, local platforms for child protection or gender equality, and initiatives seeking to bring together community actors and young people with government or NGO systems (Parkes et. al., 2017). However, in order to work effectively, the need for prioritizing work on gender and SRGBV and for committing resources – including time, funding and expertise – were repeatedly highlighted. However, the study reveals that structures and partnerships were limited in what they could achieve, hindering attempts to address SRGBV (Parkes at. al., 2017).

Furthermore, Parkes at al. (2017) mentions that four countries in Africa, namely Côte d'Ivoire, Togo, Zambia and Ethiopia have focused on strengthening, reporting and responses to cases of SRGBV, particularly child sex abuse. The four countries have developed professional codes of conduct for schools, and school-based reporting systems. Moreover support for schools is needed to strengthen these systems with clear guidance for all members of school communities on responsibilities and actions to take following SRGBV. There is much scope for strengthening more comprehensive reporting and response systems, with contextually sensitive, well-resourced and sustainable initiatives, such as phone reporting lines, integrated support centres and well trained and supported community health workers (Parkes et al., 2017).

In addition, Parkes et al., (2017) indicates that initiatives have been implemented in schools in Côte d'Ivoire, Togo, Zambia and Ethiopia, through collaborations between governments, development partners and NGOs. These include training to develop teachers' skills in non-violent pedagogies; improving the ways in which the curriculum addresses gender, sex and relationships; and initiatives with young people, to provide safe spaces and clubs.

Parkes et al., (2017) adds that, although some of the interventions to prevent and respond to SRGBV in Côte d'Ivoire, Togo, Zambia and Ethiopia have been evaluated, many do not routinely collect monitoring data or evaluate effectiveness, resulting in governments, NGOs and schools having insufficient evidence to make decisions relating to SRGBV. Parkes et al also observes that there have been a number of robust surveys and qualitative studies providing data on SRGBV, but more work is needed to develop a survey that can measure multi-dimensional SRGBV at regular intervals, including

patterns across demographic groups and locations. Some promising collaborations have developed to engage policy makers, researchers and development partners in sharing research evidence, and there is much scope to expand these at national, mid and local levels in order to strengthen the capacity to interpret, evaluate and use data and research to ensure evidence-informed approaches to action on SRGBV.

Parkes et al., (2017) reports that an overview of laws and policies in Zambia shows that SRGBV has gained increasing attention, particularly since 2011, when the Anti-GBV Act and Education Act heralded a large amount of policy activity. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee commended legal reforms in Zambia aimed at eliminating gender discrimination against women and promoting gender equality, including the 2011 Anti-GBV Act and the 2011 Education Act (Parkes et al., 2011). It is envisioned that the policies, plans and guidelines would improve the quality of training in gender-responsive teaching and learning methodologies for teachers to encourage change in social norms and traditional attitudes towards the gender role of boys and girls and implement a zero-tolerance policy to end violence against girls, sexual abuse and harassment in schools and ensure that perpetrators are punished (Ibid). Table 2.3 below outlines the policy, plans and guidelines taken to address SRGBV in schools.

Table 2.3: A chronology of SRGBV in Policies, Plans and Guidelines

Education Policy (1996)	Sets out the structure of the education system. Policy has made it compulsory for basic education from Grade 1- Grade 9 to promote universal basic education of good quality. Gender is addressed as an area of special concern, with a view to increasing parity in access to, participation in, and successful completion at all phases, and the document proposes affirmative actions, including bursaries for girls and strategies to increase numbers of female teachers. Although gender-based violence is not addressed explicitly one of the strategic interventions proposed is: "the development by the Ministry and Education Boards of procedures for preventing sexual harassment of employees and pupils" (p. 63) and "The Ministry will review and enforce penalties against school pupils, teachers and other educational personnel engaging in sexual harassment of pupils or education employees or making a school-girl pregnant." (p. 65)
Education Sector National Implementation Framework lll 2011-2016 (NIF lll) (extended to end of June 2017)	Aligned with the r-SNDP, this sets out the strategic focus of the Education Sector towards achieving Vision 2030. With the overarching goal to "increase equitable access to quality education and skills training to enhance human capacity for sustainable national development".
National Strategy on Ending Child Marriage in Zambia (2016-21) (MOG)	Coordinates multi-sectoral responses in order to reduce children's vulnerability to marriages, emphasising the role of social services such as education to prevent child marriage; strategy addresses beliefs and practices, and facilitates provision of child sensitive services; and sets up national coordinating unit to monitor
Guidelines on the Administration and Management of Guidance and Counselling in the Education Sector 2014 (MoGE)	These guidelines are intended for school counsellors, guidance teachers, head teachers, college counsellors and lecturers, other educational administrators and other stakeholders. They aim to improve the provision of school guidance services in the education system.
National HIV/AIDS Strategic Framework 2014/16	Addresses comprehensive sexuality education (CSE).
National Child Policy (2015) (MYSCD)	To coordinate and manage the formulation and implementation of multi-sectoral child welfare and development programmes in order to facilitate attainment of their full potential in the enjoyment of life –including violence against children. A National Plan of Action Child Policy is not yet finalized

Source: Wakesah (2019)

Other measures put in place include the establishment of a number of committees within the Ministry of Education (MoGE), such as the Project Coordinating Committee (PCC) and the Programme Implementation Technical Committee (PITC), which include both NGO and cooperating partner representation. NGOs often assist with policy

dissemination through their links to local communities and schools (Parkes et al., 2017). Forum for Africa Women Educationalists of Zambia (FAWEZA), has developed simplified versions of the Anti-GBV Act, the re-entry policy and the Education Act, picking out elements relating to violence against learners, to share in schools and communities.

The new Code of Ethics for the Teaching Profession in Zambia was developed and being implemented by the Teaching Service Commission and the Zambia Teaching Council, with support from teacher unions (Parkes et al., 2017)

2.6 Source of Adolescent Sexual Reproductive Health Services (ASRHS)

Santhya and Jejeebhoy (2015) indicates that, although adolescents require safe and supportive families, safe and supportive schools and positive and supportive peers in many countries, the environment, including parent–child relationships and relationships between adolescents and their teachers or other potential adult mentors, falls short of meeting adolescents' needs and protecting their rights (Dick et al., 2006). Available evidence suggests that parents rarely provide children information or guidance on SRH matters (Biddlecom et al., 2007; Jejeebhoy & Santhya, 2011; International Institute for Population Sciences [IIPS] and Population Council, 2010). For example, in Burkina Faso, less than two-fifths of girls and one-tenth of boys reported that a parent had discussed these matters with them (Biddlecom et al., 2007).

In India, hardly any (less than 1%) youth reported that a parent had discussed reproductive processes with them (International Institute for Population Sciences [IIPS] and Population Council, 2010). At the same time, DHS data show that in many countries of Asia and Sub-Saharan Africa, less than three-fifths of adults support the provision of education about condoms to young people. Programme precedents for engaging parents, religious leaders and community influential and other gatekeepers are sparse and there is a need to create and test appropriate interventions in diverse sociocultural contexts (World Health Organization (WHO), 2007).

Coskun (2005)[4] reveals that, in Turkey, there is no comprehensive study of adolescents at the national level. The limited number of studies on sexual/reproductive health of young people has not focused on perceptions of sexual/reproductive health, attitudes and behaviours related to sexual/reproductive health. Coskun reports that the results of all studies conducted in Turkey show that adolescents have insufficient knowledge about sexual/reproductive health and their main sources of information are friends, parents and mass-media. On the other hand, they are interested in having information and counselling services on these issues.

A study in Turkey (Coskin, 2005) reveals that the most common three sources of SRH information among adolescents were "book/magazine/encyclopedia", "peers/friends" and "school/teacher", respectively. "Physician/professional" was found as one of the last sources of information in both universities. Coskin adds that the majority of the students did not receive any SRH services, and the most common services have been received as "information", "curative", and "consultancy"(2005)

The World Young Women Christian Association (YWCA) (2016) reports that adolescents in Sub-Saharan Africa (SSA) have particular reproductive health vulnerabilities such as high adolescent birth rates. This group contributes to over 50% of the global proportion of births taking place in adolescence and to over 23% of the burden of disease due to pregnancy, child and maternal health, with severe implication for their access to education and livelihood options.

In Ethiopia, Binu et al., (2018) reports that out of the 768 study subjects, 739 participants underwent all the study components giving response rate of 96%. About 157 (21.2%) school adolescents reported that they utilized SRH services. However, inconvenient times, lack of privacy, religion, culture, and parent prohibition were barriers to SRH service uptake cited by the school adolescents (Ibid). The study concludes that the overall utilization of sexual and reproductive services was low among school adolescents in Ethiopia (Binu et al., 2018). Health workers revealed that history of

[4] *The literature is dated, however, this researcher found it very useful and relatable to the current situation*

perceived STIs symptoms, sexual experience and information were the association factors of sexual and reproductive service utilization among secondary school youths.

In Ghana, findings indicate that the majority of adolescents had good knowledge about the available SRH services, with an emphasis on the different forms of contraceptives (Amankwaa, Abass and Gyasi, 2017). However, the use of the various SRH services was challenging and reduced to counselling services. Amankwaa, Abass and Gyasi (2017) states that adolescents were faced with various difficulties in their bid to access SRH services, including social stigma, attitude of service providers, fear of teachers and the anticipated negative response of parents due to the complex sociocultural structure of the Ghanaian society. Discussion with elders about SRH issues was considered a taboo. The study reveals that females were more likely to be aware of the availability of the youth corner in the nearby general hospital and the youth friendly health services centre. From the study (Amankwaa et al., 2017) male respondents reported having used condoms, females disclosed topics such as teenage pregnancies, abortions, contraction of STIs and use of other forms of contraceptives like pills than their male counterparts.

In Nigeria (Ajike and Mbegbu, 2016) more than half, 268 (79.5%) of the respondents did not know of a specific Adolescent/Youth Friendly Reproductive Health Services (A/YFRHS) provided in study area. Ajike and Mbegbu (2016) states that friends/peers (45.7%) were the best source of information on A/YFRHS. The most popular services known among the adolescents were family planning (81.6%), voluntary counselling and testing (73.8%), and sexually transmitted Infections (67.3%) (Ibid). The participants knew what adolescent/youth friendly services were but did not know where to get these services from because they were not aware of the available A/YFRHS facilities. Poor knowledge about services was also an indicator of poor awareness in the area (Ajike and Mbegbu, 2016).

Bedho (2014) points out that studies on local knowledge showed increased utilization of available YFRHS among those who knew and registered for the services. Depaah et. al., (2015) expounds that despite the satisfaction of youths with the available Youth Friendly Sexual and Reproductive Services, service utilization was generally poor and this was partly attributable to the fact that majority of the youth had no knowledge of

the existing facility-based sexual and reproductive health service despite their existence in their area. In addition, Feleke et al., (2013) reports that most of the youths that utilized available A/YFRHS were knowledgeable of the services and consequences of non-utilization, therefore more educated youths were found to utilize the available service more than non-educated youths as most of them were not aware of the consequence associated with the non-utilization of those available youth friendly services. Ajike & Mbegbu (2016) concludes that, the findings indicate that awareness/knowledge of available services would motivate more youths to utilize the service.

Pearce's (2019) findings in Namibia shows that the girls have access to SRHS. However, they lack a comprehensive understanding of their Sexual and Reproductive Health Rights (SRHR). This could have affected the meaning attached to their reproductive health. The study reveals that the girls are aware of a variety of SRHS available at their local health centres but needed more information on the side effects. The most commonly sought after SRHS was the contraceptive 'injection', family planning pills, condoms and the morning after pill. Others included counselling services and general health information. The findings indicate that barriers such as the high cost of service in private facilities, the waiting time in government facilities, negative attitudes from nurses and lack of parental support and discussion on issues surrounding sex and sexuality continue to impact access to SRHS (Pearce, 2019).

Okonofua (2012) points out that, African nations face challenges in effectively designing and implementing programs for adolescent access to SRHS. These challenges include political, economic, religious and cultural factors. He argues that these influences are sometimes intersectional in creating barriers to access to ASRH and programing. Okonofua (2012) further contends that social and religious barriers influence access to SRHS and information in the Sub-Saharan Africa. Religious teachings are centered on abstinence and cultural norms value sexual purity, encouraging girls to refrain from any sexual activity until marriage. However, these ideas do not reflect the reality on the ground as majority of the adolescents reported being sexually active but do not have access to health centers for fear of being stigmatised because they are sexually active (Okonofua, 2012).

Kibombo et. al., (2008) also reports that the major challenge reported by most key informants in the Sub-Saharan Africa is the reluctance and fear among adolescents to open up and discuss their SRH concerns or seek appropriate and timely care when faced with an SRH condition that requires medical attention. Kibombo et. al., (2008) reports that many health care providers, for example, reported that most adolescents—those who are brave enough to seek services—are often hesitant to disclose their actual condition, which sometimes results in the wrong diagnosis of their illness and then the wrong prescription. The Pharmacists reported that some adolescents go to pharmacies and drug shops to buy a specific drug and refuse to divulge the condition they are going to treat, which makes it difficult to advise them on the appropriate medicine to use.

Kibombo et al., (2008) reveals that another major challenge reported by teachers was lack of supplies and appropriate tools to use to educate adolescents. Most teachers reported that they lack information-education-communication (IEC) materials on SRH issues which would help enhance learning. Teachers in schools also lack condoms and aids (such as dummy penises) for demonstration purposes (Kibombo et. al., 2008). Kibombo et al., reveal that teachers in schools reported that they do not have sanitary pads to give to girls and the majority of parents, for a variety of reasons ranging from poverty to ignorance, are unable to provide them for their daughters.

2.7 Critical Review of Empirical Studies, Contradictions, and Inconsistencies

A review of literature from Europe, Asia and the United States of American reveal that CSE was not implemented at the same time. America, for example, introduced sexuality education in 1913, but it is still experiencing high numbers of teenage pregnancies. Europe has low cases of teenage pregnancies, and it is revealed that Sweden established sexuality education in 1955 and it has evolved today to address the needs of the adolescents. The literature however does not indicate whether the programme has been effective or not. There is *no indication of the impact of CSE on academic performance or culture.* The literature also indicates CSE is influenced by norms and values on sexuality and young people. The literature does not indicate if the norms and values are universal because Europe has reduced teenage pregnancies, but the United States still records high numbers although this could also be largely due to the size of Americas' population.

It is also argued that CSE is grounded in fundamental human rights, empowerment and protection of adolescents' well-being and dignity. Countries are signatories to the Convention on the Rights of the Child (CRC).However, School Related Gender Based Violence is experienced in schools which are supposed to protect the adolescents. The literature reveals that adolescents have been empowered through CSE, but only discusses the use of condoms, delay in sexual activities and does not provide for any empowerment in academic performance between boys and girls. The studies do not discuss the well-being and dignity of male and female pupils.

In Sub-Saharan Africa, literature reveals that governments are committed to protecting adolescents and young people and ensure that they have access to SRH services. However, culture and religion has affected the implementation of the programme and provide services to adolescents and young people. Words such as condoms, masturbation, sex and sexuality cannot be mentioned. In Zambia, the key players involved in the implementation of CSE who ensure that both male and female pupils are protected against SRGBV, have not put adequate measures in place to punish the perpetrators in schools. There is acknowledgment that SRBGV occurs in schools and policies have been designed. Nevertheless, they are gender blind. There is no mention of School Related Gender Based Violence in the documents. These are some of the gaps which this review has exposed and thus, this research seeks to address it. It is also further noted that CSE is a new concept to Zambia, therefore, there are limited empirical literature sources in form of books written on the subject apart from many reports and studies done arising from either research or implementation. This is another gap.

2.8 Knowledge Gap

CSE is a robust area of study in public health. However, there is relatively very little known about CSE in education and the effectiveness towards learners and teachers in schools. This study addresses this gap by examining how CSE is delivered in schools, the effectiveness of the cascading approach as well as the duration allocated for the topics in schools and how both teachers and learners have responded to the programme over time.

Currently, there is limited documentary evidence to explain why teenage pregnancies remain high especially in primary schools in Zambia. The problem could be broad based including socio-economic, cultural, and physical environments within which children and young people operate. The literature reviewed further indicates the effect of CSE on social and health wellbeing for adolescents and does not include the teachers in the schools. Further, there is no sex disaggregation of data when collecting information on Sexual Reproductive Health among adolescents.

2.9 Summary of the Chapter

The literature reveals the United States of America and European countries as having a long history of CSE and SRH and the delivery has been influenced by norms and values on sexuality and young people. Through this literature review, it has been established that CSE is called by different names but it is aimed at behavioral change among adolescents due to the increase in HIV/AIDS and unwanted pregnancies in children. In other regions such as the Asia, Latin America and Caribbean, CSE was established in the 1980s and 1990s. It was through the declarations that countries have established laws, policies, guidelines or strategies on how to implement CSE in schools. Sexuality education was introduced in the year 2000 in the Sub-Saharan Africa.

Despite its variations in accuracy, content, emphasis and effectiveness, CSE is grounded in the fundamental human rights, empowerment, protection of adolescents' well-being and dignity. However, CSE has not been fully accepted in Africa and the Arab states due to religious and cultural beliefs and values.

The literature reveals that CSE is implemented by local governments with the support from the Federal Government with consent from the families, community groups and healthcare professionals. Sweden was the first country in Europe to make CSE mandatory in schools and it is spread in various subjects. It is observed that in Europe, CSE includes topics on gender, gender equality, relationships, and respect for diversity. Switzerland has ensured that CSE is implemented according to the needs in each of the three (3) Cantons taught in the specific languages of French, German and Italian. It is implemented as a separate subject and integrated into wider subjects. CSE is mandatory but with the possibility of opting out and the number of hours is not defined across the

countries implementing it. In the Sub-Saharan Africa, the implementation of CSE is donor-driven and has been incorporated in the school curricula. It is taught by trained in-service teachers.

The literature further reveals that SRH services are provided to adolescents. However, sources of information are books, magazines, peers, social media and encyclopedia. Barriers to accessing SRH information include stigma, religion, culture and lack of parental support. To protect the adolescents against School Related Gender Based Violence, measures have been put in place to make schools safe places. Policies have been designed and the literature establishes that it is mostly girls that are victims of SRGBV than boys. Perpetrators include both male and female teachers. Teachers fail to provide information on SRH due to lack of teaching and learning materials.

Chapter Three: Theoretical and Conceptual Framework

3.0 Introduction

This chapter presents the theories on which the study is based and how these theories can be used to explain the phenomenon being examined. . Further, the chapter demonstrates how these theories are related to the study in that they directly shed light on how learners acquire knowledge and skills and how this works to influence behavior and or how learning takes place. The research is premised on three theories; being the Social Learning, the Critical Discourse Analysis and the Institutional Theories. The second part of the chapter presents the conceptual framework which the study followed.

3.1 Theoretical Framework

3.1.1 Critical Discourse Analysis

Wodak and Meyer (2008) states that Critical Discourse Analysis (CDA) as a network of scholars emerged in the early 1990s, following a small symposium in Amsterdam, in 1991. CDA as a school or paradigm is characterized by a number of principles: for example, all approaches are problem-oriented, and thus necessarily interdisciplinary and eclectic. Bukhari and Xiaoyang (2013) adds that CDA is a field that is used to analyze the written and spoken texts in order to explore the discursive sources of power, dominance inequality and bias. It critically evaluates how these discursive sources are maintained and reproduced within specific social, political, and historical contexts (Van Djik, 1998).

Fairclough (1993) explains that CDA is a discourse analysis approach which aims to systematically explore, often, opaque relationships of causality and determination between; (a) discursive practices, events, and texts, and; (b) wider social and cultural structures, relations and processes; to investigate how such practices, events, and texts arise out of and ideologically shape the relations of power and struggles over power; and to explore how the opacity of these relationships between discourse and society itself are a factor in securing power and hegemony. In examining the implementation of CSE in selected primary schools, the relationship between culture and CSE plays an important role in establishing how learners get influenced by the social construct as argued by Fairclough (1993). This social construct assumes that there is dominance in relationships between boys and girls and this comes from deep rooted culture of

hegemony from most patriarchal societies. This theory exposes that boys feel more entitled in a classroom situation than girls. If girls have to stay afloat, there is need for a strong safeguard measure to ensure that girls feel as equal as boys and protected. Further, Wodak and Meyer (2008) expounds that CDA is characterized by the common interests in de-mystifying ideologies and power through the systematic and reproduceable investigation of semiotic data (written, spoken or visual). As can be seen through this study, boys projected more of a superior attitude than equality when answering questions through language. For example, on who feels safe at school between a boy and a girl, most boys said they do and they do not need protection even when going home. However, the girls said they do not feel safe from bigger boys. Through the use of language, CDA helps to understand how a social construct plays a part in determining how a culture engraves itself into people through generations. This is supported by Fairclough and Wodak, 1997), who states that CDA sees 'language as social practice' and considers the 'context of language use' to be crucial. CDA understands discourses as relatively stable uses of language serving the organization and structuring of social life (Wodak and Meyer, 2008). Within this understanding, the term 'discourse' is of course used very differently by different researchers and also in different academic cultures (Wodak, 2006).

There are two schools of thought for CDA, the traditional and Modern (Bukhari and Xiaoyang, 2013). The modern traditional school sees the role of language as descriptive, whereas the modern School of Social Constructionists suggests that discourses have the capability to (re-) construct social reality (Jorkinen et al., 1993, Fairclough, 2005). Fairclough (2005), the pioneer in the field of Critical Discourse Analysis, contends that social phenomena are socially constructed.

Bukhari and Xiaoyang (2013) explains that since the beginning of formalized education, research has been used to improve education and to determine in a wide range of situations. Through various research methods, teachers hope to obtain reliable and accurate information about important issues and problems that face the educational community. Bukhari and Xiaoyang (2013) indicates that knowledge of research is an essential as well as integral component of professional preparation for attaining skills and competence for all teachers. Bukhari et al. (2012) points out that teachers should be

knowledgeable about multifarious approaches of research to promote creative, innovative and sound solutions to learning and teaching issues. Since CDA is both a theory and a method, the study was interested in the relationships between language used in the delivery of CSE in schools and the society or communities as well as the environment learners are exposed to. CDA was used to help to describe, interpret, and explain such relationships.

Bukhari and Xiaoyang (2013) believes that one who wants to make transparent such as ideological dichotomy in discourse needs to analyze discourse. This involves examining the context of discourse; historical, political, or social background and its main participants; analyzing power relations in the schools; identifying positive and negative opinions; us vs them; making explicit the presupposed and implied and evaluating all formal structures.

CDA offers an effective research methodology for carrying out research not only in the area of the discourse of educational institutions but also that of the classroom itself, making it useful to scholars and practitioners of critical pedagogy. One prime tenet of critical pedagogy is that classroom is a place in which power is circulated, managed, exploited, resisted and often directly impacted by institutional policies and changes (Huckin et al., 2012). Therefore, this research found CDA useful in understanding the way learners behave and use power to maintain dominance. This, more specifically relates to objective (ii) which deals with the relationship between culture and CSE in selected primary schools in Zambia. CDA was also useful in addressing objective (v) which sought to understand and identify sources of gender-transformative behaviours and how these impact a culture; and if not checked, could determine a lower place for women in society.

3.1.2 Social Learning Theory (SLT) of Bandura

David (2016) explains that the Social Learning Theory (SLT) deals with the ability of learners to imbibe or absorb and display the behaviors exhibited in their environment. According to David, SLT originated from Albert Bandura who believed that behaviorism alone cannot explain all there is about learning. Bandura believed that behavior and the environment affect each other. The Social Learning Theory is relevant to the study in examining the implementation of CSE in selected Primary Schools

because it assumes that people are influenced by the world around them (David, 2016). Objective (iii) of this research sought to check whether there is any effect resulting from learning about CSE. Indeed, through Bandura's classical behavioural conditioning, learners are able to model themselves on successful people and eventually also excel. This model is essentially used in many institutions under social learning because for the students, their socialisation starts in the home and further, the different communities they live in. WHO (2006) states that, social, cultural, and economic factors influence sexual decision-making by boys and girls, as individuals and within society.

The Social Learning Theory stipulates that people or students can learn new behaviors by observing others. This refers to the reciprocal relationship between social characteristics of the environment, how they are perceived by individual and how motivated and able a person to reproduce behaviors they see happening around them ((David, 2016). WHO (2006) reveals that natural sexual curiosity, experimentation and learning before and during adolescence are both normal and healthy and occur in all cultures. According to WHO (2006), adolescence is a time for learning to love oneself and others and to be responsible in one's relationships. During this period, young people develop intimate bonds and learn to enjoy the pleasures of sexual activity.

Adolescents also learn about the health risks associated with sexual practices and behaviours, and their vulnerability to these risks – often at first hand. This period sets the stage for mature adult sexual relationships (WHO, 2006). Therefore, learning about CSE which starts in grade five maintains a need for maturity for the learners so that the CSE content remains relevant to those who are either adolescents and or approaching it.

Navabi (2014) adds that, the Social Learning Theory assumes that people learn from interactions with others in a social context. Shaffer (2005) contends that people learn from each other via observation, imitation and modeling. For this process to be successful, Shaffer states that motivation is a key ingredient because students should want to demonstrate what they have learned. However, David (2016) points out that not all observed behaviors are effectively learned. He also adds that behavior can be controlled by self-regulation and making judgments about the environment depending on the source of the stimuli. The Social Learning Theory therefore is important to this

study as it takes the experiences of the children to the classroom and was thus an appropriate model to help answer objective (iii) which is mainly an affective domain type.

3.1.3 Institutional Theory

The first of the major approaches to institutional analysis is the normative approach advocated for by March and Olsen (1984; 1989; 1996). They argue that the best way to understand behavior (seemingly both individual and collective) is through a "logic of appropriateness" that individuals acquire through their membership to institutions. They contrast this normative logic with the "logic of consequentiality" that is central to rational choice theories. March and Olsen (1984) argue that people functioning within institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities. Further, these standards of behavior are acquired through involvement with one or more institutions and the institutions are the major social repositories of values.

Berthod (2016) states that, the institutional theory of organisations puts institutions at the core of analysis of its design and conduct. This is relevant in examining the implementation of sexuality education in 15 selected primary schools in Central, Lusaka and Southern Provinces. The pedagogical approaches in the delivery of CSE are critical institutional nomenclatures which makes this theory suitable to help shed more light in this study especially under objective (i). Berthod points out that organisations do not operate in a vacuum. He adds that they deal with a magnitude of external influences such as cultural differences, legal requirements, norms, conventions and with the diversity of actors.

Peters (2000) supports that the Institutional Theory also provides the opportunity to analyse the internal development of the institutions or the process of institutionalization. An institution can remain well institutionalised but through changes, it can alter its nature and can affect the impact on the individuals with interest. The study was interested in the institutionalization of the CSE and SRHR including other implementing partners and as Peters (2000) states, institutionalization involves infusing a structure with values and policies that are appropriate with the structures in the schools. Objective

one was also checking whether CSE is institutionalised in the ministry of Education. By this, there is need to ensure that the programme is self-sustaining even beyond donor support.

Finally, the institutional theory using Samuel Huntington's argument that advances analyzing four key dimensions which institutions can use to assess the structures (Peters, 2000). The anatomy of the institution represents the capacity of institutions to make and implement decisions and this is operationalized into budgets and sources of revenue. Institutions also require the capacity to manage its workload and develop procedures to process the tasks in a timely manner. Peters (2000) further states that, institutionalization is also better analysed by the complexity and coherence dimensions that include the internal management capacity of the structure; it also includes the standardization of procedures and the routinisation of practices within the Ministries. In order to effectively anchor CSE, there was need to ensure that it is placed in the hands of the Ministry of Education including other related systems of the ministry that include integrating CSE in the examination council, standard motoring tool apart from situating it in the national curriculum. This speaks to the importance of such a theory like the Institutional Theory.

3.1.4 Critical Review of theories /Gaps in the Theories (Criticism of Theories)

Firstly, multi theories have been used in this research to help explain a diverse range of objectives aimed at examining the implementation of CSE in selected primary schools in Southern, Central and Lusaka Provinces. Three theories, therefore, have been used and these are the Critical Discourse Analysis, Social Learning, and Institutional Theories. The Critical Discourse Analysis is based on principles and assumes that approaches are problem oriented. It analyses texts to explore the discursive sources of power, dominance, inequality, and bias among young people in a formal setting such as a school. Further, CDA evaluates how discursive sources are maintained and reproduced within special social, political, and historical contexts. Critical Discourse Analysis also explores social and cultural structures as well as relations and processes. It also states that written, spoken and visual semiotics should be analysed because language is a social practice. It has three (3) models which are critical in analyzing the social construct of language; power relations in schools and in the classroom and examine the social, political, culture, religion and historical contexts. Although this theory explains the study, it does not give specific details of how texts are used to create hegemony among

learners. However, there is evidence that every child is a product of social construct. If CSE has to succeed, there is a lot of work needed to ensure that dominance, texts and somewhat bullying are well managed.

The Social Learning Theory (SLT) of Bandura postulates that new behaviour is learnt through observation, imitation and modeling. The theory does not state whether the behaviours learnt are positive or negative. However, it is succinctly clear that learners learn about ASRH and CSE. The Institutional theory assumes that people within institutions behave as they do because of normative standards. Standards of behavior are acquired through the involvement with others or more institutions and according to the institutional theory, these are the major repositions of values. What the theory fails to mention is that values of institutions differ due to different political, economic, social, cultural and environmental factors. The standards cannot be the same because of the different histories that countries and institutions share.

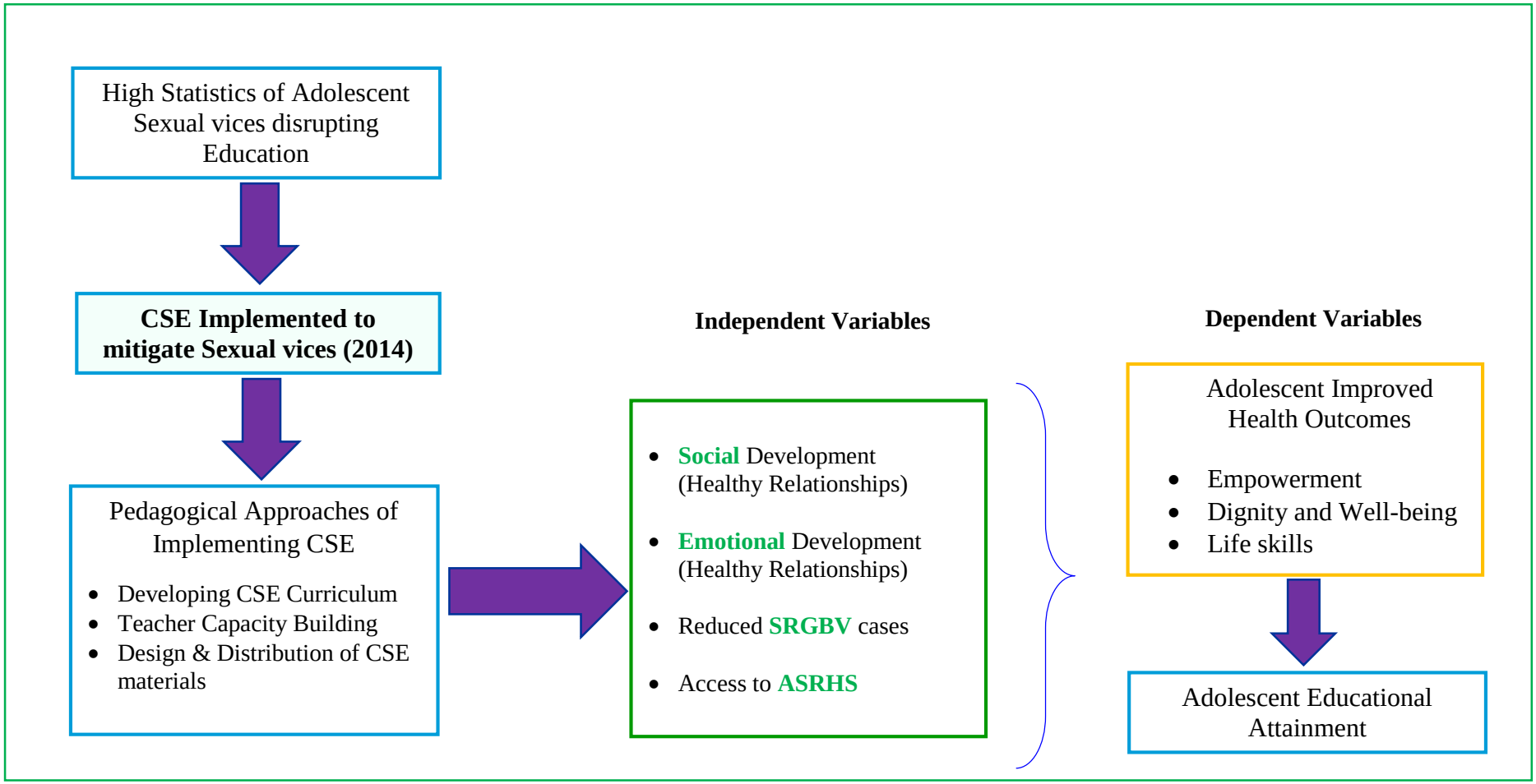
According to the institutional theory, institutions are affected by external influences such as cultural differences, legal requirements, norms, conventions and the diversity of actors. The theory is critiqued because the external influences clash with the local cultures, legal framework, norms and with actors as well. CSE has not been accepted in some of the Sub-Saharan African countries and Asia and actors have recommended that certain terms such as sexuality, condom, masturbation and sex be removed from the programme content. However, this study will draw on the positive side of these theories and maximize on how the three theories contribute to supporting the study. These three theories were chosen from among many others because they are specific and operate within the confines of educational domains and they help clarify how learners learn CSE thereby portraying the differences that are seen and that they are based on many variations which have potential to affect behaviour and change the outcomes.

3.2 Conceptual Framework

For SRH to be implemented, effective pedagogy is key in delivering effective learning of CSE. The pedagogical approaches encompass cultural sensitivity, developing CSE curriculum, capacity building for teachers, design and distribution of CSE materials in schools. The key pedagogical factors are framed in human rights values, gender

equality, accuracy, gender transformative, age appropriateness, and effective coordinators, participatory and team-teaching. With this pedagogy in place, SRH will evolve in schools which includes socio-emotional development (healthy relationships), reduction in SRGBV and access to Adolescent Sexuality Reproductive Health Services (ASRHS). Eventually, this will result in an attainment of improved health outcomes that includes three major elements of prevention of STIs, prevention of HIV/AIDS, and prevention of unintended pregnancies. The prevention of these three vices will result in empowerment, dignity and well-being, and life skills in adolescents which can be regarded as improved health outcomes. This conceptualisation is illustrated below:

Figure 3.0: Conceptual Framework on the Implementation of Comprehensive Sexuality Education in Schools: A problem Analysis



Source: Author, 2022

3.3 Operationalisation of concepts

Comprehensive Sexuality Education: Comprehensive Sexuality Education is defined as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. The aim is to equip children and young people with knowledge, skills, attitudes and values that will empower them to; realize their health, well-being and dignity, develop respectful social and sexual relationships, consider how their choices affect their own wellbeing and that of others and understand and ensure the protection of their rights throughout their lives.

Life Skills: Life skills are defined as psychosocial abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. They are loosely grouped into three broad categories of skills: cognitive skills for analyzing and using information, personal skills for developing personal agency and managing oneself, and inter-personal skills for communicating and interacting effectively with others.

Health Relationships: A healthy relationship is when two people develop a connection based on mutual respect, trust, honesty, support, fairness/equality and good communication

Unintended pregnancies: An unintended pregnancy is a pregnancy that is either unwanted, such as the pregnancy occurred when no children or no more children were desired or the pregnancy is mistimed, such as the pregnancy occurred earlier than desired.

Dignity and well-being: Dignity and wellbeing refer to the state of physical, mental and social well-being. There is actually a connection among the concepts of dignity, well-being and quality of life. Dignity also seems to flow from two components: internal ("how I see myself') and external ("how others see me").

Empowerment: Empowerment is the process of giving individuals power to create their own dwellings, it is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights. If used to refer to young people, it simply means empowering young people and strengthening resilience.

School Related Gender-Based Violence: This is defined as acts or threats of sexual, physical or psychological violence happening in or around schools towards male and female pupils. It includes verbal abuse, bullying, sexual abuse and harassment.

3.4 Summary of the Chapter

Chapter three provides a platform to discuss theories that have been used to anchor this study, providing clear linkages to how young people behave the way they do and what justification can support that behaviour before they can be targeted for behaviour change. The contextual background provided also gives a strong basis to argue the relevance of each theory used in the study examining the implementation of CSE in selected primary schools. Below is the discussion of the theories and the theoretical framework.

Critical Discourse Analysis theory is a discourse analytical approach which aims to systematically explore often opaque relationships of causality and determination between discursive practices, events, and texts, and wider social and cultural structures, relations and process; to investigate how such practices, events, and texts arise out of and ideologically shape the relations of power and struggles over power; and to explore how the opacity of these relationships between discourse and society itself are a factor in securing power and hegemony. This is a common phenomenon where human beings exist. Power play does not only affect the older people but also the young ones. In examining the implementation of CSE in primary schools, this study found CDA to be aligned and directly linked to the possible causes that affect the way learners behave towards each other especially boys towards girls in what is referred to as bullying. This theory further exposes that boys feel more entitled in a classroom situation than girls. In other ways, if girls should stay afloat and maintain an equal balance with boys, there is need for a strong safeguard measure to ensure that they feel as equal as boys and protected.

Secondly, the study also utilised the Social Learning Theory as espoused by Bandura which deals with the ability of learners to absorb and display the behaviors exhibited in their environment. In Bandura's classical behavioural conditioning, learners are able to model themselves on successful people and eventually excel. This model is used in many institutions under social learning because their socialization starts in the home and the different communities, they live in. The theory argues that social, cultural, and economic

factors influence sexual decision-making by boys and girls, as individuals and within society. This is the theory that brings out peer influences whether good or bad. Peer influence is critical at adolescence stage and shapes modeling through good decision making. The power to do so is endowed in the soundness of positive socialization among the young people. The Social Learning Theory therefore is important to this study as it takes the experiences of the children to the classroom and help shape behaviours.

Lastly, the study utilised the Institutional Theory in helping to understand how values are formed and adhered to through the power of belonging to an institution. The theory argues that the best way to understand behavior (seemingly both individual and collective) is through a logic of appropriateness that individuals acquire through their membership to institutions. The theory postulates that people in institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities. Further, the theory points out that organisations do not operate in a vacuum. He adds that they deal with a magnitude of external influences such as cultural differences, legal requirements, norms, conventions with the diversity of actors. The three theories are best to guide this research as they are practical and directly relate to the focus of the research that include institutions that offer educational services, socialization processes of young people and how they transition into adulthood as well as the discursive use of text in social language to dominate and take control especially around relationships of opposite sex among young people. The chapter also covered the theoretical framework which highlighted the dependent and independent variables which are critical in guiding the study.

Chapter Four: Research Methodology

4.0 Introduction

The previous chapter critically reviewed at length the different literature that explains how different research and scholarly work have been crafted to help understand the issue of SRHR and CSE and how these theories are directly linked to the concepts at hand. The chapter also discussed the theoretical framework highlighting the variables that are at play in the study. This chapter provides the methodology that was used in the study to examine the implementation of Sexuality and Reproductive Health programme among adolescents in 15 selected primary schools in Kabwe, Lusaka and Choma districts. Chapter four presents the methodology of this research.

This chapter is therefore structured in the following manner: the initial discussion will elucidate the research design, philosophical position in the research and the implications that it could have on the research procedures and the findings. This includes the researcher's identity, values and beliefs in relation to the research in order to minimize or eliminate any preconceptions and bias that the researcher could have on the investigation as a whole. Following this discussion are the procedures used in the collection and analysis of the data. Other issues of discussion include sampling strategies, ethics, and reliability and validity. A conclusion is then given. Cresswell (2014) states that research is an activity of finding information through chosen procedure/procedures that describe, explain and report the findings with a purpose of adding knowledge to the already existing body of knowledge. The definition of research therefore may vary from one scholar to another. However, in this study the definition of McMillan and Schumacher has been adopted which simply and generally defines research as "a systematic process of collecting and logically analysing data for some purpose" (McMillan and Schumacher, 2006: p143-158)

4.1 Philosophical Standpoint

This study is underpinned on the Pragmatic Worldview philosophy. Pragmatism derives from the work of Peirce, James, Mead, and Dewey as noted by Holmes, (1992). Other writers include Murphy (1990), Patton (1990), and Rorty (1990). There are many forms of this philosophy, but for many, pragmatism as a worldview arises out of actions, situations, and consequences rather than antecedent conditions as in post positivism. There is a

concern with applications—what works—and solutions to problems (Patton, 1990). The philosophy argues that instead of focusing on methods, researchers emphasize the research problem and use all approaches available to understand the problem (Rossman and Wilson, 1985). As a philosophical underpinning for mixed methods studies, Morgan (2007), Patton (1990), and Tashakkori and Teddlie (2010) convey its importance for focusing attention on the research problem in social science research and then using pluralistic approaches to derive knowledge about the problem. Using Cherryholmes (1992), Morgan (2007), and the researcher's own views, pragmatism provides a philosophical basis for this research. Drawing on this philosophical basis, this study uses mixed methods research. Creswell (2007) states that, mixed methods research is a type of research in which a researcher combines elements of qualitative and quantitative research approaches such as use of qualitative and quantitative viewpoints. The philosophical standpoint or paradigm stands on the post- positivist paradigm that data evidence and rational considerations shape knowledge (Creswell, 2014). The researcher collects information using instruments based on measures completed by the participants or by observations recorded by the researcher (Creswell, 2014).

In line with the pragmatic worldview philosophical underpinning, the aim of the research was to examine the implementation of CSE and reproductive health among adolescents in selected primary schools. It is posited that the implementation of sexuality and reproductive health hinges on the perceptions and experience; therefore, it is recognized that perceptions are intangible and unconsciously held by the learners and teachers. A qualitative approach was therefore needed in order to encourage research participants to describe their lived experiences in the implementation of sexuality and reproductive health and an interpretative approach was needed to analyse the descriptions in order to determine their experiences (Creswell, 2014).

The implementation of sexuality and reproductive health in schools is delivered in the classrooms by trained teachers. There is a pedagogical approach used to provide a heath well-being in later adolescence and young adulthood. However, a contrasting ontological perspective was taken by the researcher who views sexuality and reproductive health as a human conceptualization of the phenomena students and teachers witness every day. The researcher regards sexuality and reproductive health not as an external body of facts to be

transferred to a learner but as a creation involving the way in which adolescents relate to phenomena, make sense and meaning and form personal understanding. From this perspective, sexuality and reproductive health is therefore a human construction created by understanding the phenomena and how it is interpreted.

From this ontological perspective, the focus for the research is not the subject of sexuality and reproductive health, nor the learner or the teacher, but the relationship between the two. In other words, the implementation of sexuality and reproductive health in schools involves focusing on the relationship between the learner together with the teacher and their experience of sexuality and reproductive health.

In this regard, the researcher's ontological perspective of sexuality and reproductive health being a human construction supports the epistemological stance of learning and teaching sexuality and reproductive health through subjective, interpretative sense-making and meaning (Creswell, 2014). This view, therefore, has an impact both upon the way the researcher decides to obtain data pertaining to the implementation of sexuality and reproductive health and the way in which the data was analysed in terms of both how sexuality and reproductive health and how new knowledge from the research is brought about.

In order to examine the implementation of sexuality and reproductive health among teachers and learners, the researcher's positionality was not articulated, this was to avoid risk of bias. The methodology used is where participants were free to express their own views on the implementation of sexuality and reproductive health in primary schools, without leading questions from the researcher and without judgement. Hence, the methodology employed includes aspects of the methods of data collection which are in line with the philosophical underpinning of the research. Similarly, in order to ascertain the findings on the implementation of sexuality and reproductive health among teachers and learners, all the data collected was included without preconceived ideas from the researcher on what the range might include. The collection of data was true to what the students and the teachers were saying. In this regard, a method of data collection was used where students and teachers were free to recall and describe their experiences on sexuality and reproductive health and a method of analysis where the descriptions were interpreted to

examine the implementation of sexuality and reproductive health in a valid and reliable way.

4.2 Research Design

The research employed a convergent parallel mixed method design which, according to Creswell (2014), is a method in which a researcher converges or merges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem. In this design, the researcher typically collects both forms of data at roughly the same time and then integrates the information in the interpretation of the overall results. This design is preferred because qualitative tends to be open-ended without predetermined responses while quantitative usually includes close-ended responses contained in the questionnaires Creswell (2014). The design was used because mixed method resides in the idea that both methods have bias and weaknesses and therefore, the collection of both quantitative and qualitative data counterbalances the weakness of each form of data (Creswell, 2014). With the mixed method design, triangulation was employed and according to Creswell (2014), triangulation is a method used to increase the credibility and validity of research findings. Credibility refers to trustworthiness and how believable a study is whereas validity is concerned with the extent to which a study accurately reflects or evaluates the concept or ideas being researched.

Triangulation in this study on examining the implementation of CSE in 15 selected primary schools was used by combining theories and methods and this helped to ensure that fundamental biases arising from the use of a single approach, be it quantitative or qualitative are overcome. Triangulation enriched this research as it offered a variety of datasets i.e. qualitative and quantitative to explain differing aspects of a phenomenon of interest. A pragmatic worldview was used as a philosophical underpinning for this study. As a philosophical underpinning for mixed methods studies, Morgan (2007), Patton (1990), and Tashakkori and Teddlie (2010) convey its importance for focusing attention on the research problem in social science research and then using pluralistic approaches to derive knowledge about the problem.

In the researcher's own views, pragmatism provided a philosophical basis for research especially on a topic like this one which examines the implementation of CSE arising from

a problem observed that there is insignificant progress in terms of results. The problem is, despite the heavy investments into the project in terms of both technical and financial resources, there is little progress in terms of learners dropping out of school, early marriage and poor health outcomes. This is supported by Creswell (2014) who explains that the research merges qualitative and quantitative data in order to provide a comprehensive analysis of the research problem in a practical way. The study practically collected both forms of data at the same time and integrated the information in the interpretation of the results.

Johnson and Onwuegbuzie (2004) explain that the goal of mixed methods research is not to replace either the quantitative or qualitative approaches to research, but rather to draw from the strengths of these approaches and to minimise possible weaknesses. The rationale for choosing a mixed method research design for the study was to: gain data about a wider range of interests; understand more fully – and thus get a fuller research picture; generate deeper and broader insights; enhance the significance of interpretation; allow for unexpected developments; clarify underlying logic; facilitate both outsider and insider perspectives, thereby improving research; facilitate a better understanding of the relationship between variables; allow appropriate emphasis at different stages of the research process; and to explain idiosyncratic circumstances, approaches, opinions and practices of different respondents.

Questionnaires for adolescents, Key Informant Interviews (KII), Focus Group Discussion (FGD) as well as lesson observations were used as tools to collect data in 15 selected primary schools. The quantitative data were analysed using Statistical Package for Social Sciences (SPSS) and the qualitative data were analysed using thematic analysis in which objectives and research questions were used to create themes that guided the analysis. The findings from the focus group discussions for learners and teachers, Key informant interviews and lesson observations were captured in note form and audially recorded in some cases.

Narrative data were interpreted qualitatively through the use of thematic analysis. Statistical data were analysed using the SPSS mainly by creating the data interface templates in the SSPS version 16 software guided by the objectives of the research and

then after a thorough cleaning of the data, the data set was run to generate different data shapes as utilisable information.

4.3 Study Sites

The study was conducted in three districts of Zambia namely Kabwe, Lusaka and Choma (figure 4.0). The sites were selected as a representation of rural, urban and peri-urban settings of the population who experience their socio-economic realities differently which has a bearing on concepts of sexuality among adolescents. Further, the selection of the districts was based on the implementation of Comprehensive Sexuality Education (CSE) in schools as well as the school dropouts due to teenage pregnancies (Ministry of Education, 2019). The selected schools in each district had high cases of unintended pregnancies among adolescents in 2018.

Figure 4.0: Selected Study Sites highlighted in red

Source: One World Maps

4.4 Study Population

The study had a multi-layered target population of three cohorts namely learners, educators and administrators. The target population for learners were all pupils in the selected districts aged between 12 and 17 years attending primary education. Further, all primary schools in the three selected districts were a target population. The target population of educators were all primary school teachers and head teachers in the selected districts. For administrators, the target population were Ministry of Education and Ministry of Health officers associated with the implementation of CSE.

Table 4.0: Target Population

	Population	**Kabwe**	**Lusaka**	**Choma**	**Totals**
1	Primary Schools				
2	Pupils	3,000	4,500	3,000	10,500
3	Educators				
4	Administrators				

Source: MoE Bulletin (2019)

4.5 Sample Size

From the four populations of the study, sample sizes were calculated with the Yamane equation formula as follows: -

$$n = \frac{N}{1+N\,(e)2}$$

n = Sample size

N = Population size

e = Level of precision or sampling error which is ± 0.07

(b) Primary Schools

Schools were purposively sampled on the basis of high adolescent pregnancies recorded in 2019 from each of the selected districts inspite of having trained teachers in CSE as indicated in Table 4.1 below: -

Table 4.1: Schools with number of unintended pregnancies and teachers trained in CSE

District	Schools	Number of unintended pregnancies	# of teachers trained in CSE per each school
Choma	Shampande Primary	13	6
	Mwapona Primary	11	13
	Choma Primary	13	11
	Total	**37**	**30**
Kabwe	Makulu Primary	13	5
	Katondo Primary	11	11
	Muwowo Primary	9	8
	Total	**33**	**24**
Lusaka	Ngwerere Primary	8	63
	Kamulanga Primary	9	54
	Timothy Mwanakatwe	8	66
	Total	**23**	**183**

Source: Ministry of General Education, 2018

Correlation – a correlation analysis was conducted on Table 4.2 to determine any correlation between number of unintended pregnancies and teachers trained in CSE.

Table 4.2: Correlation between number of unintended pregnancies and teachers trained in CSE

	Number of unintended pregnancies	*# of teachers trained in CSE per each school*
Number of unintended pregnancies	1	
# of teachers trained in CSE per each school	-0.807649442	1
Pearson correlation of -0.8 shows that there is a strong negative correlation.		

Interpretation: In conclusion, when there is a higher number of teachers trained in CSE there tends to be a lower number of unintended Pregnancies.

The sample size for primary schools was therefore 9.

(b) Pupils

There was a high number of teenage pregnancies recorded in the selected districts in 2019 as indicated in Table 4.3 below: -

Table 4.3: Table for Teenage pregnancies per 3 sampled schools

District	Pupils
Kabwe	33
Lusaka	23
Choma	37

Source: Ministry of General Education, 2019

The sample size for pupils was then calculated with the Yamane equation formula for the three selected districts as indicated below: -

Lusaka	**Kabwe**	**Choma**
$\boldsymbol{n = \frac{N}{1+N\,(e)2}}$ $\boldsymbol{n = \frac{4{,}500}{1+4{,}500\,(0.07)2}}$ $\boldsymbol{n = 300}$	$\boldsymbol{n = \frac{N}{1+N\,(e)2}}$ $\boldsymbol{n = \frac{3{,}000}{1+3000\,(0.07)2}}$ $\boldsymbol{n = 200}$	$\boldsymbol{n = \frac{N}{1+N\,(e)2}}$ $\boldsymbol{n = \frac{3{,}000}{1+3000\,(0.07)2}}$ $\boldsymbol{n = 200}$

The sample size for pupils was therefore **700**

(c) Educators

The sample size for teachers and headteachers was dependent on the sample of schools selected for each district. The criteria of selection of teachers was based on teachers that have been trained in HIV, Adolescent Sexual Reproductive Health and Sexuality Education from the sampled provinces, and below is the population from each province by sampled districts: -

Table 4.4: Teachers Trained in CSE by Sampled Districts

Province	District	Male	Female	Total
Central	Kabwe	10	14	24
Southern	Choma	13	17	30
Lusaka	Lusaka	78	105	183
Total		**101**	**136**	**237**

Source: Ministry of General Education, 2019

Thus the sample for educators from each districted is indicated in Table 4.5 below:-

Table 4.5: Sample Size of Educators

A	**Head Teachers**		
	Kabwe	2	
	Lusaka	2	
	Choma	2	
			6
B	Teachers		
	Kabwe	5	
	Lusaka	10	
	Choma	5	
			20
	Total		**26**

(d) Administrators

The study sampled 2 officers each associated with implementation of CSE at the Ministry of education and the Ministry of Health. Thus the sample size for administrators was 4.

Table 4.6 below presents a summary of the sample size of the study: -

Table 4.6: Summary of the sample size of the study

		Sample Size	Total
1	Primary Schools		
	Kabwe	3	
	Lusaka	3	
	Choma	3	6
2	Pupils		
	Kabwe	200	
	Lusaka	300	
	Choma	200	700
3	Educators		
	Head teachers	6	
	Teachers	20	26
4	Administrators		
	Ministry of Education	2	
	Ministry of Health	2	4
	Total Sample Size		**736**

4.6 Sampling Techniques

4.6.1 Quantitative Sampling

Sampling refers to the selection of a subset of persons or things from a larger population, also known as a sampling frame (Scott and Morrison, 2007). The purpose of sampling is to achieve a fair representation of a particular population (Gall et al., 2007; Neuman, 2011). The selection of the schools in the study employed the use of a sampling frame and mapping of the schools with high prevalence of teenage pregnancies. Information was supplemented by review of existing school documents in order to verify number of school-dropouts and the reasons.

A probability sampling method was used through a simple random sampling to select learners to answer the questionnaire. Simple random sampling involves each member of the population receiving an equal chance of being selected in the sample pool. For quantitative sampling, papers for ‘yes’ and ‘no’ for ‘yes’ meaning you are selected to participate and ‘no’ you are not were put in a box, shaken and asked learners to randomly pick. Those who picked ‘yes’ were selected per grade to answer the questionnaire. The

respondents were chosen by chance thereby reducing any selection bias. The study used the Yamane equation to determine the sample size of pupils in primary schools in Lusaka, Kabwe and Choma districts. This was to ensure that the sample size is representative in all the sampled schools.

4.6.2 Qualitative Sampling

A non-probability sampling procedure (Cozby, 2009) was used for the selection of knowledgeable participants from schools, Ministry of Education and Ministry of Health involved in the implementation of CSE in schools. For this reason, purposive sampling was used to select the head teachers and teachers. Purposive sampling was used because the population was specific such as teachers per school who received training in CSE and head teachers. These are specific and inappropriate for random sampling.

Snowball sampling method was used to select this category of respondents because they are not many and somewhat hard to find in big numbers. Snowballing typically is used in surveying groups that are difficult to reach, respondents are tasked with calling on more respondents (the ones they know) to take part in the sample hence snowballing. This is how the sample of an otherwise hard-to-recruit group increases, or snowballs, in size. Although the method risks a selection bias, it was a better option for this study in identifying this category of respondents who have received training in CSE.

The sample was selected through random sampling for pupils and teachers trained in CSE in each school and a gender balance of respondents was ensured. Below is the breakdown of the observations, interviews and focus group discussions which were conducted in each district.

4.7 Inclusion and exclusion criteria

Creswell (2014) states that eligibility criteria in research are requirements that should be met for a person to be included in a study or trial. These requirements help to make sure that participants in a study are like each other in terms of specific factors such as age, type and other related characteristics. The inclusion and exclusion criteria for this study were: -

a) The study included all sampled primary schools in the three selected districts of Kabwe, Lusaka and Choma;
b) The study included all adolescent primary school learners aged 12 -17 years attending primary school education in the selected three districts;
c) The study included only teachers who were trained in CSE and actively teaching for at least a minimum of two years and head teachers of primary schools;
d) The study included Ministry of Education and Ministry of Health officers responsible for supporting CSE programmes;
e) The study excluded out of school adolescents in the selected districts; and
f) The study excluded parents and guardians of learners as well as health officers in health facilities in the selected districted.

4.8 Data Collection Tools

To yield data for the qualitative investigation, different measuring instruments were employed (Vooslo, 2014). Measuring instruments included different types of interviews (standardized open-ended, semi-structured and structured), observations and content analysis or review of documents (Cooper and Schindler, 2011; Thomas et al., 2011).

4.8.1 Secondary Data

Secondary information was collected through desk reviews of various literature on comprehensive sexuality education in schools. The various literature included those on training reports, guidance teacher's reports, policy documents and publications as sources on CSE implementation literature. These were accessed and reviewed at school level.

4.8.2 Primary Data

Primary information was obtained through questionnaires, interviews and focus group discussions in the selected schools in Kabwe, Lusaka and Choma districts. Below are the data collection tools used to obtain information from the primary sources:

4.8.3 Quantitative Data Collection Tools

Questionnaire

The quantitative section deals with the statistical analysis and numerical data to provide quantitative information (Lund, 2005; Thiétart, 2007). Vooslo (2014) states that,

quantitative research requires objectively evaluating the data which consist of numbers, trying to exclude bias from the researcher's point of view. The quantitative method makes use of a questionnaire and involves the numerical analysis of data gathered by means of structured questionnaire (Vooslow, 2014). The questionnaire was administered with the help of research assistants to the adolescents in schools to examine the implementation of CSE in primary schools and the pedagogical approaches used in delivering CSE in schools; review the relationship between culture and CSE in selected primary schools; examine the effect of CSE in the selected primary schools in Zambia on the socio emotional development of adolescents; and analyse how primary schools are addressing School Related Gender Based Violence in implementing CSE and identify where adolescents access gender-transformative sexual reproductive health services.

4.8.4 Qualitative Data Collection

4.8.4.1 Structured observation guide

The purpose of the structured observation was to provide a brief account of the context of the schools in order to facilitate an understanding of the setting in which the teachers teach, and learners learn and to provide information on how the teachers teach and learners learn on CSE in the classroom. Structured observations were conducted in all the selected primary schools in Kabwe, Choma and Lusaka districts. These were conducted during the sessions when subjects integrating CSE are being taught in the schools. A tool was designed, and the following were considered:

i. The language used;
ii. Physical location and surroundings;
iii. Materials used;
iv. Pedagogical approaches used; and
v. Questions and comments.

Table 4.7: Structured lesson observations

District	Structured observations
Kabwe	3 Schools
Choma	2 Schools
Lusaka	2 Schools
Total Sample size	**7**

Source: Author, 2020

4.8.4.2 Key Informant Interview Guide (KIIs)

Interviews were conducted or carried out with the Head teachers, guidance teachers and selected officers of the ministry of health and education respectively. The interviews which were recorded, transcribed, and coded for analysis took place in their offices. The purpose of the interviews was to analyse the pedagogical approaches in the implementation of sexuality education and reproductive health among adolescents in schools from 2014 to 2018; how schools are addressing School Related Gender-Based Violence (SRGBV) and examine the sources of gender-transformative sexual reproductive health services among the adolescents.

4.8.4.3 Focus group discussion guide

A focus group discussion guide was employed to examine the comprehensiveness of sexuality education among adolescents in schools; identify where adolescents access gender transformative and age appropriate SRH services as well as the measures to address SRGBV among male and female learners. This was conducted in-depth in a comfortable environment to get a wide range of opinions, attitudes, feelings or perceptions from a group of individuals who share some common experience relative to the subject under study. This strategy only discloses what is important to individual respondents, but the group setting also attempts to create a synergistic environment resulting in a deeper and more insightful discussion. Further, teachers who received training in CSE as well as guidance teachers were hosted for a focus group discussion. This was to validate and confirm the information obtained from learners.

Focus group discussions were conducted in the selected primary schools with learners in grades 5, 6 and 7. Below is the summary of the focus groups conducted; the focus group discussion for learners had between 8 and 10 participants. An average of between 48 to 50 learners took part in the focus group discussions.

Table 4.8: Mixed Grade Focus Group Discussions – Learners

District	Target respondents	Number
Kabwe	Learners in grade 5, 6 and 7	2
Choma	Learners in grade 5, 6 and 7	2
Lusaka	Learners in grade 5, 6 and 7	2
Total		**6**

Source: Author, 2020

The focus group discussion for teachers had between 3 and 6 participants as schools were not in session due to Covid 19 restrictions at the time. Only few teachers could be in school. However, even with these numbers, saturation was achieved. An average of between 30 to 36 teachers took part in the focus group discussions at school level.

Table 4.9: Focus group discussions – Teachers

District	Target respondents	Number
Kabwe	Trained teachers in CSE and Guidance & Counseling teachers	2
Choma	Trained teachers in CSE and Guidance & Counseling teachers	2
Lusaka	Trained teachers in CSE and Guidance & Counseling teachers	2
Total		**6**

Source: Author, 2020

4.8.4.4 Reliability

Salkind (2006; 2009; 2012) refers to dependable, consistent, stable, trustworthy, predictable and faithful as synonyms for reliability. More specifically, Delport and Roestenburg (2011) concede that reliability deals with what is being measured. Muijs (2011) states that whenever researchers want to measure something, there is some element of error called measurement error. Reliability then refers to the extent to which test scores are free of measurement error (Vooslo, 2014).

Although it is rare to have perfect reliability, Neuman and Kreuger (2003), as well as Salkind (2006; 2009; 2012), suggest procedures to increase the reliability of measures. This study used the following proposed procedures:

i. Increase the number of items or observations, i.e. the use of multiple indicators of a variable;
ii. Eliminate items that are unclear;
iii. Standardize the conditions under which the test is taken;
iv. Moderate the degree of difficulty of the instrument;
v. Minimise the effects of external events;
vi. Standardise instructions;
vii. Maintain consistent scoring procedures; and
viii. Use pre-tests, pilot studies and replications.

4.8.4.5 Validity

Vooslo (2014) expounds that validity is the primary concern of all researchers who gather educational data. Validity is the most important quality of a measured dependent variable. This is because validity refers to the extent to which an empirical measure accurately reflects the concept it is intended to measure, yielding scores that reflect the true variables being measured (Vooslo, 2014). Further, Vooslo (2014) explains that validity refers to the soundness of the interpretation of scores from a test, the most important consideration in measurement. The dependable variable in the study is CSE and this was measured.

4.8.4.6 Reliability and validity

Vooslo (2014) states that qualitative researchers have begun to question the relevance of the term validity in most qualitative research. Terminologies such as credibility, dependability, confirmability, trustworthiness, verification, and transferability were used instead in the study. In other words, if the study tools are reliable and valid, the information generated will be credible, dependable by other users and it is confirmable. This means that if other researchers go in, they should be able to obtain similar outcomes. Further, the information is trustworthy and verifiable, and it is transferable. This means that the research is credible, and it can guide and properly inform the users. The new trend now emphasises the use of rigour to ensure reliability and validity in qualitative research (Tobin & Begley, 2004). The study therefore used the following criteria:

Credibility: Engagement with the data (recordings, notes and transcripts) were done intensively to demonstrate clear links between the data and the interpretations. Interviews and focus group discussions were conducted and adjustments were made in accordance with suggestions and recommendations.

Dependability: Dependability is analogous to the notion of reliability in qualitative research. The purpose of this test is to show indications of stability and consistency in the process of inquiry (Reige, 2003). Care was taken to ensure that the research process is logical, traceable, and clearly documented in a reflexive manner by giving a detailed account of the research process.

Authenticity*:* The development of the question items were based on the theoretical framework (Vooslo, 2014). The study included three theories being the Critical Discourse

Analysis theory, Social Learning Theory and the Institutional theory which helped to analyse pedagogical approaches in delivering CSE in the classrooms and the conflict between culture and comprehensive sexuality education. An interview was conducted during the pilot to ensure the yielding of reasonable, un-biased and valid data.

Confirmation: Vooslo (2014) states that an audit process should be implemented by working forward, as well as backward through the research process, to ensure that the data and interpretations of the findings are sound and confirm findings. The intention during the interpretation process is not to generalize findings to a population, but to identify accepted principles and trends related to the research topic. The findings in this research do not generalise to the entire population but the principles are applicable in some form because of the trust worthiness of the principles of research used.

4.9 Pilot Study

Bless et al. (2006) defines a pilot study as a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments, and analysis are adequate and appropriate. Wilkinson and Birmingham (2003) adds that, the researcher can begin to identify and correct imperfections by piloting or testing a questionnaire with a select few people to establish their clarity. Piloting further assists in eliminating ambiguous questions, as well as in generating useful feedback on the structure and flow of the intended interview. Welman et al. (2009) and De Vos et al. (2011) summarise the purpose of the pilot study as follows:

i. To detect possible flaws in the measurement process (such as ambiguous instructions, and inadequate time limits);
ii. To identify unclear or ambiguously formulated items. In such a pilot study the actual questions are put to the participants, and they are then asked to indicate how they have interpreted the formulated questions; and
iii. An opportunity for researchers and assistants to notice non-verbal behaviour (on the part of participants) that may possibly signify discomfort or wording of the questions (Welman et al., 2009).

The pilot stage has the advantage of getting the designed questions refined, modified and enhanced in preparation for the real research. The findings obtained from the pilot further

helped to unearth important answers to the research (Robson, 2002). Oppenheim arguing on the importance of piloting states that: A poorly designed survey will fail to provide accurate answers to questions under investigation; it will leave too many loopholes in the conclusions; it will permit little generalisation; it will produce much irrelevant information, thereby wasting case material and resources (Oppenheim 1992).

The weaknesses of a poor design identified above could be avoided by a pilot, and hence this research undertook to pilot the questions of the interviews. The sample used was purposely selected. These are teachers who received training in CSE and classes of learners in which CSE was being integrated. The recorder was used to capture the responses; notes were also taken and consequently the responses were analysed. The process of coding was an exercise that provided practice in preparation for the real research.

With the help of the trained research assistants, the pilot study was conducted in Lusaka at Kabulonga and Chongwe Primary schools. This is because CSE was implemented in these schools and teachers were trained in HIV and CSE. The findings of the pilot were used to adjust the tools to ensure that they were clear and easy to use. The final questionnaire and FGD guides were discussed as well as analysed and approved by the two supervisors and the University of Lusaka Ethical Review Board (UERB) before commencing data collection.

4.10 Working with the research assistant

My research assistant was chosen for his expertise in fieldwork. He is an adolescent Sexual Reproductive Health expert with Men's network focusing on reproductive health and research. He had worked as a research assistant before and had extensive skills in interviewing young people and teachers. The research assistant was conversant with the local terrain and was familiar with the languages used in the area being Tonga, Bemba and Nyanja which was an added advantage. However, he had no knowledge of teaching methods as he is not a teacher by profession himself. It was also not clear to what extent this was going to impact the study. In this regard, the researcher had to spend a month with the research assistant before commencing data collection. By the end of the month, the research assistant had become conversant with the teaching techniques being used to deliver CSE at

classroom level and were able to do the pilot together. Further, traveling together also helped us to bond and build a strong team.

As a researcher, I benefited much from the research assistant because he helped me juggle between my two roles of researcher and observer, which was not an easy task. He constantly reminded me of my role as a researcher each time my emotions seemed to take over. He corrected the use of the language, particularly, Bemba and Nyanja on account of his fluency with it and further edited the transcripts and helped in the cleaning of the data. Together, we compared notes and contrasted them. He was also able to take notes and administered questionnaires throughout the period of data collection and his field notes were sufficiently valuable (Jorgensen, 1989; Seale, 1999; and Denscombe, 2003)[5].

4.11 Researcher positionality on the study

Denscombe (2007) has advised on the importance of the researcher declaring his/her standpoint and philosophical position within the research because of its potential influence on the research procedures and the findings. In any research the researcher is the key instrument whose potential to affect the research could be high. Therefore, the researcher should have skill and competence in the instruments to be used. Further still, the researcher should inject rigor in the whole research process to improve the credibility of the research (see Wellington, 2000).

Baszanger and Dodier (2004:p14) argue that the person of the researcher is critical to the "quality of scientific knowledge and soundness of ethical decisions". Therefore, my ontological and epistemological beliefs were declared in an attempt to 'distance' myself from the studied normal everyday beliefs and suspend my judgements on social issues for the period of the research in order to improve the external validity of the research and as already been noted, to reduce biases (Denscombe, 2007). Although I am a staff member of the United Nations involved in supporting government in the implementation of CSE and SRHR, I did not distance myself completely to the extreme end of the continuum for the very reasons that Lofland et al., (2006) warns against. He states that extreme distance may result in failure to collect rich data. Therefore, my past experience and prior knowledge of

[5] *Although this is dated literature, the researcher found it useful and relevant to explain the context*.

the topic under examination were relevant to the research as pointed out by Wellington (2000).

4.12 Data Analysis

Strauss and Corbin (1998) describe analysis as "science and an art" that entails interaction between the researcher and the data. Analysis is a process that transforms raw data into findings (Lofland et al., 2006). It is the process through which the collected raw data are sorted out into bits, reduced, displayed, verified and given meaning (Miles and Huberman, 1994). Under this section, descriptive statistical techniques were applied to organise, analyse and interpret the quantitative data. Data from the questionnaire was statistically analysed using the Statistical Package for Social Sciences (SPSS) version 16 to obtain results for the quantitative interpretation. The statistical procedure involved the use of descriptive statistics in graphical and numerical ways to present and analyse the gathered data. Two-way frequency tables or cross tabulations were used to explore response patterns of different target groups (Pietersen and Maree, 2007). Central tendency measures (e.g. mean, frequencies and ranking) were applied to describe the distribution of responses and to identify characteristic values. Chi-square and ANOVA tests were used to test some selected variables to determine the difference and or the relationship between variables.

Additionally, qualitative data were also presented thematically in tables in order to show the similarities and differences among the responses from the key informants and pupils. Creswell (2014) states that data analysis should proceed hand -in-hand with other parts of developing the qualitative study, namely, the data collection and the write-up of findings. While the interviews were on-going, data were analysed for the interviews and discussions conducted earlier and the narrative was included in the final report. Quantitative data was used to support qualitative data. Because text and image data are so dense and rich, not all of the information can be used in the qualitative study (Creswell, 2014). In the analysis of qualitative data, MacQueen and Namey (2012) recommend that researchers need to 'winnow' the data. Therefore, qualitative data were aggregated into small number of themes like four to five themes.

4.13 Ethical Considerations

Ethics is a philosophical term derived from the Greek word *ethos*, meaning character or custom and connotes a social code that conveys moral integrity and consistent values (Partington, 2003). More in relation to the ethics of science, Mouton (2001) is of the opinion that the ethics of science concerns what is wrong and what is right when conducting research. To this end all researchers, regardless of research designs, sampling, techniques and choice of methods, are subjected to ethical considerations (Gratton and Jones, 2010). This research adhered to the process of conducting research which includes confidentiality of the participants and the signed consent. To this end, the following ethics were adhered to:

i. A detailed, prescribed application was submitted to the Research Ethics Committee of the University of Lusaka for approval to conduct the research;
ii. Introductory letters were sought from the University of Lusaka to conduct research in the schools and this was presented to the District Educational Boards (DEBs) in each Province. The letter was presented to the respondents with the questionnaires to encourage their participation in the research. Information was also provided to the participants concerning the nature of the study, participation requirements (e.g. activities and duration), confidentiality and contact information of the researcher;
iii. Permission was obtained from the Provincial Education Offices of the Ministry of Education, different district offices and the selected schools;
iv. Consent, permission, and approval for the research was obtained from the Headteacher of each selected school;
v. Informed consent for learners was obtained at three levels and these were: for participants and respondents under the age of 16, consent was provided by the school and parents. Besides that, children also provided assent on their own before the focus group discussions;
vi. Participants and respondents were not subjected to any risk of unusual stress, embarrassment, or loss of self-esteem. Their safety was guaranteed and protected by ensuring that there is gender representation in the research team in order to protect the interest of the female learners especially;
vii. The researcher ensured that participants and respondents remained anonymous.
viii. The right to professional privacy and confidentiality of information obtained was guaranteed by a written statement in the cover letter; and

ix. The research was conducted in accordance with the ethical requirement to report the findings in a comprehensive and honest manner.

CSE and ASRH are culturally sensitive issues which require a careful approach. In this regard, the researcher ensured that learners were separated into gender FGDs. This was to allow comfortability among young learners. Further, learners younger than the adolescent age were in their own groups to respond to questions that related to their age (age appropriate) engagement. Additionally, the FGDs helped in the classroom with open doors to ensure that learners were safe from any form of harm.

Ethical issues and considerations have mainly to do with permission to carry out the research, the participation of respondents, the community and public as well as the process employed to analyse data (Busher, 2002). Caution was taken to avoid any harm to participants in the light of sensitivity of the research theme concerning responses about sexuality, sexual reproductive health known by teachers and pupils in the selected primary schools in Lusaka, Kabwe and Choma districts.

4.14 Limitations of the study

One of the major limitations for this study was the period during which the study was carried out. The study was conducted during the period of COVID-19 and non-examination classes were not in school. This required making follow ups to ensure that learners were met at the agreed time. For the learners in schools, contact hours or school activities were not disrupted. Scheduling with the key informants and learners was sychronised with their schedules and the desire not to disrupt the daily functioning of the school's operation yet keeping to the timeframe of the research deadline posed as a limitation.

Another limitation in conducting the study during the period of COVID-19 was carrying out structured observations, interviews and focus group discussions with learners in the non-examination classes. The pupils were randomly selected and then through the teachers, the learners were identified, and the limitation was in finding the learners as attending school was in phases. Further, the process of collecting data took longer as this required to make second follow ups of students who were in non-examination classes since they were not in school during data collection. This also had a cost implication on the researcher.

Another limitation which affected the study was the issue of social/physical distancing which schools were not adhering to. Before data collection began in the selected schools, information was provided to the learners on the government's directive to wear protective face masks, use of hand sanitisers and frequent washing of hands with alcohol-based soap. This was to avoid community's perception that the researcher was not sensitive to the social and cultural norms in each location.

The other limitation that affected the study is the language. While the tools were in English, the questions were asked in local languages in some cases in order to effectively communicate and this to a certain extent, affected the originality of the questions in the tools as they required rephrasing and interpreting. The researcher however sought to work with local research assistants who were proficient in Bemba (Kabwe), Tonga (Choma) and Nyanja (Lusaka) respectively.

4.15 Summary of the Chapter

This section summarises the discussions of this chapter, the focus of which was the methodology employed in the study. Both qualitative and quantitative approaches, specifically ontological and epistemological were adopted for their appropriateness to the study of the phenomenon under investigation on examining the implementation of comprehensive Sexuality Education in selected primary schools. The approaches were selected for their appropriateness to collect in-depth information. This is because of naturalistic characteristics that enable one to collect data from participants in their natural environment in close proximity. To collect such data, the following methods were employed; lesson observation, interviews (focus group and in-depth interviews), and analysis of documents. Collecting the data through these methods called for a consideration of different measures to ensure their validity and reliability.

The instrument used in this research process is human and hence issues regarding researcher positionality have been discussed. This is important in order to minimise contaminating data. Therefore, my identity, beliefs, values, previous experiences related to the investigation, and motivation were declared to raise the reliability and validity of the findings. Further, collecting information from human participants in their natural settings raised ethical concerns. Effort was made to ensure that research ethics were adhered to

throughout the study to faithfully represent the respondents fairly. Collecting data can be an interesting activity. However, if they are not given meaning, they will not mean anything to a reader. It is an important phase in the process of research that needs to be handled well. To give meaning to data, thematic analysis was used to analyse both qualitative and quantitative data. This process included coding, categorising, and noting the emerging themes. This was possible through interacting with the data, examining the responses, and being able to identify the emerging themes. The next chapter is the presentation of findings for the quantitative data. This will include giving the studied a voice while adhering to the ethical concerns as outlined above.

Chapter Five: Presentation of Findings

5.0 Introduction

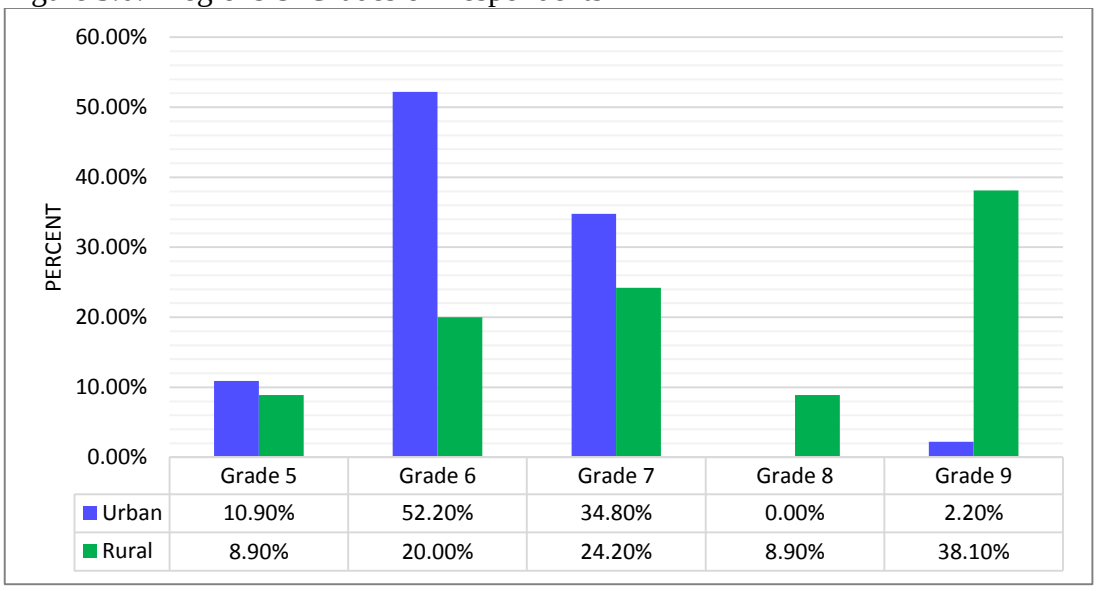
This chapter presents analysis of both qualitative and quantitative data generated in the study. The data is presented in textual and diagrammatic forms. Qualitative data includes verbatim narratives in appropriate sections. Quantitative data generated from questionnaires administered in the selected primary schools were analysed using Test Statistical Packages. Pearson's Chi-square and ANOVA methods were applied to test selected variables for a relationship and differences, where possible. The study aimed at examining the implementation of ASRH in 9 selected primary schools. It was conducted premised on the statement of the problem which argues that, although Comprehensive Sexuality Education (CSE) has been implemented since 2014, there had been notably insignificant progress in the intended outcomes by 2018. Thus, the study's objectives included establishing the implementation of CSE; reviewing the relationship between culture and CSE; examining the effect of CSE on the social-emotional development of adolescents; analysing how implementing CSE addresses SRGBV; and identifying sources of ASRHS for young people in primary schools.

The chapter is arranged thematically in line with the study objectives. Descriptive points are made for presented data. Demographic information is analysed at the start of the chapter to highlight characteristics of the population under study and create a context.

5.1 Demographic Information

(a) Regions and Grade of Respondents - In terms of rural and urban representation in this study, the findings demonstrate that 10.9% grade five, 52.2% grade six, 34.8% grade 7, and 2.2% grade nine in rural areas whereas there were 8.9% of grade five, 20% grade six, 24.2% grade seven, 8.9% grade eight and 38.1% grade nine in urban areas (figure 5.0). This demonstrates that there was representation across all the grade levels that integrate CSE from grade 5 through to 7 including grade 8 and 9. Some primary schools have learners up to grade 9. The integration of CSE commences in grade 5 through to grade 12.

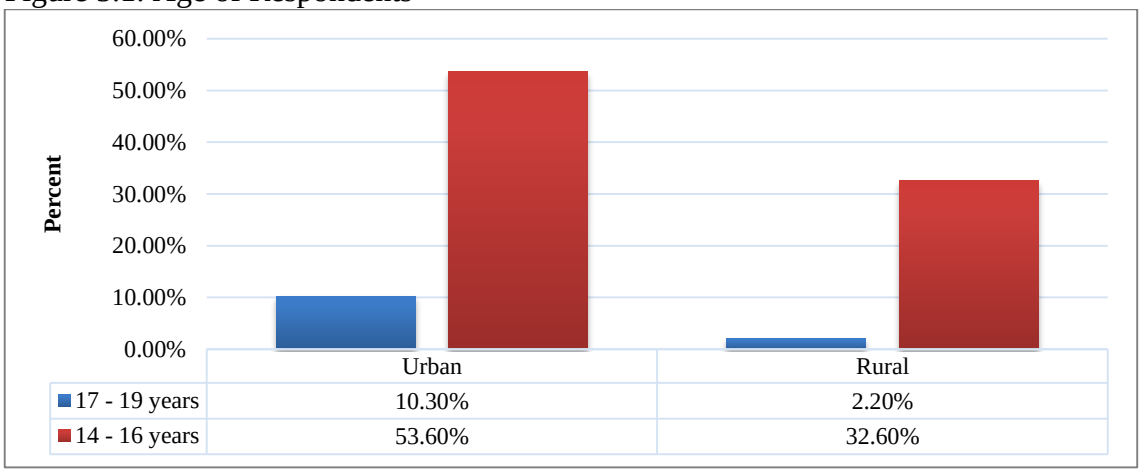
Figure 5.0: Regions & Grades of Respondents



Source: Author, 2020

(b) Age of Respondents – Figure 5.1 below reveals that more learners in the age bracket of 14-16 at 53% were coming from the urban set up whereas only 32% were coming from a rural set up. For the 17-19 years; 10.3% were coming from the urban set up whereas only 2.2% were coming from rural set up. This demonstrates that both rural and urban learners took part in the study although the figure demonstrates that there were more participants in urban areas compared to rural areas. CSE was rolled out to both urban and rural schools in Zambia (Ministry of Education).

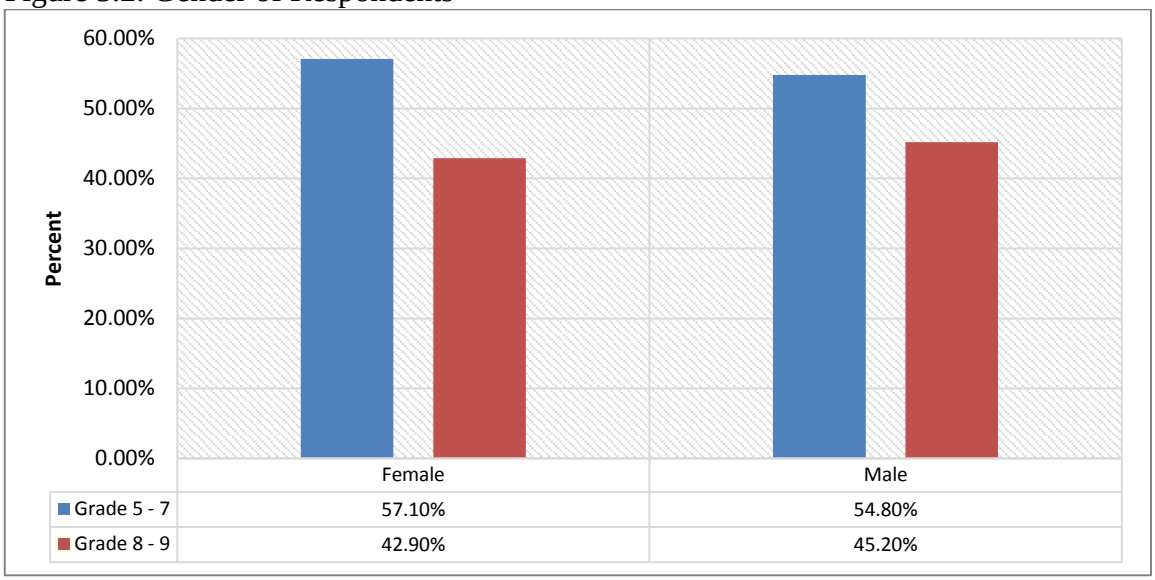
Figure 5.1: Age of Respondents



Source: Author, 2020

(c) Gender of Respondents – Figure 5.2 below indicates that there was a near balance between male learners and female learners in grades 5-7 and grades 8-9 giving 57.1% females and 42.9% male grades 5-7 learners whereas 54.8% were female learners and 45.2% males in grade 8-9 learners. This depicts a positive gender picture of the participants across all the three study sites of Kabwe, Choma and Lusaka.

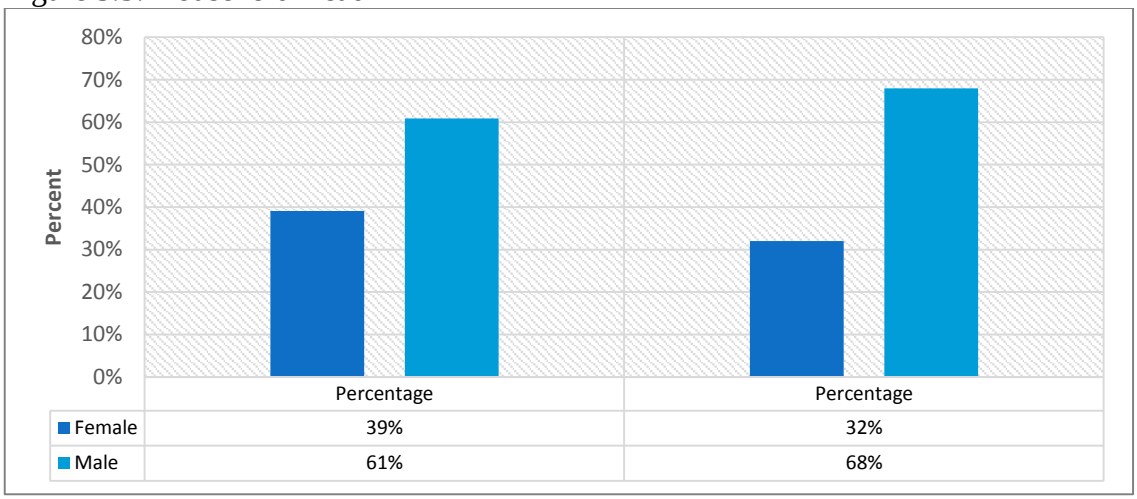
Figure 5.2: Gender of Respondents



Source: Author, 2020

(d) Household Head – Figure 5.3 below indicates that there were more males heading households at 67.6% compared to females at 32.4%. Further, there were more males in both rural and urban settings who reported living in households headed by males as opposed to females. This demonstrates that there are more males heading households than females. In terms of power dynamics, this shows that there are more men making decisions at home than women. This could have potential in form of power dynamics to affect the way girls decide about their sexuality. For example, it is very difficult for a girl to be in a relationship than a boy. A boy would do so with pride whereas a girl could not do so. Therefore, this could also mean sexuality issues are a preserve for the boys and not girls. This makes boys take decisions more than girls.

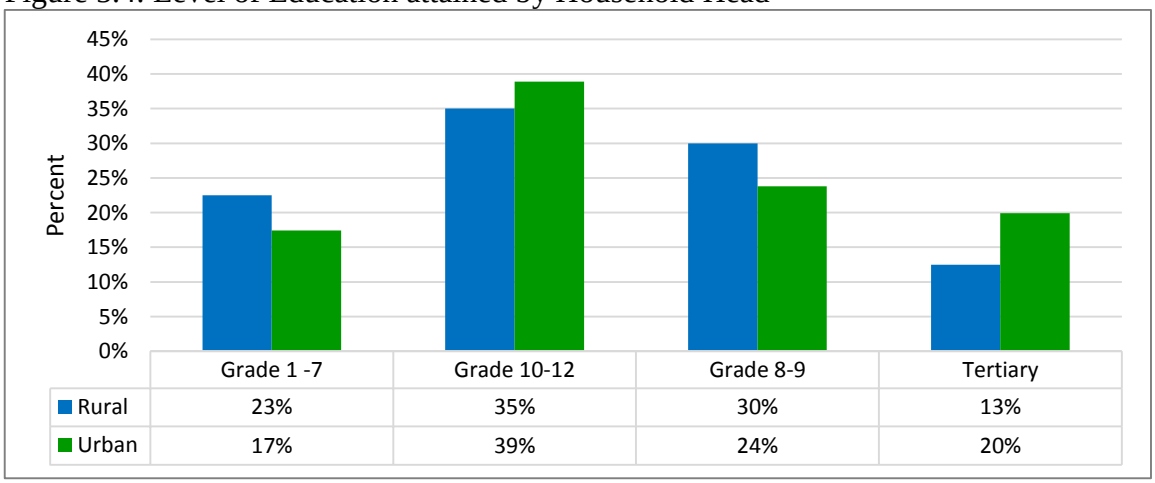
Figure 5.3: Household Head



Source: Author, 2020

(e) Education Level of Household Head – Figure 5.4 below indicates highest level of education attained is grade 10-12 at 35% in rural areas and 38% in urban areas. Grade 8-9 was second attainment at 30% in rural areas and 23.8% in urban areas. The study findings demonstrate that only 19.9% in urban areas attained tertiary education level whereas only 12.5% in rural areas attained tertiary education level. This shows that the participants were largely coming from households where economic opportunities are limited and subsequently pointing to the fact that they may not have adequate access to information on CSE and ASRH. This also demonstrates that the families maybe be largely conservative based on limited information on reproductive health.

Figure 5.4: Level of Education attained by Household Head



Source: Author, 2020

(f) Income Source of Household Head – Respondents were requested to indicate the multiple sources of income for heads of households. Table 5.0 below indicates the multiple scores for income sources for household heads of the 700 respondents. A majority score of 52.2% was that of work/employment followed by sale of crops at 25.0%, 14.6%-piece work and 13.9% sale of livestock. The source of income is limited and somewhat weak for most families. This demonstrates that access to economic opportunities is limited, thereby having influence in the way children perceive information on adolescent sexual reproductive health.

Table 5.0: Source of Income by head of household

Categories of sources of income	Kabwe	Choma	Lusaka	Overall
	%	%	%	%
Work	55.1%	48.2%	51.7%	52.2%
Sale of crops	32.5%	21.5%	16.1%	25.0%
Wage/salary	20.7%	13.6%	5.6%	14.6%
Piece work	16.1%	15.2%	8.9%	13.9%
Sale of livestock	19.7%	7.9%	6.7%	12.9%
Rentals	14.1%	7.3%	13.3%	12.0%
Petty trading	10.2%	5.8%	12.8%	9.6%
Retail trading	11.1%	6.8%	5.6%	8.4%
Sale of fish	10.2%	3.1%	5.0%	6.8%
Social cash transfer from GRZ/NGOs	7.5%	4.2%	4.4%	5.8%
Remittances	7.5%	3.7%	3.3%	5.3%
Other specify	0.0%	0.0%	0.6%	0.1%

Source: Author, 2020

5.2 Implementation of Comprehensive Sexuality Education (CSE) (Objective 1)

5.2.1 Factors associated with Implementation of CSE

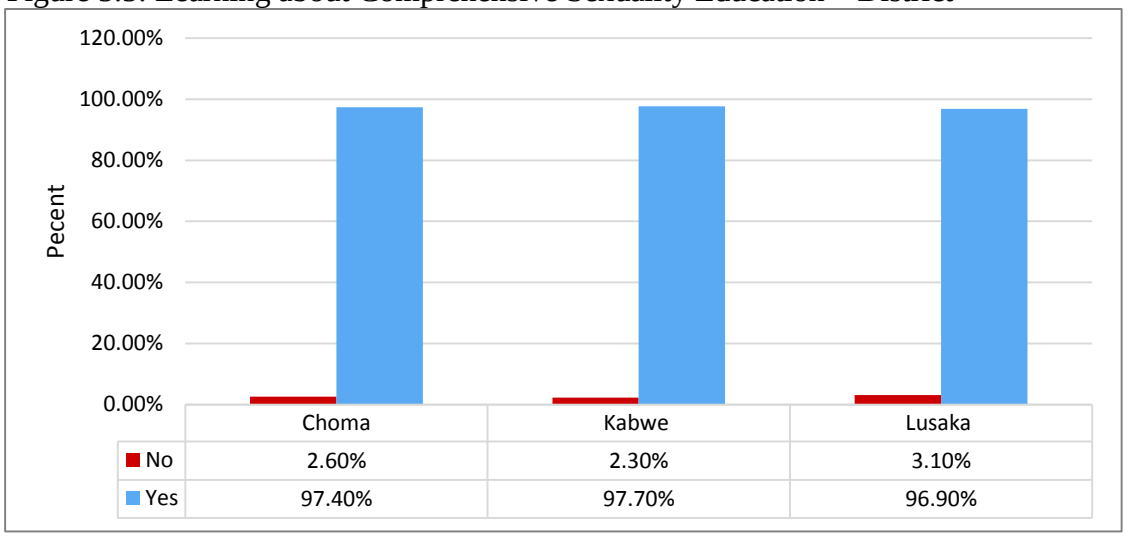
(a) Learning about Comprehensive Sexuality Education (CSE) – Figure 5.5 below indicates that young people are learning CSE with 97.4% in Choma saying yes and only 2.6% saying no, 97.7% saying yes in Kabwe and 2.3% saying no and 96.9% in Lusaka saying yes whereas only 3.1% said no. The urban and rural responses also show that learners in both

rural and urban areas are saying they are learning about CSE at 90.5% saying yes in rural areas against 9.5% saying no whereas 97.9 said yes in urban areas against 2.1% saying no. This was supported by the feedback from teachers' focus group in which a teacher in his own words said:

- *"Although I was not trained in CSE, I have access to the content because we were oriented. The orientation has helped me understand what CSE is all about and what it is not." ... T-SCPS - Choma,*

This confirms that CSE is being implemented especially among the teachers who were oriented through a cascade and or college hub models of implementation, respectively. In other words, if teachers are trained then learners are learning about CSE at school level.

Figure 5.5: Learning about Comprehensive Sexuality Education – District



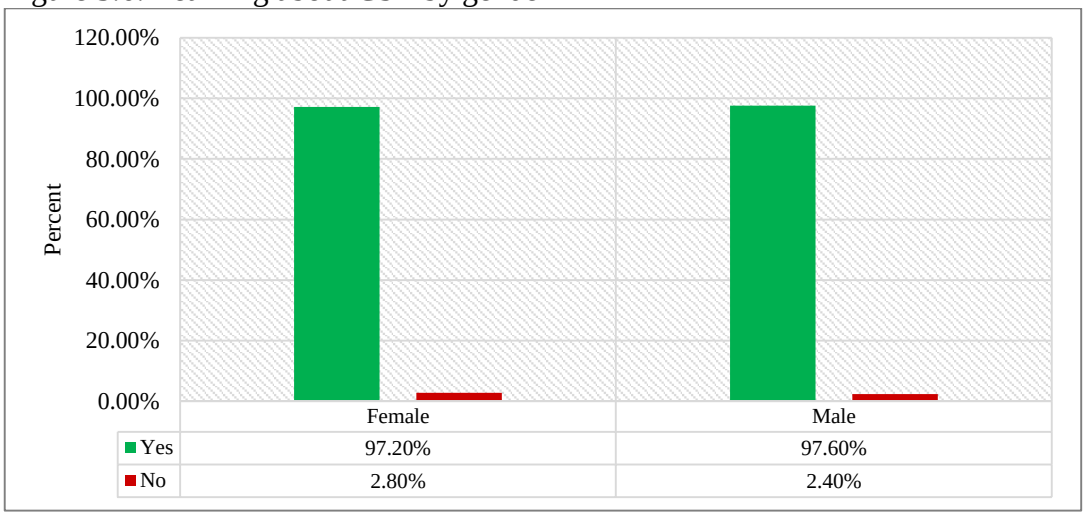
Source: Author, 2020

(b) Learning about CSE by Gender – Figure 5.6 below indicates below that both males and females were able to confirm that they are learning about CSE in schools at 97.6% (male) and 97.2 % (female). The number of those who said no is at 2.4 (males) and 2.8 (females). This is confirmed by the Ministry of Education CSE framework of 2014 which provides that CSE implementation starts from grade 5 to 12. Teachers receive training to be able to effectively deliver CSE at classroom level. However, the teaching of CSE has not been without challenges. These challenges are numerous, and some were recounted by teachers including lack of materials to support the effective delivery of CSE. In a teacher's own voice:

- "*After we received an orientation, I have been trying hard to ensure that I integrate CSE. However, I am having challenges in that I do not have*

materials like posters as teaching aids and books. There is need for more materials to help us teach effectively at school" ... TKPS4, Kabwe.

Figure 5.6: Learning about CSE by gender

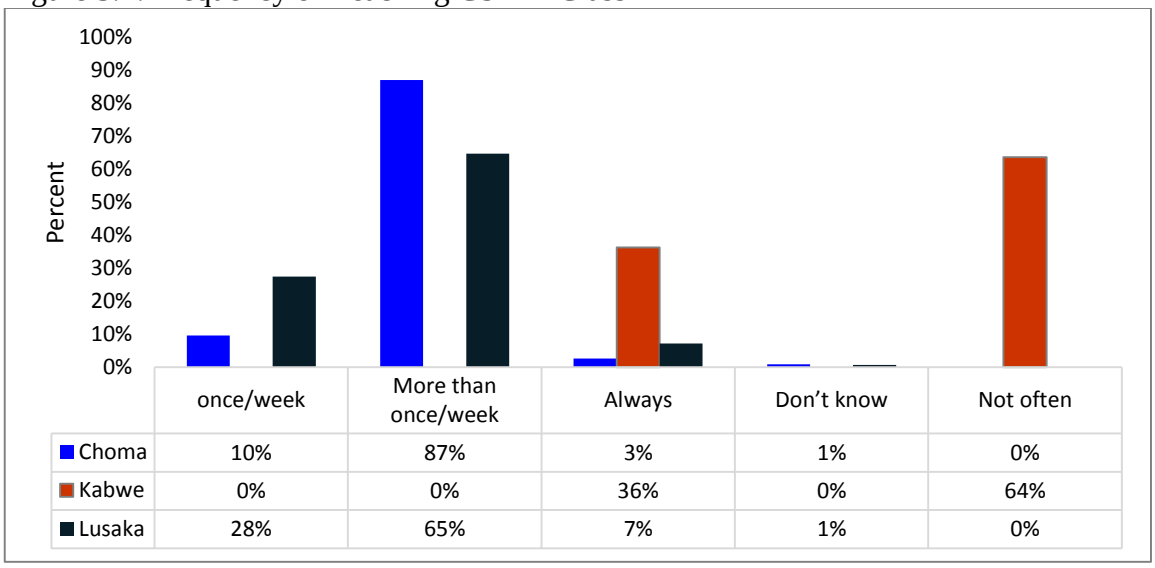


Source: Author, 2020

(c) Frequency of Teaching CSE in Class – Figure 5.7 below indicates that learners responded by saying they often learn about CSE at least more than once at 87% in Choma and 64.7% in Lusaka. There seems to have been a problem with understanding the question for respondents in Kabwe as most of them said they do not often learn about CSE at 63.7%. In a focus group discussion with teachers, this was clarified that since the term being used is 'integration', learners may not be aware that what they are learning is CSE because it is covered in carrier subjects. There is no subject known as CSE as it is infused in already existing subjects. Therefore, learners may not be aware about this technicality. However, the study established that the CSE integration takes place at least once per week. In a focus group discussion, a learner had this to say:

- *"…. we learn about puberty and our bodies once in a week" ... L-SPS, Choma.*

Figure 5.7: Frequency of Teaching CSE in Class



	once/week	More than once/week	Always	Don't know	Not often
Choma	10%	87%	3%	1%	0%
Kabwe	0%	0%	36%	0%	64%
Lusaka	28%	65%	7%	1%	0%

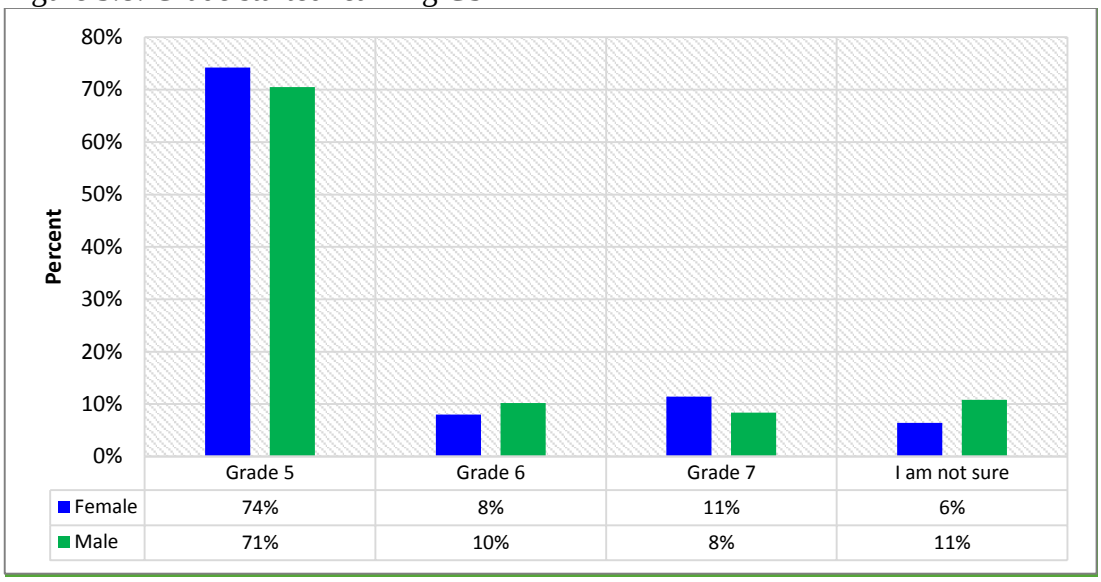
Source: Author, 2020

(d) Commencement of Learning CSE – Figure 5.8 below indicates that pupils start learning CSE in grade 5. Both male and female learners confirmed this at 74.2% (female), 70.5% (male). The CSE framework developed by the Ministry of Education guides that CSE teaching starts in grade 5. This is consistent with the framework and confirms what is happening at school level. There are other learners who said they started learning CSE in grade 6, 7 and indeed those not sure. However, the policy guideline is that CSE is taught from grade 5 to grade 12 in the Zambian School set up. In a learners' voice;

- *"... we started learning about our body changes in grade 5 and now I am in grade 7"... L-SPS Choma.*

While other pupils were able to confirm this, other learners could not demonstrate that they knew about CSE. This confirms that there are learners who still do not understand the CSE and what it stands for. This calls for more awareness and training in particular for teachers.

Figure 5.8: Grade started learning CSE



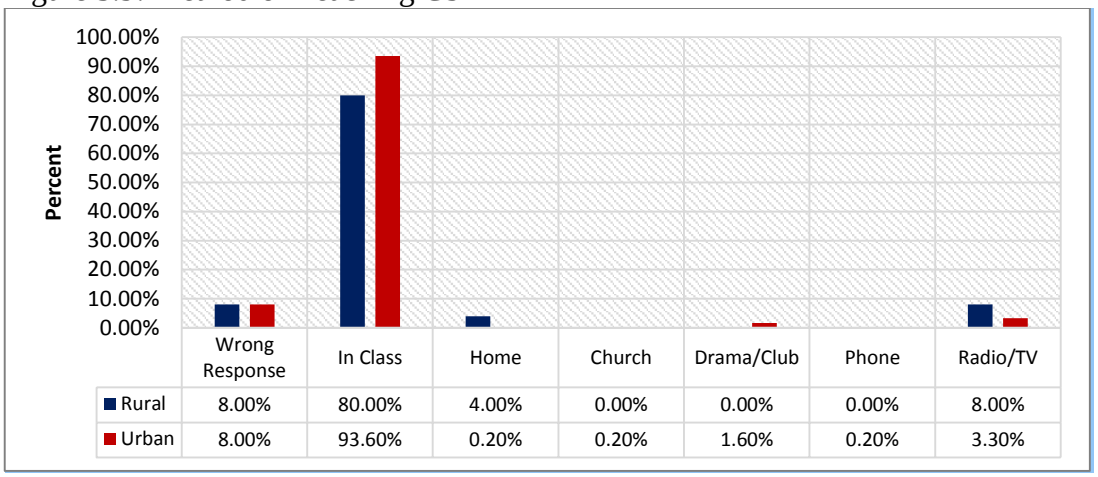
Source: Author, 2020

(e) Method of Teaching CSE – Figure 5.9 below demonstrates that 93.6% of learners in urban areas and 80% of learners in rural areas state that CSE is taught in the classes. CSE is not a standalone subject, but it is integrated in carrier subjects as provided for in the CSE framework. Although negligible, there are some who stated that they learn through churches, home, school dramas, radio and television. Teachers have been trained to teach CSE at classroom level. Previously teachers were trained through a cascade model and now they are being trained through colleges of education as hubs of teacher training. In a key Informant's voice, he had this to say:

- *"One of my teachers was invited to attend a CSE training workshop in Livingstone organised by UNESCO and Ministry of Education and since his return, he has reported to me and I have given him permission to orient other members of staff including conducting lesson demonstrations in teacher group meetings." ... KI, SCPS, Choma.*

This confirms that CSE is being taught in schools especially among those teachers who have been trained.

Figure 5.9: Method of Teaching CSE

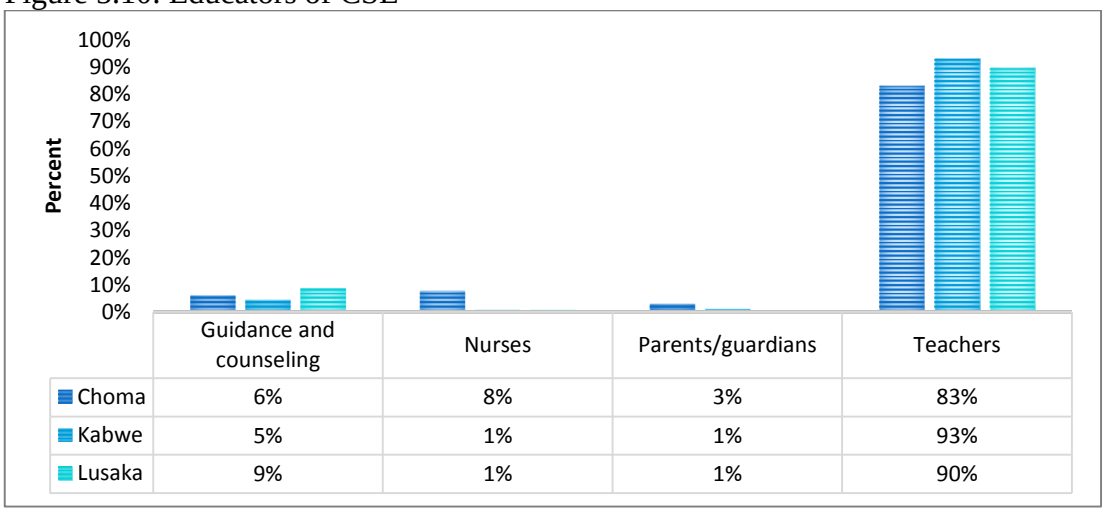


	Wrong Response	In Class	Home	Church	Drama/Club	Phone	Radio/TV
Rural	8.00%	80.00%	4.00%	0.00%	0.00%	0.00%	8.00%
Urban	8.00%	93.60%	0.20%	0.20%	1.60%	0.20%	3.30%

Source: Author, 2020

(f) Educators of CSE – Figure 5.10 below indicates educators of CSE with teachers at 82.9% (Choma), 93% (Kabwe) and 89.5% (Lusaka). This implies that learners know whose responsibility it is to teach CSE. However, CSE is also being taught informally through guidance teachers, nurses, and parents/guardians. While learners were this direct in their response, others still felt nurses, guidance teachers and parents make good teachers and sources of their information. This implies issues of CSE remain a challenge for many and not only young people. As has been observed, parents remain the least ranked implying that there is no interaction regarding issues of CSE and Sexual Reproductive Health between children and parents although parent child communication is one of the key elements of a good CSE programme.

Figure 5.10: Educators of CSE



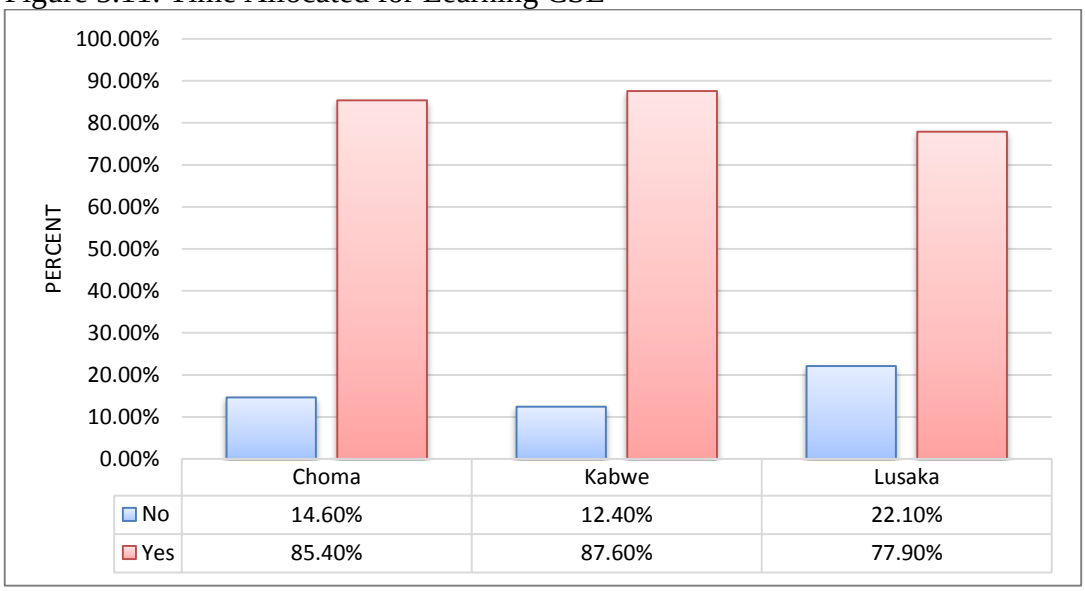
	Guidance and counseling	Nurses	Parents/guardians	Teachers
Choma	6%	8%	3%	83%
Kabwe	5%	1%	1%	93%
Lusaka	9%	1%	1%	90%

Source: Author, 2020

(g) Time Allocation for Learning CSE - Generally, across all the study sites, learner responses were that the time allocated for CSE is adequate at 77.9% affirming in Lusaka while 22.1% objecting, 87.6% in Kabwe affirmed whereas 12.4% objected and finally 85.4% in Choma affirmed and only 14.6% objected (see figure 5.11). The variation in responses demonstrates that learners feel the time allocated to learn CSE is adequate while others feel it is not. In Lusaka, for example, the percentage was higher for those objecting to adequacy of time. This confirms that there are young people who would wish to have much time allocated to learning CSE as they have a lot of questions especially around reproduction and puberty as some of the most popular topics. In a pupils' own voice:

- *"…. the time to learn CSE is too short and is within a period or two per week. We need more time to ask many questions about growing up, puberty and how to prevent pregnancies" – L – KPS , Kabwe*

Figure 5.11: Time Allocated for Learning CSE



Source: Author, 2020

(h) Dominant Topics in CSE – Table 5.1 below indicates that all topics in CSE as outlined in the framework are being taught. Respondents were requested to make multiple choices on topics that were dominantly being taught in CSE in their classes. The multiple scores in Table 5.1 below indicates that most taught topics include puberty at 81.3% (Kabwe) 48.9% (Choma) and 76.1% (Lusaka) whereas reproduction is at 68.5% Lusaka, 51.6% (Kabwe) and a 14.3% (Choma) and HIV and AIDS at 56% (Lusaka), 0.8% (Choma) and 0.3% (Kabwe), respectively. While there is a wide range of topics in CSE, only puberty, reproduction and HIV are prominently being taught. However, one of the major pillars of

CSE is hygiene, respectful relationships and GBV. Teachers, through a focus group discussion, also reviewed that they only teach what they feel they know better and they have supporting materials like books. In a teachers' voice:

- "*…I have a huge teaching workload in science, and I teach exam classes as well. I don't think I have the time to spend on CSE with the COVID-19 that has already taken away the time to teach"… T-SCS 1, Choma*

This demonstrates that teachers do not understand that CSE is policy and that it should be implemented at school level. This is more reason some teachers regard it as optional and as when they have time to teach it.

Table 5.1: Dominant Topics in Comprehensive Sexuality Education (CSE)

	Kabwe	Lusaka	Choma	Overall
	%	%	%	%
Puberty	81.3%	76.1%	48.9%	72.6%
Reproduction	51.6%	68.5%	14.3%	48.5%
HIV/AIDS	0.3%	56.0%	0.8%	17.3%
Family	0.7%	41.3%	8.3%	14.7%
Hygiene	0.3%	32.1%	20.3%	14.4%
Relationships	12.8%	7.1%	11.3%	10.7%
Not sure	5.9%	4.3%	29.3%	10.6%
Wrong Response	6.2%	10.3%	18.8%	10.2%
Abuse	6.2%	0.5%	0.8%	3.3%
Culture	2.8%	1.6%	0.0%	1.8%
Subjects covering CSE	1.7%	0.0%	7.5%	2.5%
Body Changes	0.0%	0.0%	5.3%	1.2%
Early Marriages	1.0%	0.0%	0.0%	0.5%
GBV	0.7%	0.0%	0.8%	0.5%

Source: Author, 2020

(i) Learners' Preferred CSE Topics – Further enquiry was made on the learners' preferred CSE topics. Respondents were again requested to make multiple choices of preference of the topics. Table 5.2 below indicates the multiple scores with the most preferred topics being puberty (54.2%) and reproduction (39.8%). However, key topics like culture, early

marriages and hygiene are seemingly not preferred by learners. On further enquiry during focus group discussions, it was indicated that these are traditional matters where it is not common for a male or female teacher to discuss menstrual hygiene. Generally, this is known as a preserve of aunties and grandmothers in society to handle.

Table 5.2: Learners' Preferred CSE Topics

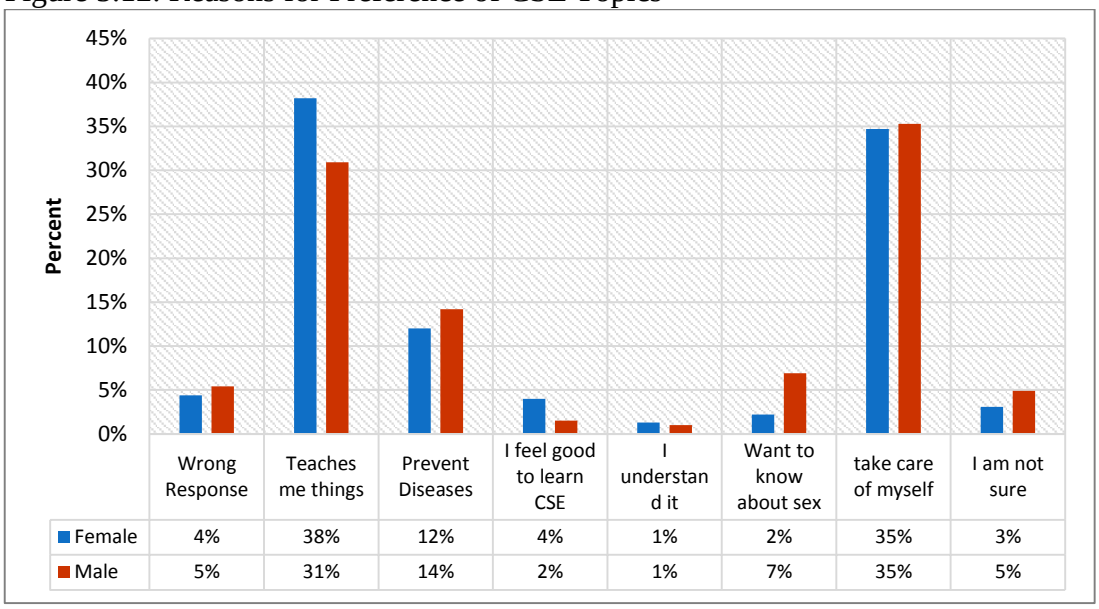
	Kabwe	Lusaka	Choma	Overall
	%	%	%	%
Puberty	60.7%	59.6%	25.5%	54.2%
Reproduction	31.8%	65.6%	14.3%	39.8%
Wrong Response	7.5%	7.1%	18.4%	9.3%
Not sure	8.6%	4.9%	42.9%	13.4%
HIV/AIDS	0.0%	31.1%	0.0%	10.2%
Family	0.7%	18.6%	8.2%	7.8%
Hygiene	0.4%	19.7%	0.0%	6.6%
Relationships	3.9%	3.3%	2.0%	3.4%
Subjects covering CSE	1.1%	3.8%	8.2%	3.2%
Abuse	2.1%	0.0%	0.0%	1.1%
Body Changes	0.0%	0.0%	6.1%	1.1%
Culture	1.4%	1.1%	0.0%	1.1%
GBV	0.7%	0.0%	2.0%	0.7%
Early Marriages	0.4%	0.0%	0.0%	0.2%

Source: Author, 2020

(j) Reasons for Preference of CSE Topics - Learners variedly provided responses to this question (figure 5.12). 48.60% and 37.20% said they like CSE because it teaches them things, they did not know. Others at 35% (female) and 25% male said CSE teaches them to take care of themselves including prevention of diseases at 12% (female) and 14% (male). The qualitative responses as can be seen from the graph were varied. While others said CSE helps them to learn about things that include their bodies and menstrual hygiene, others just said they like CSE as it makes them feel good. Generally, issues of sexuality generate interest even among adults themselves. Therefore, this may not just be a subjective

feeling but something that is inherent in every human being through lived experiences of childhood.

Figure 5.12: Reasons for Preference of CSE Topics



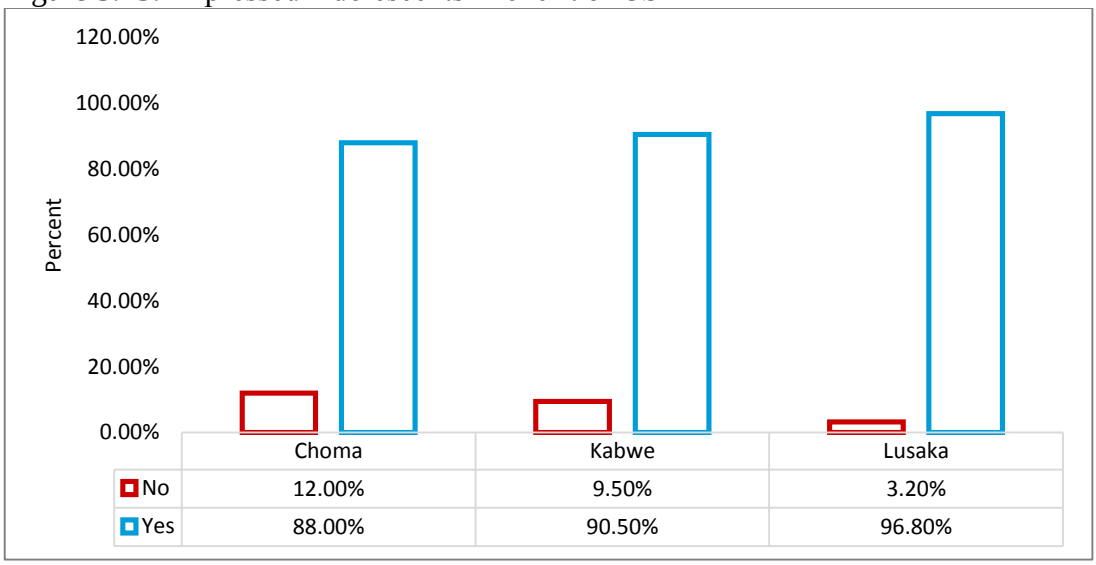
Source: Author, 2020

(k) Expressed Adolescents' Benefit of CSE - Figure 5.13 below above indicates that most young people in Choma, Kabwe and Lusaka acknowledged that CSE had benefited them. Learners in Choma said CSE had benefited them with 88% affirming and only 12% objecting, 90.5% in Kabwe affirmed and only 9.5% objected. In Lusaka, 96.8% affirmed while only 3.2% objected. This confirms that young people know the benefits of CSE as seen in the statement from one of them:

- "… *"We learn a lot of things in CSE including family, relationships and that you can come back to school after falling pregnant although it's embarrassing somehow to have a baby when you are a pupil…" L- NPS, Lusaka.*

FGDs also revealed the issue of the reentry policy as attested by the learner's voice. The *Ministry of Education Statistical Bulletin* of 2016 demonstrates that there was a reduction in the number of teenage pregnancies of up to 1,600 in one year between 2016 and 2017. This confirms that CSE has benefited learners to appreciate what they learn either through formal settings like classrooms and/or informal.

Figure 5.13: Expressed Adolescents' Benefit of CSE



Source: Author, 2020

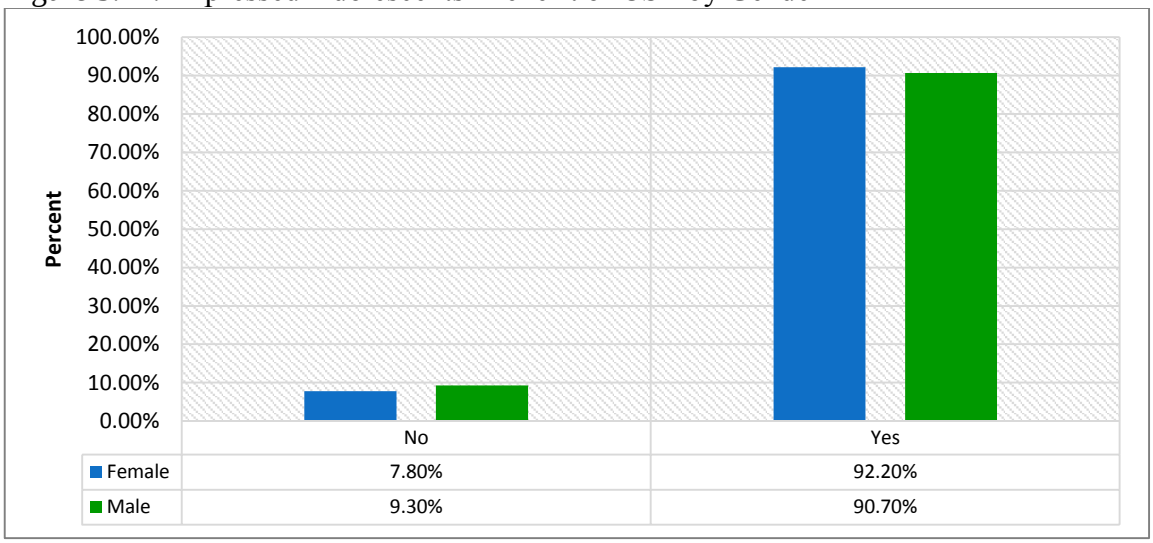
(l) Expressed Adolescents' Benefit of CSE by Gender - When checked on gender basis, the evidence shows that both males and females confirm that CSE has helped them as adolescents (figure 5.14). 92.2% (Females) and 90.7% (males) indicated that CSE has helped them in different ways. Through a Teachers Focus Group discussion, it was clear that learners have benefited from CSE. In a teacher's own voice, this is what was stated:

- "*The rate for teenage pregnancy in this school has gone down because of the sessions we give our learners in CSE. For example, there was no pregnancy case in 2020 while we had 1 case in 2019, we have had more than 4 to 5 cases in 2017 and 2018 respectively"- Teacher-Focus Group Participant, Kabwe.*

This demonstrates that CSE is being taught and learners are benefiting from it.

The presentation of the quantitative and qualitative data has both supported each other in providing evidence that CSE is being delivered at school level, learners are accessing it and it has benefits including improving health outcomes. However, the challenge remains, the insignificant progress in terms of expected impact which is not yielding on the ground to the expected scale.

Figure 5.14: Expressed Adolescents' Benefit of CSE by Gender



Source: Author 2020

5.2.2 Challenges in Implementation CSE

The study has established several challenges in implementing CSE and these challenges include, among others: -

Inadequate teaching and learning materials

Lack of adequate materials to teach and learn CSE at school levels. Teachers who have received training are willing to integrate CSE but the majority lack adequate support to effectively deliver good lessons. In a focus group participant's own words, had this to say:

- *"... I have been oriented in CSE but the challenge is we don't have materials to use as text books, we just use the usual science books which do not have some of the content in CSE..." Teacher FGD members, Choma*

Religious Indoctrination

The other challenge is that which deals with heavy religious indoctrination in which teachers are having challenges to reconcile their beliefs with the need to implement government policy of integrating CSE. The demands of their faith dictate that you cannot talk about topics thought to be explicit t especially if you are also a lay leader in the church as that would compromise on the values they espouse. This is already a conflict which requires a deliberate approach to resolve or it affects the delivery of CSE. In a teacher's own words, this was stated

- *"… I find the teaching of CSE very difficult as I am a church leader besides my teaching job. If this minute I am teaching CSE which mentions heavy names of private parts, the other time I am preaching in church, this is compromising my values"… Teacher FGD member, Kabwe*

Low impact of the Programme

It also remains a challenge that despite the heavy investments in terms of resources into the implementation of CSE, the low impact remains characteristic of the programme. For example, there is consistently a very high number of female learners who drop out of school due to teenage pregnancy, many teenage girls go into early marriages at the expense of their ambition for a better future. Their prospects are curtailed, and these become part of the poor with little access to economic opportunities.

Culture and its influence

Culture is another stumbling block in the success of CSE. The custodians of culture who are also traditional and religious leaders perceive CSE as inappropriate for young people. However, there are also many religious and traditional leaders who perceive CSE as appropriate. It is this constant friction which poses a challenge and a threat to the future implementation of CSE in Zambia. Recently, Zambia witnessed an aggressive campaign against the implementation of CSE. Without careful consideration by the Ministry of Education, CSE would have come to an end. Thus, religion and culture can have serious influence if not well managed as seen in the extract below.

- *"… For as long as we keep leaving traditional and religious, behind, the challenge of the opposition to CSE will persist…" KI, MoE Headquarters.*

Neglecting Gender Based Violence content

While the study established that CSE components are being taught, it was also observed that key components of CSE that include Gender Based violence are being neglected in the

content and this leaves young people vulnerable to the effects of violence especially at school, on the way to and from school. In a pupils' own words, this is what they had to say:

- *"… Big boys take away my food and money every day on the way to school but I fear to report…" Learner, CPS, Choma.*

The statement above confirms the challenge that bullying, although not much, still takes place within and in surrounding areas of the schools. Therefore, this remains a concern in the implementation of CSE in schools.

Incomprehensive Service Delivery

A lack of comprehensive SRH services on offer and in cases where they exist, the services offered are unfriendly to young people who in turn shun them.

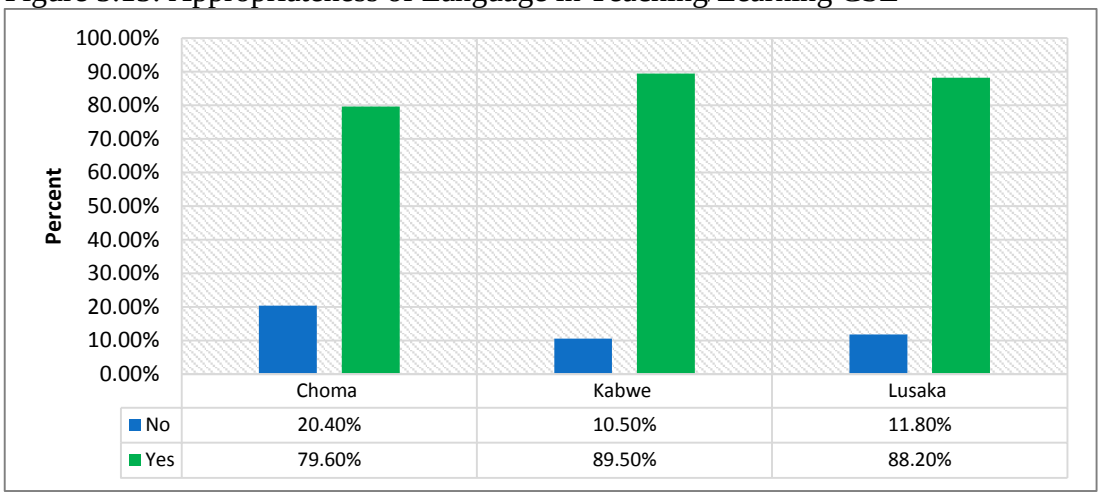
5.3 Relationship between Culture and Comprehensive Sexuality Education (Objective 2)

(a) Appropriateness of Language in Teaching/Learning CSE - The initial enquiry on culture and CSE focused on language appropriateness in the teaching and learning of CSE. Figure 5.15 below indicates that learners in Choma stated that CSE is appropriate with language at 79.6% whereas only 20.4% said CSE is inappropriate with language. In Kabwe, 89.5% said it is appropriate and only 10.5% said it is not. Lusaka had 88.2% responding that it is appropriate while only 11.8% said it is not. These findings imply that, majority of learners affirmed the appropriateness of language used in teaching CSE. In other ways, despite Zambia being a conservative society, at least the majority of the respondents among young people in this case were agreeable that CSE was appropriate with language. However, during a focus group discussion, it was observed that there were still issues that require opening up to. For example, learners were not able to openly discuss puberty even among girls. This was prominent in Choma urban and rural schools. Learners were generally shy to speak on any CSE issues especially if it touched on the sexuality aspect of their society. This was also confirmed by a Teachers Focus Group where a teacher said in own words:

- *"….as a church leader myself, I find it difficult to teach the children explicit things such as sexuality and tomorrow they come to my church*

to hear me teach against such. This contradicts my personal and religious values…" FGD teacher member, Choma.

Figure 5.15: Appropriateness of Language in Teaching/Learning CSE



Source: Author, 2020

(b) Appropriateness of Topics in CSE with Religion - Figure 5.16 below indicate that learners in Choma (79.4%) affirmed that topics in CSE were appropriate with religion with only 20.6% objecting. In Kabwe, 58.2% learners affirmed while 41.8% objected to appropriateness of CSE topics to religion. For Lusaka, 56.5% affirmed while 43.5% objected. The high proportion of objections in Lusaka and Kabwe raises concern for the study. The young people's responses to a certain extent demonstrate that issues of CSE remain widely misunderstood by communities. Religion equally plays a part in painting a grey picture of a concept so well intended for the welfare of the young people. In a teacher focus group discussion, one teacher in her own words had this to say:

- *"I am a pastor's wife (bana Shimapepo) and talking about the vagina and penis before the children who also attend church with me is not easy and somewhat compromising on my personal values, I would rather speak abstinence and the word of God to them" FGD Teacher Participant, Kabwe.*

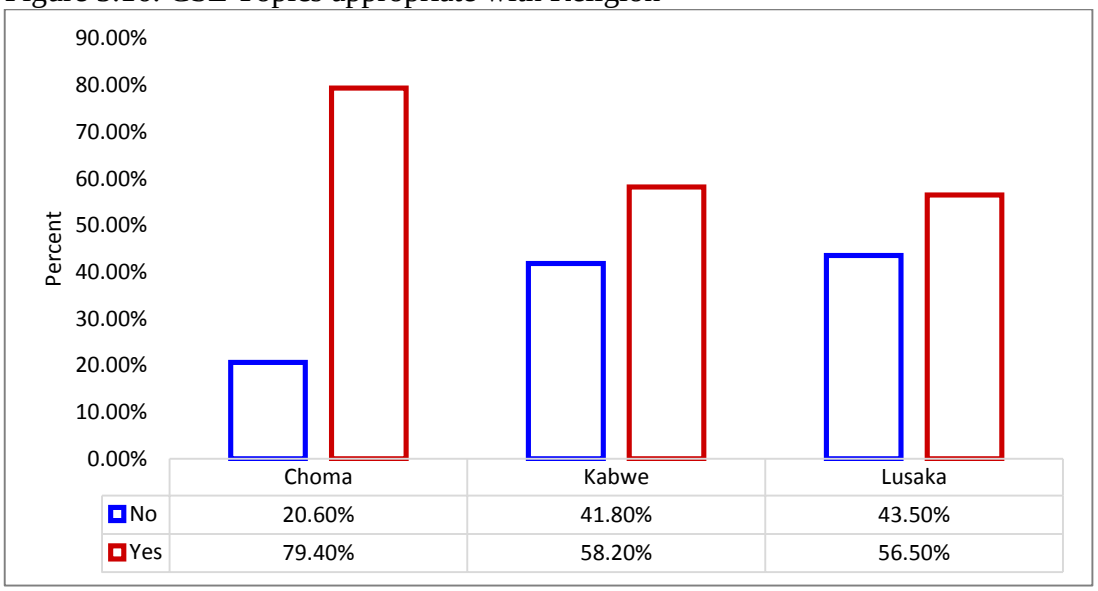
The study also found out that teachers hold a view that CSE is contributing to the moral decay among the young people. For example, in a focus group discussion, teachers argued that CSE is sexualizing learners as it is awakening sexual and erotic minds children do not yet have. The teacher stated that:

- *"CSE is contributing to moral decay among learners because after learning about sexuality, they develop ideas to begin to engage in sexual intercourse with boys…" Teacher FGD participant- Choma.*

While this was coming from a teacher, it can also be stated that it was an overstatement, not based on facts but opinions of the teachers who are also members of the community. However, religion appears to remain a big factor in the implementation of CSE. For example, a teacher in Lusaka had this to say:

- *"Unless religious and traditional leaders are involved in ensuring that CSE is supported, it will keep facing opposition at school level as they have influence in what goes on in school" … Teacher FGD Participants - Choma.*

Figure 5.16: CSE Topics appropriate with Religion



Source: Author, 2020

An enquiry was further made on identifying specific topics in CSE which were inappropriate with religion. Respondents were requested to make multiple choices on topics they thought were inappropriate with religion. Table 5.3 below indicated multiple scores with topics such as puberty and reproduction (50.2%) and puberty (24.5%) not being appropriate with religion. There were relatively higher scores in Kabwe at 53.80% and 35.60% as well as in Lusaka at 64.90% and 14.40%, respectively. It is not clear why the scores on topics that are inappropriate were high in Lusaka and Kabwe when these are cosmopolitan environments and not rural areas where people hold religious beliefs so close to themselves. On the contrary, some teachers indicated that most topics were appropriate

with religion. All this depended on the language the teachers use. For example, using a local language to teach body parts would not be appropriate for many people with their religious beliefs as doing so would be resisted. A participant teacher stated that:

- *"Unless religious and traditional leaders are involved in ensuring that CSE is supported, it will keep facing opposition at school level as they have influence in what goes on in school***" …** *Teacher FGD Participant -Choma.*

Table 5.3: Topics not appropriate with religion

Description	Kabwe	Lusaka	Choma	Overall
	%	%	%	%
Reproduction	53.8%	64.9%	12.1%	50.2%
Puberty	35.6%	14.4%	13.2%	24.5%
Not sure	13.0%	14.4%	64.8%	22.6%
Wrong Response	11.5%	12.1%	9.9%	11.4%
HIV/AIDS	0.0%	28.2%	0.0%	9.5%
Family	0.0%	10.3%	6.6%	4.6%
Hygiene	0.0%	9.2%	1.1%	3.3%
Relationships	2.0%	2.3%	2.2%	2.1%
Subjects covering CSE	1.6%	2.9%	1.1%	1.9%
Abuse	1.6%	0.0%	0.0%	0.8%
Body Changes	0.0%	0.6%	1.1%	0.4%
Culture	0.8%	0.6%	2.2%	1.0%

Source: Author, 2020

(c) Appropriateness of CSE Topics with Culture - Figure 5.17 below indicates that learners in Choma felt that the topics were a taboo at 53.8% and only 24.1% saying not a taboo. In Kabwe, 34.7% learners said CSE was a taboo whereas 43.7% said CSE was not a taboo and 21.7% said they did not know. Equally Lusaka scored 36.3% with learners indicating that it was a taboo, 40.7% said CSE was a taboo and 23.1% said they do not know. The findings demonstrate that CSE is not a taboo and if well explained by trained teachers, chances of a higher success are very promising.

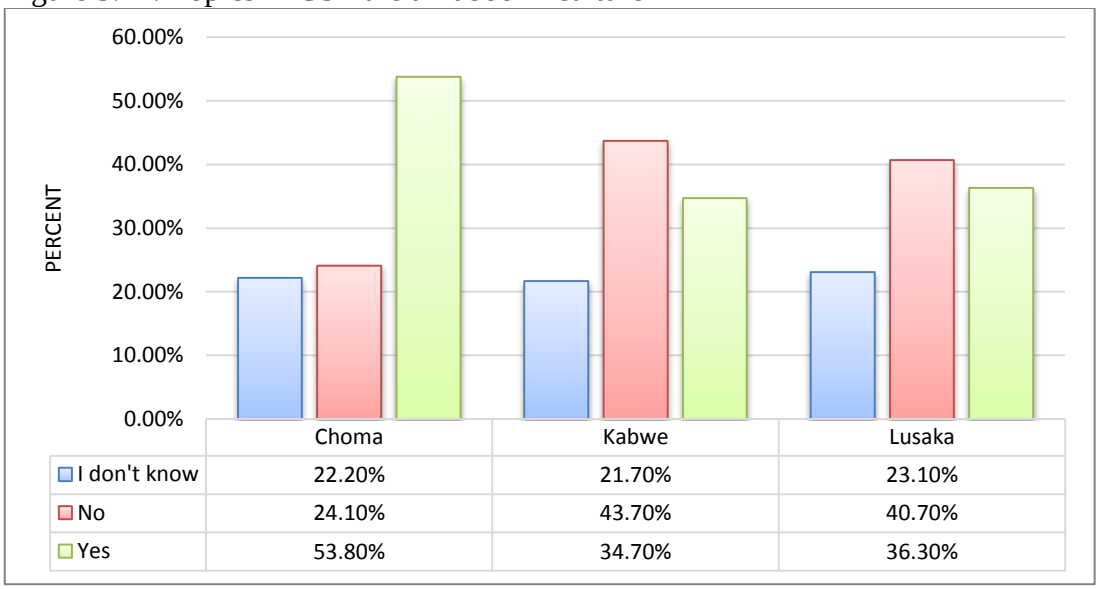
A further enquiry was made to identify which CSE topics were not a taboo for culture. Respondents were requested to make multiple choices on topics they considered not a taboo. Table 5.4 below indicates multiple scores of topics in CSE which were not viewed as a taboo. As can be noted, topics like puberty are still not viewed as taboo as well as culture and relationships including HIV. The challenge is the social construct developed by society. What society considers a taboo is usually designed by the community itself. Thus, the work of CSE should also aim at deconstructing these perceptions that are affecting the welfare of young people.

Table 5.4: Topics not a Taboo in Culture

Description	Kabwe	Lusaka	Choma	Overall
	%	%	%	%
Reproduction	41.2%	41.3%	2.9%	33.6%
Wrong Response	18.9%	40.8%	47.1%	32.2%
Not sure	17.1%	8.9%	37.3%	18.3%
Puberty	20.2%	6.7%	8.8%	13.2%
HIV/AIDS	0.0%	18.4%	0.0%	6.5%
Family	0.4%	5.6%	1.0%	2.4%
Relationships	8.8%	0.0%	2.0%	4.3%
Culture	6.1%	0.0%	0.0%	2.8%
Hygiene	0.0%	6.1%	0.0%	2.2%
Abuse	0.4%	0.0%	0.0%	0.2%
Body Changes	0.4%	0.6%	2.0%	0.8%
Subjects covering CSE	0.0%	0.0%	3.9%	0.8%
GBV	0.0%	0.0%	1.0%	0.2%

Source: Author, 2020

Figure 5.17: Topics in CSE are a Taboo in culture



	Choma	Kabwe	Lusaka
I don't know	22.20%	21.70%	23.10%
No	24.10%	43.70%	40.70%
Yes	53.80%	34.70%	36.30%

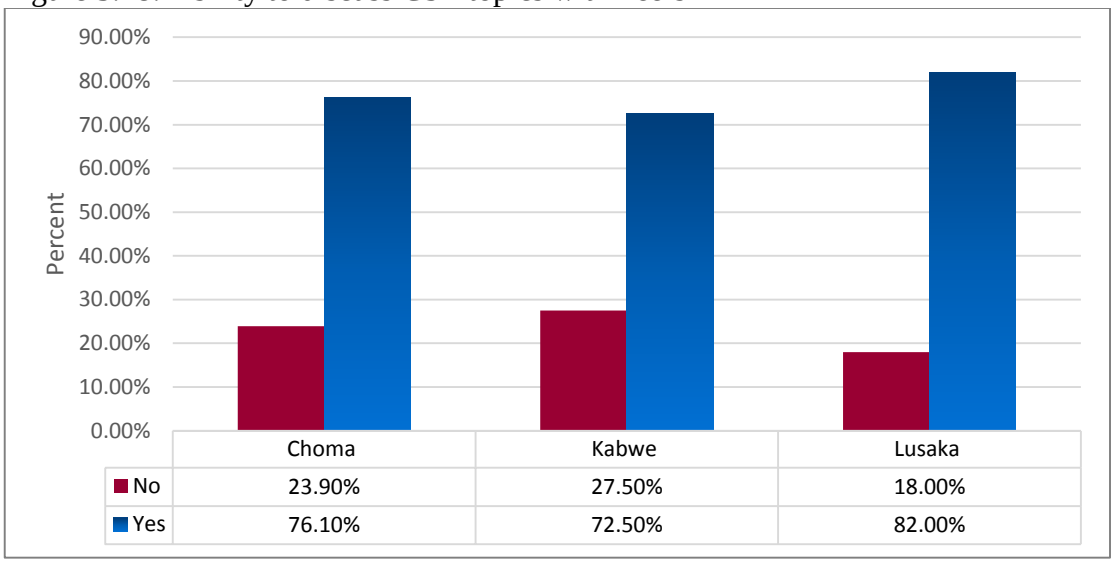
Source: Author, 2020

(d) Ability to Discuss CSE Topics with Peers - Figure 5.18 below indicates that learners can discuss CSE topics with peers with 76.1% of learners in Choma affirming, and 23.9% objecting. In Kabwe, 72.5% affirmed that they can discuss CSE freely with their peers whereas 82% of respondents in Lusaka affirmed they are able to discuss CSE freely with their peers and only 18% objected. The findings on this study demonstrate that peers are able to discuss CSE with their colleagues. Although this is so, there is no indication that learning about CSE gives young people ability to talk about it and neither the opposite is true. Most learners become confident to openly talk about CSE and not necessarily that they learnt it in school. In a learner's own words:

- *"…I learnt about CSE from the youth group in my community and since then, I am still supporting it by openly speaking about it where I have a chance… L- CPS, Choma.*

Therefore, this confirms that learners can talk about CSE freely no matter how much silence and shame it may be seen to carry to talk openly about some topics like menstrual hygiene. However, there are some learners who are still not able to talk about CSE freely.

Figure 5.18: Ability to discuss CSE topics with Peers



Source: Author, 2020

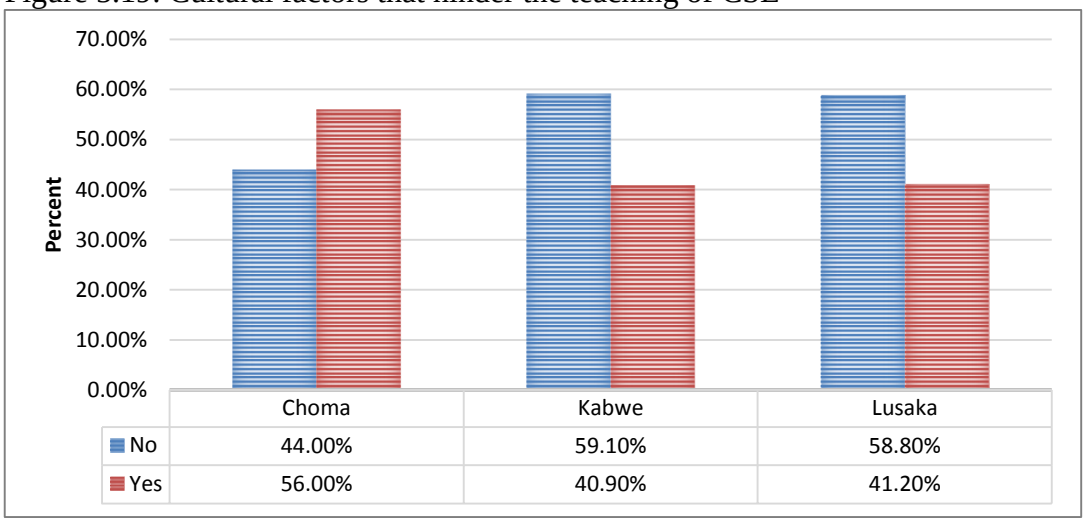
(e) Factors Hindering Delivery of CSE in Schools – The study enquired into factors that could be hindering the delivery of CSE in schools. Cultural and religious factors were the focus of the enquiry.

The findings indicated that 56% of learners in Choma affirmed that there were cultural factors that hindered the teaching of CSE whereas 44% of learners objected that there were no cultural factors that hindered the teaching of CSE (figure 5.19). In Kabwe, 40.9% respondents affirmed that there were cultural factors that affected the teaching of CSE whereas 59.1% of respondents objected that there were no cultural factors. For Lusaka, 41.2% of respondents affirmed that there were cultural factors whereas 58.8% objected that there were no cultural factors affecting the teaching of CSE. Through a focus group discussion with teachers, the researcher established that there were cultural factors that play a part in hindering the openness learners or teachers should have regarding the teaching of CSE. For example, female learners rarely asked and or answered questions. This is why some focus groups were designed to be for female learners only so that issues of cultural sensitivities could be handled independently. Even with that, some girls remained silent. In a teachers' own words, this is what was said:

- *"I find it very difficult to explain the concept of pregnancy to my learners since one of the pupils is my daughter… Teacher, FGD participant, Kabwe.*

The statement points to a deeply entrenched cultural issue around the matters of sexuality. It is also important to note that, the study established that males, all the time, are able to dominate the issue of sexuality both among the young and the old. This was prominent through the teachers and learners focus group meetings.

Figure 5.19: Cultural factors that hinder the teaching of CSE



Source: Author, 2020

Religious factors were also alluded to by respondents as a hindrance in the delivery of CSE. Figure 5.20 below indicates that 59.5% (Choma), 38.1% (Lusaka) and 37.5% (Kabwe) affirmed religious factors as a hindrance in delivery of CSE. Inversely, 62.5% (Kabwe, 61.9% (Lusaka) and 40.5% (Choma) objected to religious factors being a hindrance to the teaching of CSE in schools. The findings show that the 'Yes' was strong in Choma whereas the 'No' was strong in Kabwe. The study further established that the community around some schools in Choma was very religious hence the strong opinions against CSE. This contributed to sustained criticism because some teachers were members of different churches. Through a focus group discussion, a teacher had this to say:

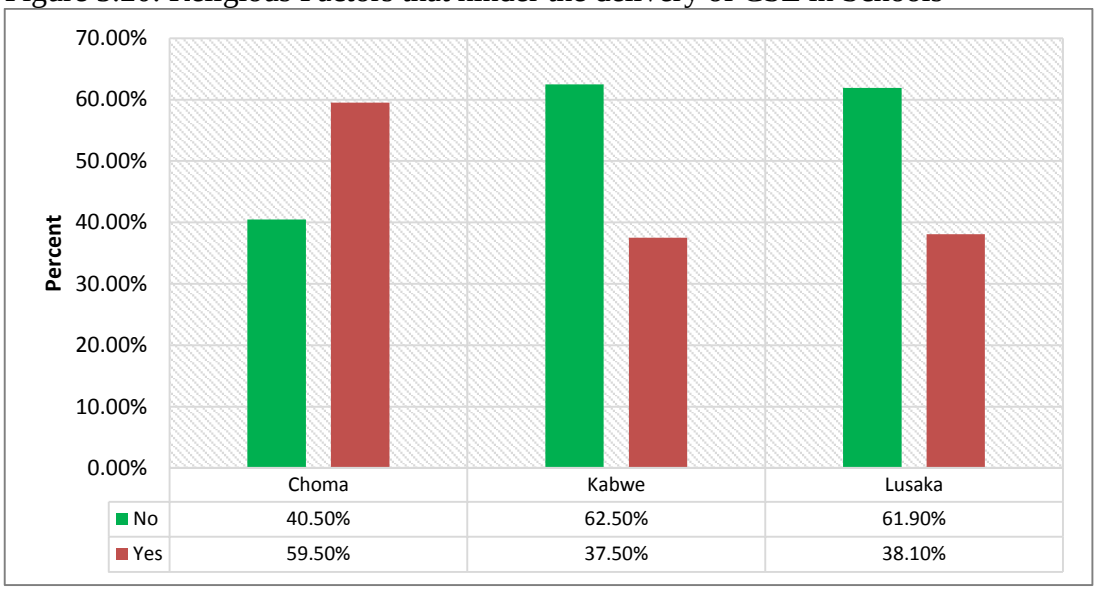
- *"Unless religious and traditional leaders are involved in ensuring that CSE is supported, it will keep facing opposition at school level as they have influence in what goes on in school*" **…** *Teacher FGD Participants - Choma.*

From this above, teachers feel that the church should have a say on CSE as they are the custodians of the moral consciousness of the society. Therefore, they felt that CSE and SRH had come to sexualise the young people which, in fact, could not be the case. If not addressed, this has potential to affect the intended outcomes of the programme because no

matter how much teachers are trained, some would not be able to effectively teach CSE at school.

The responses under this objective have demonstrated that cultural and religious inclinations, although not so prominent, have a bearing in the implementation of CSE. Therefore, there is need for a close collaboration between the church and the traditional leadership as they are the custodians of the moral consciousness and traditions of society, respectively. If left unchecked, this too has potential to affect the implementation of CSE not only at school level but the whole country.

Figure 5.20: Religious Factors that hinder the delivery of CSE in Schools



Source: Author, 2020

5.4 Effect of CSE on Social-emotional Development of Adolescents (Objective 3)

(a) Adolescents Engaging in Risky Sexual Behaviours - Figure 5.12 below gives evidence that young people engage in risky sexual behaviours. 54.7% (Lusaka), 37.4% (Kabwe) and 43.6% (Choma) indicate that young people were engaging in risky sexual behaviours and illicit activities that include unprotected sexual intercourse, drug and alcohol abuse. There are still those who said that young people do not engage in risky sexual and ilicit behaviours - 31.3% (Lusaka), 44.4% (Kabwe) and 43.6% (Choma). This confirms young people engage in risky behavior as demonstrated by the numbers of female learners who drop out of school. A teacher participant stated:

- *" ...In my grade 6 class, I have two girls who are pregnant and will soon be going away to deliver. This is actually a reduction from 6 in the*

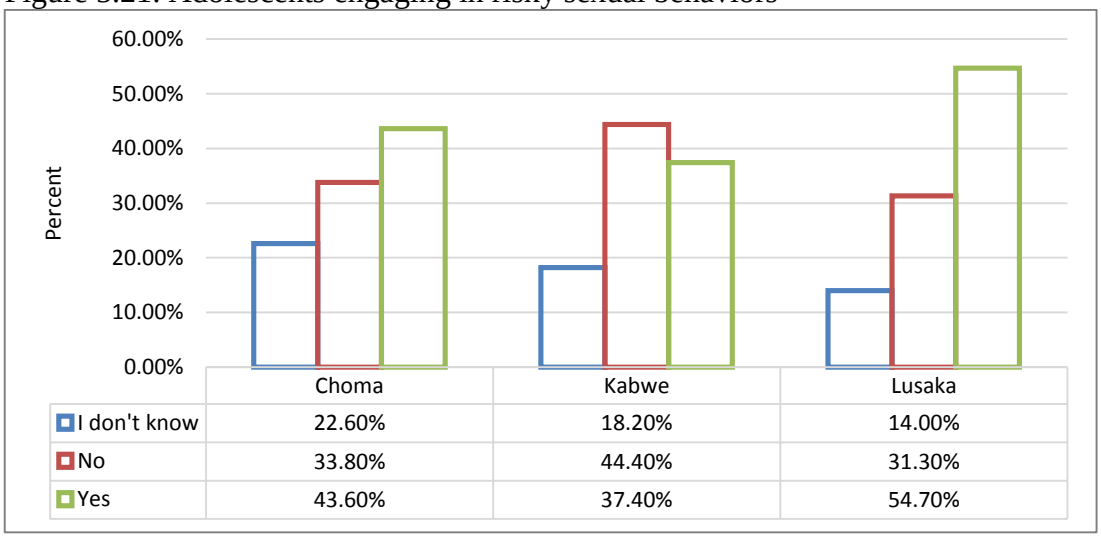
past two years in grade 5, 6 and 7. ".. FGD participant, Teacher, Kabwe

It must be pointed out that this was not one isolated case but many cases in different schools visited by the researcher. There is need to learn more about CSE because young people would understand their bodies better and be able to learn how to prevent pregnancies and other related challenges including sexually transmitted infections. Additionally, in a pupil's focus group, a learner had this to say:

- "*I know girls who have boyfriends, and they sometimes have sex during the weekend but they say they are using pills…" Learner, FGD, female pupil Participant, Choma.*

The above statement shows that sex is happening among young people, and they lack information on how to make use of the available CSE knowledge.. In this regard, more teachers should be trained in CSE to help mitigate the poor risk perception among young people which if unaddressed could pose a major threat on the socio-economics of the learners

Figure 5.21: Adolescents engaging in risky sexual behaviors



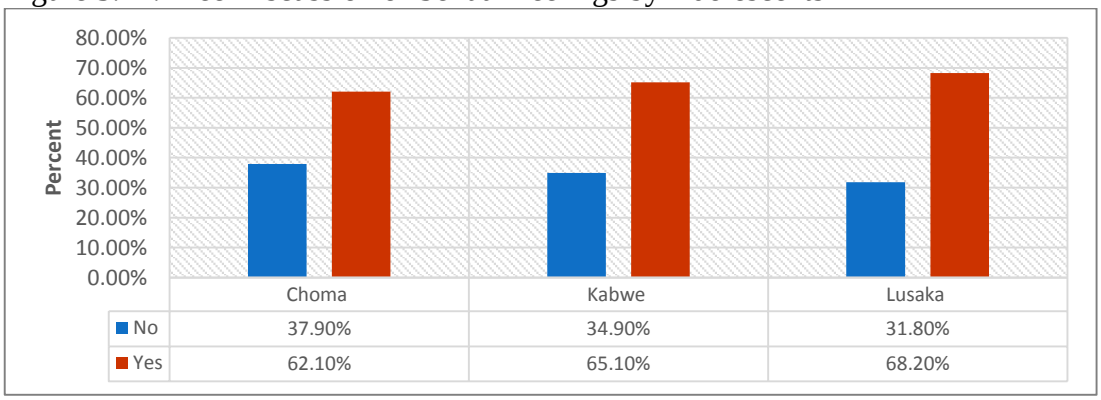
	Choma	Kabwe	Lusaka
I don't know	22.60%	18.20%	14.00%
No	33.80%	44.40%	31.30%
Yes	43.60%	37.40%	54.70%

Source: Author, 2020

(b) Free Discussion of Sexual Feelings by Adolescents - Figure 5.22 below indicates that learners are able to freely talk about sexual feelings with anyone. 62.1% (Choma), 65.1% (Kabwe) and 68.2% (Lusaka) were the ratings of the learners who said they are able to freely talk about their sexual feelings with anyone. However, there are those who said they

are not able to talk freely about their sexual feelings with anyone. Choma had 37.9%, Kabwe scored 34.9% and Lusaka 31.8%. In other words, for those not able to speak to anyone about their sexual feelings confirm that either the cultural or religious issues still bear effect on many people including young ones as demonstrated by the study. Until such a time when information will be so evenly shared among many people, will the cultural or religious sensitivities recede.

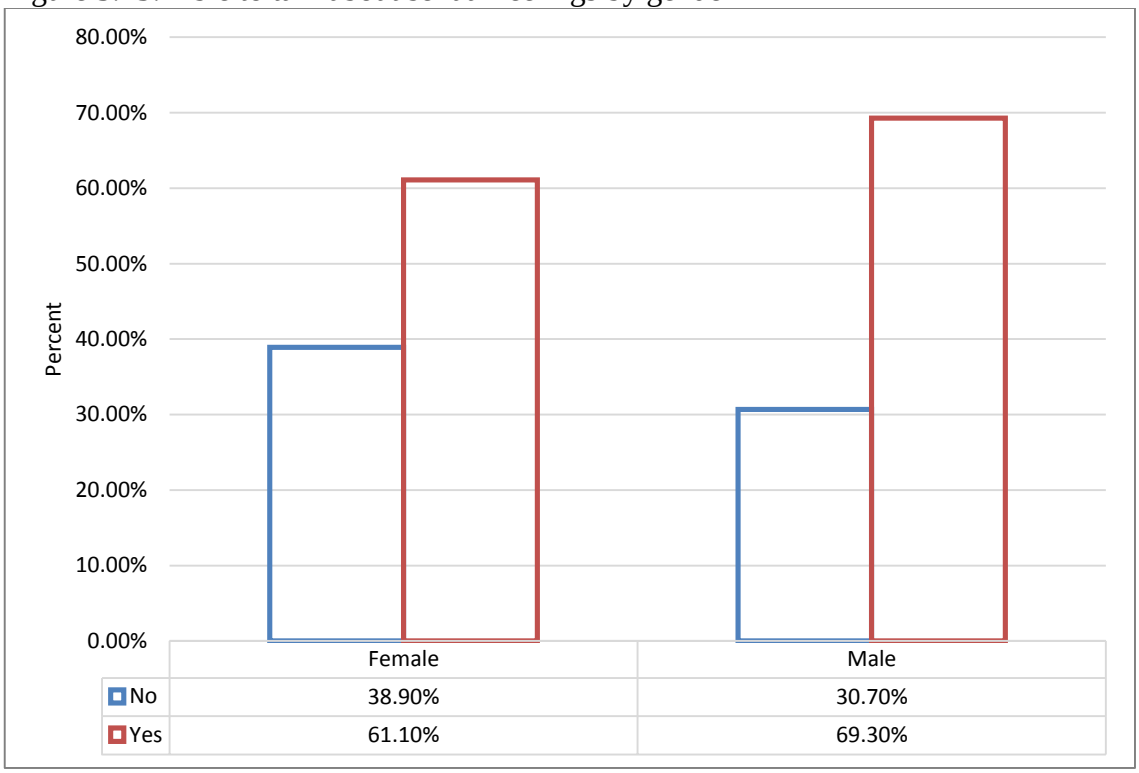
Figure 5.22: Free Discussion of Sexual Feelings by Adolescents



Source: Author, 2020

A further enquiry was made on the same issue with gender parity. On this gender basis, the finding indicate that 69.3% of the males and 61% of the females stated that they were able to freely discuss their sexual feelings whereas 30.7% of the males and 38.9% of the females stated that they were not free to discuss their sexual feelings (figure 5.23). In other words, both males and females felt the liberty to openly talk about their feelings without any power play while others did not. This was supported by a-girls-only focus group discussion where some girls were able to openly state that they talked about sexual feelings with their grandmothers and sometimes their friends in finding ways of what to do when they felt like that. Although this was 'heavy' for some to share due to cultural reasons, the researcher used female research assistant to help engage with these young adolescent girls.

Figure 5.23: Able to talk about sexual feelings by gender



Source: Author, 2020

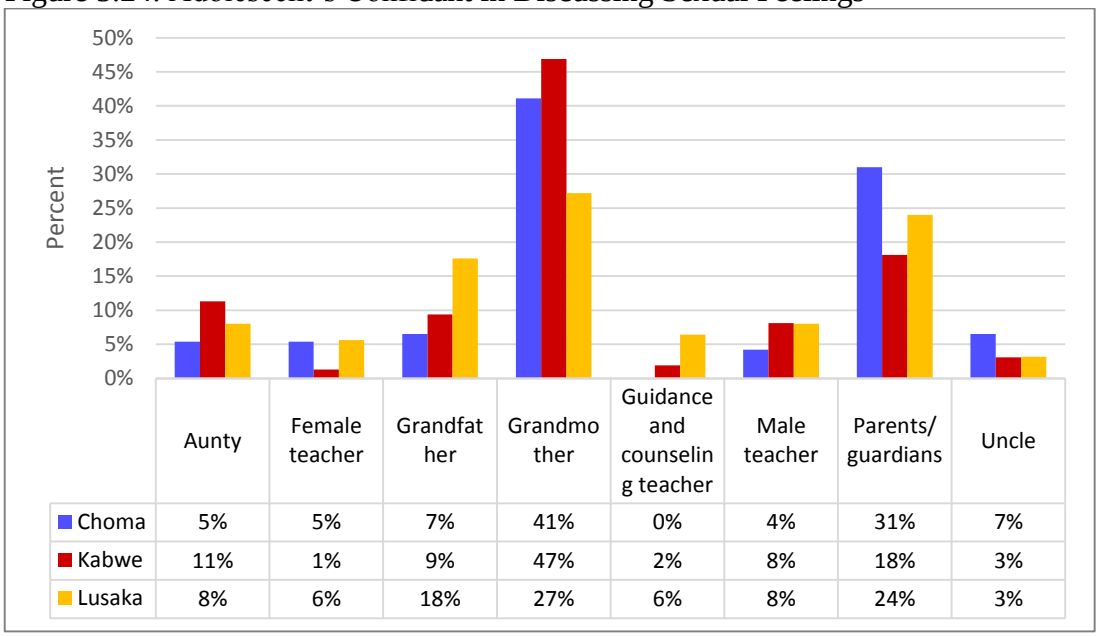
(c) Adolescent's Confidant in Discussing Sexual Feelings - Figure 5.24 below indicates that learners are mostly comfortable to discuss their sexual feelings with a grandmother. The evidence gathered shows that 41.1% (Choma), 46.9% (Kabwe) and 27.2% (Lusaka) stated that they were comfortable to discuss their feelings with their grandmothers. Another preferred person was the category of parent and/or guardian where learners responded by 31% in Choma, 18% in Kabwe and 24% in Lusaka, respectively. Very few learners chose either male or female teacher despite the fact that CSE was being taught by teachers. This presents a different picture all together to note that learners do not prefer teachers as their sources of information when so much has been done to train teachers so that they are able to effectively teach/integrate CSE at school level. The challenge is why learners are having difficulties to trust teachers. It is also not clear whether it is a formal relationship that exist between teachers and learners or not. Whatever the case, teachers should be trusted because they are trained to deliver safe and formal content of CSE learners. After all, most of the benefits being perceived are those that come through the efforts of teachers. For example, through a focus group discussion with teachers, the researcher established that teachers are

doing a lot to achieve the desired results. In a teachers' own words, the following was stated:

- *"Because of the knowledge gained through CSE, the school through the guidance office has managed to retrieve 4 girls from early marriages between 2017 and 2019 and took them back to school" ... FGD teacher member, Choma.*

The above statement confirms the support that schools offer to learners which should enhance trust between them. Perhaps this calls for more research around the relationship between teachers and learners and find ways to ensure it is a relationship of trust.

Figure 5.24: Adolescent's Confidant in Discussing Sexual Feelings



	Aunty	Female teacher	Grandfather	Grandmother	Guidance and counseling teacher	Male teacher	Parents/ guardians	Uncle
Choma	5%	5%	7%	41%	0%	4%	31%	7%
Kabwe	11%	1%	9%	47%	2%	8%	18%	3%
Lusaka	8%	6%	18%	27%	6%	8%	24%	3%

Source: Author, 2020

A further enquiry was made on how free and confident adolescents were able to discuss their bodies. Figure 5.25 below indicates that young people are able to discuss their bodies. For example, in Choma 66.8% of the respondents said they were able to talk about their bodies and 33.2% said they were not able to. In Kabwe, 76.5% said they were able to while 23.5% were not. In Lusaka, 83.2% said they were able to while 16.8% said they were not able to. This demonstrates that cultural inclinations held by learners present a challenge in being free to talk about own bodies. This is important because when learners are not able to talk about their bodies, they will not be able to freely ask for services at healthy facility

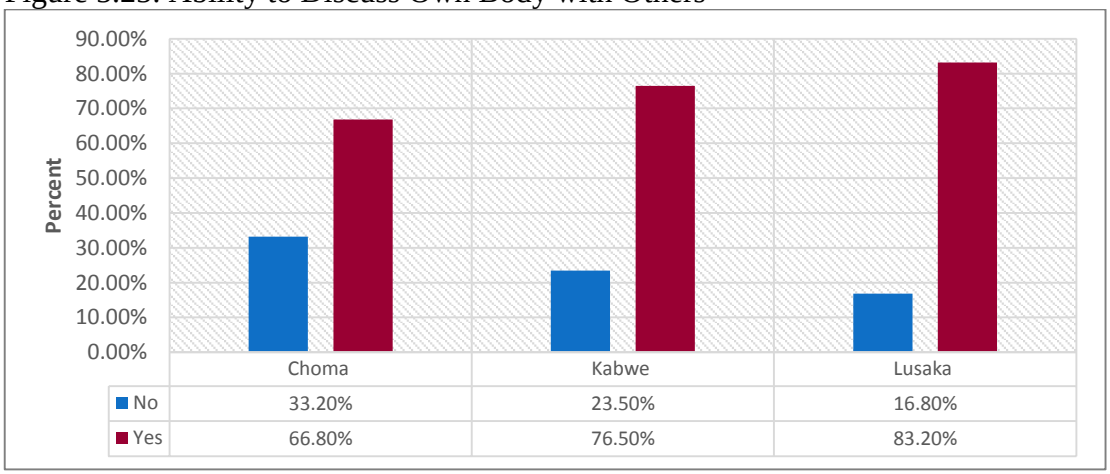
or school environment as a result of being shy. This compromises the quality of health among young people and departs from the aim of CSE which is improved health outcomes among in school adolescents. In a learners' focus group discussion, a pupil had this to say;

- *"… I am not able to talk to my father about sexual feelings and my body as he can be upset with me" … Female learner, MPS, Kabwe.*

- *"…I am only free to talk about my body to my friend, the one I trust…" Male learner, SCS, Choma.*

There is need to strengthen parent child communication in order to ease the tension on sexual matters between parents and children. Currently, there is no relationship with trusted sources especially among young people and parents.

Figure 5.25: Ability to Discuss Own Body with Others



Source: Author, 2020

5.5 Implementing CSE addressing School Related Gender Based Violence (Objective 4)

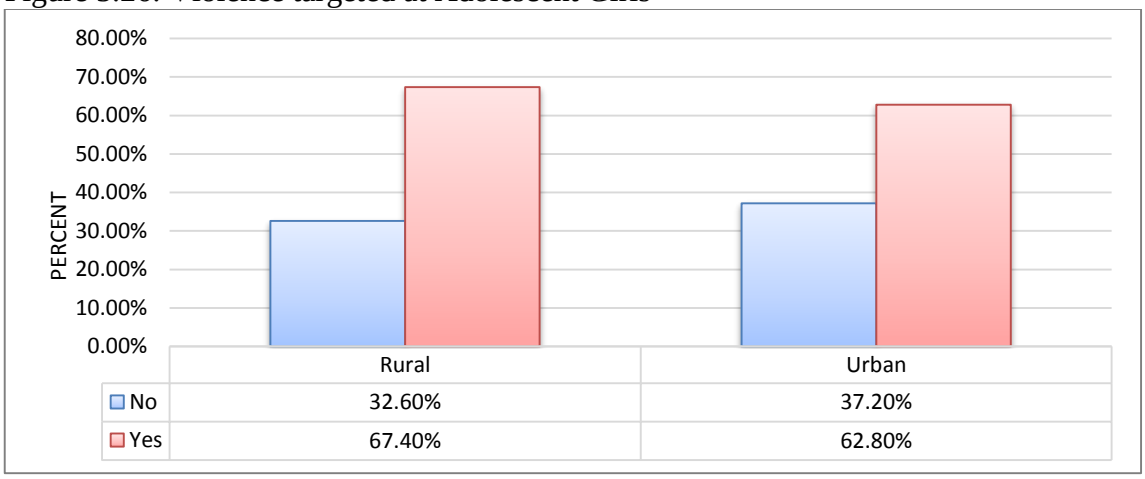
(a) Adolescent Girls and SRGBV - Figure 5.26 below indicates that there is violence targeted at girls only at 67.4% rural and 62.8% urban, 32.6% in rural areas and 37.2% in urban areas said there is no violence targeted at the girls only. One of the key pillars of CSE is the prevention of violence among young people in schools. In a focus group discussion, a female learner had this to say:

- *"… One day as I was coming to school around 10:00 hours in the morning, two boys stopped me on the way and asked for my food and the pocket money amounting to k10.00 which I had. They also mocked me and touched my breasts…" FGD Participant learner, Choma.*

- *"… the boys in grade 7 send me to bring food from home every day…"*
  FGP learner, Kabwe

Gender based violence is not just physical but psychological as depicted by this study. Bullies make schools not safe and CSE should continue to aim at ensuring that schools become better places for all whether male or female.

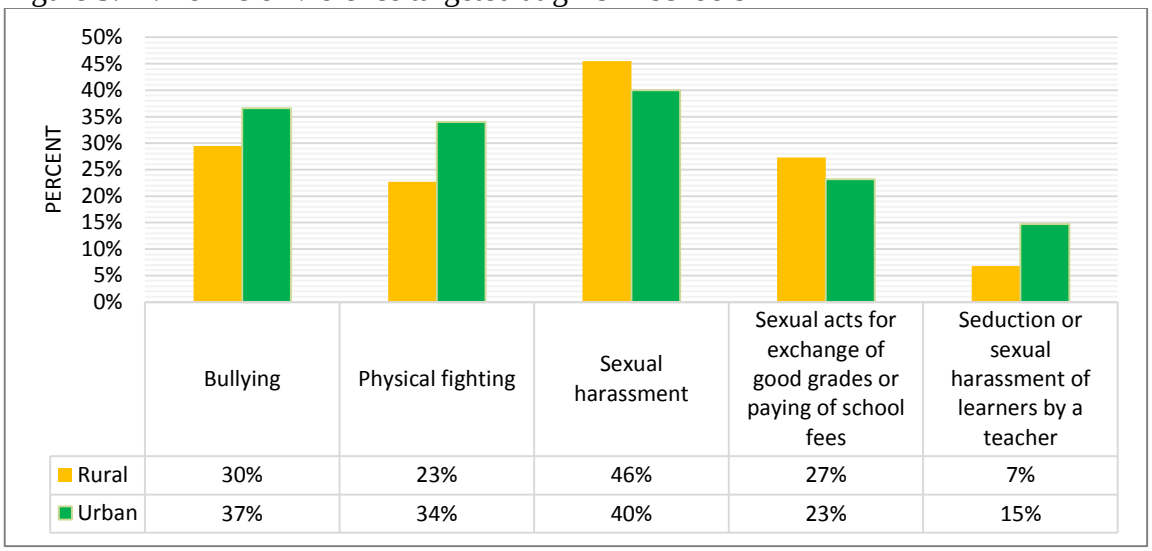
Figure 5.26: Violence targeted at Adolescent Girls



Source: Author, 2020

A further enquiry was made on the forms of violence perpetrated against girls. Findings indicated that learners were able to identify the forms of violence targeted at girls (Figure 5.27). These include sexual harassment at 45.5% in rural areas and 40% in urban areas. The other form of violence targeted at girls is bullying and rated at 29.5% in rural areas and 36.6% in urban areas. Sexual acts for exchange of good grades also is another form of psychosocial violence targeted at girls. Under this one, 27.3% in rural areas and 23.2 in urban areas said this form of violence occurs. Physical fights were also identified at 22.7% in rural areas and 34% in urban areas saying this form of violence occurs. Although no learner was able to openly talk about this for fear of victimization, the hidden vice occurs in schools and in attempting to resolve this, subtle means should be applied.

Figure 5.27: Forms of violence targeted at girls in schools



Source: Author, 2020

Enquiry on how violence perpetrated against girls affects adolescent girls was made. Figure 5.28 below indicates that 44.2% of respondents in Choma, 10.1% in Kabwe and 46.6% in Lusaka said girls are being bullied and harassed. There are also traces of evidence, although negligible in some parts but prominent in Kabwe at 53% that there is evidence teenage pregnancies occur, increase in absenteeism as well as girls dropping out of school because of this targeted violence. This was confirmed by the head teacher in Lusaka who said, "…*when girls fear to come to school, they will perform poorly in school*". Therefore, schools should remain safe places for all, free of bullying and physical harassment. In a focus group discussion for learners, pupils were able to confirm that violence affects girls a lot because most of the times they are the target by the bullies. In a teachers' own words, this was stated:

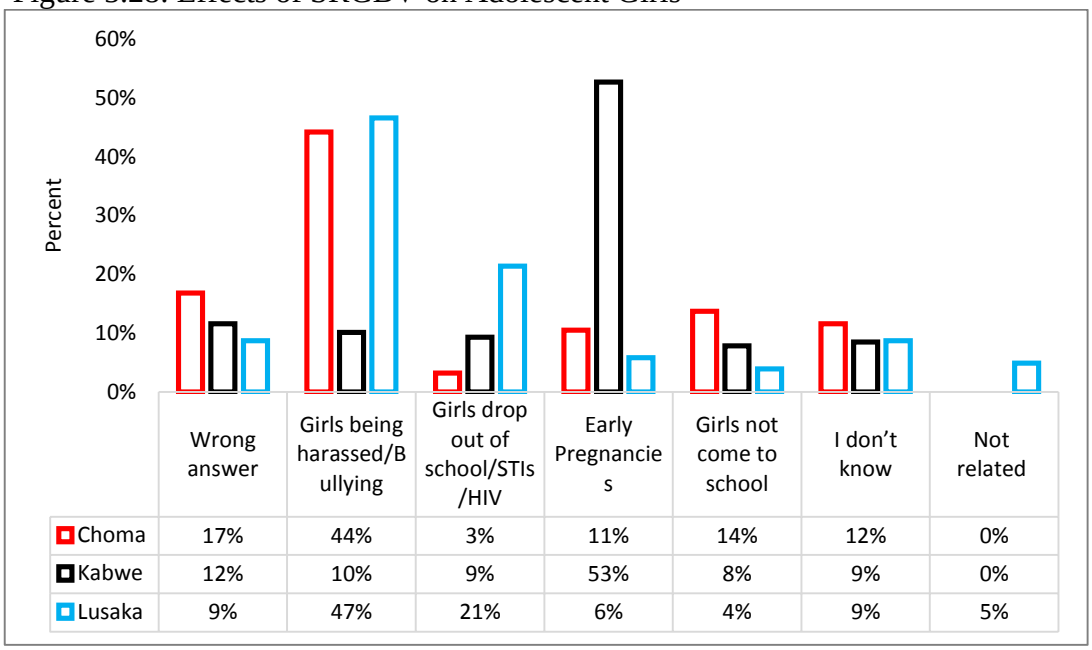
- "…*I have been working with the police victim support unit who once in a while are invited in the school to talk to the learners and guide them on what to do when they feel they have undergone violence and abuse…" Guidance teacher, Lusaka.*

The above statement reveals one of the ways of preventing violence in schools. This involves, having police presence at school or within its surroundings. Such a presence helps to reduce cases of violence like is the case of KPS in Kabwe where cases of violence are very low because the school has the police in the school vicinity. This also guarantees protection to vulnerable young people as it makes it easier to report any cases of violence and deters would be offenders from perpetrating the vice. Evidence shows that violence

affects girls in many ways including girls being harassed in school at 44% and 47% in Choma and Lusaka, respectively. Others reported sexual violence that include coerced sex leading to violent relationships causing pregnancies at 53% in Kabwe and school absenteeism. This finding demonstrates that violence in which boys target girls with all sorts of negative remarks, inappropriate touches and sometimes beating is common. In own remarks, a female learner through a-girls-only focus group had this to say;

- *… we have big boys in this school who bully us girls. They tell us that if we refuse when they are proposing, they will beat us after school…" FGD learner, Choma.*

Figure 5.28: Effects of SRGBV on Adolescent Girls



	Wrong answer	Girls being harassed/Bullying	Girls drop out of school/STIs /HIV	Early Pregnancies	Girls not come to school	I don't know	Not related
Choma	17%	44%	3%	11%	14%	12%	0%
Kabwe	12%	10%	9%	53%	8%	9%	0%
Lusaka	9%	47%	21%	6%	4%	9%	5%

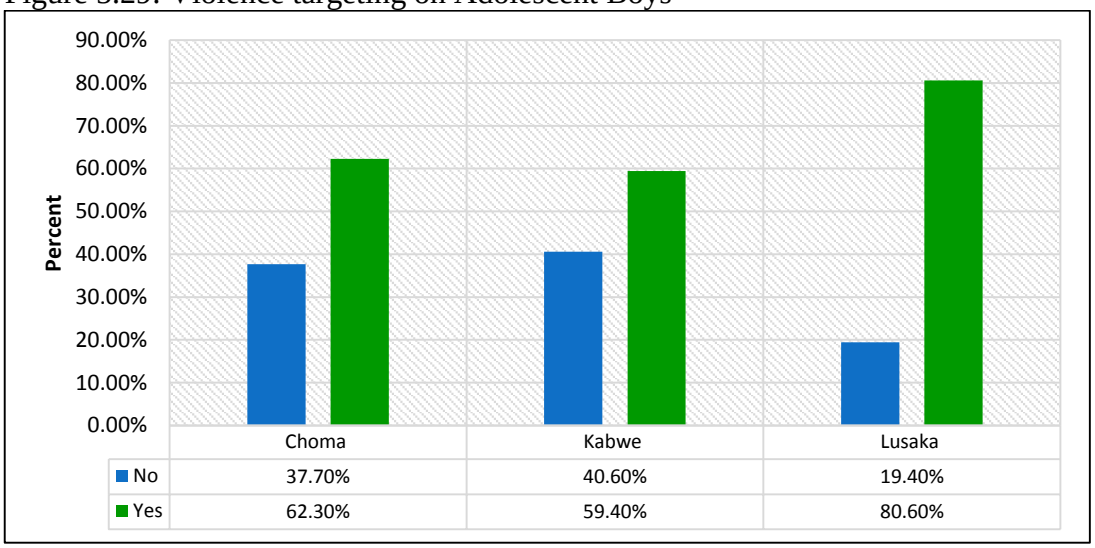
Source: Author, 2020

(b) Adolescent Boys and SRGBV - Figure 5.29 below provides evidence of the violence targeted at the boys only. In Choma, 62.3% of the respondents, 59.4% in Kabwe and 80.6% in Lusaka said there are forms of violence that are targeted at the boys only whereas 37.7% of respondents in Choma, 40.6% in Kabwe and 19.4% in Lusaka said there are no violence acts targeted at the boys.

A key informant stated that boys engage in fights especially fighting for females. As soon as the school gets to know, the deputy and the guidance teacher move in to resolve the problem. In her own words, a guidance teacher had this to say:

- *"… I have had boys fighting among themselves especially over a female. These are vicious fights that sometimes I ask for male teachers to help. I provide counseling if the case is simple or I engage parents to come to school if the case involves assault…" Guidance teacher, MCPS, Kabwe.*

Figure 5.29: Violence targeting on Adolescent Boys



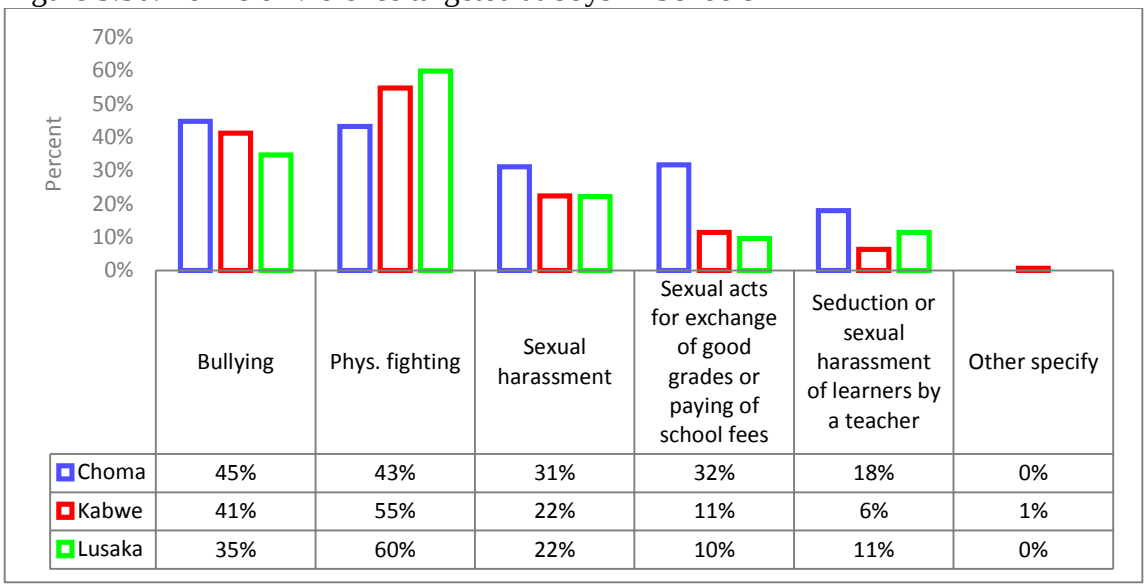
Source: Author, 2020

Further enquiry was made on forms violence that affects adolescent boys. Figure 5.30 below indicates that bullying is the leading targeted form of violence for boys at 44.8% in Choma, 41.2% in Kabwe and 34.7% in Lusaka. This is followed by physical fighting at 43.2% in Choma, 54.8% in Kabwe and 59.9% in Lusaka. The respondents also reported isolated incidences of sexual acts at 31.7% in Choma, 11.4% in Kabwe and 9.6% in Lusaka. Specifically, these forms especially the sexual one was not categorically stated. In a learner's own words had this to say:

- *… we have big boys in this school who bully us girls. They sometimes get our food, money and sometimes touch us in bad ways…" SCPS, FGD learner member, Choma.*

One of the key pillars of CSE implementation is the prevention of School Related Violence which if not taken care of, has the potential to cause death as was the case in Lusaka in the year 2020. Therefore, there is need to ensure that reporting systems in schools are strengthened and learners feel protected and safe.

Figure 5.30: Forms of violence targeted at boys in Schools



	Bullying	Phys. fighting	Sexual harassment	Sexual acts for exchange of good grades or paying of school fees	Seduction or sexual harassment of learners by a teacher	Other specify
Choma	45%	43%	31%	32%	18%	0%
Kabwe	41%	55%	22%	11%	6%	1%
Lusaka	35%	60%	22%	10%	11%	0%

Source: Author, 2020

Further enquiry was made on how this violence affects adolescent boys. Table 5.5 below demonstrates that boys are affected by the violence and harassment leading to absenteeism and eventually dropping out of school. The study found out that 51.2% of respondents in Choma, 14.4% in Kabwe and 42.2% in Lusaka said boys get affected by harassment from fellow boys. This was confirmed in a-boys-only focus group discussion in which one of the boys had this to say:

- *"... big boys take my food and money every time my mother gives me" ...FGD learner member, Lusaka.*

The statement above confirms that bullying still exist in schools and affects boys too. However, in some cases it goes unnoticed.

Table 5.5: Effects of SRGBV on Adolescent Boys

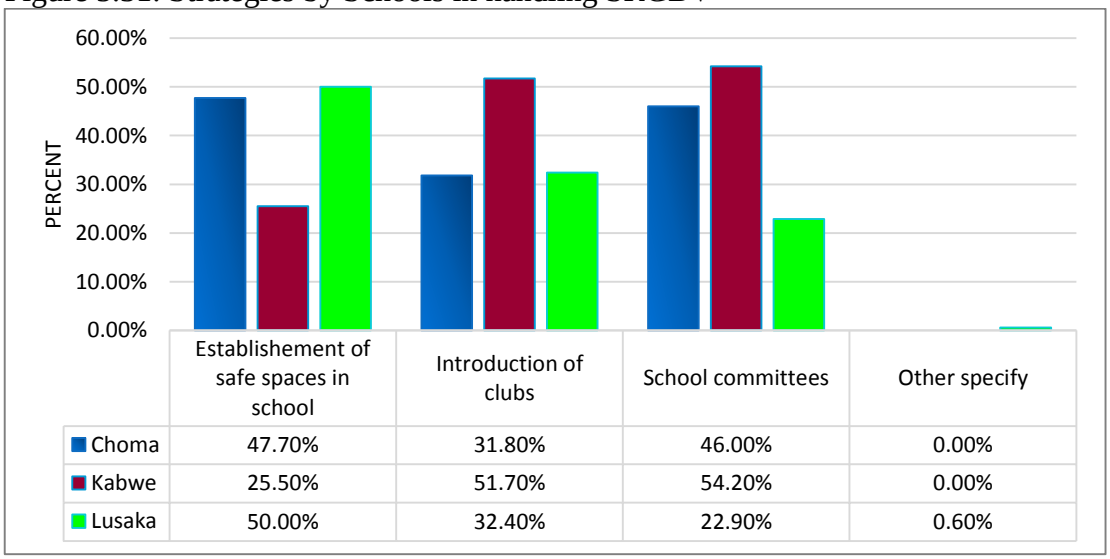
Description	Choma	Kabwe	Lusaka
Wrong answer	18.30%	22.20%	10.20%
Boys to boy harassment	51.20%	14.40%	42.90%
Engaging in Physical fighting / Fight for girls causing Injuries	7.30%	35.60%	23.50%
Boys stop attending school	3.70%	7.80%	4.10%
Start engaging in unprotected sex	2.40%	5.60%	12.20%
I don't t Know	17.10%	14.40%	7.10%
Totals	100%	100%	100%

Source: Author, 2020

(b) Strategies of Schools against SRGBV - The study findings indicated that there are a number of ways in which schools address school related gender-based violence (Figure 5.32). Some of these ways include establishment of safe spaces in schools rated at 47.7% (Choma), 25.5% (Kabwe) and 50% (Lusaka). The other one is introduction of clubs which the respondents across the 3 study sites rated as 31.8% (Choma), 51.7% (Kabwe) and 32.4% (Lusaka) and formation of school committees at 46% (Choma), 54.2% (Kabwe) and 22.9% (Lusaka). These are, but just some of the ways in which schools are responding to addressing school gender-based violence. Some of them include strengthened guidance and counseling focus in schools and now the emergency of mental health support in schools. Although it is a new phenomenon, mental health is a critical aspect of young people's welfare. In a teacher's own words, he had this to say:

- *"... some of these boys in this school abuse drugs and sometimes they smoke marijuana within the vicinity of the school. They do this with the support of older boys from the community. We usually call the police when that happens..." Guidance teacher, NPS, Lusaka.*

Figure 5.31: Strategies by Schools in handling SRGBV



	Establishement of safe spaces in school	Introduction of clubs	School committees	Other specify
Choma	47.70%	31.80%	46.00%	0.00%
Kabwe	25.50%	51.70%	54.20%	0.00%
Lusaka	50.00%	32.40%	22.90%	0.60%

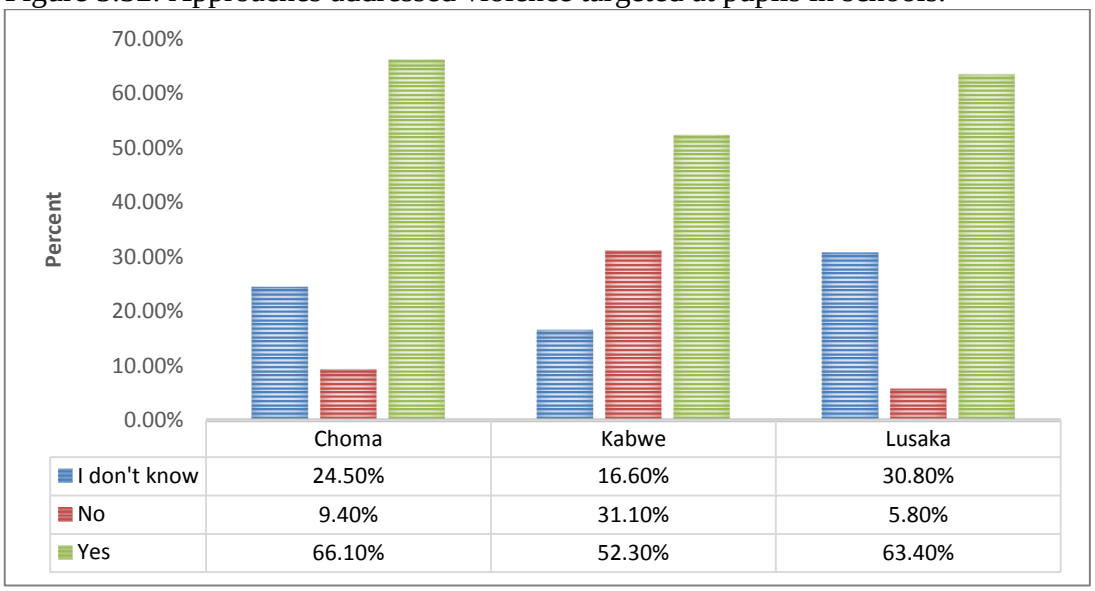
Source: Author, 2020

Findings further indicated that learners appreciated that these approaches had helped in addressing the issues of violence at 66.1% (Choma), 63.4% (Lusaka) and 52.3% (Kabwe) (figure 5.32). However, there are those who said 'no' at 9.4% (Choma), 31.15 (Kabwe) and 5.8% (Lusaka), implying that the approaches have not helped the situation at all. There is also a category of those who said they do not know, or they did not have an answer at all. This was confirmed by teachers' focus groups who stated that although cases have gone

down, they are still taking place on the way to or from school as those are the places where fights have shifted to since, learners know that they would be punished or expelled if this happens in the school grounds, for example. In a head teachers' own words, this is what was said;:

- *"… reports of learners fighting happen on the way to or from school. Even bullying takes place there as they know that in the school environment, this will not be tolerated…" KI, KPS, Lusaka.*

Figure 5.32: Approaches addressed violence targeted at pupils in schools.



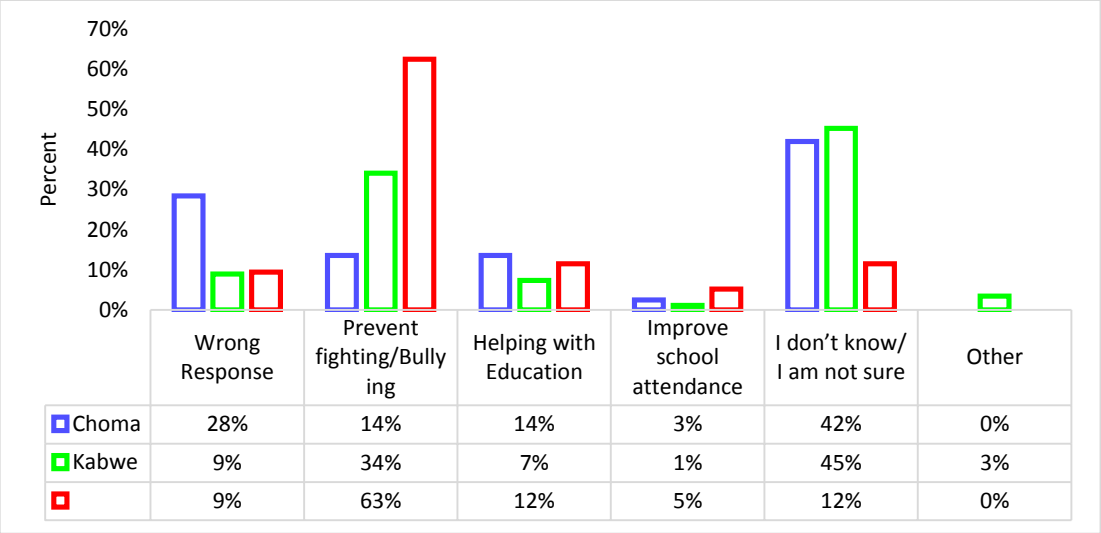
	Choma	Kabwe	Lusaka
I don't know	24.50%	16.60%	30.80%
No	9.40%	31.10%	5.80%
Yes	66.10%	52.30%	63.40%

Source: Author, 2020

Further Figure 5.33 below provides evidence that the approach of addressing school related gender violence has helped girls in terms of prevention of fights and bullying at 13.6% (Choma), 34.1% (Kabwe) and 62.5% (Lusaka). Others are those to help with access to education and improving school attendance when a school environment is free from violence. This was supported by the focus group discussion for learners which stated that girls are being protected with access to education more than boys in that the school ensures that they protect them from harm as they cannot defend themselves easily. In own words, a learner had this to say:

- *"… as girls we fear boys as we cannot defend ourselves when they are harassing us. The school makes sure that we are protected from the bad boys…" Learner, CPS, Choma*

Figure 5.34: Whether the approach has helped the girls



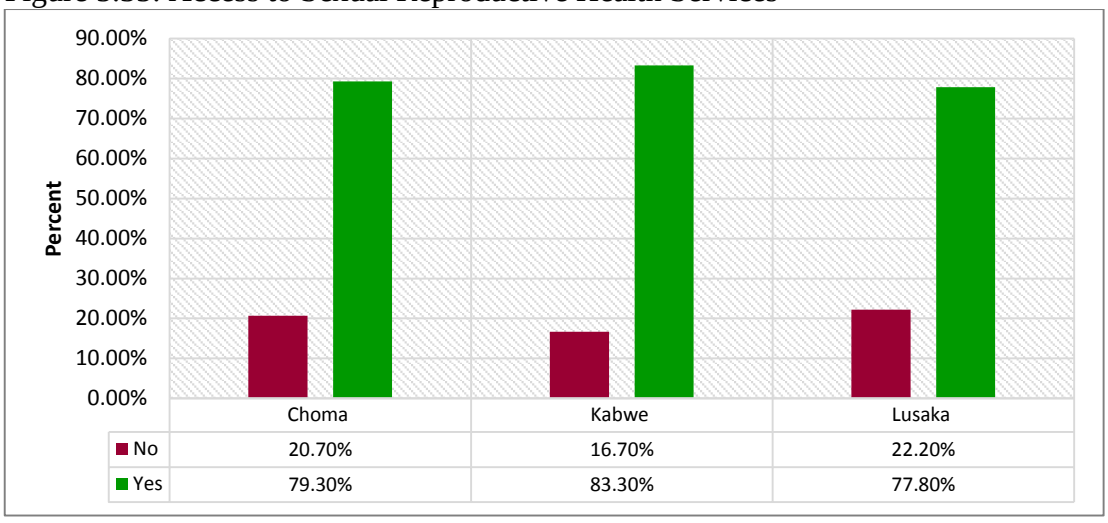
	Wrong Response	Prevent fighting/Bullying	Helping with Education	Improve school attendance	I don't know/ I am not sure	Other
Choma	28%	14%	14%	3%	42%	0%
Kabwe	9%	34%	7%	1%	45%	3%
	9%	63%	12%	5%	12%	0%

Source: Author, 2020

5.6 Sources of Adolescent Sexual Reproductive Health Services (Objective 5)

(a) Access to ASRHS by Adolescents

Figure 5.35: Access to Sexual Reproductive Health Services



	Choma	Kabwe	Lusaka
No	20.70%	16.70%	22.20%
Yes	79.30%	83.30%	77.80%

Source: Author, 2020

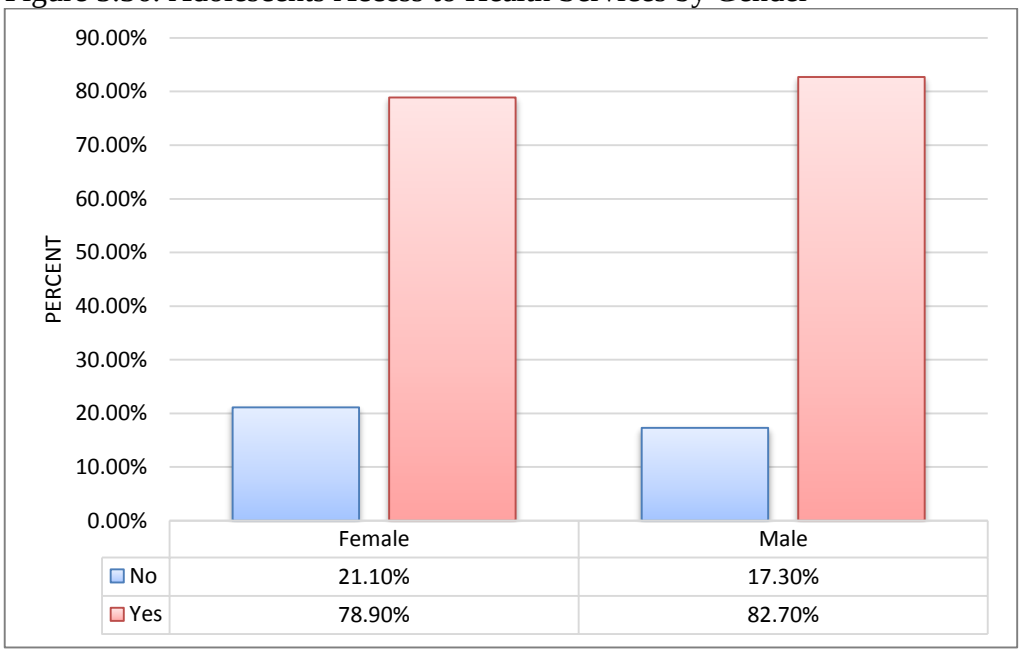
Figure 5.35 reveals that the learners are having access to sexual reproductive health services. For example, 79.3% of the respondents in Choma, 83% in Kabwe and 81% in Lusaka all said they have access to reproductive health services at either school or facility. On the contrary, 21% in Choma, 17% in Kabwe and 22% in Lusaka said they have no access to reproductive health services at either school level or facility. Although the rate at

which young people were accessing services was high, this study through a focus group discussion with learners, found out that young people still face several obstacles accessing sexual and reproductive health services. These barriers relate to availability and accessibility as well as the quality of the services provided in some cases. In a learners' own voice, the following was stated:

- *"… it's not easy to go to the clinic as a young person because nurses will start asking me questions like I am a badly behaved child" … FGD member, Choma.*

The statement above confirms that even if services can be available, young people are still constrained to access them due to different scenarios that include unfriendly staff at facilities as stated in the verbatim above. Unless services are available, it may remain a serious challenge to ensure a good quality CSE that links young people to services that meet their needs.

Figure 5.36: Adolescents Access to Health Services by Gender



Source: Author, 2020

Further, the study sought to analyse whether the access to the health services is influenced by one's gender. The findings of the study indicated that both males and females had access to the health services at 78.9% (Female) and 82.7% (Male) (Figure 5.36). Only 21.1% (female) and 17.3% (male) said they had no access to health services. The findings demonstrate that one's gender does not matter in accessing the ASRHS services. This is

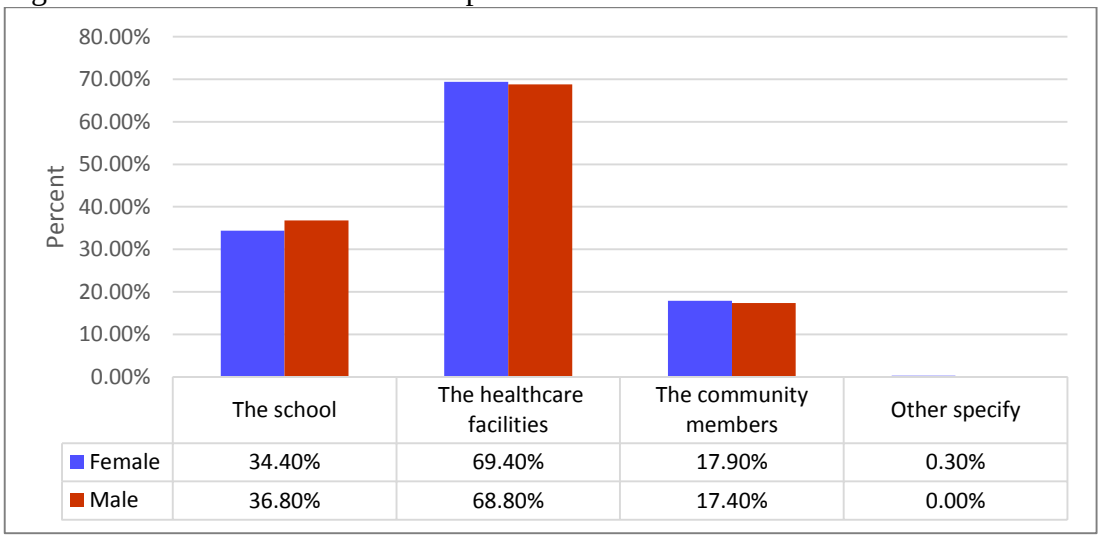
good as it shows that even females are assertive to freely access the services. Through a girl's only focus group, a learner had this to say:

- *"... as girls, we are free to ask for sanitary pads from the Dreams Project when we need them. Even our guidance teacher gives us for free..." FGD female member, Kabwe*

The statement confirms that learners have access to services. However, there are those who are not assertive to freely ask when they need the services. It is, however, encouraging to note that those who report access are more than those not accessing the services.

(b) Providers of ASRHS to Adolescents

Figure 5.37: Providers of Sexual Reproductive Health Services to Learners



	The school	The healthcare facilities	The community members	Other specify
Female	34.40%	69.40%	17.90%	0.30%
Male	36.80%	68.80%	17.40%	0.00%

Source: Author, 2020

The study established that health care facilities are the leading providers of health services in all the study sites covered. When checked on gender basis, it was found that 69% (females) and 68.8% (males) stated that health care facilities are the ones providing health services to young people. Additionally, there was another segment of respondents who felt that the services are being provided by schools. For example, 34.4% (females) and 36.8 (males) stated that schools provided health services to learners while 17.9% (females) and 17.4% (males) stated that services were provided by community members. This is supported by what was said in own words by a KI in Choma as follows:

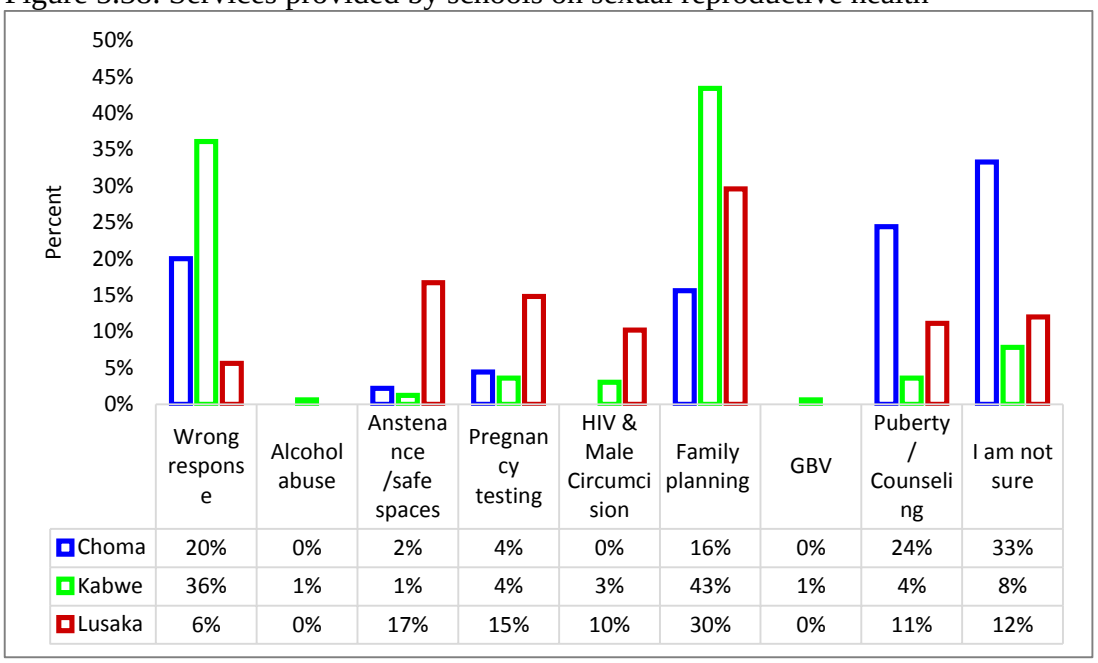
- *"…. We do not have any written referral between the school and the clinic. When a child is sick, we just take them there, but in more cases, parents*

take such responsibility as they notice that the child is sick while at home" ... KI - SCS, Choma.

The statement above demonstrates that schools do not provide services but refer cases to the health facilities near the schools.

(c) Services Provided by Schools on ASRH

Figure 5.38: Services provided by schools on sexual reproductive health



	Wrong response	Alcohol abuse	Anstenance /safe spaces	Pregnancy testing	HIV & Male Circumcision	Family planning	GBV	Puberty / Counseling	I am not sure
Choma	20%	0%	2%	4%	0%	16%	0%	24%	33%
Kabwe	36%	1%	1%	4%	3%	43%	1%	4%	8%
Lusaka	6%	0%	17%	15%	10%	30%	0%	11%	12%

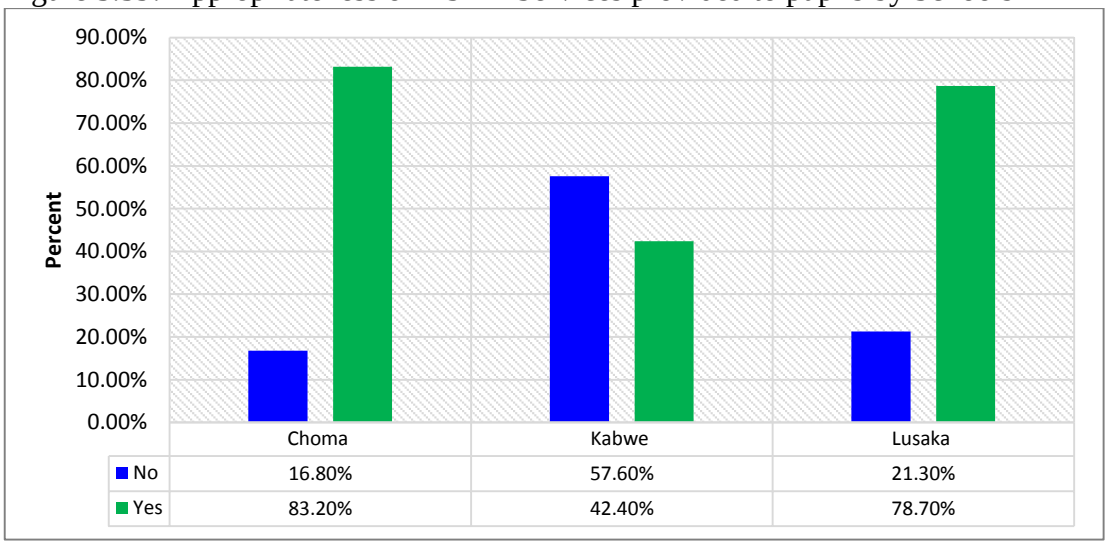
Source: Author, 2020

Figure 3.58 above shows that most of the respondents indicated that schools are providing counselling services as well as information on puberty and growing up. Although on a small scale, 24.4% (Choma), 3.6% (Kabwe) and 11% (Lusaka) of respondents indicated that they receive puberty information as well as counseling through schools. The Figure also shows that 15.6% (Choma), 43.4% (Kabwe) and 29.6% (Lusaka) said they receive male circumcision, condom and family planning information at school level. From these findings, it is also evident that learners do not access health products such as condoms and family planning from schools as the products are not allowed on school premises. However, only information is allowed to be shared. In own words through a focus group discussion for girls only, a respondent had this to say:

- *"…I learn from school about family planning, but I fear to go to the clinic because my aunt works there as a nurse and she will tell my mother if I go…" Pupil FGD member, Lusaka.*

The above statement also resonates with the previous discussions that learners have challenges in accessing products like condoms and family planning. Consequently, the risk of unwanted pregnancies increases thereby impacting the Ministry of Education negatively as it struggles to deal with the burden associated with unwanted pregnancies among school going children. Unless parents come to terms with the fact that their children are engaging in unprotected sex, this could remain a huge challenge. Perhaps this is part of the reasons creating challenges in the implementation of CSE.

Figure 5.39: Appropriateness of ASRH Services provided to pupils by Schools



Source: Author, 2020

A further enquiry was made on whether services provided on ASRHS by schools are appropriate. Figure 5.38 above indicates that 83% of respondents in Choma, 42.4% in Kabwe and 78.7% in Lusaka said that the services being offered were appropriate. However, 16.8% (Choma), 57.6% (Kabwe) and 21.3% (Lusaka) said that the services were inappropriate in terms of meeting the needs of the learners. The score of services not being appropriate was highest in Kabwe. The Kabwe response was further followed with a focus group discussion to check why the response for services being inappropriate was highest in Kabwe. The teachers indicated that learners go to a *Dreams Center* which is a USAID supported project. The centre has programmes for girls only. These programmes are

incentivised with school stationary and soft drinks whenever girls visit the centre. This could explain why the rating for Kabwe is higher in comparison to others. In own words, a pupil had this to say:

- *"… we go to the Dreams Center and they give us what girls want whereas at the government clinic they don't and we don't find fellow young people…" FGD female learner, Kabwe*

(c) Services Provided by Health Facilities on ASRH

Table 5.6: ASRH Services provided by the health facilities

Description	Choma	Kabwe	Lusaka	Total
Prevention of HIV/STIs counseling	11.60%	84.20%	76.60%	72.40%
Wrong response	9.30%	2.20%	2.70%	3.30%
I don't know	51.20%	8.70%	9.90%	14.50%
Health Services for adolescents and information	25.60%	3.30%	5.40%	6.80%
Family Planning	0.00%	0.00%	4.50%	1.50%
HIV/ pregnancy testing	2.30%	0.50%	0.90%	0.90%
Male circumcision	0.00%	1.10%	0.00%	0.60%

Source: Author, 2020

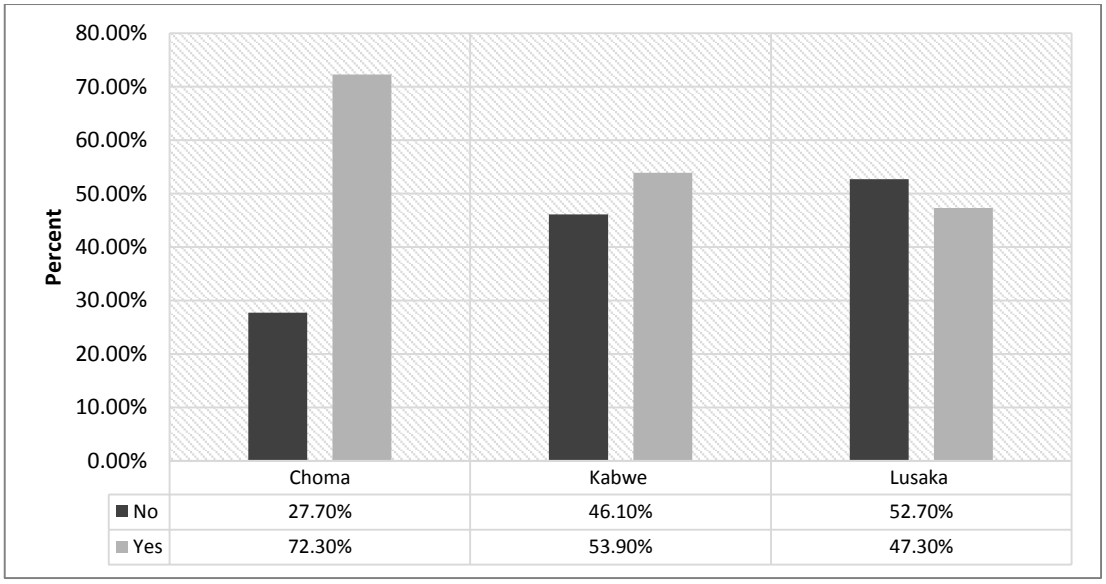
Table 5.6 above indicates a range of services that include prevention of HIV/STIs, counseling services, pregnancy testing and male circumcision provided by health facilities. Findings indicate that HIV prevention at 11.6% (Choma), 84.2% (Kabwe) and 76.6% (Lusaka) as one of the services provided at health facilities. Others, although low, are health services for adolescents at 25.6% (Choma), 3.3% (Kabwe) and 5.4% (Lusaka). This was confirmed by a Key Informant from the Ministry of Health who stated that the services are provided by the health facility as a standard procedure for government facilities. In her own words, she had this to say:

- *'… the Ministry of Health has a responsibility to ensure that services are provided to all who need them irrespective of the age as long as they are eligible…"*

The above comment supports the assertions that the Ministry of Education cannot give condoms and family planning to young people whereas the Ministry of Health gives because that is within their mandate. Therefore, the separation of functions is clearly evident where the Ministry of Education ensures that information is provided whereas the

Ministry of Health provides the actual services that accompany the information to young people as it does to the rest of the population who seek such health services.

Figure 5.39: Appropriateness of ASRH Services provided to pupils by Health Facilities

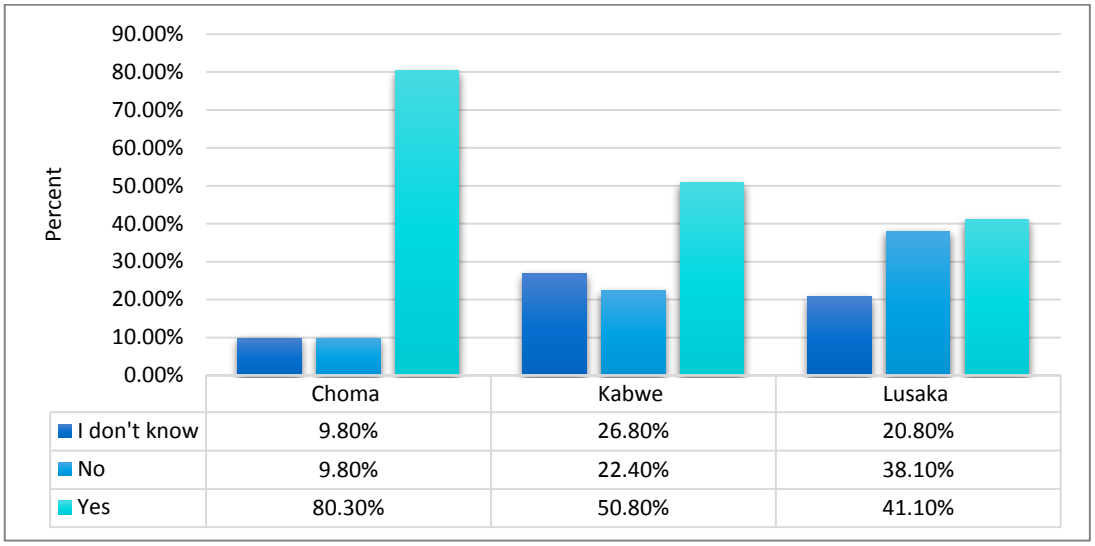


Source: Author, 2020

Further enquiry was made on the appropriateness of ASRH services provided by health facilities. Figure 5.39 above indicates that the perception of respondents as to whether the services were appropriate or not varied significantly with of72.3% (Choma), 53.9% (Kabwe) and 47.3% (Lusaka) stating that the services provided in health facilities were appropriate for adolescents whereas 27.7% (Choma), 46.1% (Kabwe) and 52.7% (Lusaka) stating that the services were inappropriate. This perception is based on what learners felt about the appropriateness of the services. As can be seen, there were more young people saying that services were appropriate as opposed to those saying that the services were not.

(d) Services Provided by NGOs on ASRH

Figure 5.40: NGOs providing ASRH services in schools



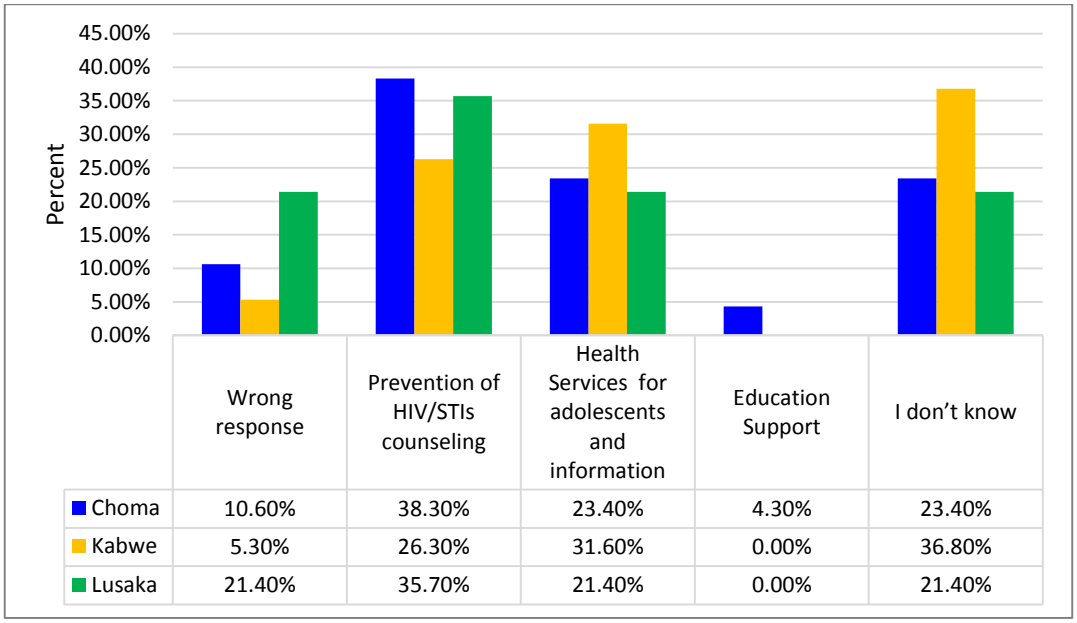
	Choma	Kabwe	Lusaka
I don't know	9.80%	26.80%	20.80%
No	9.80%	22.40%	38.10%
Yes	80.30%	50.80%	41.10%

Source: Author, 2020

Figure 5.40 above indicates that the respondents were able to confirm that there are NGOs working in schools which provide ASRH services. From the responses, 80.3% (Choma), 50.8% (Kabwe) and 41.1% (Lusaka) were able to confirm that NGOs were working with schools to provide health services whereas 9.8% (Choma), 22.4% (Kabwe) and 38.1% (Lusaka) could not agree as they said that there were no NGOs working in schools providing ASRH services.

NGOs work to supplement government efforts in implementing programmes that aim to better the lives of the people. The study found out that there were NGOs in Choma that included Plan International, Child Fund, and Global fund whereas in Lusaka, there were Southern Africa AIDS information disseminating Service (SAFAIDS), Regional Education Psychosocial Support Initiative (REPSI) and in Kabwe; Dreams and World Vision. These provided additional SRH services and information to learners in schools besides the Ministry of Education CSE project supported by UNESCO with resources from SIDA, Sweden since 2014.

Figure 5.41: ASRH Services provided by the NGOs



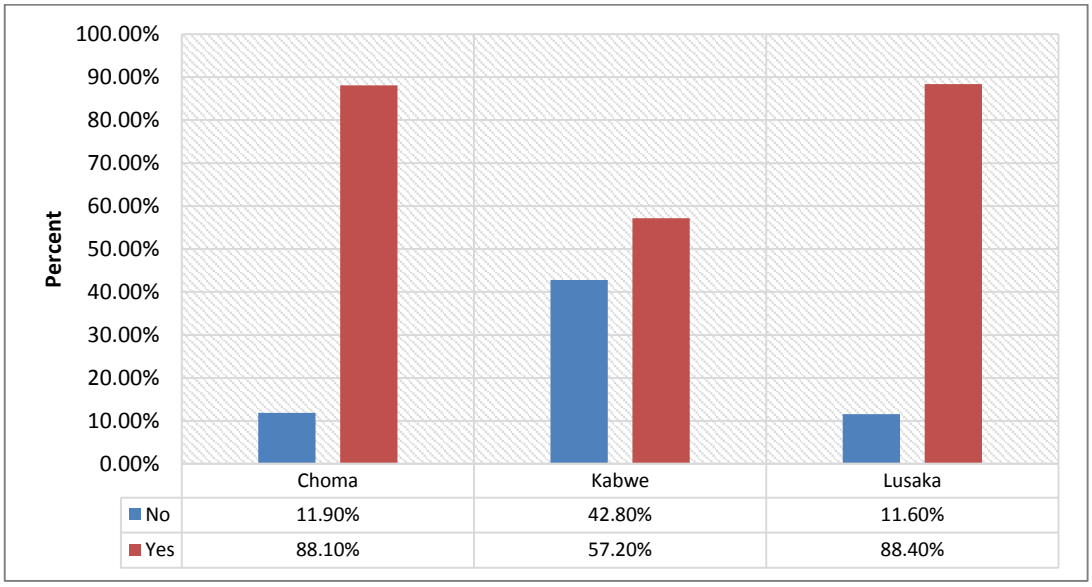
	Wrong response	Prevention of HIV/STIs counseling	Health Services for adolescents and information	Education Support	I don't know
Choma	10.60%	38.30%	23.40%	4.30%	23.40%
Kabwe	5.30%	26.30%	31.60%	0.00%	36.80%
Lusaka	21.40%	35.70%	21.40%	0.00%	21.40%

Source: Author, 2020

Further enquiry on ASRH services provided by NGOs indicated that prevention of HIV/STIs, counseling, health services for adolescents and information support were among the services young people accessed with support of NGOs (figure 5.42). 38.3% (Choma), 26.3% (Kabwe) and 35.7% (Lusaka) said they accessed HIV testing and counseling including STIs through NGOs that worked with the schools. The other responses indicated 23.4% (Choma), 31.6% (Kabwe) and 21.4% (Lusaka) for those who confirmed that adolescent sexual reproductive health services were provided by the NGOs. These are the same NGOs as outlined above that provide these services to supplement efforts already being done by the ministry with its cooperating partners.

(e) Accessing ASRH Information by Adolescents

Figure 5.42: Access to ASRH information

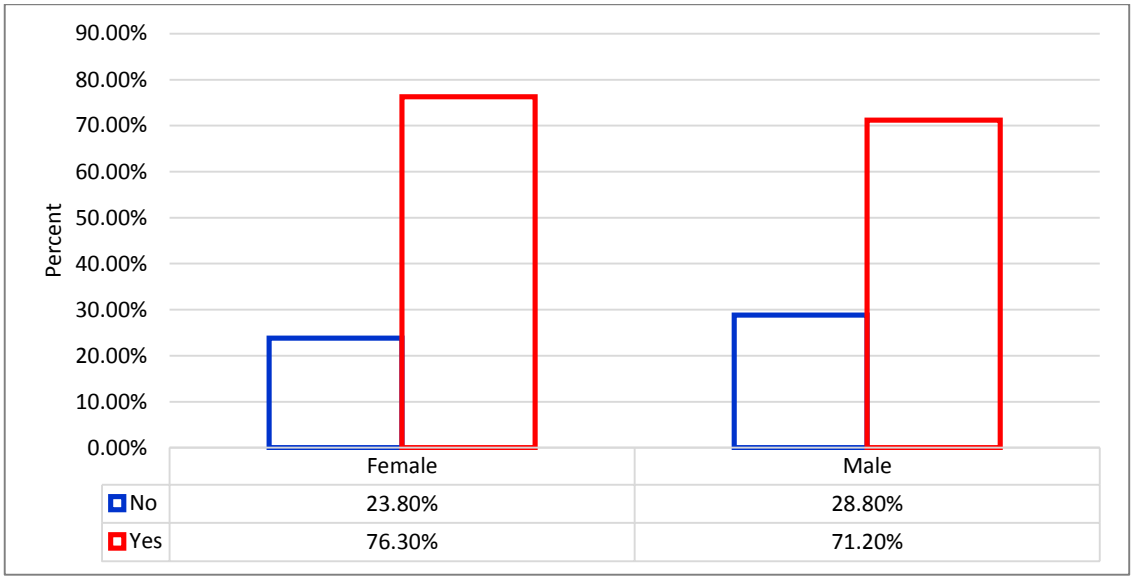


Source: Author, 2020

Figure 5.42 above demonstrates that young people had access to Sexual reproductive health services with 88.1% (Choma), 57.2% (Kabwe) and 88.4% (Lusaka) confirming that they had access be it at school level or facility level. Other responses indicate that 11.9% (Choma), 42.8% (Kabwe) and 11.6% (Lusaka) said that they had no access to ASRH services. This was supported by a focus group discussion with teachers that confirmed that young people had access to information on ASRH at both school and health facility level. CSE works to ensure that young people have access to information on CSE that is linked to services. Through a Key Informant, in his own words, had this to say:

- *"… our learners do have access to the information at school level and what we can't give, we either invite a nurse and or they visit the health facility to learn more and possibly see what they learnt in abstract form like demonstrations on how to use condoms which is also covered in science books including Home Economics…" Teacher FGD member, Kabwe.*

Figure 5.43: Access to information on ASRH by Gender



Source: Author, 2020

On a gender basis, Figure 5.43 above indicates that 76.3% (female) and 71.2% (male) said they had access to information on sexual reproductive health services. It was important for this study to check whether there was a disproportionate or unequal access between boys and access to the services provided. The findings show that both girls and boys had good access ranging above 70%. However, it was also observed that 23.8% (Females) and 28.8% (males) said they did not have access to the services. This was also confirmed by guidance teachers who said that there was no difference between girls and boys in terms of accessing the information on SRH as they were all interested and during club meetings, the most interesting topics are usually those that border on puberty and reproduction.

Table 5.7: Sources of Information for ASRHS

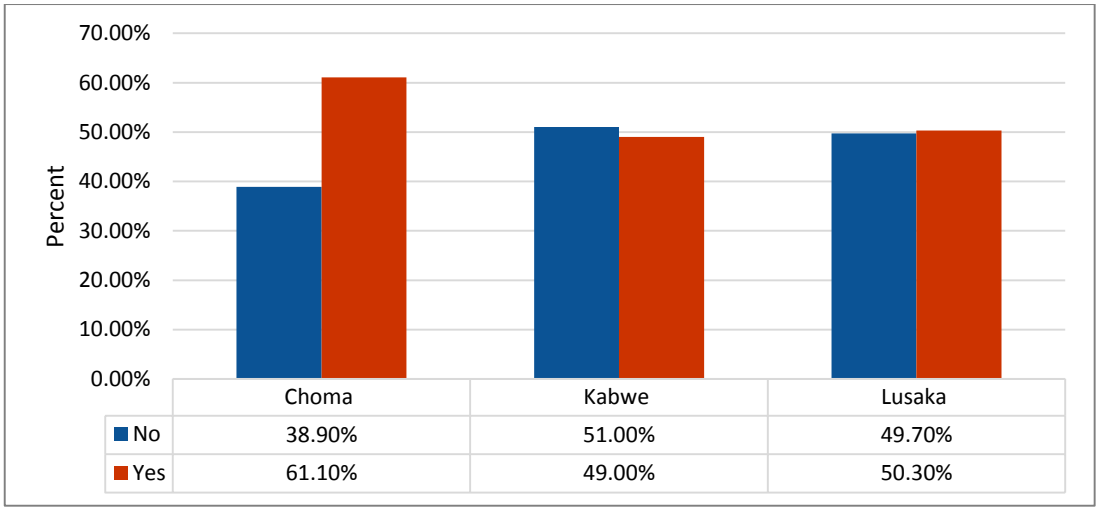
Sources of information	Kabwe	Choma	Lusaka	Overall
	%	%	%	%
The radio	54.9%	54.8%	42.0%	51.5%
Television	43.1%	45.7%	53.3%	46.5%
Male teachers	22.4%	22.3%	23.7%	22.7%
Female teachers	27.8%	26.6%	21.3%	25.8%
Guidance and counseling	31.9%	22.3%	27.8%	28.1%
Traditional teachers	18.3%	12.8%	20.7%	17.3%
Friends	32.2%	23.9%	26.0%	28.2%
Teachers	27.1%	29.8%	36.1%	30.2%
Mother	16.9%	33.5%	19.5%	22.4%
Father	12.5%	13.8%	7.1%	11.5%
Brother	11.9%	11.2%	9.5%	11.0%
Sister	9.5%	18.6%	10.7%	12.4%
Magazines	10.5%	13.3%	18.9%	13.5%
Books	19.3%	23.4%	17.8%	20.1%
Movies	17.6%	22.3%	20.7%	19.8%
Other specify	0.0%	0.5%	0.0%	0.2%

Source: Author, 2020

An enquiry with multiple choices on the sources of accessed information on ASRH by adolescents indicates numerous sources (Table 5.7). However, radio stood out with a score of 51.5% and individual study site scores at 54.8% (Choma), 54.9% (Kabwe) and 42.0% (Lusaka) saying they get information on ASRH through radio. Television was second with a score of 46.5% with individual site scores at 45.7% (Choma), 43.1% (Kabwe) and 53.3% (Lusaka) saying they get information through television. The study also found out that only 22.7% of the respondents said they get information through male teachers and 25.8% get information through female teachers. As earlier stated, the concern is,despite training over 60% of teachers in the delivery of CSE at classroom level between 2014 and 2018, teachers are still not preferred as sources of information on CSE. It is not clear why learners feel this way. It could be that the formal relationship that exist between teachers and

learners affect information sharing. Perhaps it's time to begin to rethink the pedagogy being used to deliver CSE lessons.

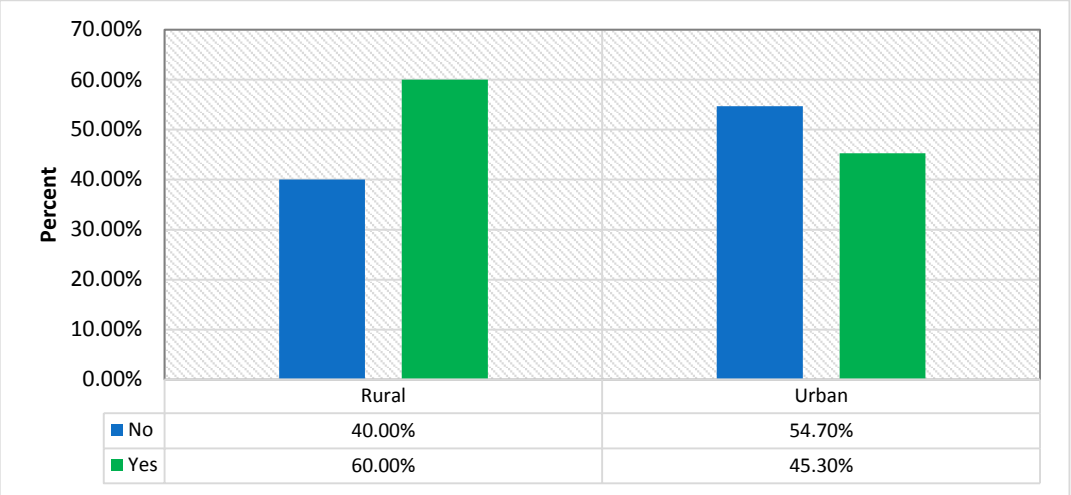
Figure 5.44: Challenges in accessing Sexual Reproductive Health Services



Source: Author, 2020

In terms of challenges in access to ASRHS at school level, there were variances in the responses (figure 5.44). In Choma, for example, 61.1% said they had challenges while 38.9% said they did not have challenges. In Kabwe, 49% said they had challenges while 51% said they did not have challenges at all and in Lusaka, 50.3% said they had challenges in accessing ASRHS while 49.7% said they did not have challenges. The variation in responses point to the fact learners are in different geographical locations with different challenges accessing information on ASRH and CSE. While others found it easy to access the information through the school system, others still found it easy to access it through radio and or other means that could include television and friends.

Figure 5.45: Challenges in accessing sexual reproductive health services from NGOs



Source: Author, 2020

Figure 5.45 above demonstrates that 60% of the respondents in rural schools said they had challenges in accessing services provided by NGOs while 40% said they do not had challenges. At least 45.3% of respondents in urban areas said they had challenges in accessing services provided by NGOs whereas 54.7% said they did not have challenges at all. This fact confirms that challenges vary. For the rural areas, there are more NGOs that go into schools than there are in urban areas. For urban areas, access could mean just walking into any nearest clinic and or any youth friendly center which are readily available whereas the situation in rural areas could be different. In a young person's own words, he had this to say:

- *"… I walk about 3 kilometers to the clinic which is far from where I stay and sometimes, I just stay home and use traditional medicines my mother gives me…"*

This means that some poor health seeking behaviors in young people are compounded by long distances to health facilities, compelling young people to seek alternatives to health treatment. This could have debilitating effects to one's health especially with wrong and self-treatment.

Table 5.8: Preferred Sources of information on ASRH

Preferred Sources of information	Kabwe	Lusaka	Choma	Overall
	%	%	%	%
Mother	47.4%	27.8%	34.4%	38.9%
Father	52.9%	21.0%	27.8%	38.1%
Male teachers	29.2%	40.1%	44.4%	35.9%
Sister	42.3%	23.5%	22.5%	32.3%
Friends	34.4%	26.5%	30.5%	31.3%
Brother	40.5%	19.1%	19.2%	29.5%
Teachers	30.6%	25.9%	27.2%	28.5%
Female teachers	24.7%	31.5%	28.5%	27.5%
Traditional teachers	19.2%	22.8%	33.1%	23.7%
Other specify	0.7%	0.0%	0.0%	0.3%
Guidance and counseling	38.5%	35.8%	27.8%	35.1%

Source: Author, 2020

A multi-choice response in Table 5.8 above indicates a score of 35.9% of respondents who said male teachers were a better source of information on CSE and ASRH whereas 27.5% respondents said female teachers were the best source of information. In this category, respondents felt that parents were the preferred sources of information at 38.9% and 38.1%, respectively. Clearly, there are variations based on what young people felt.

The findings show that CSE is being taught through schools and teachers are key means of delivery. However, in this response, it is clear that teachers are not being given the prominence in terms of preference needed. This should be a concern and a challenge worth establishing as to why teachers are not preferred as much as parents and guidance and counseling teachers. In other words, this is a challenge on its own as teachers were trained to deliver CSE at classroom level. Therefore, efforts should be made to ensure that learners become comfortable to learn from teachers through effective methods because that is what they are trained to do.

Table 5.9: Sources preferred to obtain information on CSE and ASRH

Sources of information	Urban	Rural	Overall
	%	%	%
The radio	44.2%	54.8%	44.9%
Television	45.6%	35.7%	44.9%
Doctors	45.4%	33.3%	44.6%
Nurses	33.5%	33.3%	33.5%
Friends	28.4%	14.3%	27.5%
Teachers	27.0%	28.6%	27.1%
Male teachers	20.0%	21.4%	20.1%
Guidance and counseling	25.8%	19.0%	25.3%
Female teachers	19.3%	16.7%	19.1%
Traditional teachers	16.8%	11.9%	16.5%
Mother	23.7%	21.4%	23.5%
Sister	20.0%	23.8%	20.3%
Books	19.1%	35.7%	20.3%
Movies	18.8%	11.9%	18.3%
Father	15.4%	7.1%	14.9%
Brother	13.3%	2.4%	12.6%
Magazines	12.1%	11.9%	12.1%
Other specify	0.2%	0.0%	0.2%

Source: Author, 2020

Table 5.9 above indicates that radio (44.90%) and television (44.9%) are leading preferred sources of obtaining information on ASRH and CSE followed by medical personnel or doctors at 33.5% and nurses at 33.40%. The education environment components of teachers (27.5%) and books (20.3%) do not form a strong preferred source. This is how learners prefer the sources of information on CSE and ASRH. As can be observed, teachers are not still the preferred sources which is quite concerning and a challenge itself. More information is required to establish why teachers are not preferred as sources of information even when they are the one teaching CSE in schools. The challenge here again is that radio and television are still prominent as sources of information on CSE and SRH and not teachers, yet CSE is a curriculum designed content intended to be delivered by trained teachers. The fact that they are not preferred as sources of information presents a challenge and justifies a clarion call for a need to challenge the status quo. In a learners' own words, had this to say:

- *"… I learn more about CSE from radio and television where they advertise condoms because my teacher does not teach us these things..." Learner, FG member, Kabwe*

5.7 Test Statistics of Selected Quantitative Variables

This study sought to demonstrate the quantitative aspect of the research through testing some selected variables from different objectives particularly covering objective 1 and 2. The following therefore is a presentation of the test statistics using Pearson's 'Chi Square and ANOVA tests.

5.7.1 Chi Square Test

Camilli and Hopkins (1978) states that a chi-square test is a statistical test used to compare observed results with expected results. They further support that the purpose of this test is to determine if a difference between observed data and expected data is due to chance, or if it is due to a relationship between the variables you are studying. Pearson's Chi-square test was used in this study to test if there is a significant relationship between two categorical variables. Assumptions included that both variables are categorical and it is also assumed that all observations are independent of the other. In this case, the hypothesis testing was based on the claim that there is no relationship between learning CSE and the ability among young people to freely discuss CSE topics with peers.

Formula

$$\chi^2 = \sum \frac{(O_i - E_i)^2}{E_i}$$

Equation 1: Chi square Formula.

Where;

χ^2 = chi squared

O_i = observed value

E_i = expected value

Hypotheses

H_0: There is no relationship between learning CSE and the ability among young people to freely discuss CSE topics with peers

H_1: There is a relationship between learning CSE and the ability among young people to freely discuss CSE topics with peers

Test statistic: Pearson Chi-quare test

Rejection criteria: Reject H_0 if p-value <0.05

Results:

Table 5.10: Ability to discuss Sexuality Education topics with peers

		D11. Are you able to discuss Sexuality Education topics with your peers?					
		No		Yes		Total	
		Count	Row N %	Count	Row N %	Count	Row N %
C13. Has Comprehensive Sexuality Education helped you as an adolescent?	No	18	31.6%	39	68.4%	57	100.0%
	Yes	144	23.5%	469	76.5%	613	100.0%
	Total	162	24.2%	508	75.8%	670	100.0%

Source: Author, 2020

Table 5.10.1: Ability to discuss Sexuality Education topics with peers

Pearson Chi-Square Tests		
		D11. Are you able to discuss Sexuality Education topics with your peers?
C13. Has Comprehensive Sexuality Education helped you as an adolescent?	Chi-square	1.861
	Df	1
	Sig.	.173

Source: Author, 2020

Conclusion

From the test result above we conclude that the Sig (p-value=.173) is more than 0.05. Hence, there is insufficient evidence to reject H_0. We therefore conclude that there is no

relationship between learning CSE and the ability among young people to freely discuss CSE topics with peers. In other words, young people learn about CSE but whether what they learn influences them to openly discuss CSE is not related to their ability to discuss it openly with peers.

5.7.2 ANOVA Test

Fisher (2007) describes ANOVA as a type of statistical test used to determine if there is a statistically significant difference between two or more categorical groups by testing for differences of means using variance. Another Key part of ANOVA is that it splits the independent variable into two or more groups. For example, one or more groups might be expected to influence the dependent variable while the other group is used as a control group and is not expected to influence the dependent variable. One-Way ANOVA can compare the mean across three or more groups. In this particular test, the researcher wanted to check whether there was any significant difference in the age groups of the learners who participated in the study. Assumptions included: the responses for each factor level have a normal population distribution, these distributions have the same variance, and the data are independent. Below is the hypothesis, the test statistic and the conclusion.

$$\boldsymbol{F = \frac{MSE}{MST}}$$

Equation 2: ANOVA

Where:

F = ANOVA coefficient

MST = Mean sum of squares due to treatment

MSE = Mean sum of squares due to error

Hypotheses

H_0: There is no significant difference among the ages of participants in the three districts which were used as study sites; Lusaka, Choma, Kabwe.

H_1: There is a difference in age in at least one of the groups

Test Statistic: ANOVA

Rejection Criteria: Reject the H_0 if p-value is less than 0.05

Results:

Table 5.10.2: ANOVA

ANOVA					
B2. Age of respondent					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	542.409	2	271.204	98.169	.000
Within Groups	1925.550	697	2.763		
Total	2467.959	699			

Source: Author, 2020

Conclusion

From the above result, it is noted that Sig. (p-value) is less than 0.05. Hence there is strong evidence to reject the H_0 and conclude that there is a difference in age in at least one of the districts. In other ways, there is at least one district in which the average age is not equal to the rest.

5.8 Summary of the Chapter

This chapter has provided key quantitative and qualitative information by objectives concerning findings in terms of what learners had to say on questions asked via questionnaires. The objectives that sought to check on ways in which CSE is implemented revealed that although teachers are trained to teach CSE, learners still do not recognise them as influential figures, there is evidence that CSE is being taught in schools, services are available both in schools and health facilities although there is need to be deliberate in ensuring that services are mentioned and understood. Some learners may not know what these services are.

The chapter has also established that there is a near balance in terms of gender as regarding access to ASRHS services. This is competitive as both boys and girls have access to services without issues of power play. The chapter has also established that there is a relationship between culture and CSE as some of the learners felt some content were taboo and could not be taught to learners. Additionally, religion plays a pivotal role in creating

values which guide how communities operate. Some of the teachers were religiously inclined thereby making their work of integrating CSE difficult.

The Chapter also discussed issues around gender-based violence and how schools are responding to the challenge through making reporting provisions of perpetrators of violence in a pursuit to make schools safe for all. The Study also, through two test statistics, utilising Pearson's Chi square test and ANOVA demonstrated that there is at least one district in which the average age is not equal to the rest and young people learn about CSE but whether what they learn influences them to openly discuss CSE is not related to their ability to discuss it openly with peers.

Chapter Six: Discussion of the Findings

6.0 Introduction

Chapter six discusses findings of the study that aimed at examining the implementation of Sexuality and Reproductive Health (SRH) among adolescents in 15 selected primary schools in Choma, Lusaka and Kabwe districts, respectively. The study was premised on the statement of the problem that enquired into the insignificant statistical progress on scaling down adolescent challenges in sexual reproductive health in spite of the introduction of CSE in 2014 by the Ministry of Education and the high investment in it. It has been noted that there is a characteristic insignificant achievement in terms of programme outcomes without clear pointers. The chapter discusses the findings in a themed manner drawing key outlines of the themes from the objectives and research questions. The objectives thematic analysis are the pedagogical approaches to delivering CSE, the relationship between culture and CSE, the effect of CSE on the social-emotional development of adolescents, how primary schools are addressing school related gender-based violence (SRGBV) in implementing CSE and sources of gender-transformative adolescent sexual reproductive health services (ASRHS) for young people in primary schools.

In addressing the statement of the problem in this research, the researcher utilized three theories to explain different phenomena that arise based on the literature review; these are Critical Discourse Analysis, Institutional and Social Learning Theories supported by a pragmatic Worldview as an underpinning philosophy, aligning the discussion to the presentation of findings in chapter five. The requirements of this research were systematically studied, observed, and applied by the researcher throughout the course of the study using both qualitative and quantitative methods to collect and analyse the data. The study explored 700 adolescent learners on the quantitative front and 6 teachers' and 6 learners focus group discussions, 6 key informant interviews and 7 lesson observations across 15 schools in Choma, Kabwe and Lusaka.

The academic demands were highly emphasized by the researcher in order to achieve the objectives of this study with the aim to contribute significantly to the effective implementation of CSE in Zambia. The researcher has also determined new strategies to improve the implementation of CSE. Therefore, the discussion of the findings is structured

according to the issues arising from the problem statement, also highlighted in the objectives and research questions. Research questions largely informed the themes besides those that emerged from the study. These issues were also addressed through the literature and the findings of the main research study. The chapter ends with a summary.

The response rate of the study established that there were more learners in grade six who took part in the study in rural areas compared to other grades at 52% and 53.6% in urban areas. This shows a fair representation of study participants although there were variations as depicted in chapter five across grades. Of interest is the study finding which reveal that learners in both rural and urban areas were aged between 14 and 16 whereas others were aged 17-19. This demonstrates that the most critical age in adolescence was captured under the study. In terms of gender representation as provided in chapter five, the study found out that there were more females who participated in the study than males. The response rate validates the findings of the study as they are representative of the population under study. Therefore, extrapolation of these findings to other similar populations is a possibility.

Table 6.0: Confidentiality Codes for schools & research participant voices

#	CODE	DISTRICT
1.	Teacher Voice: T-SCS 1	Choma
	Learner Voices: L-SCS 1	Choma
	Key Informant Voice: KI - SCS	Choma
2.	Teacher Voice: T-CPS 2	Choma
	Learner Voices: L-CPS 2	Choma
	Key Informant Voice: KI – CPS 2	Choma
3.	Teacher Voice: T-PPS 3	Choma
	Learner Voices: L-PPS 3	Choma
	Key Informant Voice: KI – PPS 3	Choma
4.	Teacher Voice: T-KPS 4	Kabwe
	Learner Voices: L-KPS 4	Kabwe
	Key Informant Voice: KI – KPS 4	Kabwe
5.	Teacher Voice: T-MPS 5	Kabwe
	Learner Voices: L-MPS 5	Kabwe
	Key Informant Voice: KI – MPS 5	Kabwe
6.	Teacher Voice: T-MPS 6	Kabwe
	Learner Voices: L-MPS 6	Kabwe
	Key Informant Voice: KI – MPS 6	Kabwe
7.	Teacher Voice: T-NPS 7	Lusaka
	Learner Voices: L-NPS 7	Lusaka
	Key Informant Voice: KI- NPS 7	Lusaka
8.	Teacher Voice: T-NPS 8	Lusaka
	Learner Voices: L-NPS 8	Lusaka
	Key Informant Voice: KI- NPS 8	Lusaka

Source: Author, 2020

Key to the intialised confidentiality codes:

T – Teacher, L – Learner, KII- Key Informant Interview, Shampande Combined School (SCS), Choma Primary School (CPS), Popota Primary School (PPS), Katondo Primary School (KPS), Muwowo Primary School (MPS1) Makululu Primary School (MPS2), Ngwelele Primary School (NPS)

6.1. Contextual characteristics in relation to implementation of ASRHS

Demographic characteristics of respondents revealed diverse elements that have a bearing on adolescents' response to ASRHS. Three characteristics were noted in the study as having a critical bearing on the implementation of ASRHS. These included male headed households, education attainment of household heads and income sources for household heads.

Male Headed Households - The study established that there were more male headed households (67.6%) compared to females headed households (32.4%). Further, more males in both rural and urban settings reported living in households headed by males as opposed to females. In other words, most homes were dominated by males in terms of headship. This domination of males in households has an implication of female sexual reproduction issues being sidelined in a patriarchal oriented culture. It implies that girls are expected to be submissive and their voice on matters such as sexuality suppressed. Thus with this suppression, adolescent girls easily succumb to male pressure on sexual demands resulting in high levels of adolescent pregnancies in spite of CSE being delivered in schools. Therefore, this strong patriarchal dominance should become a starting point in addressing ASRHS especially for females by creating safe home environments for discussions of sexuality in the homes. When ASRHS originates from a home environment, implementation of CSE in schools will ride on this and could facilitate the attainment of notable achievements than was the status from 2014 to 2018.

Household Heads Education - On education attainment of household heads, the study revealed that the highest level of education attained ranged between grade 10-12 with 35% in rural areas and 38% in urban areas. The second level is for those who attained grade 8-9 at 30% in rural areas and 23.8% in urban areas. The findings indicate that there are limited heads of households who attained tertiary level of education in both urban and rural areas. Having semi-literate household heads has the implication of limited knowledge on several issues including adolescent sexual reproduction health. Thus, this limited information in homes creates an environment of ignorance in adolescents from their childhood on sexuality. By the time they are exposed to CSE in schools, this becomes an entirely new notion which, unknowingly, could be resisted internally. This is compounded by its absence in the home environment. Therefore, adolescents are more likely to perpetuate their lived experiences which are characterized by limited knowledge on sexuality

evidenced by high numbers of female learners dropping out of school due to teenage pregnancies. Therefore, the study has demonstrated that there is an association between low levels of education of household heads and school dropouts as access to information (and its consumption) is not ascertained. In other words, there is an association between low levels of education and the ability to access and consume information on ASRHS.

Household Heads Income - On sources of income by heads of households, the study revealed that most of them are engaged in work/employment followed by sale of crops, piece works and sale of livestock. As was demonstrated by the evidence, the source of income is limited and unreliable for most families. These findings indicate that levels of poverty are rampant among the selected study population. This implies that poverty levels leading to inequalities could affect the way young people and their parents perceive causes of social problems including adolescent sexuality. It therefore becomes imperative that for implementation of ASRHS, poverty levels must be included in the assessment of these programmes. Sexual abuse incited by poverty has a detrimental impact on the education of learners. Thus if this poverty element is not factored in the implementation of ASRHS, even the delivery of CSE will rarely have the desirable outcomes among learners.

6.2 Implementation of Comprehensive Sexuality Education (CSE) in Schools

6.2.1 Training and Orientation of Teachers

The study established that training and orientation of educators in CSE are important for understanding the content and delivery to the learners. Teachers at CPS affirmed that they had been trained in the integration of CSE and expressed confidence in teaching CSE provided they had access to materials needed to make the teaching easy.

As part of strengthening pedagogy, the Ministry of Education has been training teachers including head teachers as a way of building their capacity to manage and supervise the integration of CSE in their daily teaching. A key informant interview at the Ministry of Education Headquarters stated that, although teachers are being trained, more remains to be done as more teachers require training in CSE in order to attain a comfortable balance in numbers and awareness raising. For example, at MPS 5 in Kabwe which is also one of the largest compounds (township) in Zambia, teachers confirmed receiving training in CSE through Ministry of Education intervention via Malcom Moffat College of Education and the DREAMS Project. In terms of orientation of teachers at school level, the study found

that some teachers who attended a CSE training were able to report back and conducted orientation meetings at school level. A focus group discussion at CPS1 reveal that a school guidance teacher worked with the school In-set Coordinator monthly to organise teacher group meetings to discuss CSE and share methods that make it easy for children to understand. Further, the headteacher at PPS3 in Choma added that equipping teachers with CSE knowledge was the best way to empower them in order to effectively teach the learners. Interviews conducted with teachers reveal that CSE is implemented among the teachers that were oriented through a cascade and/or college hub models of implementation respectively.

The need to capacitate teachers is a critical one and supported by Moate and Cox (2015) who contend that both pre-service and in-service teachers should be trained to deliver an effective CSE programme. Training for CSE is largely supported by UNESCO with funding from SIDA (Sweden and Irish Aid). In this regard, teacher training is focused on amplifying CSE content in the curriculum, emphasizing a learner-centered approach in teaching and helping teachers to reconcile their own values and attitudes and to feel confident delivering CSE as expected. However, despite these efforts and support, there is insignificant progress being made in terms of health outcomes.

The findings of the study are not consistent with what Moate and Cox (2015) state in their supposition that both pre-service and in-service teachers are trained to deliver CSE in the country. The findings show that not all teachers are trained at least in the 15 schools of the study. Further, this study findings are consistent with Ketting and Ivanova (2018) who observe that the delivery of CSE differs widely between and even within countries. Despite the differences, the assessment in sexuality education in Europe and Central Asia reveals that sexuality education has become the norm in most countries including Zambia. Remarkable progress although not uniform in Zambia has been made to ensure that CSE is taught to learners. It is however a new concept for countries like Zambia and therefore, a few teething problems are without exception.

6.2.2 Learning about Comprehensive Sexuality Education (CSE)

The findings of this study show that across all the three regions the researcher visited, learners overwhelmingly said that they were learning CSE. This is a clear indication and evidence that learners are indeed learning about CSE in schools. The responses were also

further analysed by urban and rural categories and confirmed that learners in both rural (90.5%) and urban (97.9) were learning CSE.

On equity gender analysis in terms of access to learning CSE /SRH learning and or services, the study revealed that both males and females were able to confirm that they were learning about CSE in schools at 97.6% (male) and 97.2% (female). This is also a positive gender picture which does not show that either males or females are disadvantaged. There was however a small group of respondents among learners who said that they did not learn CSE. This could point to the need for engagement so that learners could fully understand the CSE integration.

This universal access to learning about CSE is supported by UNESCO (2009) which states that the international agreements over the past decades such as the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 have extended the scope of the Convention on the Rights of the Child (CRC). These organizations have affirmed the right of all children and adolescents in receiving sexual and reproductive health (SRH) information, education and services in accordance with their specific needs. This is in line with what the Ministry of Education has been doing in ensuring that learners have access to CSE education through trained teachers. This is supported by the Institutional Theory which provides that the major approach to institutional analysis is the normative approach advocated for by March and Olsen (1984; 1989; 1996)[6]. They argue that the best way to understand behavior (seemingly both individual and collective) is through a "logic of appropriateness" that individuals acquire through their membership to institutions. They contrast this normative logic with the "logic of consequentiality" that is central to rational choice theories. This is consistent with what teachers training aims at achieving; raising awareness of consequences for actions which young people may engage in through formal learning. The institution such as a school, therefore, lays a firm foundation in what its members (learners and teachers) believe in. March and Olsen (1984) argue that people functioning within institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities. These standards of behavior

[6] *Although this is outdated literature, the researcher found that it was very useful to support the finding.*

are acquired through involvement with one or more institutions and the institutions that include schools are the major social repositories of values which learners acquire for a lifetime. In order for this to happen, teacher training should remain central to the delivery of CSE. At the time of the report, the majority of in-service teachers were yet to be trained while many more were joining the system.

6.2.3 Frequency of Teaching CSE in Class

Through an interaction with learners, the study found that learners often learn about CSE at least more than once per week in Choma (87%) and in Lusaka (64.7%). Further, on whether learners feel the time allocated to learning CSE is adequate across all the study sites, the learner's responses were that the time allocated for CSE is adequate with 78% Lusaka, 88% Kabwe and 85% Choma saying the time allocated to integrate CSE is adequate. There seems to have been a problem with understanding the question for respondents in Kabwe as most learners at 63.7% said they did not often learn about CSE. This was followed up with more questions with teachers in a focus group discussion to validate the response. Teachers were able to confirm that learners may not be aware that what they are learning is actually CSE as it is integrated in already existing subjects and not a subject on its own. This was supported by quantitative responses which reveal that most learners were learning CSE from grade five. The study found that both male and female learners confirmed learning about CSE. The CSE framework developed by the Ministry of Education guides that CSE teaching starts in grade 5. This is consistent with the framework and confirms what was happening at school level (MoE 2014).

6.2.4 Commencement of Learning CSE

There are other learners who said they started learning CSE in grade 6, 7 and indeed those who were not sure. However, the policy guideline by the Ministry of Education was that CSE is taught from grade 5 to grade 12 in the Zambian school system. Rutgers (2018) supports that Sexuality education in Switzerland is well developed and lessons commence early between the ages of 4 and 8 years and continue through secondary school. Goldman (2009) in a study on sexuality education for young people in Australia supports that young people access to sexuality education at a younger age yields better results that includes high retention in school, increased knowledge on sexuality education thereby improving health and education outcomes. This is slightly lower in age to that of Zambia but somewhat similar using the age appropriacy in content as the basis of argument.

6.2.5 Integrated Method of Teaching CSE

The study has established that CSE has been rolled out to all schools and is being implemented through a pedagogical approach of integration. The study established that the integration of CSE in schools has been done in various subjects such as social studies, home economics, civic education, integrated science, and religious education. In an interview with the Deputy Head teacher, representing the Head teacher of KPS 4 revealed that teachers have been integrating CSE and that there was evidence in the school through the presence of CSE books that the teachers went through during their training at Zonal centers in 2019. The study reveals that teachers were able to outline the same subjects being used to carry CSE content during teaching.

In terms of methodology, during a focus group meeting, teachers further revealed that they are mostly using group discussions, role plays and question and answer as methods of teaching or integrating CSE at school level. At MPS, the study reveals that, teachers and the head teacher had been exposed to CSE content and they had ideas about the concepts being used. For example, the head teacher was able to state the benefits of CSE and why the Ministry introduced it in 2014. Further, the head teacher reported that 43 teachers had been trained in CSE. Although this was an orientation meeting lasting one day, at least teachers appreciated the content and have been integrating CSE in their daily teaching. A teacher at TKPS recounted how he was trained and that he was trying hard to integrate CSE despite facing challenges of insufficient learning and teaching materials. Despite this integration through carrier subjects by trained teachers, there was still insufficient progress regarding results.

This is supported by the IPPF (2016) which reports that there are a limited number of studies examining CSE in a range of outcome areas. Even though some countries have scaled up CSE programmes in schools, implementation is often nowhere near good enough. IPPF (2016) further contends that where implementation is happening, delivery is often outdated and non-participatory, teaching staff are not adequately trained and content focuses exclusively on health outcomes, rather than the recognition of rights. Sometimes the information is scientifically inaccurate. Teachers have been trained although not adequate to go round, learners confirm learning about CSE yet this does not seem to

translate into the desired outcomes. There is need for more support in terms of training teachers and scaling down CSE to all levels of the ministry.

This is supported by Wakesah (2019) who outlines the subjects covered from grade five in upper primary school to grade twelve. This pedagogical approach is anchored on the Social Learning Theory (SLT) which adequately provides that students begin their socialization in the home and further in the different communities they live in. What they learn at school is a mere reinforcement of the values they have already attained at home. This is further supported by David (2016) who explains that the SLT deals with the ability of learners to absorb and display the behaviors exhibited in their environment. David adds that SLT originated from Albert Bandura who believed that behaviorism alone cannot explain all there is about learning as many facets are at play in the development of a child. Bandura therefore believed that behavior and the environment affect each other. The SLT therefore provides that people are influenced by the world around them.

Thus in relation to SLT, the integration done in the learning of CSE is also dependent on what factors surrounds the children in a particular environment. This explains why teenage pregnancy is characteristic of communities where peer influence is common. One girl gets pregnant, another finds it easy and acceptable, and it becomes a normal practice yet remaining detrimental to the welfare of young people. This is supported by the WHO (2006) which states that social, cultural and economic factors influence sexual decision-making by boys and girls, as individuals and within society.

The pedagogy approach of integrating CSE in the carrier subjects needs to be understood by both teachers and learners. There is need to make it clear to the learners that CSE is an integrated concept and not taught as a subject. Furthermore, teachers should be made aware of how the integration should be done or has been done in order to make it easier for them to handle CSE.

Comprehensive Sexuality Education has been integrated in the daily teaching because of the knowledge acquired. The Headteacher for PPS in Choma said; teachers are using the knowledge and information from other subjects such as Biology, Religious Education and Home Economics when teaching CSE on reproduction and menstrual hygiene. Other

teachers including some learners do not know about CSE as earlier stated. There seems to have been a problem with understanding the question for respondents in Kabwe as most learners said they do not often learn about CSE at 63.7%. This was followed up with more questions with teachers in a focus group discussion to validate the response. Teachers were able to confirm that learners may not be aware that what they were learning was CSE as it was integrated in already existing subjects and not a subject on its own. In other words, CSE is infused in subjects already being taught in schools.

The teachers are aware that CSE is integrated in subjects like science, religious education, and home economics. At Ngwelele Primary School, the study findings show that learners are learning topics in CSE which include abstinence, puberty, personal hygiene, pregnancy prevention and respect. They also learn about human rights, HIV and STIs. A learner during a focus group discussion confirmed that they learn about CSE and cover topics in relationships, family and that one could come back to school after delivering your baby although it is somehow embarrassing. This confirms that learners were benefiting from the delivery of CSE at school level.

The teachers who attended a focus group meeting indicated that they integrate CSE about three times a week through different subjects referred to as carrier subjects. These include Integrated Science, Social Studies, Religious Education and Home Economics in primary Schools and Home Economics, Biology, Religious Education and Civic Education in secondary schools. For Zambia, CSE is in the main curriculum and is examinable by the Examination Council of Zambia. Ketting and Ivanona (2018) provides that sexuality education in Switzerland is mandatory, but with the possibility of opting out. Further, in the United Kingdom, since 1996, Sex and Relationship (SRE) has been compulsory in public (Local authority-run) schools but not in the private schools. The Education Act of 1996 provides that Sexuality and Relationship Education is compulsory for public (not private schools) from the age 11 onward. This shows that the situation is not different from others. The fact that CSE is now examinable in Zambia, this means learners have to learn about it without it being optional. The Table (6.1) below is a detailed illustration of how CSE is integrated and at what level of the grade system in the Ministry of Education:

Table 6.1: How CSE is integrated into different subjects per grade level

Primary Level	**Secondary Level Junior**	**Senior Secondary Level**
Integrated Science	Integrated Science	Biology
Social Studies	Social Studies	Civics/Civic Education
Home Economics	Religious Education	Religious Education
	Home Economics	Home Economics

Source: Wakesah (2019)

The integrated model of delivery for CSE has been under implementation in schools since 2014. However, a desk review of the educational statistical bulletins of the Ministry of Education over a 10-year trends analysis reveals that the problem of teenage pregnancies remains high and a major concern. The trends analysis is shown in Table 6.2 below:

Table 6.2: Number of Teenage Pregnancies and Re-admissions since 2011

Year	Pregnancies Primary School	Re-admissions Primary schools
2011	13,929	5,106
2012	12,753	4915
2013	12,500	4,492
2014	13,275	5,322
2015	13,277	5,217
2016	11765	5,423
2017	10,684	5,527
2018	11,453	4,917
2019	11,502	5,669
2020	12,330	5,078

Source: Ministry of Education (2011 - 2020)

The Table (6.2) of the trends analysis above shows that while the number of teen pregnancies among school going learners have been somewhat constant especially between 2011 and 2016, there has been a steady increase in the number girls going back to school after delivering their babies due to the effect of the re-entry policy. The evidence from the trends table shows that there were 7, 398 girls who returned to school between 2014 and 2017. This demonstrates a steady and stable increase and attributing the success to the benefit of the re-entry policy. It is also important to note that the intervention of CSE

implementation only started in 2014. From 2016, there is evidence that the trend of teenage pregnancies has been going down but only marginally despite the investment in the design and implementation of the CSE and SRH programmes. There are variations of success in different places while the model of implementation remains the same.

Implementing CSE in schools is consistent with the Institutional Theory used in this study. The institutional theory which is one the major approaches to institutional analysis is the normative approach advocated by March and Olsen (1984; 1989; 1996)[7] who argue that the best way to understand behavior (seemingly both individual and collective) is through a "logic of appropriateness" that individuals acquire through their membership to institutions. March and Olsen (1984) argue that people functioning within institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities.

In other ways, the logic of implementation of CSE uses schools as unique platforms to reach many young people and seeking to catch them young in the framework of the institution where values are passed on from teachers to the learners targeting behaviour change. Berthod (2016) supports that the Institutional Theory of organisations puts institutions at the core of analysis of its design and conduct. This theory was therefore adequate and relevant in examining the implementation of sexuality education in 15 selected primary schools in Central, Lusaka and Southern Provinces because CSE is contextualized within the framework of an institution, a school in this regard.

The study findings are consistent with the definition of CSE Ministry of Education Framework (2013) and the UNESCO technical guidance which both state that CSE is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realize their health, well-being, and dignity, develop respectful relationships, consider how their choices affect their own wellbeing and that of others, understand and ensure the protection of their rights throughout their lives.

[7] *Although this is outdated literature, it was imperative to relate to the finding of the study*

6.2.6 Educators of CSE

On who teaches CSE, the study established that the responses from the learners show that it is the teachers at 82.9% (Choma), 93% (Kabwe) and 89.5% (Lusaka). Through these responses, it is clear that learners know whose responsibility it is to teach CSE, and this is supported by the MoE (2014) curriculum framework which states that schools remain central in the delivery of CSE at school level. Other learners mentioned Guidance and counseling teachers at 6.2% (Choma), 6.6% Kabwe and 8.9% Lusaka said nurses provide CSE/SRH information. Others at 3.1%, 1.3% and 0.5% said parents give them information needed. However, the fact remains, formal school settings provide that CSE can be effectively taught by trained teachers in schools and this has been demonstrated by the findings.

6.2.7 Dominant & Preferred Topics in CSE

The study enquired into preferred topics in CSE and established that they are puberty and reproduction related ones. Key topics like culture, early marriages and hygiene are seemingly not liked by learners according to the findings. On reasons why learners like CSE topics, the study found that both male and female learners do like CSE because it teaches them things they did not know about, and this helps them to understand their bodies better. This is consistent with what teachers said in focus group discussions. The study further revealed that all topics as outlined in the CSE framework are being taught. However, the study revealed that most taught topics include puberty, reproduction and HIV and AIDS, respectively. It is however concerning that topics like GBV, child abuse and menstrual hygiene do not receive due attention despite these topics being central and direct contributors to CSE as key content.

The study also checked on what learners say about whether CSE has helped them or not. The delivery of CSE is for pupils to develop their knowledge about Sexual Reproductive Health Rights, (SRHR), Sexually Transmitted Infections (STIs), reproduction, the human body, contraceptive methods as well as their voices to question the norms, identity, gender, gender equality and relationships. Its aim is to help develop respectful relationships among young people. This is discussed in the expressed adolescent benefit of CSE below.

6.2.8 Expressed Adolescents' Benefit of CSE

Teachers at Choma Primary School were able to identify benefits of teaching CSE and link them to the teaching of CSE content at school level. The guidance teacher was able to recount the benefits that include the reduction in the number of girls falling pregnant. She indicated that there was no pregnant case in 2020 whereas in 2019 there was only one case and four to five cases in 2017. This demonstrates an improvement which directly links with the benefits of CSE. Additionally, the findings of this study in Kabwe urban indicate that CSE implementation has been effective with evidence of a drop in teenage pregnancies. The KI of the school further recounted that, CSE has contributed to the reduction in teenage pregnancies in the school from 12 and 15 cases in 2018 to only one pregnancy in 2020. She attributed this remarkable reduction in teenage pregnancies to the influence of CSE and the work of partners like USAID DREAMS project which runs dream centers for girls in Central province.

Further, teachers through a focus group discussion also indicated that learners are changing in behaviour because of the information they are receiving through learning about CSE. Further, the study indicated that most young people in Choma, Kabwe and Lusaka acknowledged that CSE has helped them. Learners in Choma said CSE has helped them with 88% saying yes and only 12% saying no, 90.5% in Kabwe said yes and only 9.5% said no. 96.8% said yes in Lusaka while only 3.2% said no. This confirms that young people know the benefits of CSE. This was also counterchecked on gender basis and the learners both males and females confirmed that CSE has helped them as adolescents. This is good as demonstrates that there is no power play between males and females. This is because access to information does not require discrimination.

The benefits accrued to adolescents in a learning institution supports what the Institutional Theory expounds. Berthod (2016) states that the Institutional Theory of organisations puts institutions at the core of analysis of its design and conduct. This is relevant in examining the implementation of sexuality education in 15 selected primary schools in Central, Lusaka and Southern Provinces. Berthod points out that organisations do not operate in a vacuum. He adds that they deal with a magnitude of external influences such as cultural differences, legal requirements, norms, conventions and with the diversity of actors. The

teaching of CSE is an institutional matter which means that with the correct knowledge, skills and abilities and resources, it should be fairly easy to integrate CSE.

6.2.9 Challenges in Implementation CSE

Despite these positive reactions, the challenge persists. Mackay and Barrett (2010) compares that the US has one of the highest teen pregnancy rates in the industrialized world. The dual adds that each year in the US, more than 750,000 women ages 15–19 become pregnant with more than 80 percent of these pregnancies unintended. This relates very well with the findings in this study regarding the perpetual teenage pregnancies that affect the educational progression of girls in schools. Further, the challenges being faced in Zambia are similar elsewhere as supported by the Future of Sex Education Initiative (2011) which explains that the National Sexuality Education Standards in the United States were developed to address the inconsistent implementation of sexuality education nationwide and the limited time allocated to teaching the topic.

The source further reveals that health education, which typically covers a broad range of topics including sexuality education, is given very little time in the school curriculum. This is exactly the case for Zambia where most responses were indicating that learners were sometimes having CSE integration once per week or not at all. One of the concerns in this study is the concern for the insignificant progress being achieved over the years since the programme started in 2014. There is a deep sense of argument among teachers whether CSE should be given the due prioritisation it deserves or not. As a result, there is this constant neglect to integrate CSE as teachers do not feel compelled to teach as they do for mathematics and sciences including English. A teacher at SCS confirmed to the researcher that a huge teaching workload in science and that he teaches exam classes and so he could not find time to teach CSE. This to a certain extent confirms that teachers have little understanding that CSE is policy.

The assertion above is supported by the Ford Foundation (2014) which reports that the delivery of CSE in schools varies across the rest of the country. A study by researchers at the University of Ibadan found that the percentage of secondary schools within states providing Family Life Health Education (FLHE) ranged from 13.5 to 100%, and most states have no budget line for the program. This is like the situation in Zambia where

partners are expecting results of the implementation where government is not spending resources in the training of teachers apart from the support from partners. Additionally, a study on program delivery of CSE (Esiet, 2012) found multiple challenges, including a limited number of trained teachers, leading to the curriculum being delivered by untrained teachers; crowded classrooms; insufficient learning materials; and inadequate monitoring mechanisms.

The challenge, however remains: why there is little change in behaviour among learners? There is no clear explanation why the more the CSE is provided through formal schooling, the more the challenges persist through poor health and education outcomes that include school dropouts due to teenage pregnancies. This would require further follow up with an in-depth study. The study also found out that teachers are having challenges to teach CSE while others find it easy. This means there is no 'one size fitting all' type of methodology for content like CSE since from inception, this type of content was aimed at being given as IEC and lately targeting behaviour change as part of the main curriculum. There is therefore need to rethink the way CSE is being delivered or the selective approach would continue thereby yielding less impact on the target.

Challenge of CSE Coordination - Through a key Informant Interview (KII) at NPS School in Lusaka, the study brought out the issue of weak coordination in the implementation of CSE at the Ministry and school levels. This is in reaction to the newly introduced model of using colleges of education as training hubs instead of the cascade model. The researcher at this point took keen interest to further probe what else could be attributed to the weak coordination and how best the situation can be improved. The KI stated that, currently the training is being done by the colleges of education while previously, the training was being done by the Provincial Resource Center Coordinators (PRCC), passing it down to the District Resource Center Coordinators (DRCC) and the Zonal Inset Coordinators up to the school level via what was referred to as a cascade model.

The head teacher further stated that, "in that model, we could reach out to the PRCCs, or DRCCs or indeed the zone for support". It was unclear whether colleges would be responsive enough when there was need for support from schools. This could contribute to

even more challenges in teachers taking CSE seriously. The challenge of coordination was confirmed by the Ministry of Health Assistant Director through a key Informant Interview who said that there were challenges with coordinating adolescent sexual reproductive health as most people were not trained in this area including some health workers that included nurses and medical doctors. The assistant director added that this could be a major cause of the challenges that affect the delivery of services to young people at health facility level as the lack of capacity affects coordination. This is supported by Shiffman et. al. (2018) who reveal that in Nigeria the creation of the National Guidelines on Sexuality Education set the stage for the Federal Government's forward movement on sexuality education, including the adoption of the Guidelines and their subsequent delivery of CSE in schools. There are many people who still hold divergent views about CSE and to a certain extent this affect coordination. Only people that agree can work together.

Further, teachers wondered as to how the coordination would work since they were trained by the college in this regard, the Zambia Institute of Special Education (ZAMISE). The guidance teacher further stated that the role of the PRCCs and DRCCs and ZICs were not emphasized in the new model. The general perception from the FGD participants was that, while the new model of training was aimed at ensuring quality of information sharing down to the school level, the model presents a challenge on accountability and lines of support from the ministry structures.

The challenge of free for all type of coordination of CSE within the Ministry of Education is critical. The Principal Education Officer was honest enough to state that there was no standard training manual for CSE and as a result, standardization was still a challenge and remained dependent on a partner supporting the activity at the time. Further, even at directorate level, there was no common understanding of respective roles and functions as no one took responsibility and leadership on CSE. The arguments here are supported by the Institutional Theory which provides that these were all pointing to the ability of the institution to ensure that its members were equipped to deliver an effective CSE. The Institutional Theory was adequate as provided for by Peters (2000) who argues that the opportunity to analyse the internal development of the institutions or the process of institutionalization resides within the institution. Peters (2000) adds that, an institution can remain well institutionalised but through changes, it can alter its nature and can impact on the individuals with interest. The study is interested in the institutionalization of the

Ministries and other implementing partners and as Peters (2000) states, institutionalization involves infusing a functional structure with values and policies that are appropriate with the structures in the schools.

Challenge of Quality Learning Environment - In terms of teachers and classroom sufficiency, the study established that although the school registered a 100% pass rate which was an automatic progression for all grade seven learners to grade eight, the school had several challenges which included insufficient classrooms and fewer teachers. For example, one teacher handled two grades, one in the morning and another in the afternoon thereby leaving the teacher too tired to be effective. Furthermore, this researcher also found out that teachers and learners shared toilets at MPS1 in Kabwe. These challenges widened the already existing inequalities among young people thereby further discouraging learning. A teacher at MPS recounted during a focus group discussion that teachers at the school shared toilets with learners and as women, they found it very difficult to freely use the toilets. The situation equally could be very difficult for girls.

Another challenge the study noted on quality of learning environment was the school being in the vicinity of prison and prisoners especially those in the medium term who were free and were able to move about thereby posing a danger to the girls around the school. In his own words, the KI stated that;

- *…"Prisoners come to the community around the school with beans in exchange for sexual Intercourse with school-girls in grade 5, 6 and 7. Most of them fall pregnant and drop out of school and opt to marry the prisoners once they are released from jail" … KI, Kabwe*

It is clear from this narrative above that the context around this particular school was not suitable for learning and did not present an environment that protects the young people especially girls. The desperation for marriage was confirmed through a-girls-only FGD at MPS in which one girl stated that she would prefer to marry a prisoner because he was also a human being and that she would want marriage.

MPS1 is a special case as most learners are from a community where role modelling is a challenge. There were no people who had emerged from that community to become career people. In this particular community, there was urgent need for sensitization to be carried out on the value of education.

These issues should be addressed if we are to talk about quality education in such a school. In terms of school dropouts, different from other schools, at MPS1, the study revealed that the case was different. A 3-year trend analysis on teenage pregnancies show that cases were on the increase with no hope of a decline. The data obtainable through the guidance teacher's office show that four girls dropped out of school in 2018, six girls in 2019 and eight girls in 2020. These numbers may look small, but it is important to view them from the size of the community being referred to. The situation required a quick intervention in order to reverse the trend. This means a meaningful CSE programme should be organised in the school with direct involvement of learners and teachers. This is supported by UNESCO (2015) which adds that the delivery of CSE requires a specially trained teacher to teach CSE as a stand-alone subject. Stand-alone CSE classes are taught in South Africa, Namibia, and Zimbabwe. In a stand-alone, there is accountability as opposed to integration which Zambia is currently using.

Challenge of use of technology - The study also checked whether technology had a role to play in ensuring smooth delivery of CSE at school level. The findings show that no technology is being exploited. Some of the findings show that; although learners are now able to learn about human rights, challenges persist such as a generational gap in technology manipulation as revealed by the FGD held at SCS in Choma. For example, teachers use old technology of books only to deliver topics in CSE whereas learners were using modern technology through mobile phones to learn ahead of the teachers on their own. As a result, there seems to be a mismatch in knowledge sharing between teachers and learners because some pupils were way ahead and already knew a lot around the issue of sexuality education.

Challenge of Culture and Religion - Another challenge that emerged was the aspect of religion and traditional culture which made many teachers fail to teach sexuality as this was viewed to be at variance with the religious norms and values of society. This response was consistent with some of the arguments advanced early on that teachers were having challenges to teach CSE because of their religious and cultural inclinations. This, however, is also consistent with teachers who have not been trained in a formal CSE training as they lack knowledge about CSE content and methods of delivering it. The CSE content is scientifically accurate and age appropriate as stated in the Ministry of Education CSE curriculum framework (2014). Other teachers as revealed during a focus group discussion

at Choma Primary School contended that cultural norms are a major concern as the teaching of such things like menstruation were a responsibility of parents, grand-mothers, and aunties at family level. They further added that male teachers had a problem to talk about what they did not experience, female teachers and/or indeed aunties should do this.

There are several pieces of evidence from Africa and Asia showing cultural resistance to adolescents' sexual education (Krozier, et al., 2010). Even in more liberal cultures, discussing sexuality for adolescents has not been without challenges; at least at the family level, parents-adolescents sexual communication has faced some difficulties (Turnbulla, et al., 2008). This therefore confirms that the resistance being faced in Zambia is not unique to Zambia alone but globally including in some western cultures.

Challenge of Teacher Attitude - The attitude for teachers in delivering CSE remains a challenge as others continue to feel and think it is 'sinful' to mention body parts such as *penis* and *vagina* including their functions. It is also true that Zambia is mostly a religious and conservative country hence such an outcome at individual level among citizens. The study also found out that teachers hold a view that CSE is contributing to the moral decay among the young people. Teachers argued that CSE is sexualising learners as it is awakening sexual and erotic minds children do not yet have. During a focus group discussion, a teacher openly told the researcher that CSE is contributing to moral decay and gives young people the mind they did not have for sex. This was happening during the period of intensive and aggressive opposition to CSE in Zambia led by two prominent Bishops from the evangelicals. The head teacher of CPS stated that the children were too young and a bit more unaware of the concepts being used such as CSE. Therefore, the age at which they are exposed to learn about CSE is quite too young. She recommends that they could start learning about CSE in grade seven and eight onwards as this would be age appropriate and suitable for them.

Challenge of Materials – The study established that more learning and teaching materials including the CSE framework needed to be printed and distributed to schools. At the time, the materials were insufficient leading to low impact among learners in schools. In terms of materials to support the teaching of CSE, the guidance teacher at NPS however stated that she received CSE books although they were very few for the learners.

6.3 The relationship between Culture and Comprehensive Sexuality Education

The findings of the study indicated that culture influences the implementation of Comprehensive Sexuality Education (CSE) and Sexual Reproductive Health Rights (SRHR) in schools. In reviewing the relationship between culture and CSE, questions around appropriateness of CSE to religion, language and culture were asked.

6.3.1 Appropriateness of Topics in CSE with Religion

It is argued that religion is an essential element of the human condition. Hundreds of studies have examined how religious beliefs mold an individual's social and psychological being. Research has explored how an individual's religion (religious beliefs, religious denomination, strength of religious devotion, and so on) is linked to their cultural beliefs and background. This is supported by Roudsari et al., (2013) who state that, despite clear reasons for necessity of sexuality education for adolescents, CSE is still a contested issue and faces challenges in most cultures. Further, while some researchers have asserted that religion is an essential part of an individual's culture, other researchers have focused more on how religion itself is a culture. The key difference is how researchers conceptualize and operationalise both terms. Moreover, the influence of communication in how individuals and communities understand, conceptualize, and pass on religious and cultural beliefs and practices is integral to understanding exactly what religion and culture are.

The researcher therefore sought to establish whether religion and culture including language being used had an influence on the implementation of CSE and or whether it is bearing influence to the insignificant progress being witnessed in the implementation of CSE since its inception in 2014. Religious and traditional leaders should be involved in ensuring that CSE supported for the opposition to come down as these are gate keepers of our communities. While CSE is viewed as a sensitive matter, a religious perspective creates barriers if people choose to judge the contents therein.

Further, learners in Choma said topics were appropriate with religion at 79.4% against 20.6% of those who said the topics were not appropriate with religion. Learners in Kabwe and Lusaka said the topics in CSE were not appropriate. The responses in Kabwe and Lusaka were quite concerning as to why learners felt that some topics were not appropriate. This is consistent with the discussion on the views of some of the teachers who said that their beliefs were at variance with the teachings of the bible and their culture as some of

them took to active religious engagements thereby affecting their perception and ability to deliver CSE.

6.3.2 Appropriateness of Language in Teaching/Learning CSE

On the language used to teach CSE, the findings show that English was the language predominantly used to teach CSE in schools. The study found out that 78.5% of learners in Choma, 94.7% in Kabwe and 89.8% in Lusaka stated that they learned about CSE in English. There were however negligible scores of those who said they learned CSE in Tonga at about 17.3% in Choma, 6.4% in Nyanja in Lusaka and 3.7% in Bemba in Kabwe. This therefore confirms that CSE is being taught largely through English which is the official media of instruction in schools. However, this did not rule out completely the local language use in explaining certain details which learners may not be able to clearly understand in English. Further, the findings of the study show that learners in Choma stated that CSE was appropriate with language at 79.6% whereas only 20.4% said CSE was not appropriate with language. In Kabwe, 89.5% said it was appropriate and only 10.5% said it was not. Lusaka had 88.2% responding that it was appropriate while only 11.8% said it was not. Going by the findings of the study, most learners in total (86.4%) said yes against 13.6% of those who said no. This study finding demonstrates that CSE does not depart from the cultural values and norms of a society as attested by the respondents in this study.

6.3.3 Appropriateness of CSE Topics with Culture and Religion

In terms of the relationship between culture and CSE, through a focus group discussion with teachers, the study established that both teachers and KI were able to state that culture played an important role in influencing the delivery of CSE at school level and depending on the local context. For example, teachers at SCS and CPS were able to state that different cultures exist around schools such as initiation ceremonies when a girl becomes of age. The moment a girl went through the initiation process, she became shy and her performance went down in school as the focus changes to a relationship as opposed to education. Teachers stated that, they found it challenging to teach difficult concepts around sexuality like gender, pregnancy, dangers of sexual intercourse and puberty to mention but a few as the local language presented a challenge and a possible cultural conflict since teachers also had biological children in the classes they taught. The resultant effect of this was that learners were unable to ask questions during lessons covering such content and a teacher found it easy to ignore such content and move on to more comfortable contents. In the same

vein, religious inclinations as stated earlier, continued to challenge teachers as some of them were leaders in their religious organisations like the Seventh Day Adventist Church and Evangelicals or indeed Pentecostal churches which are deeply conservative on such matters. This is also supported by Roudsari et al., (2013) who expose some common concerns that are associated with providing sexuality education for adolescents; for example, many parents, teachers and policymakers believe that that can result in early sexual activity and privation of childhood innocence. Unfortunately, these are people who are supposed to be well informed yet their perception of things is different or tainted with religious and cultural believes and values. To some extent, this makes the implementation of CSE difficult

The study further enquired whether CSE is viewed as a taboo in a culture. As can be seen, topics like puberty, though scoring low at 22% and 14%, are still not viewed as taboo. However, there was also a mixture of responses as some felt that some CSE topics were a taboo while others did not. Therefore, teachers should not feel restrained to teach CSE related topics as these do not go against the culture at least as established in the three study sites.

6.3.4 Factors Hindering Delivery of CSE in Schools

Roudsari al et., (2013) states that, despite clear reasons for necessity of sexuality education for adolescents, CSE is still a contested issue and faces challenges in most cultures and Zambia has not been an exception. In 2020 during the time of data collection, the researcher found out that Zambia was witnessing an aggressive and systematic campaign against the implementation of Comprehensive Sexuality Education (CSE) in Zambian Schools. Subsequently, a motion to suspend the teaching of CSE was raised and debated in parliament on 7th and 8th October 2020. This private member's motion to suspend CSE was rejected unanimously by Members of Parliament on 8th October 2020. The arguments used by the CSE opposers in Zambia at the time were a replication of the arguments advanced by Family Watch International (FWI) in similar campaigns and petitions conducted in other countries. Under the 'Protect Zambia Children campaign', the Evangelical Fellowship of Zambia (EFZ) was at the time circulating a petition to withdraw CSE from the Zambian Schools with support from Family Watch International on what

they termed ‘15 Harmful Elements of CSE on Children’. This to a certain extent had potential to affect the responses of the target group of this study.

As a result of this opposition to CSE, the findings further show that teachers who keenly followed the debate in the media in some schools were resistant to integrate CSE in their daily teaching siding with the position of the opposers. This demonstrates that religion and culture to some extent has potential to affect the delivery of CSE at school level. As gatekeepers of sexual health information for adolescents, adults define content of information that adolescents receive, whereas there is a gap between what they perceive adolescents need and what adolescents themselves really need (Avusabo-Asare, et al., 2008). Further, sexual education is a form of value-based education and due to political, cultural, religious and ethnical diversities, agreement on values especially in controversial areas of sexuality remains challenging (Halstead and Reiss, 2003).

The study used the Social Learning Theory to understand why communities and individuals react the way they do using a religious mask. The Social Learning Theory stipulates that people or students can learn new behaviors by observing others (David, 2016). This refers to the reciprocal relationship between social characteristics of the environment, how they are perceived by individuals and how motivated and able a person to reproduce behaviors they see happening around them. The WHO (2006) reveals that natural sexual curiosity, experimentation and learning before and during adolescence are both normal and healthy and occur in all cultures. However, despite this explanation, there remains a context of cultural and religious values that do not sit well with the fact that this is a reality and until communities including the Zambian one open up and accept that young people engage in sexual activities, will we confront the problem our communities face. The implementation of CSE has been ongoing since 2014 and to date, the numbers of female learners who drop out of school due to teenage pregnancies, low levels of comprehensive knowledge on HIV among young people, acquisition of STIs and general poor health outcomes remain a huge challenge.

The study also sought to check whether there are cultural factors that hinder the teaching of CSE. The findings show that generally, there is a feeling that there are **no** cultural factors that significantly impede the teaching of CSE in schools and equally there are **no** religious

factors that hinder the teaching of CSE in schools. It is important to note that the Yes was strong in Choma whereas the No was strong in Kabwe leaving more room for further enquiry for such a mixed reaction.

6.3.5 Appropriateness of Topics in CSE with Religion

This study was also checking under the same objective whether topics in CSE are appropriate with religion. The study found out that 79.4% of respondents in Choma said topics in CSE were appropriate with religion against 20.6% of those who said the topics were inappropriate with religion. In Kabwe, 58.2% of the respondents said topics were appropriate whereas 41.8% said topics were not appropriate and in Lusaka 56.5% said topics were appropriate while 43.5% said topics were not appropriate with religion. The responses in Kabwe and Lusaka are quite concerning as to why learners with a reasonably high percentage in each case felt that topics were not appropriate. The study also queried on which topics, particularly, were not appropriate with religion. The study found out that learners felt that topics like puberty and reproduction were not appropriate with religion at 50.2% and 24.5% saying puberty and reproduction were not appropriate with religion. There were relatively higher scores in Kabwe at 53.8% and 35.6% as well as in Lusaka at 64.9% and 14.4%. This could speak to the fact that some communities were deeply or heavily religious and this could have had a bearing on the responses. This is consistent with the findings through a teacher focus group discussion in Choma and Kabwe which confirmed that there was conflict between religion and teacher personal values which affected the way teachers felt. There is a cocktail of responses under this question which are exposing the fact that learners have different views which could require deeper enquiry through further research.

The findings above are consistent with what other writers have said and cited in literature review. Kumi-kyereme, et al., (2008), for example, state that, "as gatekeepers of sexual health information for adolescents, adults define content of information that adolescents receive, whereas there is a gap between what they perceive adolescents need and what adolescents themselves really need". Sexuality education is a form of value-based education and due to political, cultural, religious, and ethnical diversities, agreement on values especially in controversial areas of sexuality remains challenging.

It is also important to appreciate that issues of sexuality are part of our humanity and a bi-product of our socialization learning. This is supported by the Social Learning Theory as espoused by David (2016) and explains that the Social Learning Theory (SLT) deals with the ability of learners to absorb and display the behaviors exhibited in their environment. SLT originated from Albert Bandura who believed that behaviorism alone cannot explain all there is about learning. Bandura believed that behavior and the environment affect each other. The Social Learning Theory therefore assumes that people are influenced by the environment around them (David, 2016).

For the learners, their socialization starts in the home and further, the different communities they live in. According to the World Health Organisation (2006) social, cultural, and economic factors also influence sexual decision-making by boys and girls, as individuals and within society. The Social Learning Theory stipulates that people or students can learn new behaviors by observing others (David, 2016). This refers to the symbiotic relationship between social characteristics of the environment, how they are perceived by individuals and how motivated and able a person to reproduce behaviors they see happening around them. Every human being therefore has the shame, the silence that surrounds sexuality education in some sectors of society should not be viewed only as religious but cultural as well as the two being interdependent of each other.

6.3.6 Ability to Discuss CSE Topics with others

The findings show that the picture can change with consistency. More evidence from this study demonstrate that learners can discuss CSE topics with peers freely as well as with their parents. Overall, this demonstrates that although leaners are learning CSE in school, many feel they cannot openly discuss CSE with their parents. This calls for a strengthened Parent to Child Communication programme. This is supported by the cultural argument discussed earlier that the issue of sexuality is surrounded by the shame and silence. Unless a push for CSE in schools is strengthened and implementers remaining consistent, there is a risk of losing the gains so far achieved.

Through a focus group discussion, one of the teachers recounted how it was possible to talk about certain concepts in CSE as they taught learners, admitting that these concepts had been there in subjects like Biology since time immemorial. She however indicated that

not all teachers would find it easy to talk about these issues of CSE as some are shy to do so to their learners including their own children. Teachers also confirmed this in a separate focus group discussion in which they stated that they found it difficult to handle some of the content in CSE. Content like puberty, conception, Sexual intercourse and its dangers and body parts seem so difficult to talk about openly to young people.

This is supported by Boler et al. (2003) who through his study found out that in both India and Kenya, though teachers played a major role in giving young people information on HIV/AIDS and sexuality they were constrained by social and cultural factors. The result of this was that teachers resorted to 'selective' teaching where they restricted teaching only the biological aspects and left out those that had to do with sex and relationships. Evidently, this is the influence of culture and religion. It has potential to compromise the content of CSE/SRHR.

The study under this objective also utilised a Critical Discourse Analysis (CDA) theory to help understand how learners and teachers use language to convey meaning. Critical Discourse Analysis contends that social phenomena are socially constructed in any society. This is supported by Wodak and Meyer (2008) who state that CDA as a school or paradigm is characterized by several principles: for example, all approaches are problem-oriented, and thus necessarily interdisciplinary and eclectic. Critical Discourse Analysis (CDA) is a field that is used to analyze the written and spoken texts to explore the discursive sources of power, dominance inequality and bias. It critically evaluates how these discursive sources are maintained and reproduced within specific social, political, and historical contexts.

Fairclough and Wodak, (1997) state that CDA sees 'language as social practice' and considers the 'context of language use' to be crucial. CDA understands discourses as relatively stable uses of language serving the organization and structuring of social life. There are two schools of thought for CDA, the traditional and Modern (Bukhari & Xiaoyang, 2013). The modern Traditional School sees the role of language as descriptive, whereas the Modern School of Social Constructionists suggests that discourses have the capability to re-construct social reality (Jorkinen et al., 1993, Fairclough, 2005). The

pioneer in the field of Critical Discourse Analysis contends that social phenomena are socially constructed.

Bukhari and Xiaoyang (2013) explains that since the beginning of formalized education, research has been used to improve education and to determine in a wide range of situations. Through various research methods, teachers hope to obtain reliable and accurate information about important issues and problems that face the educational community. Bukhari and Xiaoyang (2013) adds that knowledge of research is an essential as well as integral component of professional preparation for attaining skills and competence for all teachers. Since CDA is both a theory and a method, this study was interested in the relationship between language used in the delivery of CSE in schools and the society or communities as well as the environment learners are exposed to and CDA was used to help to describe, interpret, and explain such relationships.

The teaching of CSE is done through a language that learners understand. Although English is the main language and medium of instruction, teachers are free to use other languages that communicate to the learners. Unfortunately, if care is not taken, the use of text can be used a source power to affect the way males and females relate to each other. Boys and girls through CSE learn that they are equal, and they can collaborate to help each other in many ways.

6.4 The Effect of CSE on the Social-emotional Development of Adolescents

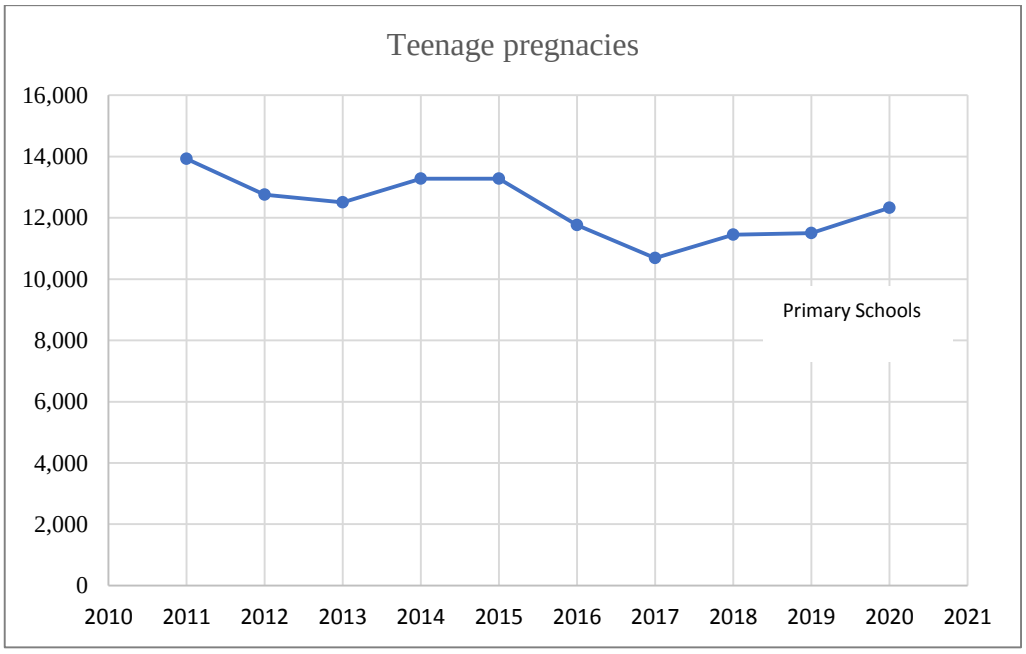
This domain of questions aimed at enquiring into whether there has been an effect, be it positive or negative, in the teaching of CSE to the learners and young people in schools. Central to the focus of the interaction was the understanding that CSE is one of the interventions to improve ASRH through the provision of school based sexuality education whose components among others include; abstinence only, abstinence plus and comprehensive sexuality education: Abstinence only referring to more conservative approach, promoting sexual abstinence for youth before marriage to reduce risk for pregnancy or STIs whereas abstinence plus programs promote abstinence as the main strategy for sexual risk reduction but also offer information on modern pregnancy and STI prevention methods.

6.4.1 Adolescents Engaging in Risky Sexual Behaviours

Through a focus group discussion on whether CSE has had a positive effect on the lives of the learners, both teachers and learners responded in the affirmative saying CSE has helped to reduce cases of teenage pregnancies in schools. Pupils, for example, at Choma Primary School indicated that CSE had helped some of their friends who had been careless with boys to complete their education without falling pregnant. Further, a focus group discussion for teachers at MPS in Kabwe revealed that CSE was having a positive effect on the learners in terms of information that was helping them to change their ways of social interaction. The study has revealed that although learners still get pregnant, there is an observable reduction of pregnancies according to their teachers.

The three-year overall school statistics on school dropout at MPS revealed that; nine learners in 2018 dropped out of school due to teenage pregnancy, in 2019, six and in 2020, four learners. This reduction justifies the fact that CSE is working as can be seen by the trend over a period of 3 years. The outcome may not be a 'magical bullet' but certainly, the effect of the programme was being attested by the end users of the programme. This was also consistent with UNESCO (2017) and UNFPA (2018) reports that indicated that CSE works when started early and consistently delivered by trained teachers yet keeping it age and culturally appropriate. The study finding is also supported by the Ministry of Education who stated that CSE was beginning to bear fruit through increased awareness, reduction in school dropouts although insignificant as demonstrated in the graph below especially for 2016.

Figure 6.0: Reduction in Teenage Pregnancies



Source: MoE EMIS Bulletin

The argument above is supported by Yu (2010) who contends that CSE had positive impact on religious commitment and participation of religious activities. In a New Zealand longitudinal study of a cohort of 1,020 participants, Paul et al., (2000) found that religious beliefs/practices were an important factor enabling them to sustain sexual abstinence to age 21. Equally, a study of 1,153 adolescents in Nigeria by Odimegwu's (2005) revealed its positive effect on both sexual attitudes and initiation. In addition, its positive impact on condom use was reported in a US study of 230 first year students at a Catholic university (Zaleski and Schiaffino, 2000). From these studies, CSE has positive impact on the lives of learners if applied correctly. However, for Zambia, the concern has been the insignificant progress since the inception in 2014. If a project with such great potency over a long period of time is not yielding positive results, it could be time to get to the drawing board and revisit (and perhaps adjust) the approach.

On whether the young people engage in risky sexual behaviour, the study established through this evidence that young people engage in risky sexual behaviours. 54.7% (Lusaka), 37.4% (Kabwe) and 43.6% (Choma) responded that young people were engaging in risky sexual behaviours that included unprotected sexual intercourse, drug abuse including alcohol. There are still those who said that young people did not engage in risky sexual behaviours at 31.3% (Lusaka), 44.4% (Kabwe) and 43.6% (Choma). These

responses could support the importance of CSE in schools. This is further supported by American College Obstetricians and Gynecologist (2016) which states that CSE programs reduce the rates of sexual activity, sexual risk behaviors (e.g. number of partners and unprotected sexual intercourse), Sexually Transmitted Infections, and adolescent pregnancy.

The impact of CSE was explored on the sexual knowledge and skills in England. Stephenson et al. (2004) conducted a school-based randomised trial of over 8000 pupils aged 13 to14 to evaluate the long-term effect of pupil-led sex education. The programme showed some positive impact on self-reported knowledge of methods to prevent STIs and skills in using condoms at age 16. This means that CSE is effective but is it being implemented well in Zambia? Why are we having this insignificant progress on a well-intended programme?

6.4.2 Free Discussion of Sexual Feelings by Adolescents

The study further found out that learners can freely talk about sexual feelings with anyone. The rating were at 62.1% (Choma), 65.1% (Kabwe) and 68.2% (Lusaka) of the learners who said they could freely talk about their sexual feelings with anyone. However, there were those who said they were not able to talk freely about their sexual feelings with anyone as follows: Choma had 37.9%, Kabwe scored 34.9% and Lusaka 31.8%. This means that the respondents were divided over the level of freedom they had regarding being able to freely talk about their sexual feelings. The question was further analyzed on gender basis and the findings show that 69.3% of the males and 61% of the females said they could freely talk about their sexual feelings whereas 30.7% of the males and 38.9% of the females said they were not free to talk about their sexual feelings. In other words, both males and females felt at liberty to freely talk about their feelings without any power play based on gender while others did not. This demonstrates the effect of CSE being experienced in the lives of young people. The study further found out that learners are not able to freely talk about their sexual feelings due to the silence and the shame that comes with knowing that one is engaging in sexual activities at a young age in the community.

There are some learners at the same school who said, they did not have clear knowledge about when a boy could make a girl pregnant. This came to light when pupils at CPS, PPS and KPS were unable to explain what makes girls pregnant through focus group discussion

meetings. Whether this was due to shyness or not having the knowledge, it remained unclear to the researcher. In some cases, some participants were too young to comprehend higher level thinking (HLT) around reproductive health since some were in grade 5 and 6 at the time of research.

Through a focus group discussion, learners were able to outline changes that occur at puberty when girls and boys are growing up. Further, teachers at Shampande Primary school supported the views of the learners by saying CSE had helped many young people to access critical information on how to prevent pregnancy. Additionally, learners at Choma Primary school stated that they had benefited from CSE as the information they had obtained helped them to know how to prevent pregnancies and freely ask for what they wanted as individuals. Others said, CSE had helped them not to become pregnant and that they then knew that sex was for adults. This explains that sex was happening among young people, and that they lacked information on how to make use of the available CSE knowledge.

6.4.3 Adolescent's Confidant in Discussing Sexual Feelings

On whom the respondents were comfortable to talk to about their sexual feelings, the study found out that learners were mostly comfortable to talk about their sexual feelings with a grandmother. The evidence gathered shows that 41.1% (Choma), 46.9% (Kabwe) and 27.2% (Lusaka) said that they were comfortable to talk with their grandmother. Very few learners chose either male or female teacher even though CSE was being taught by teachers. This is concerning especially that teachers are the ones who have been trained to deliver CSE. This is consistent with what teachers said earlier on that there is discomfort to talk about sexuality issues with learners because some of the learners were their biological children. The study further exposed that young people could talk about their bodies freely and were also at liberty to ask questions. This speaks to the effect of a good programme but perhaps too little impact at outcome level.

6.4.4 Effect of CSE on Adolescents

In terms of effect of CSE on the lives of learners, the head teacher at MPS had challenges to quantify that in the face of an antagonistic approach from the community who seem to resist CSE, and their reasoning is based on lack of knowledge. Further, he stated that it was a difficult experience to convince the parents who did not believe in the value of education

to allow their children to come to school. Prisoners who had been in jail for many years without access to spouses for their conjugal rights felt entitled to 'prey' on young girls thereby indiscriminately impregnating them leading to the reported school dropouts in the school. In other words, there was no sign of CSE positive effect in this school.

In examining how the CSE programme was having any effect on the lives of the learners, again, the Social Learning Theory (SLT) was applied in helping to understand how learners shape behavior thereby leading to learning. The SLT stipulates that people or students can learn new behaviors by observing others (David, 2016). This refers to the reciprocal relationship between social characteristics of the environment, how they are perceived by individual and how motivated and able a person is to reproduce behaviors they see happening around them.

The World Health Organization (2006) reveals that natural sexual curiosity, experimentation and learning before and during adolescence are both normal and healthy and occur in all cultures. The study therefore used the theory of social learning to understand adolescence and sexuality. According to World Health Organisation (2006) adolescence is a time for learning to love oneself and others and to be responsible in one's relationships. During this period, young people develop intimate bonds and learn to enjoy the pleasures of sexual activity. Adolescents also learn about the health risks associated with sexual practices and behaviours, and their vulnerability to these risks – often at first hand. This period sets the stage for mature adult sexual relationships (World Health organization, 2006). Learning about CSE is heavily based on one's socialisation and exposure to age-appropriate information. In schools where socialisation is affected by conservatism and the culture of shame and silence around CSE and SRH issues, learners remain closed thereby causing no impact on the teaching of CSE.

The study also utilized the Institutional Theory which espouses that the first of the major approaches to institutional analysis is the normative approach advocated by March and Olsen (1984; 1989; 1996)[8]. They support that the best way to understand behavior (seemingly both individual and collective) is through a "logic of appropriateness" that

[8] *Although this is dated literature, the researcher found it useful to explaining behaviour*

individuals acquire through their membership to institutions. They contrast this normative logic with the "logic of consequentiality" that is central to rational choice theories.

March and Olsen (1984) argue that people functioning within institutions behave as they do because of normative standards rather than because of their desire to maximize individual utilities. Further, these standards of behavior are acquired through involvement with one or more institutions and the institutions are the major social repositories of values. Further, according to Berthod (2016), the institutional theory of organisations puts institutions at the core of analysis of its design and conduct. This theory was relevant in examining the implementation of sexuality education in 15 selected primary schools in Central, Lusaka and Southern Provinces as schools present perfect grounds for implementation of CSE. Berthod points out that organisations do not operate in a vacuum. He adds that they deal with a magnitude of external influences such as cultural differences, legal requirements, norms, conventions and with the diversity of actors (Berthod, 2016). Peters (2000) adds that the institutional theory also provides the opportunity to analyse the internal development of the institutions or the process of institutionalization.

In examining the effect of CSE on the lives of the young people, the logic of consequentiality which is also central to rational choice theories through the institutional theory implies that learners learn more effectively through institutional values and the course of consequences others go through present in themselves a learning curve for many because they can see them on return basis through the re-entry policy. The consequences represent the pain of the many missed opportunities and others would not like to go through the same.

6.4.5 Attitude and Behaviour Change among Learners

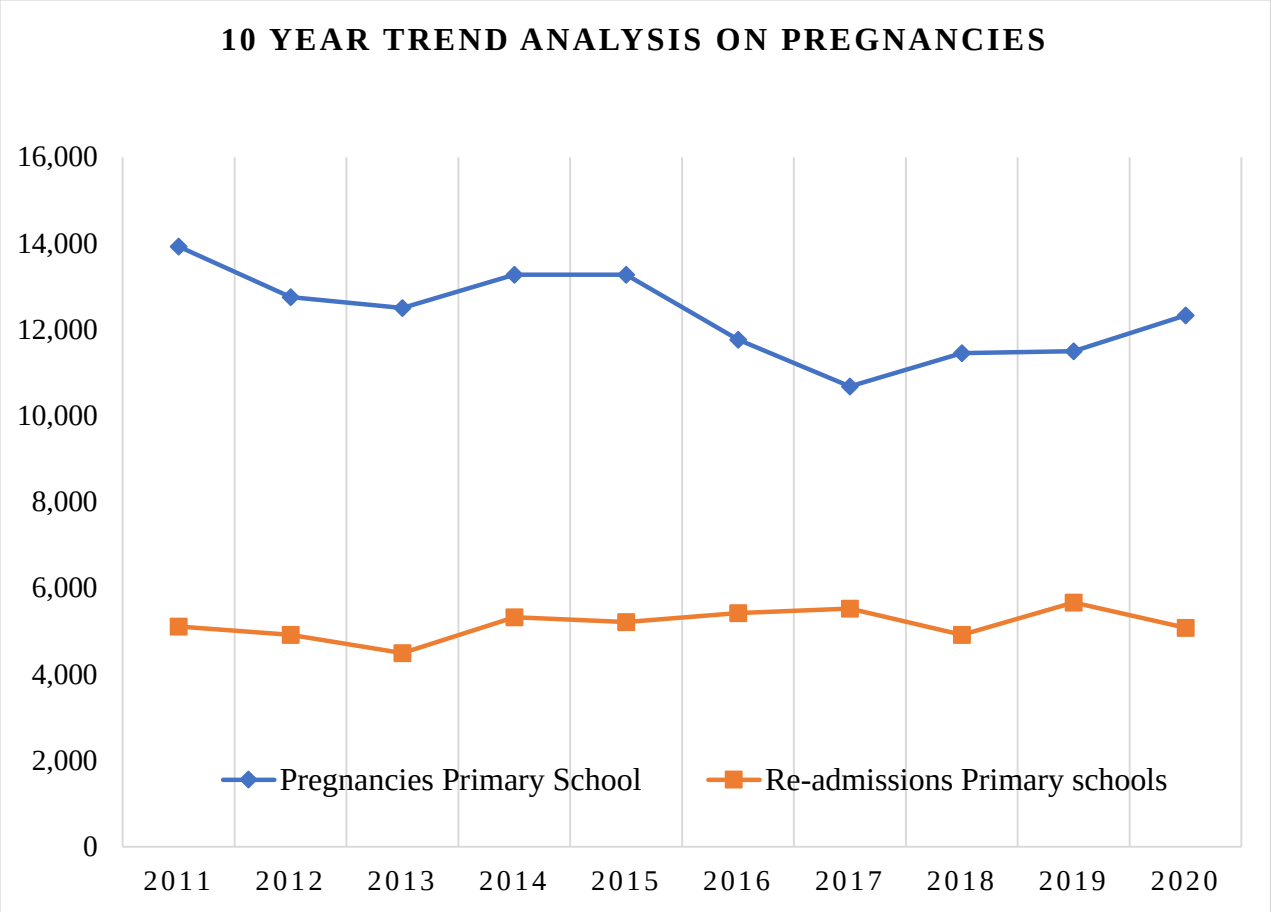
The findings of this study continue to indicate that attitudes in learners have also improved. For example, female learners can freely ask for menstrual hygiene sanitary pads being distributed for free at school. This change in attitudes is attributed to an increase in knowledge due to the provision of CSE at school level. Prior to this, female learners could not ask for sanitary ware as it was perceived shameful for a girl to openly be on menstrual cycle. The Key Informant at CPS confirmed this assertion emphasizing that more of such support should continue for girls as this will help them a lot to develop self-esteem during the time they are on their periods thereby increasing on their school attendance.

However, apart from these positive effects, there have been challenges as not all learners are changing because they do not get the same information from teachers since not every teacher was trained in CSE. Some teachers were resisting CSE because they lacked understanding of its content and benefits as they thought CSE was 'spoiling' children with moral decay. The aspect of no change in behaviour is anchored on the values children have from families. The impact of family communication appears to depend on what parents talk about. This is confirmed by a longitudinal study by Romo et al., (2002) who documented matters of talking about dating and sex among 55 Latino mothers and their children. Dialogue about values and beliefs was found to have a positive impact on attitudes to premarital sex and sexual initiation; however, talking about everyday activities had no effect (Yu, 2010). This emphasises the need for the role of parents in ensuring that information on ASRH and CSE is shared and contribute to helping young people attain the desired behaviour change.

6.4.7 Re-entry Policy and Positive Effect on Learners

The Ministry of General Education with support from its cooperating partners produced the re-entry policy in 1996 whose aim was to encourage girls who fall pregnant to go back to school after delivering their babies. This is consistent with Zambia's belief that all its citizens have a right to education regardless of their gender. This is on the underpinning that early and unintended pregnancy leads to a colossal loss of educational opportunities for girls: A high proportion of pregnancies among adolescent girls aged 15-19 years in Zambia are unintended, and nearly half of all adolescent girls who have ever been pregnant are out of school in Zambia. The re-entry policy therefore is a critical piece of policy to help such girls. The CSE being implemented in Zambia has also helped the learners who dropped out of school due to teenage pregnancy to return to school after they have delivered their babies. A guidance teacher in Choma confirmed that as a school they helped to withdraw four girls from early marriage between 2017 and 2019. Further, the statement above on the effect of CSE is supported by the Ministry of Education Statistical Bulletin (2018) which indicates that there was a reduction in teenage pregnancies in 2015 from 16,382 to 15,222 in 2016 representing a 7.6%. This is a positive effect of CSE on the beneficiaries although much needs to be done. The challenge remains; less than half of those girls who drop out due to teenage pregnancies return to school after delivering their babies as demonstrated in a 10 year trends analysis for primary schools only below:

Figure 6.1: Pregnancies and Re-admissions after falling pregnant in Primary Schools



Source: MoE EMIS Bulletins

The study has also demonstrated that there are challenges which have remained consistently glaring. For example, some of these challenges include lack of adequate materials and insufficiently trained teachers in CSE. Another participant in a teacher's focus group stated that parents around the school community sometimes preferred their children to get pregnant. This came to light when the school guidance teacher followed up one learner who had dropped out of school due to pregnancy. She informed the researcher that it was shocking to hear the mother of the teenage girl say; it is better if my child has a baby now as a sign that she is fertile instead of going to traditional healers looking for fertility in future.

It is clear from the above that parents who think it is a good thing if their children were having babies now as a sign of progress, lack knowledge that if girls are educated now, then they are empowered for life. An Interview with the Ministry of Health also exposed

that many young people especially girls have access to family planning. However, even if they were to have access, there is stigma as many parents think family Planning is poisonous to the bodies of young people. In this regard, there is need for community awareness to be able to change this kind of mindset. It is such thinking that would make it difficult to develop communities like the Makululu Community which is one of the largest shanty compounds (townships) in Zambia.

6.5 Implementing CSE in addressing School Related Gender-Based Violence

UNESCO Global guidance on addressing school-related gender-based violence (2018) states that School-related gender-based violence (SRGBV) affects millions of children, families, and communities. It involves acts or threats of sexual, physical, or psychological violence occurring in and around schools. These acts are perpetrated because of gender norms and stereotypes, and enforced by unequal power dynamics. The forms of SRGBV have been documented in all countries around the globe, though reflected differently within and between countries (Leach et al., 2014).

Patterns of violence are related to the varying histories, political economies, socio-cultural conditions, and institutional frameworks – as depicted in the outer layer of the diagram (Johnson Ross et al., 2017; Parkes et al., 2017c; Parkes et al., 2017b; Westerveld et al., 2017). Johnson Ross et al., 2017 states that SRGBV has very real consequences in learners' lives, ranging from low self-esteem and depression to early and unintended pregnancy and sexually transmitted infections including HIV. This violence also has a serious impact on educational outcomes, with many students avoiding school, achieving below their potential, and possibly dropping out completely. In line with the same, this study sought to check whether school related gender-based violence exists in schools? The focus group discussions and also the key informant interviews revealed that SRGBV exists at school level and contributes to making other learners shun school.

6.5.1 Adolescent Girls and SRGBV

The study findings also show that learners were able to identify the forms of violence targeted at girls. These include sexual harassment at 45.5% in rural areas and 40% in urban areas. The other form of violence targeted at girls is bullying rated at 29.5% in rural areas and 36.6% in urban areas. Sexual acts for exchange of good grades also is another form of

violence targeted at girls by teachers. Under this one, 27.3% in rural areas and 23.2% in urban areas said the form of violence occurs. Physical fights were also identified at 22.7% in rural areas and 34% in urban areas saying the form of violence occurs.

Social Status - This confirms that SRGBV is still rampant in schools and the schools sometimes know little about it as most cases go unreported. Some pupils are bullied because of their social status. For example, one learner was bullied all the time because other pupils (bullies) thought the girl was pompous as she was coming from a well to do family. This particular case came to the attention of the school authorities and the guidance teacher moved into provide counseling and since that time, that girl had not reported any case of bullying at school or on the way to/from school. The study through a survey among learners also found out that there was violence targeted at girls only at 67.4% rural and 62.8% urban. However, 32.6% in rural areas and 37.2% in urban areas said there was no violence targeted at the girls only. One of the key pillars of CSE is the prevention of violence among young people in schools. Violence makes schools unsafe and have potential to lead to injury and or death in some cases where it was not addressed. This is confirmed by UNESCO (2012) on a study on incidences of SRGBV which highlights that this violence can occur in the classroom, in teacher residences, toilets, dormitories, and the roads and areas near schools, among others.

This type of violence was made up of a variety of actions that include, but are not limited to: (i) Bullying, including verbal and/or physical harassment; (ii) Sexual harassment, also referred to as 'teasing' or insinuation; (iii) Sexual acts in exchange for good grades or for the paying of school fees; (iv) Non-consensual touching or sexual assault; (v) Seduction or sexual harassment of learners by a teacher; and (vi) Tolerance (or encouragement) of male dominance or aggression within the school environment. UNESCO further supports that the prevailing gender norms legitimize violent behaviours toward girls, thereby rendering these acts invisible and reinforcing gender identities that subordinate girls. Boys may also be targets if they do not conform to prevailing norms of masculinity (2012).

Location of the schools - In the case of PPS, a rural based school in the outskirts of Choma, the study revealed that there were no cases of bullying and or school related gender-based violence because the school population was small and almost all the families around the school closely know each other. Therefore, such close relationships work as a deterrent to

bullying as learners fear to be confronted at either school or family level. The head teacher further added that bullying thrives where families do not know each other. However, the cases of CPS and SCS are different as these are urban based schools and there was a huge variation in relationships both at school and at home.

The KI at MPS also revealed that cases of school Related Gender Based Violence (SRGBV) were not a common place issue at the school. Only a few cases get reported and immediately the guidance teacher moves in to help learners appreciate each other and move as one. There are however few cases of bullying that are reported, and teachers move in to help learners and punish the perpetrators.

It was observed that the community was interdependent at and around MPS in Kabwe and therefore, cases of SRGBV were not reported. Violence therefore is only commonplace where the community is so divergent and competitive. The MPS community was so homogenous and a small school community where learners co-exit and support each other. The research also observed that school attendance was low among learners. Perhaps there was need to incentivise school attendance in order to create demand and competition for parents to send children to school within the community. However, teachers through a focus group discussion revealed that bullying and verbal abuse happens among learners. Those who feel victimized are able to report to the guidance teacher although this is common, narrated the guidance and counseling teacher at the school.

Beating - At CPS, the KI cited one of the recent cases in which a girl who was a class monitor was beaten for listing one of the boys for making noise in class for possible punishment by the teacher. This is a clear case of power play based on gender imbalance where a girl has a challenge to provide leadership in class where there are boys. This affects girls' confidence in leading others. It is also clear that there was a weak protection system in such cases. Parkes et al. (2017) supports those four countries in Africa, namely Côte d'Ivoire, Togo, Zambia and Ethiopia which have focused on strengthening, reporting and remaining responsive to cases of SRGBV, particularly child sex abuse. The four countries have developed professional codes of conduct for schools, and school-based reporting systems. Parkes et al (2017)further adds that support for schools is needed to strengthen these systems with clear guidance for all members of school communities on responsibilities and actions to take reporting SRGBV.

Boy-girl relationships - The other case was of the two grade nine boys fighting for a girl. The matter was reported and both boys were counselled by the guidance teacher and supported to change. The girl/boy relationships are rampant in schools. This is common among adolescents as they begin to feel attracted to the opposite sex. This is a normal curve of growth in young people. However, if not well guided, can lead into violence which is undesirable. This study also found out that 44.2% of respondents in Choma, 10.1% in Kabwe and 46.6% in Lusaka said girls were being bullied and harassed. There were also traces of evidence, though negligible in some parts but prominent in Kabwe at 53% that there was evidence that teenage pregnancies occur, increase in absenteeism as well as girls dropping out of school because of this targeted violence at girls.

Fear of Others - While bullies persist in schools, the case at CPS was different as it reflected the fear of the bullies by other learners. When asked whether they report these bullies, the response was that; "we fear to report because they can then follow you on your way home or to school to beat you some more".

6.5.2 Adolescent Boys and SRGBV

The study also found evidence of violence targeted at the boys only. The study narrowed down to the specific forms of violence which affect boys and the findings demonstrate that bullying is the leading targeted form of violence for boys followed by physical fighting. The respondents also reported isolated incidences of sexual acts in Kabwe and Lusaka. Specifically, these forms especially the sexual ones were not categorically stated. This is supported by the study findings which shows that boys are affected by the violence in terms of bullying and harassment leading to absenteeism and eventually dropping out of school depending on the severity of the act.

6.5.3 Strategies of Schools against SRGBV

This research did not establish strong measures which schools have put in place to prevent school related gender-based violence apart from the normal and established guidance and counseling office in each school. This does not prevent violence as fights still exist among learners. However, at schools like KPS where they have a police station based within the school, cases of violence were rarely reported. There should be stricter measures put in

place to prevent violence as violence frequently occurs on the way to or from school in case of CPS, SCS, MPS and KPS primary schools, respectively.

The study found out that there are several ways in which schools can address school related gender-based violence. Some of these ways include establishment of safe spaces in schools rated at 47.7% (Choma), 25.5% (Kabwe) and 50% (Lusaka). The other one is introduction of clubs which the respondents across the 3 study sites rated as 31.8% (Choma), 51.7% (Kabwe) and 32.4% (Lusaka) and formation of school committees on the prevention of SRGBV at 46% (Choma), 54.2% (Kabwe) and 22.9% (Lusaka). Parkes at al. (2017) points out that such initiatives have been implemented in schools in Côte d'Ivoire, Togo, Zambia and Ethiopia, through collaborations between governments, development partners and NGOs. These include training to develop teachers' skills in non-violent pedagogies; improving the ways in which the curriculum addresses gender, sex and relationships; and initiatives with young people, to provide safe spaces and clubs. There is much more to be done to ensure that schools are safer places for both boys and girls.

Reporting Structure - This study established another area of concern which is the lack of clear reporting structure in school when a child has a case of bullying to report. Pupils could not mention during their FGD meeting that they could go to the guidance teacher. Some of them however said, they could go to the head teacher while others said they did not know. This scenario does not offer support to the victims and contributes to the challenges being faced by the teaching of CSE in schools. [Note: This study did not establish any evidence in terms of materials being used to effectively deliver CSE content integrating SRGBV at school level. In other words, there were no materials which were found in the schools visited in Choma, Lusaka and Kabwe aimed at teaching the prevention of SRGBV at school level. This therefore means that the challenge was huge and could be a contributor to the challenges of CSE implementation at school level leading to insignificant progress in terms of results. There was however a new Code of Ethics for the teaching profession in Zambia which was developed and was being implemented by the Teaching Service Commission and the Zambia Teaching Council, with support from teacher unions (Parkes et al. 2017). With this in place, it is highly hoped that schools will once again be safe for learners.

Guidance Teacher Mediation - The study findings in Lusaka show that, a Key Informant (KI) and head teacher at NPS stated that school related gender-based violence was not a common phenomenon at his school. This is because the school had taken a strong stance in helping both girls and boys to mutually co-exist as equal partners. In addition, the teachers had continued providing information on the dangers of GBV. The learners found wanting are always taken on by the guidance and counseling teacher for corrective action. However, if the situation continues, their parents are then called in to help with discipline and management of such cases. It must be pointed out that this is an isolated case of SRGBV management and deterrent measures put in place in one school only. Therefore, there is need for an elaborate mechanism to prevent and control violence in all schools as violence affects learners in so many ways as demonstrated in this study.

Connect with Respect (CwR) intervention tool - In response to the increase in the cases of school related gender-based violence in 2018, the Ministry of Education with support from UNESCO piloted the Connect with Respect (CwR) intervention tool. The CwR tool is a classroom intervention designed to increase knowledge, develop positive gender attitudes, and build the skills for respectful and non-violent relationships among boys and girls including their teachers. The overall objective of the CwR tool is to generate evidence on effective strategies in the prevention of SRGBV and build the capacity of MoE to develop future responses to address SRGBV. At NPS in Lusaka, two teachers out of ten during a teacher focus group meeting were able to confirm that they received training in connect with Respect. With training in such content, some teachers have benefited greatly in prevention of school related gender-based violence.

Furthermore, the NPS guidance teacher demonstrated that partnerships could work to a great extent possible. One of the advantages of CSE is that it fosters strengthened partnerships with the community for the benefit of the children. On the operational challenges, just like elsewhere, the guidance teacher recounted how she struggles to find personal space to work from as there is no dedicated space to work from apart from the teaching load she shares with everyone else on equal basis and being the same officer who handles the examinations in the school. This means that there is too much on her hands to be effective. The absence of a focus on SRGBV was confirmed by the KI interview at the ministry of education who pointed out that there was a weakness with regard to the

responsiveness to violence in schools. He admitted that, moving forward, there would be need for more materials on SRGBV in schools and clear guidelines to support the prevention of violence in schools.

Presence of the police post in school - On the aspect of School Related Gender Based Violence, teachers at KPS confirmed that bullying exists although very few cases are reported to the administration. Teachers felt that one of the reasons the cases were low could be attributed to the presence of the Police post situated in the school premises. KPS is in the heart of a shanty compound (township) in Kabwe urban. Due to high cases of crime, the civic leaders recommended a need for a police station to help curb crime. The police presence could be the reason for the low rate of bullying and school related violence among learners. School related gender-based violence is one of the main motivations of CSE implementation.

Punishment - For a few cases that get reported, the Deputy Head teacher said, learners get punished and helped in order to stop such behaviour through the guidance office in the school. For example, a boy who was involved in bullying was punished and counselled through the guidance office. The teachers also reported that two boys were booing a girl who was pregnant. As a result of that, the girl stopped attending class. Although the guidance teacher intervened, it was quite late and as a result, the girl had not come back to school since.

6.5.4 Effects of Strategies against SRGBV

On whether these approaches have helped, learners were saying that these approaches had helped in addressing the issues of violence at 66.1% (Choma), 63.4% (Lusaka) and 52.3% (Kabwe). However, there were those who said the approaches had not helped implying that the approaches had not helped the situation at all. There is also a category of those who said that they did not know or they did not have an answer. Further, the study establishes that the approach of addressing school related gender based violence has helped girls in terms of prevention of fights and bullying. Others include those to help with access to education and improving school attendance when a school environment is free from violence.

UNESCO (2013) states that Gender-Based Violence (GBV) knows no boundaries. This global phenomenon does not discriminate based on geography, culture, ethnicity, or economy, and is often tolerated and sustained by the very social institutions – such as schools – where children are expected to be safe and protected. UNESCO further adds that violence that occurs in and around schools (also known as School-Related Gender-Based Violence or SRGBV) continues to be a serious barrier in realizing the right to education. Girls are most at risk of GBV in and around schools, but boys may also be targeted.

The experience, or even the threat, of SRGBV often results in poor performance, irregular school attendance, dropout, truancy, and low self-esteem. Further, violence can also have serious health and psychological implications that can have long lasting effects on a child (UNESCO, 2013). This study sought to check whether or not young people in school are aware of the SRGBV and its effects. Although learners were not able to outline what forms of gender-based violence, they indicated to the researcher that they had bullying in school and that they feared to report this to school authorities as doing so could worsen the situation.

It was clear from a conversation with the learners in a focus group discussion (girls only) that they did not have a system to report cases of SRGBV at school, therefore making them feel very vulnerable. On the other hand, boys had a negative and stereo-type behaviour of being males. Boys stated that they feel they are powerful than girls and they make decisions in classrooms most of the times. This thinking is supported by Sewila (2017) in an article on reconstructing the Distorted Image of Women as Reproductive Labour on the Copperbelt. The study focuses on gender-based violence on the perception of women during the employment peak on Zambia's copper mines in early 1980s where most men were income earners as women stayed home to cook and raise families. The study further states that men indulged in alcohol and illicit behaviour which made them believe and defined women on social grounds of prostitution and people who only wanted their money.

The study also states that the declining economy in Zambia turned many women into important contributors to household welfare in the face of men's shrinking incomes from wage employment. This has aggravated the built-in tensions in the conjugal domain without transforming rights and claims in a manner that rewards women for their work efforts.

Sewila (2017) further adds that, this is also the same case in the fight against poverty in Zambia. For as long as the fight against poverty is progressively feminized, with no obvious increase in women's rights and rewards, women should not expect more because of giving more. The education system therefore should deal with the social construct first around gender in order to create equity in perception. Unfortunately, the dominant and lack of accepting lifestyles would continue to affect young people who are now growing.

The Critical Discourse Analysis Theory (CDA) is also applicable here to be able to direct social constructs that aim at protecting society members including young people. CDA contends that social phenomena are socially constructed in any society. This is supported by Wodak and Meyer (2008) who state that CDA as a school or paradigm is characterized by several principles: for example, all approaches are problem-oriented, and thus necessarily interdisciplinary and eclectic. Important to ensure that both written and spoken texts do not work to tear down the weak on gender basis especially the girls in school. This study strongly observes that schools remain the best platforms to continue to push for change towards accepting gender differences in a positive way and not the way it is now.

Teachers at Popota and Shampande Primary Schools supported this argument by acknowledging that gender remains a challenge as boys still feel more important than girls and less accepting when a girl is doing fine as opposed to the boy. This sometimes becomes a source of hostility. It was also clear from the engagements with learners and teachers including head teachers that schools did not have effective means to help learners on this subject. This is more reason why CSE is a better option to help carry out targeted and deliberate interventions at school level.

6.6 Sources of Adolescent Sexual Reproductive Health Services (ASRHS)

UNFPA (2018) states that young people are diverse and so too are their sexual and reproductive health needs. The Adolescent Health Strategy (2017-2021) show that young people require information on and access to modern contraception, emergency contraception, menstrual hygiene, HIV and Sexually Transmitted Infections (STIs) testing and treatment, pregnancy testing and services, counselling, gender-based violence and harmful practices counselling and referral, among others. Therefore, this means that services provided should respect a young person's privacy, confidentiality and obtain informed consent where possible. This study sought to establish if young people have access to these services and what exactly was available in health facilities for young people.

6.6.1 Access to ASRHS by Adolescents

The study found out that the learners were having access to sexual reproductive health services. For example, 79.3% of the respondents in Choma, 83% in Kabwe and 81% in Lusaka all said they had access to reproductive health services at either school or facility level. On the contrary, 21% in Choma, 17% in Kabwe and 22% in Lusaka said they had no access to reproductive health services at either school or at facility level. The number of young people without access to adolescent health services is quite worrying as these could be without knowledge on what they need to do when confronted with a need to make an informed decision. Further, this study also sought to analyse whether the access to the health services is influenced by gender. The findings of the study show that both males and females had access to the health services at 78.9% (Female) and 82.7% (Male) confirming that young people had access to SRHR services. Only 21.1% (female) and 17.3% (male) said they had no access to health services. This demonstrates that there was a gender balance in terms of access and no access to sexual reproductive health services. This further confirms that gender has no influence in the way young people (learners in schools) access adolescent health services.

Through focus group discussions with learners and teachers, the study was appraised of the barriers that exist in terms of access to gender transformative adolescent sexual reproductive health services. These are discussed below:

Social norms and gender inequality - This study found out that young people face several obstacles in accessing sexual and reproductive health services. These barriers relate to availability and accessibility as well as the quality of the services provided in some cases. Furthermore, entrenched social norms and gender inequality around young people and girls' sexuality mean young people's behaviours are controlled and they may be stigmatised for being sexually active. All these make it difficult, and often prevent young people from accessing sexual and reproductive health services. It was therefore one of the key focuses of this study to establish whether or not young people have challenges in accessing services with regard to the provision of CSE at school and indeed health facility levels.

The above arises from the fact the there are no youth friendly health workers in clinics. Where they exist, they are mostly untrained, older and very judgmental staff to young people. This makes young people shun accessing ARH services in health facilities. This finding is supported by Binu et al., (2018) who states that most health workers involved in working with young people are not trained and they tend to be judgmental and unfriendly. This is not supportive of the young people.

In terms of access to adolescent sexual reproductive health services, the study found out that the nearest clinic from PPS in Choma district was about 3.5 km away from the school and there was no functional referral system between the school and the clinic. The challenge of long distance was confirmed by Ministry of Health through a key informant interview at policy level. Many young people have difficulties in accessing ARH services as long distances are a big barrier. This contributes to poor health seeking behaviours seen among young people.

Pregnancy tests - The KI stated that periodically, the clinic under their outreach programme conducts pregnancy tests for girls within the clinic. The head teacher, however, could not mention the year when this was last done. Equally, the teachers and the head teachers from CPS and SCS could not relate to the questions on access to the adolescent health services. While for others the clinics are near, still there is a challenge in terms of a link to these services. This points out to how weak, ineffective, and irregular the referral system is between the school and the health facility as regards access to the adolescent sexual reproductive health including CSE.

In Lusaka at NPS, this study found out that there are about 5 learners who drop out of school every year due to teenage pregnancies. At the time of the study, there was also no existent and functional referral system between the school and the nearest clinic. Most of the children who fall pregnant just got to know on their own from home and they would stop coming to school. In the case of those wishing to access transformative gender and adolescent sexual reproductive health which include treatment of STIs and access to information, there was no link with the clinic unless they just went there on their own. This is a challenge which should be addressed if the teaching of CSE is to remain effective in schools.

This finding above is also consistent with what the Zambia Demographic and Health Survey (2018) establishes. The survey highlights significant challenges which include

negative impacts of poor sexual and reproductive health and inability to fulfil related rights. For example, close to a third of Zambian females are married as children: 31.4% of 20–24-year-olds marry before their 18th birthday (UNFPA 2018). This simply means that the need for information on CSE is huge on the ground and young people in schools have no access to transformative health services.

As noted above, there is no referral mechanism which should be able to help young people access the services needed. Unless, such issues are holistically addressed, they will continue to present a huge drawback to the implementation of CSE which is already facing challenges. Similarly, at KPS in Kabwe, there was no evidence of a referral system between the school and the health center. There is however a strong presence of a Dreams Center, a USAID Project which helps girls access adolescent sexual reproductive health and CSE information. A conversation between the researcher and the young learners through a focus group discussion revealed that there was no linkage between the school and the health facility apart from the dreams center which was also not near the school.

A need for a stronger linkage between the school and a health facility is required to ensure easy access to adolescent sexual reproductive health services for in school young people. A recent Population Council study supported by UNESCO and UNFPA indicates that Adolescents in Zambia encounter substantial sexual and reproductive health challenges, which include early unintended pregnancies by school children that also exposes them to higher HIV infection rates and early childbearing often compromising their ability to complete school and participate in national development. Overall, 29% of girls have begun childbearing. Zambia Demographic Health Survey shows that 6% of girls had already begun childbearing at age 15, but the proportion of having children increases rapidly with age, reaching 53% among girls aged 19 (ZDHS, 2018).

6.6.2 Providers of ASRHS to Adolescents

Enquiry on who provides health services where this is possible, the study found out that health care facilities are the leading providers of health services in all the study sites covered. When analyzed on gender basis, it was found out that 69% (females) and 68.8% (males) stated that health care facilities are the ones providing health services to young people. There was also another segment of respondents who felt that the services were being provided by schools while others said services were provided by community

members. The study further shows that most of the respondents indicated that schools were providing counselling services as well as information on puberty and growing up. This was confirmed by ministry of health as their key mandate which they continue to provide leadership on.

It was also encouraging to note that the teachers at MPS in Kabwe through a focus group discussion reported that there was a referral system between the clinic and the school. This meant that learners who went to the clinic during the school hours required to carry a school slip to the health authorities. The teachers informed the researcher that every child who went there with a slip received express service as there was an understanding between the school and the clinic. Consequently, the clinic carried out health outreach programmes to the school and conducted talks about the dangers of sexual intercourse between boys and girls before they are grown up and ready for marriage. There was no evidence of a linkage or referral system to the health facility at MPS. The KI stated that, "when learners are sick, they just go to the hospital where parents wish to take them". This speaks to the weakness of the referral system arising from a weak CSE programme in the school.

6.6.3 Services Provided by Health Facilities on ASRH

The study also sought to check whether the services being provided by health facilities are appropriate. The study found out that 83% of respondents in Choma, 42.4% in Kabwe and 78.7% in Lusaka said that the services which were offered were appropriate. However, 16.8% (Choma), 57.6% (Kabwe) and 21.3% (Lusaka) said that services were not appropriate in terms of meeting the needs of the learners. The score of services not being appropriate was highest in Kabwe. This prompted the research team to investigate further in order to establish the reason for that. The finding pointed out to the availability of the Dreams Center supported by USAID providing real services for girls on menstrual hygiene. The study also observed that there were more girls accessing the services as opposed to the boys. Anecdotal evidence suggested that both boys and adult males in general were known to have a poor health seeking behaviour.

6.6.4 Services Provided by NGOs on ASRHS

The study also engaged with respondents to check on what they thought about services being appropriate, what services and what support from NGO was there in schools to strengthen the implementation of CSE and ASRH. The findings demonstrate that the

services were appropriate for both boys and girls with scores of 74.2% (Choma), 64.2% (Kabwe) and 75.1% (Lusaka) whereas others were negligible. It was strange and quite concerning why learners in Choma gave a significant score of 22% saying none of the above.

In terms of the services being provided, the study found out that a range of services that included prevention of HIV/STIs, counseling services, pregnancy testing, and male circumcision were available at health facility. It was also a focus of this study to check if there was partnership aimed at strengthening the implementation of CSE and ASRH at school level. The findings show that the respondents were able to confirm that there were NGOs working in schools to provide ASRH services. For example, 80.3% (Choma), 50.8% (Kabwe) and 41.1 (Lusaka) were able to confirm that NGOs were working with schools to provide health services whereas 9.8% (Choma), 22.4% (Kabwe) and 38.1% (Lusaka) could not agree as they said there were no NGOs working in schools to provide ASRH services. The findings also show that the prevention of HIV/STIs counseling, health services for adolescents and information support were eamong the services young people accessed with support of NGOs. Quite a significant score was for those who did not know and this was a concern stimulating a further need for research.

The evidence shows that 60% of the respondents in rural schools said they had challenges in accessing services provided by NGOs while 40% said they did not have challenges. For example, 45.3% of respondents in urban areas said they have challenges in accessing services provided by NGOs whereas 54.7% said they did not have challenges at all. As can be seen from these responses, it is clear that whether urban or rural, young people seemed to have challenges while others say they did not see those challenges. It was also important to understand what services the learners were referring to.

6.6.5 Accessing ASRH Information by Adolescents

In terms of sources of information, the study shows that there are numerous sources of information to ASRH for young people. However, radio stood out at 51.3% (Choma), 44.7% (Kabwe) and 42.1% (Lusaka) saying they get information through radio. Television was the second at 49.7% (Choma), 43.7% (Kabwe) and 59.1% (Lusaka) saying they got information on ASRH through television. The study also found out that only 32.6% of the

respondents said they got information through male teachers and 30.8% got information through female teachers. [In terms of challenges in access to ASRHS at school level, there were variances in the way the study sites respondents came out. In Choma 61.1% said they had challenges while 38.9% said they did not have challenges. In Kabwe, 49% said they had challenges while 51% said they did not have challenges at all and in Lusaka, 50.3% said they had challenges in accessing ASRHS while 49.7% said they did not have challenges.

On preferred sources of information, the study findings show that learners said brothers were a better source of information on CSE and ASRH whereas others said male teachers were the best source of information including guidance teachers. Although CSE is being taught through schools and teachers are key means of delivery for CSE, the study shows that teachers are not being given the prominence in terms of preference needed. This is a concern and worth establishing why teachers were not preferred as much as parents and friends. There was need to check the model being used to ensure that it targeted teachers who were youth friendly and more open minded on issues of sexuality because teachers were pivotal in the implementation of CSE.

Further, in terms of other sources of information on adolescent sexual reproductive health and Comprehensive Sexuality Education (CSE), radio and television are still leading sources and followed by health workers. Others include nurses and teachers, respectively. This is how learners prefer the sources of information on CSE and ASRH. As can be observed, teachers were still not the preferred sources which is quite concerning. More information is required to establish why teachers are not preferred as sources of information even when they are the ones teaching CSE in schools.

The study under this objective utilised yet again the Social Learning Theory to support the findings and the arguments on access to SRH by young people in examining the implementation of CSE in 15 primary schools in Choma, Kabwe and Lusaka. The problem statement of the study was asking questions on why, despite the investments in the CSE programme since 2014, there was a characteristic low-level achievement in terms of the desired project outcomes. There are more school drop outs due to early and unintended pregnancies among school-girls, poor health seeking behaviour among learners,

dysfunctional youth friendly corners with either unprepared or ill trained health care works who are judgmental to the young service seekers. The Social Learning Theory stipulates that people or students can learn new behaviors by observing others (David, 2016). This refers to the reciprocal relationship between social characteristics of the environment, how they are perceived by individual and how motivated and able a person to reproduce behaviors they see happening around them (Ibid). The World Health Organization (2006) reveals that natural sexual curiosity, experimentation and learning before and during adolescence are both normal and healthy and occur in all cultures.

The behaviour noticed among young people at the peak of their adolescence is a result of socialization. The study used the Social Learning Theory and according to World Health Organisation (2006) adolescence is a time for learning to love oneself and others and to be responsible in one's relationships which is well espoused in the theory and gives pointers why young people behave the way they do. The theory also provides information that during this period, young people develop intimate bonds and learn to enjoy the pleasures of sexual activity, hence picking relationships. What is very important is the access to information, services and skills to act when confronted with the difficult sexual decision.

The study also revealed that in central Province, a USAID project called DREAMS was offering girls a service in terms of empowering them with information. The Dream Centers targeted girls with reproductive health information and the distribution of sanitary towels. This is supported by the Ministry of Education CSE framework (2014) which recognises the role of stakeholders in supporting the implementation of CSE at school level. This has contributed to the awareness raising about CSE and adolescent health issues among girls in Kabwe district.

6.7 Summary of the Chapter

In summary, this study has established that the sexual and reproductive health (SRH) needs of young people are often underserved and underestimated despite their demonstrated need and urgency of the services. Access and utilisation of youth-friendly adolescent sexual and reproductive health are still a big challenge for the young people or youth in general. Youth is characterized as a period of optimum health with a series of physiological, psychological, and social changes that may expose them to unhealthy explorative sexual behaviour such as early sex engagement, unsafe sex and numerous sexual partners. This study has

established structural barriers that include the negative attitude of health workers and their being unskilled and individual barriers that include lack of knowledge among youth regarding ASRH services available. Stakeholder interventions focusing on implementing CSE/SRHR should aim at intensive training of health workers and put in place quality implementation standard guidelines in clinics to offer services according to young people's needs and preferences.

Additionally, the study has also exposed that young people are not comfortable to have teachers as their sources of information on ASRH despite being taught CSE by them. There are no referral mechanisms between schools and health facilities meanwhile, the Sida supported CSE programme in Zambia seeks to establish a good CSE programme linked to health facilities for ASRHS. The study utilised the Social Learning Theory to help explain the phenomenon thereof in the findings. It is clear from the findings discussed that the CSE programme is working. However, there is a concern that the outcomes are not as effective as they should be. This is due to several gaps as have been identified and recommendations for action are made in the next chapter.

Chapter Seven: Conclusion and Recommendations

7.0 Introduction

In this chapter the conclusions derived from the findings of this study on Examining the Implementation of CSE in 15 Selected Primary Schools are described. The conclusions are based on the aim or purpose of the study, research questions and results of the study utilising a mixed method study design, in particular, the Convergent parallel mixed method anchored on the Pragmatic Worldview as a philosophical underpinning. The implications of these findings and the resultant recommendations are also explained. The recommendations are also based on the conclusions and purpose of the study.

7.1 Overview of the Study

The study was a mixed method utilising the convergent parallel mixed approach. The researcher adopted a phenomenological approach to achieve the objectives of the study. Unstructured, open, qualitative interviews and survey among 700 pupils were selected using a simple random sampling conducted with learners in Choma, Lusaka and Kabwe as well as nine focus group discussions and Key Informant interviews who were purposively selected as participants. The interviews were conducted in English and recorded, then transcribed and analysed.

The researcher worked with an independent and competent research assistant who helped moderate the researcher biases in the study. The researcher and the research assistant then compared notes to clarify discrepancies and identify similarities (Cresswell 1994). Themes and categories that emerged from the data were augmented with literature, including literature from the internet. Trustworthiness of the data was assured, and ethical considerations respected (Lincoln and Guba 1985). The findings and recommendations described below are centered on the survey feedback via questionnaire from 700 learners in three districts, nine focus group discussions, six key informants, the research questions, the objectives, and the themes emerging from the qualitative data analysis.

The aim of the study was to examine the Implementation of Adolescent Sexual Reproductive Health and Comprehensive Sexuality Education in the Selected Primary Schools in Zambia. This arises from the implementation of the CSE project since 2014 which was aimed at building the capacity of in-service teachers to effectively deliver CSE

lessons at classroom level. The problem statement is anchored on adolescence being a precarious stage for boys and girls and their health is determined by the environments and circumstances in which they live and operate. These include: the prevalence of diseases; the socio-economic environment; the physical environment; and the person's individual characteristics, behaviour and circumstances. The main health related problems facing the adolescents in Zambia, include both communicable and non-communicable diseases (NCDs), particularly: Sexually Transmitted Infections (STIs), including HIV and AIDS. Behavioural related health problems among adolescents, include early and unprotected sex, sexual abuse, early marriages and pregnancies, unsafe abortions, substance and alcohol abuse, accidents and violence, mental health, and unsafe cultural practices. Both health and behavioural related problems often lead to severe short term and long-term consequences on the health and development of the adolescents.

The implementation of CSE from 2014 – 2018 was aimed at combating some of these vices to improve the general health outcomes of young people. However, the major problem has been the insignificant progress being achieved despite a heavy investment in terms of funding and training of human resource. The research has been asking questions like where is the point being missed, could pedagogy be a problem, could it be a cultural and religious problem arising from the relationship that CSE shares with religion and culture? Could it be access and utilisation of ARH services among young people?

The problem that inspired this study was that; although CSE has been implemented since 2014, there is no study in Zambia which has been conducted to evaluate its implementation to examine the effectiveness of its pedagogy and whether cultural, religious beliefs and ASRH service provision have a bearing on the outcome currently prevailing. The limited Scholarly evidence to evaluate the full implementation of CSE has left so many questions unanswered which this study set out to respond to through an examination of the implementation of CSE in selected primary schools in Zambia.

The study was supported by three theories being the Critical Discourse Analysis Theory (CDA), the Social Learning Theory and the Institutional Theory to help explain the phenomena arising in this research. Five objectives guided the study. These are: to investigate pedagogical approaches to delivering Comprehensive Sexuality Education

(CSE) in selected primary schools, to review the relationship between culture and Comprehensive Sexuality Education in selected primary schools in Zambia, to examine the effect of Comprehensive Sexuality Education on the social-emotional development of adolescents in the selected primary schools in Zambia, to analyse how primary schools are addressing School Related Gender-Based Violence (SRGBV) in implementing CSE and to identify sources of adolescent sexual reproductive health services for young people in primary schools.

Therefore, the Chapter presents the conclusion, the recommendations of the study in several sections. The first section summarises the findings of the study in relation to the objectives. The second section discusses the policy implications of the study findings while the third section provides the recommendations for policy makers. Lastly, the fourth section highlights the limitations of the study and suggests the future research direction.

7.2 Conclusion to the research

Comprehensive Sexuality Education helps learners, teachers, and communities to obtain information which helps to form appropriate attitudes and beliefs related to sex, gender, relationships, and intimacy. Zambia currently has the largest population of young people in its history, with 82% aged 35 years and below and 35% aged 15-35 years. Adolescents account for 25% of the total population and have a significant influence on its overall health status, given that adolescence represents a vulnerable period of transformation from childhood to adulthood and, if not well managed, could lead to huge health and socio-economic consequences.

The ZDHS (2018) indicates that about 32% of adolescents aged 15-17 years and 60% of those aged 18-19 years are sexually active, and therefore face risks of acquiring HIV and other (STIs). One in five adolescent girls are already married compared to only one in 100 adolescent boys aged 15-19; and one in four girls aged 17 and six in 10 girls aged 19 have already started child -bearing. This study found out that if CSE continues being properly integrated with good coordination, policy direction and support, it can help to develop adolescents, delay sex, and improve on school retention thereby improving on health and educational outcomes for adolescents.

Adolescents and young people not only represent a significant and growing population in Zambia, but also, disproportionately bear the burden of CSE/SRHR issues including HIV. In Zambia adolescents and young people today are burdened with a cocktail of health problems mostly CSE/SRHR related that make it difficult for them to thrive.

The findings of this study are consistent with the conceptual framework indicating that policy is key in the implementation of CSE. For CSE to be implemented, effective pedagogy is key in delivering effective learning. Further, collaboration and coordination mechanism are needed to ensure that CSE curriculum is developed; capacity building of teachers; prepare lesson packages and distribute CSE teacher and learner materials in the schools including access to sexual reproductive health services in both schools and health facilities close to the school. This eventually leads to the implementation of CSE (dependent variable) in schools and Sexual and Reproductive Health Service (SRHS) being provided to the adolescents in schools. Thus, for the effective implementation of CSE, independent variables are needed which include human rights values; cultural sensitivities, gender equality; accuracy; participatory; gender transformative and age appropriateness of the content. When these variables are considered, this will lead to better health outcomes which include healthy relationships; access to effective counseling services; empowerment of learners; dignity and well-being; prevention of unintended pregnancies; prevention of HIV including STIs and reduced school related gender-based violence.

If these above are effectively considered, then the statement of the problem which largely is the insignificant progress in terms of results or outcomes of CSE implementation despite investments in terms of resources put in will have been addressed through the use of the objectives guiding the study as outlined above.

The objectives of this research were fully achieved and utilised three theories as outlined above to guide the study. The theories were very helpful and made the whole research experience practical and real. For such a study like this one, the choice of a mixed method utilising a convergent Parallel mixed study design was very useful and provided an opportunity to strengthen the arguments herein. Both the qualitative and the quantitative data was collected at the same time, and they significantly helped to complement and support the arguments advanced this research. The methodology worked very well and was

further complemented by the use of the Pragmatic Worldview as a philosophical underpinning to support the research

7.3 Contribution to the body of Knowledge

The contribution of this study to literature is anchored in the development of strategies aimed at effectively implementing CSE using functional models that include linking CSE to services between schools and health facilities, incorporating CSE in teacher training as opposed to in-service approaches as well as deliberately identifying teachers who are young at heart to lead the teacher training at school level as young teachers are current and moving with time and most likely, less judgmental to the learners. This should include health workers without exception.

The study also contributes to the body of knowledge by enriching the understanding on locally established challenges and success factors for the implementation of Comprehensive Sexuality Education and Adolescent Sexual Reproductive Health. The study also introduces use of measures that can work such as taking the training of teachers as close as possible to the school for easy ownership and a need to ensure that the implementation of CSE is a homegrown initiative for the purposes of sustaining the programme beyond donor support. In the current arrangement, this measure is weak. The study also contributes towards the understanding that there is a positive effect through teaching CSE on the lives of learners. This was established through beneficiary voices in which they were able to testify of the benefits they have seen and experienced because of learning CSE at school. Further, although there are these benefits as recounted by learners, the study contributes to the understanding that there is no effective CSE implementation in the absence of learning and teaching materials to support the delivery at classroom level.

The study also contributes that the opposition to CSE is based on misinformation and disinformation among those opposed to the idea based on religious and cultural values they hold. Through this research, it was established that the opposition was a mere call for attention and a need to participate in the development and consultation process as the opposers feel they were not consulted at the time of CSE roll out in 2013/14. This study contributes to the body of knowledge that there is a relationship between culture and CSE in that those teachers who find it challenging to integrate CSE, are responding to the

religious and cultural personal inclinations and values they hold, and this contributes to their bias against CSE and ASRH concept.

On methods of delivery, this study contributes that there is weak or no guidance at all in terms of content on SRGBV as teachers are not doing enough against evidence about bullying in the school set up. These findings have added to the gaps in knowledge on CSE/ASRH implementation in Zambia. This being a new field of study for Zambia at least, the knowledge has not been sufficient regarding what CSE is, what it is not and its intended outcomes as well as possible benefits to learners. This is true, and, that we all desire to understand the status quo of implementing sexuality and reproductive health programmes among adolescents in schools.

It is the view of this study that the evidence which has been generated will foster successful adoption of effective measures that will allow relevant partners, and these could include government, civil society and or cooperating partners to take the necessary steps in addressing the challenges in the implementation of CSE. The fact that there are no clear guidelines to support the implementation of CSE, weak sustainability mechanisms and ownership, weak coordination mechanism and omission of critical content in the delivery of CSE is a confirmation that there is more that needs to be done to ensure CSE is firmly established as a government programme. Looking at the evidence generated through this study so far, sexuality education and its implementation is still having grey areas needing attention to ensure maximum benefit of the programme in Zambia. This perhaps explains why there is insignificant progress in the implementation of CSE in Zambia despite all the good efforts that have gone into it.

7.4 Recommendations

The recommendations below are linked to the objectives of the study and the theories used. The recommendations are suggestions to policy makers to take action in order to save a well-intended programme of CSE in Zambia. If accepted, suggestions have also been made on how these recommendations would be implemented. These are segmented because some of the recommendations require immediate actions whereas others may be medium term and indeed long term for policy to take action. To this effect, the recommendations are

presented into two categories and these are: National level recommendations and recommendations by objectives as outlined below:

7.4.1 National Level Recommendations

The study reveals two pertinent aspects that hinders the progression of implementation of CSE at a national level namely lack of sustainable financing and ineffective coordination of the programme. Dependency on external (donor) funding creates a perception of the programme not being locally owned by the government through the Ministry of Education. Recommendation is thus made for sustainable local financing to support both teacher training and CSE material production. It is also recommended that coordination between stakeholders be strengthened. This is because integration of CSE requires effective co-ordination within the Ministry of Education departments and collaboration with the Ministry of Health and other stakeholders that include NGOs, CSOs and FBOs. The effective implementation of CSE is that which is linked to a health facility for many ASRH needs for young people. Therefore, it is recommended that the linkage between the school and the health facility or any other nearby space where young people can go and obtain the services be strengthened.

7.4.2 Pedagogical approaches to delivering Comprehensive Sexuality Education

There is need for capacity building in Pedagogical approaches to delivering Comprehensive Sexuality Education**.** The study revealed that only 66% of teachers in Zambia are trained in effective delivery of CSE at classroom level. This is supported by Bonjour and Vlugt, (2018) who argue that the strength of an effective programme is based on building capacities of the implementing team. In this regard, teachers need their capacity built and sustained over a period of time to create a lasting impact. Training more teachers with clear pedagogy that helps them to engage with learners and effectively handle the CSE integration at school level is crucial. The new model of training teachers through colleges of education seems to be working except teachers are concerned that they have no link to the District Recourse Center Coordinators (DRCC), Zonal Resource Center Coordinators (ZIC) and School Insert Coordinators (SIC) as the college hub model does not include these layers in their capacity building meetings. It is thus recommended that training should not leave out the DRCC, ZIC and SICS in the implementation as this will enhance effective coordination.

7.4.3 The relationship between culture and CSE

The divergent views coming from religious and traditional leaders indicate that they want to have a say as the issue at hand touches on moral values of society of which they are custodians. The recent opposition to CSE exposed a lot of gaps which would have been avoided had the traditional and religious leaders been consulted right at the beginning. This study recommends bringing closer the religious and traditional leaders in the implementation of CSE so that they have a say and feel consulted on a topic they consider sensitive like CSE/ASRHR.

7.4.4 The effect of CSE on the social-emotional development of adolescents

The evidence shows that if CSE is properly implemented, it has potential to create impact on the social-emotional development of young people. This is supported by the American College Obstetricians and Gynecologist (2016), who state that CSE programs reduce the rates of sexual activity, sexual risk behaviors (e.g. number of partners and unprotected sexual intercourse), Sexually Transmitted Infections, and adolescent pregnancy. In Zambia however, statistics indicate an escalation of these sexual vices in spite of the full scale implementation of CSE in schools. It is therefore recommended that further research by the Ministry of Education and its stakeholders ought to be done to establish the causes of this negative trend.

7.4.5 Implementing CSE in addressing School Related Gender-Based Violence

The study revealed that the current content being used in training is weak on SRGBV including information on sexual violence. The content does not reflect an urgency outlined by UNESCO (2013) which states that Gender-Based Violence (GBV) knows no boundaries. Further the Institutional Theory espouses that institutional power must ensure that institutions build a culture of tolerance and acceptance among young people which can be attained in a school system as teachers integrate CSE. It is therefore recommended that the Ministry of Education must develop an urgent action to ensure that CSE content is revised and enhanced to include SRGBV. Pivotal to this is the need to strengthen reporting mechanisms at school level for victims of SRGBV. The schools visited by the researcher show that there are no guidelines for young people to follow when reporting SRGBV. Recommendation is made to strengthen and make simple the reporting procedures and confidentiality aimed protecting the victim.

7.4.6 Sources of Adolescent Sexual Reproductive Health Services (ASRHS)

It is recommended that an audit assessment of services being offered be checked and upgraded where challenges exist. Quality and accessible information and services are the demands made by adolescents. A recommendation is being advanced to broaden the sources of information around CSE. It's clear that this is a new concept and because it talks about our sexuality, many people maintain the silence around it. Young people should learn about CSE from trusted sources to ensure that they are free from possible defilers and abusers. It was strange to note that learners do not prefer teachers as best sources of information even when teachers are trained to deliver CSE at school level. This means that the training of teachers should be enhanced and possibly exploit more innovative ways that help bridge the gap between learners and teachers.

7.5 Implications of the findings

The findings of this study have several implications on government, stakeholders, and other partners including the CSE and ASRH beneficiaries who are the learners. Below is a brief description of those implications:

- The findings of the study on challenges of the implementation of CSE show that there is a weak base for sustaining the programming for CSE as the project is heavily dependent on external support. There is no evidence that the Ministry of Education in its current form has the capacity and or willingness to take over the financing of the project beyond donor support. The implication is that the project sustainability is based on donor support and its potential to proceed beyond the funding is threatened.
- The study also established that there is no robust mechanism to coordinate the project within the Ministry of Education as there is no designated office responsible to ensure that CSE is coordinated including partners that work on CSE in the education sector. The harp Hazard nature of the coordination is a threat to project fidelity and its survival.
- The findings of the study also show that there is a strong religious inclination in schools powered by the deep-rooted religious values. Most of the teachers are either members of the church or some of them are leaders within those churches thereby compromising their ability to remain neutral and non-judgmental to the programme.

The implication is that these teachers will not effectively implement the CSE at school level and this has potential to lead to project failure.

- The study also found out that teachers do not pay attention in integrating school related gender-based violence (SRGBV) in schools. This is a clear missed opportunity because SRGBV is part of the CSE main pillars and so it should be taught. Recently there has been a spate of violence in schools leading into death in some cases. The implication is that violence in schools will continue as there is no deliberate effort to create awareness on its dangers.
- The study also demonstrated that learners do not prefer teachers as a source of information on CSE. This is surprising as teachers are trained to deliver CSE at school level. The implication is that learners may not have access to accurate and correct information.
- The study also established that it is not easy for many young people to access Adolescent Sexual Reproductive Health Services as health care workers are not youth friendly and are in some cases judgmental. Young people try to seek services but most of them shun the idea because the health facilities are not welcoming to young people. The implication is that young people are not effectively serviced and more will contract STIs including HIV and even become pregnant leading to dropping out of school.

7.6 Direction for future research

This section recommends some potentially useful future research ideas that can address some of the limitations of this study as they were not covered. Many health and development initiatives call for action to improve adolescents' prospects for a healthy and productive adulthood yet, numerous data and research gaps impede these efforts and in particular, reducing adolescent childbearing. There isn't enough information to tell a compelling story about the challenges which adolescents whether in-school or out of school go through because there is no specific data through research to address this. Further, there is need for research to address the health and economic consequences of sexual behaviours of adolescents who engage in early sex. Filling these gaps will require specific efforts that include basic data collection, in-depth research to increase understanding of adolescent behaviours and evaluations of interventions to enable decision-makers to scale up promising programs. This angle of thought is missing in this study.

The study also established that sexual and reproductive health information is not uniformly available for all adolescents at least in the three study areas visited being Choma, Kabwe and Lusaka. For example, there is no information for adolescents in vulnerable situations like in refugee camps. These are equally affected, and they interact with learners outside of their school camps. The information on CSE and ASRH is mainly self-reported among young people whether they seek the service, or it is targeted at them. Therefore, depending on what is self-reported only may have issues of under reporting of certain information which eventually impair decision making. For example, the proportion of adolescents who are sexually active is usually underestimated as opening-up on such sensitive information may expose some young people especially girls to ridicule. There is however need for this information for effective planning as its absence does not help the situation at all.

This study did not deal with the long-term economic impacts of adolescent childbearing for individuals and families, yet this information can be useful for policymakers in examining approaches to reducing poverty and inequalities. Lastly, it is not established through this research what motivates young girls who are in school to get pregnant apart from a bit of it that came out in Kabwe that some parents prefer their young to get pregnant so that they do not struggle with fertility issues once they are in marriage. There should be something beyond that which should be established through further research.

Table 7.0: Study Research Time Frame 2020 -2023

ACTIVITY	YEAR 1				YEAR 2				YEAR 3			
Project Phase	1	2	3	4	1	2	3	4	1	2	3	4
PhD Orientation												
Attend PhD orientation class												
Receive guidance notes on research and techniques												
Refining research topics with the help of professors and Doctors												
Submission of concept notes and assignments												
Proposal Writing												
Reading researches and proposal writing												
Consultations with post graduate office												
Clarifying difficult questions on research												
Submit proposal to Post Graduate Office and get assigned to Supervisors												
Proposal Presentation												
Preparation of a PowerPoint presentation												
Getting guidance from supervisors												
Addressing feedback from Proposal Presentation												
Read and understand the feedback from panel												
Further research based on the guidance												
Resubmit the revised proposal												
Receive feedback from the university and ethical clearance to proceed with the study												
The study and the tools get approved												
Ethical clearance from the University Ethics board is received												
Preparation for data collection exercise commence (Training of research assistants)												

Data collection exercise and report writing												
Obtaining permission letters from both the University and Ministry of Education to access schools												
Field work (Data collection i.e. administering questionnaires, FGDs, lesson observations and KII with stake holders.												
Data cleaning and analysis												
Report writing with guidance of the supervisors												
Finalisation of the research report												
Submission of the Report after supervisors' approval, examination and panel defence (Viva Vos)												

Note: *Study sites included Choma, Kabwe and Lusaka*

References

Adu-Mireku (2003) Family communication about HIV/AIDS and sexual behaviour among senior secondary school students in Accra, Ghana. African Health Sciences 3:7-14.

Advocates for Youths (2015) Comprehensive Sex Education: Research and Results. Available at: www.advocatesforyouth.org/storage/advfy/documents/fscse.pdf

Ajike & Mbegbu, (2016) Adolescent/Youth Utilization of Reproductive Health Services: Knowledge Still a Barrier. Journal of Family Medicine and Health Care. 2016; 2(3): 17-22. Retrieved from https://www.researchgate.net/publication/311868802_AdolescentYouth_Utilization_of_Reproductive_Health_Services_Knowledge_Still_a_Barrier

Amankwaa, Abass & Gyasi (2017) In-school adolescents' knowledge, access to and use of sexual and reproductive health services in Metropolitan Kumasi, Ghana. Retrieved from https://www.researchgate.net/publication/321937687_Inschool_adolescents'_knowledge_access_to_and_use_of_sexual_and_reproductive_health_services_in_Metropolitan_Kumasi_Ghana

American Academy of Pediatrics (2001) Sexuality Education for Children and Adolescents. Retrieved from https://pediatrics.aappublications.org/content/pediatrics/138/2/e20161348.full.pdf

American College Obstetricians and Gynecologist (2016) Comprehensive Sexuality Education. Number 678. November 2016. Retrieved from https://www.acog.org/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/11/comprehensive-sexuality-education.pdf

American Public Health Association (2014) Sexuality Education as Part of a Comprehensive Health Education Program in K to 12 Schools. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/23/09/37/sexuality-education-as-part-of-a-comprehensive-health-education-program-in-k-to-12-schools

Amoran, Onadeko and Adeniyi (2004) Parental influence on adolescent sexual initiation practices in Ibadan, Nigeria. International Quarterly of Community Health Education 23: 73-81

Applefield at. el., (2001) Constructivism in Theory and Practice: Toward a Better Understanding. Retrieved from https://www.semanticscholar.org/paper/Constructivism-in-Theory-and-Practice%3A-Toward-a-Applefield-Huber/76901b86657ba31f66d81915ce4b2dc9e7df86f0

Awusabo-Asare et al. (2017) Views of adults on adolescent sexual and reproductive health: qualitative evidence from Ghana. Occasional report 34. Guttmacher Institute: New York

Babalola (2004) Perceived peer behavior and the timing of sexual debut in Rwanda: A survival analysis of youth data. Journal of Youth and Adolescence 33: 353-63.

Bachus et al., (2012) Health sector responses to domestic violence in Europe: A comparison of promising intervention models in maternity and primary care settings. London: London School of Hygiene & Tropical Medicine. Available online: http://diverhse.eu and http://diverhse.org

Boonstra (2011) "Advancing Sexuality Education in Developing Countries: Evidence and Implications." Guttmacher Policy Review 14 (3): 17–23

Brawer (2014) Clinical depression and HIV risk-related sexual behaviors among African-American adolescent females: unmasking the numbers. AIDS Care. 2012;24:618–625.

Bedho (2014) "Assessment of utilization of youth friendly reproductive health services among college youth in Asela town, Oromia regional state, Ethiopia." masters thesis., Addis Ababa University.

Berthod (2016) Institutional theory of organizations. Retrieved from https://www.researchgate.net/publication/312572322_Institutional_theory_of_organizations

Biddlecom et al., (2007) "Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda." African Journal of Reproductive Health 11 (3): 99-110. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367115/.

Binu et al. (2018) Sexual and reproductive health services utilization and associated factors among secondary school students in Nekemte town, Ethiopia. 15:64. Retrieved from https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-018-0501-z

Bonell et al. (2006) Influence of family type and parenting behaviours on teenage sexual behaviour and conceptions. Journal of Epidemiology & Community Health 60: 502-6.

Bonjour & Vlugt (2018) Comprehensive Sexuality Education: Knowledge File. Utrecht: Rutgers International: For Sexual and Reproductive Health and Rights. Retrieved from www.rutgers.international/sites/rutgersorg/files/PDF/knowledgefiles/20181218_knowledge%20file_CSE.pdf

Brophy (1992 (Ed.) Social Constructivist Teaching: Affordances and Constraints (Advances in Research on Teaching, Vol. 9), Emerald Group Publishing Limited, Bingley, pp. 43-79.

Browes (2015) Comprehensive sexuality education, culture and gender: the effect of the cultural setting on a sexuality education programme in Ethiopia. Retrieved from https://www.researchgate.net/publication/282891781_Comprehensive_sexuality_education_culture_and_gender_the_effect_of_the_cultural_setting_on_a_sexuality_education_programme_in_Ethiopia

Brunning, Royce & Dennison (1995) Cognitive psychology and instruction, 2nd ed. Englewood Cliffs, NJ: Prentice Hall.

Camilli G, Hopkins KD (1978) Applicability of chi-square to 2 ×2 contingency tables with small, expected cell frequencies. Psychol Bull 85:163–167

Chung et al. (2005) Parent-Adolescent Communication About Sex in Filipino American Families: A Demonstration of Community-Based Participatory Research Ambulatory Pediatrics 5: 50-5.

Coskun (2005) Adolescent Sexual and Reproductive Health: An Overview and a Proposal for Further Research. Retrieved from

https://www.gfmer.ch/Medical_education_En/PGC_RH_2005/pdf/Adolescent_sexual_reproductive_health.pdf

Currie et al. (2008) Health behaviour in school-aged children: world health organization collaborative cross-national study (HBSC): Findings from the 2006 HBSC survey in Scotland

Retrieved from
http://www.education.ed.ac.uk/cahru/publications/HBSC_National_Report_2008.pdf

David (2016) The Significance of Social Learning Theories in the Teaching of Social Studies Education. International Journal of Sociology and Anthropology Research. Vol. 2, No.1, pp.40-45.

Depaah et. al. (2015) "Does facility based sexual and reproductive health services meet the needs of young persons? Views from section of Ghanaian youth." Advances in Sexual Medicine 5 (3), 61-71. DOI: 10.4236/asm.2015.53008

Denscombe, M. (2003) The Good Research Guide: for small-scale Social Research Projects. 2nd ed. Buckingham: Open University Press

Dick et al., (2006) Progress in adolescent sexual and reproductive health and rights globally between 1990 and 2016: what progress has been made, what contributed to this, and what are the implications for the future? Sexual and Reproductive Health Matters. Retrieved from
https://www.tandfonline.com/action/journalInformation?journalCode=zrhm21

Elia & Eliason (2010) Discourses of Exclusion: Sexuality Education's Silencing of Sexual Others. Journal of Youth, 7:29–48, 2010. Retrieved from
https://www.researchgate.net/publication/232839566_Discourses_of_Exclusion_Sexuality_Education's_Silencing_of_Sexual_Others

Esiet (2012) Changes in knowledge and attitudes among junior secondary students exposed to the family life and HIV education curriculum in Lagos state. Nigeria Afr J Reproduc Health. 2009;13:37–46

Family Watch International (2018) Comprehensive Sexuality Education (CSE): Sexual Rights vs. Sexual Health. Retrieved from
http://familywatch.org/fwi/documents/fwipolicybriefCSE.pdf

Feleke et. al (2013) Reproductive health service utilization and associated factors among adolescents (15–19 years old) in Gondar town, Northwest Ethiopia. BMC Health Serv Res 13(1):294

Fine and McClelland (2006) “Sexuality Education and Desire: Still Missing after All These Years.” Harvard Educational Review 76 (3): 297–338

Finer, LB and Zolna (2011) Unintended pregnancy in the United States: incidence and disparities. doi:10.1016/contraception

Fisher (2007) Statistical Methods for Research Workers. Edinburgh, United Kingdom: Oliver & Boyd; 1925.

Fonner et al. (2014) School based sex education and HIV prevention in low-and middle-income countries. A systematic review and metqa analysis, Plos One 9

Ford Foundation (2014) Sexuality &Social Change: Making the Connection-Strategies for Action and Investment. Retrieved from https://www.fordfoundation.org/media/1740/2006-sexuality_social_change.pdf

Future of Sex Education Initiative (2011) Future of Sex Education Fact Sheet. Retrieved from https://www.advocatesforyouth.org/wp-content/uploads/storage/advfy/documents/FoSE/fose-faq.pdf

Goldman, J (2010) Sexuality Education for Young People: A Theoretically Integrated Approach from Australia. Educational Research, v52 n1 p81-99 Mar 2010. Retrieved from http://www.tandf.co.uk/journals

Haberland and Rogow (2015) Sexuality Education: Emerging Trends in Evidence and Practice. Journal of Adolescent Health, 56(1), S15-21. doi:10.1016/j.jadohealth.2014.08.013

International Institute for Population Sciences [IIPS] and Population Council (2010) Youth in India: Situation and needs 2006–2007. Mumbai: International Institute for Population Sciences

International Women's Health Coalition (IWHC) (2015) Comprehensive Sexuality Education: What we Know. Retrieved from https://iwhc.org/wp-content/uploads/2015/03/comprehensive-sexuality-education.pdf

IPPF & BZgA (2018) Sexuality education in the WHO European Region, factsheets of 24 European countries. Retrieved from https://www.bzga-whocc.de/en/publications/report-on-sexuality-education-ineurope-and-central-asia-new/

IPPF (2016) Everyone's right to know: delivering comprehensive sexuality education for all young people. Retrieved from https://www.ippf.org/sites/default/files/2016-05/ippf_cse_report_eng_web.pdf

Irish Consortium (2019) Safe Education for Girls: Tackling School-Related GBV Report. Retrieved from https://www.gbv.ie/wp-content/uploads/2020/03/SRGBV-Brief-ICGBV-Website-version.pdf

Jejeebhoy & Santhya (2011) Sexual and reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries. Global Public Health. 2015 Feb 7; 10(2): 189–221.

Johnson Ross et al., (2017) Addressing School Related Gender Based Violence in Togo: A Scoping Study: UCL Institute of Education

Jorgensen, D. L. (1989) Participant Observation: A methodology for Human Studies. London: Sage Publications

Jorgensen, D. L. (2010). *Participant observation: A methodology for human studies.* Sage Publications, Inc. https://doi.org/10.4135/9781412985376

Kalembo, Zgambo, and Yukai (2013) Effective Adolescent Sexual and Reproductive Health Education Programs in Sub-Saharan Africa. Californian Journal of Health Promotion 2013, Volume 11, Issue 2, 32-42. Retrieved from http://cjhp.fullerton.edu/Volume11Issue2_2013/documents/32-42_KalemboF.pdf

Ketting & Ivanova (2018) Sexuality Education in Europe and Central Asia: State of the Art and Recent Development: An overview of 25 Countries. Retrieved from https://www.ippfen.org/sites/ippfen/files/2018-05/Comprehensive%20CountryAsia_0.pdf

Kibombo et al. (2008) Perceptions of risk to HIV Infection among Adolescents in

Uganda: Are they Related to Sexual Behaviour? Afr J Reprod Health. 200; 11(3): 168–181.

Kirby (2008) "The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior." Sexuality Research & Social Policy 5: 18–27

Kirby at al., (2011) Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: National Campaign to Prevent Teen & Unplanned Pregnancy. http://www. thenationalcampaign.org/EA2007/EA2007_full.pdf

Krause, K-L., Bochner, S. and Duschesne, S. 2006. Educational psychology for learning and teaching, 2nd ed, Victoria: Thomson.

Kost, Henshaw and Carlin (2011) Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity. NY: Guttmacher Institute. http://www.guttmacher.org/pubs/USTPtrends.pdf.

Leach et al. (2014) School- related Gender- based Violence: A global review of current issues and approaches in policy, programming and implementation responses to School-Related Gender- Based Violence (SRGBV) for the Education Sector (pp. 1-95): UNESCO.

Lefkowitz & Espinosa Hernandez (2007) Sex-related communication with mothers and best friends during the transition to university. Journal of Sex Research, 44, 17-27

Lenciauskiene and Zaborskis (2008) The effects of family structure, parent-child relationship and parental monitoring on early sexual behaviour among adolescents in nine European countries. Scandinavian Journal of Public Health 36: 607-18

Lofland (2006). Basic s of Qualitative Research. London, Sage Publications

Mackay & Barrett (2010) Trends in teen pregnancy rates from 1996–2006: A comparison of Canada, Sweden, USA and England/Wales. Canadian Journal of Human Sexuality 2010; 19(1–2):43–52.

Magnusson (2001) Adolescent girls' sexual attitudes and opposite-sex relations in 1970 and in 1996. Journal of Adolescent Health 28: 242-52.

Mainwaring, Scott and Mariano Torcal (2006) 'Party System Institutionalization and Party System Theory after the Third Wave of Democratization', in R. S. Katz and W. Crotty (eds) Handbook of Political Parties, pp. 204-27. London: Sage.

March and Olsen (1984) Olsen 1984. The New Institutionalism: Organizational Factors in Political Life. American Political Science Review 78 (3): 734-749.

March and Olsen (1989) Rediscovering Institutions. New York: Free Press.

March and Olsen (1996) Institutional perspectives on political institutions: Governance 9 (3): 247-264.

McCave et al. (2007) Assessment of difference in dimensions of sexual orientation: Implications for substance use research in a college-age population. Journal of Studies on Alcohol. 2005;66(5):620–629

McNeely et al. (2002) Mothers' influence on the timing of first sex among 14- and 15-year-olds. Journal of Adolescent Health 31: 256-65.

Ministry of Community Development; Department of Maternal Newborn Child and Adolescent Health. Making Health Services Adolescent Friendly - Developing National Quality Standards for Adolescent Friendly Health Services. World Heal. Organ. [Internet]. 2012;3. Available from: http://www.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf?ua=1

Ministry of Education and Sports (2018) National Sexuality Education Framework. Retrieved from https://s3-eu-west-1.amazonaws.com/s3.sourceafrica.net/documents/119376/UNFPA-68-090518.pdf

Ministry of General Education (2014) Directorate of Planning and Information. 2016. 2015 Educational Statistical Bulletin. Lusaka, Zambia: Ministry of General Education. https://www.moge.gov.zm/download/statistics/annual_statistics/Educational-StatisticalBulletin/2015-Educational-Statistical-Bulletin.pdf.

Ministry of General Education (2018) Directorate of Planning and Information. 2016. 2015 Educational Statistical Bulletin. Lusaka, Zambia: Ministry of General Education. https://www.moge.gov.zm/download/statistics/annual_statistics/Educational-StatisticalBulletin/2015-Educational-Statistical-Bulletin.pdf.

Ministry of General Education (2019) Directorate of Planning and Information. 2016. 2015 Educational Statistical Bulletin. Lusaka, Zambia: Ministry of General Education. https://www.moge.gov.zm/download/statistics/annual_statistics/Educational-StatisticalBulletin/2015-Educational-Statistical-Bulletin.pdf.

Ministry of General Education (19960, *Educating Our Future Policy*, Lusaka, Government Pineters

Ministry of Health (2011) Adolescent Health Strategic Plan 2011 to 2015

Moate, Randall M, and Jane A Cox (2015) "Learner-Centered Pedagogy : Considerations for Application in a Didactic Course." The Professional Counselor 5 (3): 379–389.

Moore and Chase-Lansdale (2001) Sexual intercourse and pregnancy among African American girls in high-poverty neighborhoods: The role of family and perceived community environment. Journal of Marriage and Family, 63(4), 1146-1157. https://doi.org/10.1111/j.1741-3737.2001.01146.x

Moshman (1982) Exogenous, endogenous, and dialectical constructivism. Developmental Review 2: 371-384.

Mwanakatwe J M, (1974) The growth of education in Zambia since independence,

Navabi (2014) Bandura's Social Learning Theory & Social Cognitive Learning Theory. Retrieved from http://www.researchgate.net

Odimegwu's (2005) Influence of religion on adolescent sexual attitudes and behaviour among Nigerian university students: affiliation or commitment? African Journal of Reproductive Health 9: 125-40

Okonofua (2012) Impact of an intervention to improve treatment-seeking behavior and prevent sexually transmitted diseases among Nigerian youth. International Journal of Infectious Diseases, 7, 61- 73.

Orlich, D. O., Harder, R. J., Callahan, R. C. and Gibson, H. W. 2001. Teaching strategies: A guide to better instruction, 6th ed, New York: Houghton Mifflin.

Parkes et al., (2017a) Addressing SRGBV in Ethiopia: A scoping study of policy and practice to reduce gender-based violence in and around schools: UCL Institute of Education

Parkes et al., (2017b) Addressing School-Related Gender-Based Violence in Zambia: A Scoping Study: UCL Institute of Education

Paul et al. (2000) "Hookups": Characteristics and correlates of college students' spontaneous and anonymous sexual experiences. Journal of Sex Research. 2000; 37:76–88.

Pearce (2019) Access to And Knowledge of Sexual and Reproductive Health Services among Adolescent School Girls in Gobabis, Namibia. Retrieved from http://repository.unam.edu.na/bitstream/handle/11070/2481/pearce2019.pdf?sequence=1&isAllowed=y

Peters (2000) Institutional Theory: Problems and Prospects. Retrieved from https://www.ihs.ac.at/publications/pol/pw_69.pdf

Potard, Courtois and Rusch (2008) The influence of peers on risky sexual behaviour during adolescence. Retrieved from https://www.researchgate.net/publication/23288632_The_influence_of_peers_on_risky_sexual_behaviour_during_adolescence

Prawat (1992) Teachers' beliefs about teaching and learning: A constructivist perspective. *American journal of education, 100(3)*, 354-395.

Romo et al. (2002) A longitudinal study of maternal messages about dating and sexuality and their influence on Latino adolescents. Journal of Adolescent Health 31: 59-69.

Rutgers (2018) Comprehensive Sexuality Education. Retrieved from https://www.rutgers.international/sites/rutgersorg/files/PDF/knowledgefiles/20181218_knowledge%20file_CSE.pdf

Sanders ME, Guarner F, Guerrant R, et al

An update on the use and investigation of probiotics in health and disease, Gut 2013;62:787-796.

Sani et al. (2018) School-based sexual health education interventions to prevent STI/HIV in sub-Saharan Africa: a systematic review and meta-analysis. BMC Public Health. 2016 Oct 10;16(1):1069

Santelli et al., (2017) Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact Journal of Adolescent Health, Volume 61, Issue 3, Pages 273–280.

Santhya and Jejeebhoy (2015) Sexual and reproductive health and rights of adolescent girls: Evidence from low and middle-income countries. *Global Public Health*. 2015:189–221. doi: 10.1080/17441692.2014.986169.

Schutte (2016) Implementation strategy for the school-based sex education program Long Live Love, a dynamic process. Dissertation, University Maastricht

Seal, C. (1999) The quality of Qualitative Research. London: Sage Publications.

Sexuality Information and Education Council of the United States (SIECUS) (2005) National Sexuality Education Standards: Core Content and Skills, K–12. Retrieved from https://siecus.org/wp-content/uploads/07/National-Sexuality-Education-Standards.pdf

Shaffer (2005) Social and Personality Development-5th ed. Belmont Canada: Hockett Editorial Service.

Shiffman et. al. (2018) International norms and the politics of sexuality education in Nigeria. Globalization and Health (2018) 14:63. Retrieved from https://globalizationandhealth.biomedcentral.com/track/pdf/10.1186/s12992-018-0377-2

Sidze et al. (2017) *From Paper to Practice: Sexuality Education Policies and Their Implementation in Kenya*. New York: Guttmacher Institute and African Population and Health Research Center. https://www.guttmacher.org/sites/default/files/report_pdf/sexuality-education-kenya-report.pdf.

Sikes, P. (2004) Methodology Procedures and Ethical Concerns. pp.15-33. In: Opie, C. ed. Doing Educational Research: A Guide to First Time Research. London: Sage Publication.

Somers and Gleason (2001) Does source of sex education predict adolescents' sexual knowledge, attitudes and behaviour? Education 121: 674-81.

Somers and Paulson (2000) Students' perceptions of parent-adolescent closeness and communication about sexuality: relations with sexual knowledge, attitudes, and behaviours. Journal of Adolescence 23: 629-44

Stephenson et al. (2004) Pupil-led sex education in England (RIPPLE study): cluster-randomised intervention trial. Lancet 364: 338-46

Tileston, D. W. 2004. What every teacher should know about effective teaching strategies, Thousand Oaks, CA: Sage.

Trenholm et al., (2007) Impacts of Four Title V, Section 510 Abstinence Education Programs: Final report. Retrieved from https://aspe.hhs.gov/system/files/pdf/74961/report.pdf

Tucker et al. (2007) The effect of the national demonstration project healthy respect on teenage sexual health behaviour. European Journal of Public Health 17: 33-41.

United Nations Populations Fund (UNFPA) (2014) UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender. UNFPA: New York

The UNFPA Strategic Plan: 2014-2017 is available from: www.unfpa.org/public/home/about/strategic-direction.

UNFPA Strategic Plan, 2014-2017: Report of the Executive Director (DP/FPA/2013/12). Available from: www.unfpa.org/public/home/exbrd/pid/12131.

United Nations Programme on HIV/AIDS (UNAIDS) 2018- https://www.unaids.org/en/resources/documents/2018/unaids-data-2018

accessed; February, 28, 2020

Underhill et al., (2007) Systematic review of abstinence-plus HIV prevention programs in high-income countries. Plos Med, 4(9).

United Nations Educational, Scientific and Cultural Organization (UNESCO) & United Nations Population Fund (UNFPA) Fact Sheet (2013)

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2009) International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators. Paris

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2012) A Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific. Bangkok, UNESCO. http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2013) Prevention Education in Eastern Europe and Central Asia. A review of policies and practices. Moscow, Unesco,

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2015a) Emerging evidence and lessons and practice in comprehensive sexuality education review. http://unesdoc.unesco.org/images/0024/002431/243106e.pdf

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2015b) Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review 2015. Paris: UNESCO. http://unesdoc.unesco.org/images/0024/002431/243106e.pdf.

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2016) Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO

United Nations Educational, Scientific and Cultural Organization (UNESCO), Zambia CSE Project Annual Performance Report, (2017)

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2020) Strengthening comprehensive sexuality education for young people in school settings in Zambia. Harare: UNESCO

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2018) Comprehensive Sexuality Education: Advancing Human Rights, Gender, Equality and Improved Sexual and Reproductive Health. New York

United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNAIDS (2013) "Regional Accountability Framework: Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA)." n.p.; n.d. http://www.aidsaccountability.org/wp-content/uploads/2014/04/Regional-AccountabilityFramework-140314.pdf.

United Nations Educational, Scientific and Cultural Organization (UNESCO) and United Nations Girls Initiative (2013) School-Related Gender-Based Violence (SRGBV) UNGEI – UNESCO Discussion Paper November 2013. Retrieved from http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/UNGEI_UNESCO_SRGBV_DiscussionPaperFinal.pdf

UNESCO HIV and Health Education Clearinghouse. 2016. Strengthening Sexual and Reproductive Health and HIV Prevention among Children and Young People through

Promoting Comprehensive Sexuality Education in Eastern and Southern Africa: End-Term Evaluation Report 2013–2015. Paris: UNESCO.

https://hivhealthclearinghouse.unesco.org/library/documents/strengtheningsexual-and-reproductive-health-and-hiv-prevention-among-children-and

UNFPA (2015) Emerging Evidence, Lessons and Practice in Comprehensive Sexuality

Education: a global review. United Nations Educational, Scientific and Cultural Organization: Paris.

United Nations Population Fund - UNFPA Annual Report (2018)

https://www.unfpa.org/annual-report

United Nations Children's Fund (UNICEF) (2009) Evaluation Report: 2009 Namibia, My Future Is My Choice. n.p.: UNICEF.
https://www.unicef.org/evaldatabase/index_58830.html.

Upchurch et al. (2001) Inconsistencies in reporting the occurrence and timing of first intercourse among adolescents. Journal of Sex Research 39: 197-206.

Vanwesenbeeck et al. (2016) “Lessons Learned from a Decade Implementing Comprehensive Sexuality Education in Resource Poor Settings: The World Starts with Me,” Sex Education 16 (5): 471–486.

Wakaseh (2019) Comprehensive Sexuality Education in Sub-Saharan Africa. Retrieved from https://aphrc.org/wp-content/uploads/2019/12/COMPREHENSIVE-SEXUALITY-EDUCATION-IN-SUB-SAHARAN-AFRICA-1.pdf

Weaver, Smith, & Kippax (2005) School-Based Sex Education Policies and Indicators of Sexual Health among Young People: A Comparison of the Netherlands, France, Australia and the United States. Sex Education: Sexuality, Society and Learning, v5 n2 p171-188 May 2005

Wellington (2000). Qualitive Research and basics. London, Sage Publications

Wight et al. (2002) Limits of teacher delivered sex education: interim behavioural outcomes from randomized trial. British Medical Journal 324: 1430-5.

World Health Organisation, (2006) Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries. Geneva, WHO. http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf.

World Health Organization (WHO) (2007) Helping parents in developing countries improve adolescents' health. Geneva

World Young Women Christian Association (YWCA) (2016) Sexual Reproductive

Health and Rights for Adolescents in Sub-Saharan Africa: Youth Fact Sheet. Retrieved from http://www.worldywca.org/wp-content/uploads/2016/07/World-YWCA-Sexual-Reproductive-Health-and-Rights-For-Adolescents-in-Sub-Saharan-Africa-2.pdf

Yu (2008) Perspectives of Chinese British adolescents on sexual behaviour within their socio-cultural contexts in Scotland. Diversity in Health and Social Care 5: 177-186.

Yu (2010) Sex education beyond school: Implications for practice and research. Retrieved from https://www.researchgate.net/publication/238397917_Sex_education_beyond_school_Implications_for_practice_and_research

Zaleski and Schiaffino (2000) Religiosity and sexual risk-taking behavior during the transition to college. Journal of Adolescence 23: 223-7.

Zambia Statistics Agency ZDHS (2018) Demographic and Health Survey. Lusaka: Zambia Statistics Agency.

https://www.nationsonline.org/oneworld/map/zambia-administrative-map.htm

Annexes

Annex I: Participant Informed Consent Form

Research Title: Assessing the Implementation of Sexuality and Reproductive Health among Adolescents in Selected Primary Schools in Zambia.

PLEASE READ THIS DOCUMENT CAREFULLY. YOUR SIGNATURE OR YOUR HEADTEACHER OR INDEED PARENT OR GUADIAN'S IS REQUIRED FOR PARTICIPATION. IF YOU DESIRE A COPY OF THIS CONSENT FORM, YOU MAY REQUEST ONE AND I WILL PROVIDE IT.

My name is Remmy Mukonka, the Principal investigator on the study. This is an academic study which aims to assess the Implementation of Sexuality and Reproductive Health among Adolescents in Selected Primary Schools in Zambia. Your participation in this study is voluntary and you have the right to withdraw at any time, without prejudice should you feel uncomfortable or indeed object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study:

The aim of the study is to assess the Implementation of Adolescent Sexual Reproductive Health and Comprehensive Sexuality Education in the selected primary schools in Zambia. As you may be aware, adolescence is a precarious stage for boys and girls and their health is determined by the environments and circumstances in which they live and operate. These include: the prevalence of diseases; the socio-economic environment; the physical environment; and the person's individual characteristics, behaviour and circumstances. The main health related problems facing the adolescents in Zambia, include both communicable and non-communicable diseases (NCDs), particularly: Sexually Transmitted Infections (STIs), including HIV and AIDS. Behavioural related health problems among adolescents, include early and unprotected sex, sexual abuse, early marriages and pregnancies, unsafe abortions, substance and alcohol abuse, accidents and violence, mental health, and unsafe cultural practices. Both health and behavioural related problems often lead to severe short term and long-term consequences on the health and development of the adolescents.

Further, youth-friendly sexual and School Related Gender-Based violence (SRGBV) services are not available. There are weaknesses and gaps in the policies aimed at addressing and improving adolescent health in Zambia. This study aims to engage you as a stake holder and obtain your views regarding the subject.

When filling in the questionnaires, you may come across a question or answer choices) that you find unpleasant, upsetting, or otherwise objectionable. For instance, (a few of the questions may cause you to think about negative emotional states from your past. You are free to withdraw from the exercise without any problem. Further, should you feel that you are being asked to provide confidential information about yourself, feel free not to provide if you don't feel comfortable. There are no monitory benefits in this study apart from the knowledge you will have about the study in the course of your growing up. You will not write your name on any of the questionnaires which will protect your identity. No one will be able to know which your questionnaire responses are. Finally, remember that it is no individual person's responses that interest us; we are assessing the implementation of CSE and ASRH in schools and what works well.

If you may need to contact the researcher even after the FGD, the contact is +260977788714 or the Secretary of the Research and Ethics Committee on +260978157876

Dated this _____ day of (month) _____, 20 _____

_____

_____

Signature of Participant

Signature of Person Obtaining Consent

Annex II: Key Informant Interview (KII) Guide #1: CSE Teachers

Assessing the implementation of Sexuality and Reproductive Health among Adolescents in Schools

KEY INFORMANT INTERVIEW (KII) GUIDE #1: CSE TEACHERS

1. Introduction

1.1 Interviewer and Interviewee to introduce themselves. Record the title and school of the interviewee.

1.2 Summarize the informed consent document, focusing on: purpose of the interview, confidentiality, that the interview is voluntary, and getting permission for recording.

1.3 Instructions in using this guide: Ask each main question (in bold) below to facilitate discussion. Ask probing questions, as required, depending on the information participants are providing.

2. Request written consent from interviewee

2.1 Reconfirm with the interviewee, "Do you understand the purpose of this interview? Do you have any questions regarding this interview, the purpose, or how the information will be collected?" Answer any questions the interviewee may have.

2.2 Interviewer and interviewee signs and dates the informed consent form, providing one copy to the interviewee and retaining the signed copy.

3. Discussion on the Pedagogical approaches to delivering Comprehensive Sexuality Education

3.1 How long have you been teaching at this school? Probe: Are you trained to teach CSE? When where you trained? When did you start teaching CSE? What grades are you teaching? What is the duration for CSE? How many days in a week is it taught? Is the time allocated for CSE enough? Explain why or why not.

3.2 Explain how you teach CSE? Probe: What methodologies do you use? Do you think that the methodologies help the learners understand CSE? Which methodology or methodologies are relevant and useful to the pupils? Why do you say so?

3.3 What topics are covered in CSE? Probe: Which topics are easy for you to teach? Why? Which topics are not easy for you to teach? Why?

3.4 Has Comprehensive Sexuality Education helped the adolescents at this school? Probe: How and what examples can you give? Probe how it has helped the girls? The boys? What topics have specifically helped the adolescents?

3.5 How well is the delivery of CSE to the adolescent male and female pupils? Probe: What material and delivery methods are effective? What is the ideal "dose" for delivering to the adolescent male and female pupils (how much teaching and how frequently is it conducted)? How has the sensitization or teaching helped the male and female adolescent pupils? How have chiefs and headmen, parents/guardians, religious leaders been incorporated in sensitising the adolescent male and female pupils on SRGBV? What challenges remain in the sensitization of chiefs and headsmen, parents/guardians and adolescent male and female pupils? Describe any observed stigma towards SRGBV among pupils and the community members. How many cases have the school referred to the police, healthcare facilities and chiefs or headsmen? How are SRGBV cases coordinated with the Police, healthcare facilities, and traditional leaders?

3.6 How the adolescents integrating the knowledge received through CSE? Probe: What do you think the adolescent male and female pupils know about laws that exist about SRGBV? What are reactions from adolescents? How are awareness efforts coordinated with the police, healthcare facilities and NGOs? Please describe any observed improvement or change in how the male and female adolescent pupils have their attitudes or practices.

3.7 What are the main challenges in the implementation of Comprehensive Sexuality Education? Probe: Challenges for teachers. Challenges for learners? Does the school have enough resources? Do the schools have enough materials? Do the teachers feel they are adequately prepared to teach CSE to adolescents?

3.8 What measures has the school put in place to ensure that the delivery of sexuality and reproductive health is sustained? Probe: What is available in terms of financial and human resources at the district level and within communities to sustain the program?

4. Discussion on the relationship between culture and comprehensive Sexuality Education

4.1 Please explain the culture and traditions of the community. Probe: Do the beliefs, values and norms affect the delivery of sexuality and reproductive health in schools? Are there taboos that affect the delivery of Sexuality and reproductive health?

4.2 What language or languages are you using when teaching sexuality and reproductive health? Probe: What challenges do you encounter? Are the students comfortable with the language? Are there specific topics that are difficult to teach in the local language or languages? What is been done to address each of the challenges you have mentioned?

4.3 Are the learners able to ask questions on sexuality and reproductive health? Probe: What is challenging for the learners? How do you ensure that the learners are able to speak and ask questions on sexuality and reproductive health?

4.4 Do you think that religion affects the delivery of sexuality and reproductive health? Probe: How does it affect you as a teacher? Parents/guardians and learners? What is been done to address the challenges?

4.5 What are the best measures that can be used to address the cultural factors that affect the delivery of Sexuality and reproduction health in the schools? Probe: How do you measure real change (outcomes, impacts) beyond output-level indicators that measure activity provision? What lessons learned do you capture? How do you share lessons with partners and the community?

4.6 What are the best measures that can be used to address the religious factors that affect the delivery of sexuality and reproductive health in the schools?

5. Effect of Comprehensive Sexuality Education on the Social-Emotional development of adolescents

5.1 Do the adolescents engage in risky sexual behaviors? Probe: What sexual risk behaviors do adolescent pupils engage in? Probe the risky sexual behaviors among the girls? The sexual risky behaviours among the boys? What is the cause of these risky behaviours among the male and female adolescent pupils?

5.2 Are the learners able to talk about their sexual feelings? Probe: Do learners talk about sexual desires with the teachers (male or female)? Do the teachers trained in CSE encourage the adolescents to talk about their sexual feelings?

5.3 Do the teachers trained in CSE encourage the learners to talk about sexual relationships? Probe: Why/why not?

6. School Related Gender-Based Violence (SRGBV)

6.1 What forms of school related gender-based violence occur at this schools? Probe: which forms of SRGBV are targeted at adolescent female pupils? Which forms of SRGBV are targeted towards male adolescent pupils at this school/ what is the source of the violence towards the male/female adolescent pupils? Does the school record the cases? (If recorded ask for the records)

6.2 Do the pupils report the SRGBV? Probe: Who do they report to? Do both male and female adolescent pupils report? Which cases are mostly reported? Why and why not?

6.3 How does the SRGBV affect the male/female adolescent pupils? Probe for stories to determine the effect. Positive and negative and any unintended effects observed.

6.4 What measures have been put in place to address the SRGBV targeted at the male/female adolescent pupils? Probe: How the measures were formulated/designed? Who formulated the measures? When? Does the school have the human resources? Who is involved in ensuring the measures are enforced appropriately? What has been the result, positive and negative?

6.5 What challenges does the school face in enforcing the measures? Probe: Community level, districts, provincial levels. Financial and human resources. How does the community handle GBV cases? How are GBV statutory laws implemented? What has stopped survivors from formally pursuing cases? How are children GBV survivors treated by law enforcement officials, health staff and others?

6.6 How well is the delivery on SRGBV to the adolescent male and female pupils? Probe: What material and delivery methods are effective? What is the ideal "dose" for delivering to the adolescent male and female pupils (how much teaching and how frequently is it conducted)? How has the sensitization or teaching helped the male and female adolescent pupils? How have chiefs and headsmen, parents/guardians, religious leaders been incorporated in sensitising the adolescent

male and female pupils on SRGBV? What challenges remain in the sensitization of chiefs and headsmen, parents/guardians and adolescent male and female pupils? Describe any observed stigma towards SRGBV among pupils and the community members. How many cases have the school referred to the police, healthcare facilities and chiefs or headsmen? How are SRGBV cases coordinated with the Police, healthcare facilities, and traditional leaders?

6.7 How are the adolescents integrating the knowledge received on SRGBV through CSE? Probe: What do you think the adolescent male and female pupils know about laws that exist about SRGBV? What are reactions from adolescents? How are awareness efforts coordinated with the police, healthcare facilities and NGOs? Please describe any observed improvement or change in how the male and female adolescent pupils have their attitudes or practices.

7. Sources of gender-transformative adolescent sexual reproductive health services

7.1 Do the adolescent male and female pupils have access to sexual reproductive health services? Probe: Who is providing the services? What services are provided for the adolescent male and female pupils? When were the services for the adolescent male and female pupils introduced? How have the parents/guardians reacted? What are the challenges? Is there any stigma towards the adolescent male and female pupils accessing the sexual reproductive health services?

7.2 Are the sexual reproductive health services appropriate for the adolescent male and female pupils? Probe: Are the services appropriate for the male adolescent pupils? Are the services appropriate for the female adolescent pupils?

7.3 Where do the adolescent male and female pupils access information on sexual reproductive health? Probe: Are they credible sources of information for adolescent male and female pupils? What would be the ideal sources of information on sexual and reproductive health for male and female adolescent pupils? What are the challenges?

7.4 How are the male and female adolescent pupils incorporating the messages/information into their lives? Probe: Who disseminates the information? What positive changes can be directly attributed to these activities? What are challenges? How are efforts coordinated with healthcare facilities and NGOs in

disseminating information on sexual and reproductive health for male and female adolescent pupils?

8. Closing the Interview

8.1 **"**Are there any other issues that have not been discussed that you would like to discuss?"

8.2 Ask the interviewee if they have any questions about the discussion.

8.3 Thank the interviewee for their participation in the discussion.

8.4 Ask the interviewee if the information provided can be used in the survey. Clarify that all information will be summarized and that the study will not identify any participants by name.

Annex III: Learner Questionnaire

Questionnaire serial #: _____

University of Lusaka

Assessing the Implementation of Sexuality and Reproductive Health among Adolescents in Selected Primary Schools in Zambia

LEARNER QUESTIONNAIRE

2020

The questions in this survey are designed for the adolescents pupils in schools aged 12-17 years.

Guidance for introducing yourself and the purpose of the interview:

- My name is Remmy Mukonka and I am PhD Candidate from the University of Lusaka pursuing post graduate studies in education.
- The school has been selected from all the primary schools in the district because you are implementing Comprehensive Sexuality Education. The purpose of this interview is to obtain

Information on how CSE is delivered; relationship between culture and CSE; effect of CSE on the Social-Emotional development: School Related Gender-Based Violence (SRGBV) and how it is addressed and sources of gender-transformative adolescent sexual reproductive health services

- The survey is voluntary and the information that you give will be confidential. The information will be used to prepare the final academic report, but will not include any specific names. There will be no way to identify that you gave this information.
- Could you please spare some time (around 45 minutes) for the interview? Consent given ☐

SECTION A: IDENTIFICATION PARTICULARS

A.1. Province Name:	
A.2. District Name:	
A.3. Ward Name:	
A.4. Region (1. Rural, 2. Urban)	
A.5. Name of School	
A.6. Name of project area catchment:	
A.7. Grade of the Pupil	
A.9. Date of Interview:	Date MM / DD / YYYY [____/____/_____]
A10. Name of enumerator:	

SECTION B: DEMOGRAPHIC INFORMATION **(I am now going to ask you questions about you)**		
Respondents (BIO DATA) adolescents aged 12-17		√
B.1	Respondents gender	
	a. Female	[ ]
	b. Male	[ ]
B.2	Age of respondent:	[ ]
B.3	Who do you live with?	
	a. Mother	[ ]
	b. Father	[ ]
	c. Mother and father	[ ]
	d. Grandmother	[ ]
	e. Grandfather	[ ]
	f. Grandmother and Grandfather	[ ]
	g. Any other, please specify……..	[ ]
B.6	How many people live in your household including yourself?	[ ]

Head of Household (BIO DATA)		
B. 7	Head of household gender	
	a. Male	[ ]
	b. Female	[ ]
B. 8	How old is the household head?	[ ]
B. 9	Has the household head attended school?	
	a. Yes	[ ]
	b. No	[ ]
B. 10	What is the highest level of school attended by the head of household?	
	a. 1-7	[ ]
	b. 8-9	[ ]
	c. 10-12	[ ]
	d. Tertiary	[ ]
B. 11	What is the employment status of the household head?	
	a. Formal Employment	[ ]
	b. Informal Employment	[ ]
	c. Not employed	[ ]
B. 12	What is the MAIN source of income for the household head? [Multiple responses]	[ ]
	a. Work	[ ]
	b. Sale of crops	[ ]
	c. Piece Work	[ ]
	d. Sale of Livestock	[ ]
	e. Wage/Salary	[ ]
	f. Remittances	[ ]
	g. Petty Trading	[ ]
	h. Retail Trading	[ ]
	i. Rentals	[ ]
	j. Social Cash transfer from GRZ/NGOs	[ ]
	k. Sale of fish	[ ]
	l. Others (Specify):_____	

SECTION C: Pedagogical approaches to delivering Comprehensive Sexuality Education		
C. 1	Do you learn about Comprehensive Sexuality Education? Yes No	 [ ] [ ]
C. 2	How often is it is taught?	
C. 3	In what grade did you start learning Comprehensive Sexuality Education? a. Grade 5 b. Grade 6 c. Grade 7 d. I am not sure	 [ ] [ ] [ ] [ ]
C. 4	How is Comprehensive Sexuality Education taught?	
C. 5	Who teaches Comprehensive Sexuality Education (CSE)? a. Teachers b. Nurses c. Guidance couselling teacher d. Parents/Guardians e. Other, please specify…….	 [ ] [ ] [ ] [ ] [ ]
C. 6	Is the time allocated for Comprehensive Sexuality Education enough? a. Yes b. No	
C. 7	If no, explain why the time allocated for Comprehensive Sexuality Education is not enough …… …… …… ……	
	What topics do they teach you in Comprehensive and Sexuality Education? a. 1……	

C.8	b. 2…… c. 3…… d. 4…… e. I am not sure	
C.9	Which topics do you like in Comprehensive Sexuality Education? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure	
C.10	Why do you like these topics …… …… …… ……..	
C.11	Which topics do you not like in Comprehensive Sexuality Education? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure	
C.12	Why do you not like the topics? …… …… ……	
C.13	Has Comprehensive Sexuality Education helped you as an adolescent? a. Yes b. No	 [ ] [ ]
C.14	How has Comprehensive Sexuality Education helped you? …… …… …… ……	

SECTION D: Relationship between culture and comprehensive Sexuality Education		
D.1	Are the topics in Comprehensive Sexuality education appropriate with your language? a. Yes b. No	[ ] [ ]
D.2	What language is used to teach Comprehensive Sexuality Education? a. English b. Tonga c. Bemba d. Chinyanja e. Other, please specify……	[ ] [ ] [ ] [ ] [ ]
D.3	Which topics are appropriate with your language? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……..	
D.4	Which topics are not appropriate with your language? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.5	Are the topics in Comprehensive Sexuality education appropriate with your religion? a. Yes b. No	[ ] [ ]
D.6	Which topics are appropriate with your religion? a. 1…… b. 2……	

	c. 3…… d. 4…… e. I am not sure……	
D.7	Which topics are not appropriate with your religion? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.8	Are there topics that are a taboo in your culture? a. Yes b. No c. I don't know	 [ ] [ ] [ ]
D.9	Which topics are a taboo in your culture? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.10	Which topics are not a taboo in your culture? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.11	Are you able to discuss Sexuality Education with your peers? a. Yes b. No	 [ ] [ ]
D.12	Explain your answer …… …… …… ……..	

D.1	Are you able to talk about sexuality and reproductive health with your parents/guardians? Yes No	
	Explain your answer …… ……. …… …… ……..	
C.14	Are there any other cultural factors that hinder the teaching of Comprehensive Sexuality Education for pupils in your grade? a. Yes b. No	 [ ] [ ]
C.15	Explain your answer …… …… …… ……	
C.16	Are there any other religious factors that affect the delivery of comprehensive Sexuality education for pupils in your grade? a. Yes b. No	 [ ] [ ]
C.17	Explain your answer …… …… …… ……..	

SECTION E: Effect of Comprehensive Sexuality Education on the Social-Emotional development of adolescents		
E. 1	Do adolescents engage in sexual risk behaviours?	
	a. Yes	[ ]
	b. No	[ ]
	c. I don't know	[ ]
E. 2	What sexual risk behaviors do adolescents engage in?	
	a. 1……	
	b. 2……	
	c. 3……	
	d. 4……	
	e. I am not sure……	
E. 3	Are you able to talk about your feelings?	
	a. Yes	[ ]
	b. No	[ ]
E. 4	Who are you comfortable to talk to about your feelings?	
	a. Parents/Guardians	[ ]
	b. Grandmother	[ ]
	c. Grandfather	[ ]
	d. Aunty	[ ]
	e. Uncle	[ ]
	f. Male Teacher	[ ]
	g. Female Teacher	[ ]
	h. Guidance and Counseling teacher	[ ]
	i. Other, please specify……	[ ]
E. 5	Explain your answer	
	……	
	……	
	……	
	……	
E. 6	Are you able to talk about sex relationships?	
	a. Yes	[ ]

	b. No	[ ]
E. 7	Who are you comfortable to talk to about your feelings?	
	a. Parents/Guardians	[ ]
	b. Grandmother	[ ]
	c. Grandfather	[ ]
	d. Aunty	[ ]
	e. Uncle	[ ]
	f. Male Teacher	[ ]
	g. Female Teacher	[ ]
	h. Guidance and Counseling teacher	[ ]
	i. Other, please specify……	[ ]
E. 8	Explain your answer …… …… ……	
E. 9	Are you comfortable to talk about your body?	
	a. Yes	[ ]
	b. No	[ ]
E.10	Who are you comfortable to talk to about your body?	
	a. Parents/Guardians	[ ]
	b. Grandmother	[ ]
	c. Grandfather	[ ]
	d. Aunty	[ ]
	e. Uncle	[ ]
	f. Male Teacher	[ ]
	g. Female Teacher	[ ]
	h. Guidance and Counseling teacher	[ ]
	i. Other, please specify……	[ ]
E.11	Explain your answer …… …… …… ……	

SECTION F: School Related Gender-Based Violence (SRGBV)		
F.1	Is there violence targeted at girls?	
	a. Yes	[ ]
	b. No	[ ]
F.2	What form of violence is targeted towards the girls in school? [Multiple answers]	
	a. Bullying	[ ]
	b. Physical fighting	[ ]
	c. Sexual harassment	[ ]
	d. Sexual acts in exchange for good grades or for the paying of school fees	[ ]
	e. Seduction or sexual harassment of learners by a teacher	[ ]
F.3	Which form of violence affects the girls only? [Multiple responses]	
	a. Bullying	[ ]
	b. Physical fighting	[ ]
	c. Sexual harassment	[ ]
	d. Sexual acts in exchange for good grades or for the paying of school fees	[ ]
	e. Seduction or sexual harassment of learners by a teacher	[ ]
F.4	How does it affect the girls?	
F.5	Is there violence that is targeted at boys only?	
	a. Yes	[ ]
	b. No	[ ]
F.6	What form of violence is targeted towards the boys in school? [Multiple answers]	[ ]
	a. Bullying	[ ]
	b. Physical fighting	[ ]
	c. Sexual harassment	[ ]
	d. Sexual acts in exchange for good grades or for the paying of school fees	[ ]
	e. Seduction or sexual harassment of learners by a teacher	[ ]
	f. Any other, please specify……..	

F. 7	How does It affect the boys?	
F. 8	How does the school address violence that is targeted at the pupils? [Multiple answers] a. Establishment safe spaces in schools b. Introduction of clubs c. School committees d. Any other, please specify…….	 [ ] [ ] [ ] [ ]
F. 9	Have the approaches helped in addressing School related gender Based violence? a. Yes b. No c. I don't know	 [ ] [ ] [ ]
F. 10	How has the approach helped the girls? …… …… …… …….	
F.11	How has the approach helped the boys? …… …… …… ……..	
SECTION G: Sources of gender-transformative adolescent sexual reproductive health services		
G.1	Do You have access to sexual reproductive health services? a. Yes b. No	 [ ] [ ]
G.2	Who provides sexual reproductive health services? [Multiple answers] a. The school	 [ ]

	b. The Healthcare facilities c. The community members d. Any other, please specify……	[ ] [ ] [ ]
G.3	What services do the schools provide on sexual and reproductive health for adolescents? a. 1……. b. 2…….. c. 3……. d. 4…….	
G.4	Are the sexual reproductive health services provided in schools appropriate for adolescents? a. Yes b. No	[ ] [ ]
G.5	Explain your answer …… …… …… …… ……..	
G.6	Are the sexual and reproductive health services provided in schools appropriate for? a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	[ ] [ ] [ ] [ ] [ ]
G.7	Explain your answer …… …… …… …… ……..	

G.8	What services do the healthcare facilities provide on sexual and reproductive health for adolescents? a. 1……. b. 2…….. c. 3……. d. 4…….	
G.9	Are the sexual reproductive health services provided by the healthcare facilities appropriate for adolescents? a. Yes b. No	 [ ] [ ]
G.10	Explain your answer …… …… …… …… ……..	
G.11	Are the sexual and reproductive health services provided by the healthcare facilities appropriate for? a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	 [ ] [ ] [ ] [ ] [ ]
G.12	Explain your answer …… …… …… …… ……..	
G.13	Are there NGOs that provide sexual reproductive health services to adolescents? a. Yes [ ] b. No [ ] c. I don't Know	

G.14	If, yes, what services do the NGOs provide on sexual reproductive health for adolescents? a. 1……. b. 2…….. c. 3……. d. 4…….	
G.15	Are the sexual reproductive health services provided by the NGOs appropriate for adolescents? a. Yes b. No	[ ] [ ]
G.16	Explain your answer …… ……. …… …… ……..	
G.17	Are the sexual and reproductive health services provided by the NGOs appropriate for? a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	[ ] [ ] [ ] [ ] [ ]
G.18	Do you have access to information on Sexual Reproductive Health? a. Yes b. No	[ ] [ ]
G.19	Where do you get information on sexual reproductive health? [Multiple answers] a. The radio b. Television c. Male teachers d. Female teachers e. Guidance and Counseling f. Traditional teachers	[ ] [ ] [ ] [ ] [ ] [ ]

	g. Friends	[ ]
	h. Teachers	[ ]
	i. Mother	[ ]
	j. Father	[ ]
	k. Brother	[ ]
	l. Sister	[ ]
	m. Magazines	[ ]
	n. Books	[ ]
	o. Movies	[ ]
	p. Any other, please specify……	[ ]
G.20	Which sources provide information that is appropriate for adolescents? [Multiple answers]	[ ]
	a. The radio	[ ]
	b. Television	[ ]
	c. Male teachers	[ ]
	d. Female teachers	[ ]
	e. Guidance and Counseling	[ ]
	f. Traditional teachers	[ ]
	g. Friends	[ ]
	h. Teachers	[ ]
	i. Mother	[ ]
	j. Father	[ ]
	k. Brother	[ ]
	l. Sister	[ ]
	m. Magazines	[ ]
	n. Books	[ ]
	o. Movies	[ ]
	p. Any other, please specify……	
G.21	Which sources provide information that is appropriate for girls only? [Multiple answers]	[ ]
	a. The radio	[ ]
	b. Television	[ ]

	c. Male teachers	[ ]
	d. Female teachers	[ ]
	e. Guidance and Counseling	[ ]
	f. Traditional teachers	[ ]
	g. Friends	[ ]
	h. Teachers	[ ]
	i. Mother	[ ]
	j. Father	[ ]
	k. Brother	[ ]
	l. Sister	[ ]
	m. Magazines	[ ]
	n. Books	[ ]
	o. Movies	[ ]
	p. Any other, please specify……	
G.22	Explain your answer …… ……. …… …… ……	
G.23	Which sources provide information that is appropriate for boys only? [Multiple responses]	[ ]
	a. The radio	[ ]
	b. Television	[ ]
	c. Male teachers	[ ]
	d. Female teachers	[ ]
	e. Guidance and Counseling	[ ]
	f. Traditional teachers	[ ]
	g. Friends	[ ]
	h. Teachers	[ ]
	i. Mother	[ ]
	j. Father	[ ]
	k. Brother	[ ]

	l. Sister m. Magazines n. Books o. Movies p. Any other, please specify……	[ ] [ ] [ ] [ ]
G.24	Explain your answer …… …… …… …… ……	
G.25	Do you have challenges in accessing sexual reproductive health services at School? a. Yes b. No	
G.26	Explain your answer …… …… …… …… ……	
G.27	Do you have challenges in accessing sexual reproductive health services at the healthcare facilities? a. Yes b. No	
G.28	Explain your answer …… …… …… …… ……	
G.29	Do you have challenges in accessing sexual reproductive health services from the NGOs?	

	a. Yes b. No	
	Which of the following sources are a challenge to obtain information on sexual reproductive health? [Multiple responses] a. Male teachers b. Female teachers c. Guidance and Counseling d. Traditional teachers e. Friends f. Teachers g. Mother h. Father i. Brother j. Sister k. Any other, please specify……	
G.30	Which Sources would you prefer to obtain information on sexual reproductive health for adolescents? [Multiple responses] a. The radio b. Television c. Male teachers d. Nurses e. Doctors c. Female teachers d. Guidance and Counseling e. Traditional teachers f. Friends g. Teachers h. Mother i. Father j. Brother k. Sister l. Magazines m. Books	

	n. Movies f. Any other, please specify……	
G.31	Explain your answer …… …… …… ……	

THIS IS THE END OF THE QUESTIONNAIR

THANK YOU

Annex IV: Classroom Structured Observation

Assessing the Implementing of Sexuality and Reproductive Health among Adolescents in Schools

Observers Visit Record

Province:..... District:.....

Name of School:.....

Date of observation:...../...../..... Name of observer:.....

Signature:.....

Observation Results:

- Observation completed [ ]
- Not met relevant authorities at school [ ]
- Observation Incomplete [ ]
- Refused for observation [ ]
- Other (specify).....

Section A: Comprehensive Sexuality Education		
No.	Checklist	Tick
1.	Teaching resources available 1…… 2……... 3…….. 4……. Other.....	 [ ] [ ] [ ] [ ] [ ]
2.	Days when CSE is integrated or taught Monday…….. Tuesdays…… Wednesday…….. Thursday……	 [ ] [ ]

	Friday……	
3.	Duration for CSE Monday [Start:……. End:…….....] Tuesdays [Start:……End:……..] Wednesday [Start:……. End:……] Thursday [Start:……. End:……] Friday [Start:……. End:…….]	 [ ] [ ] [ ]
4.	Methodological approach used by the teacher Observer comments……..	 [ ] [ ]
5.	Pupils ask questions a. Yes b. No Observer comments……..	 [ ] [ ]
6.	Type of questions pupils ask Observer comments……...	 [ ] [ ]
7.	CSE Teacher able to answer the questions: a. Yes b. No Observer comments.....	 [ ] [ ] [ ]
Section B: IEC Materials on Sexuality and Reproductive Health		
8.	IEC materials available **[Observer to take pictures]** a. Yes b. No	

	Observer comments…….	
9.	IEC materials are gender appropriate **[Observer to take pictures]** a. Yes b. No Observer comments……	 [ ] [ ]
10.	IEC materials are age appropriate **[Observer to take pictures]** a. Yes b. No Observer comments…….	 [ ] [ ]
11.	Language for the IEC materials 1…… 2…… 3…… 4…… Observer comments……..	
12.	Other materials available 1…….. 2……. 3……. 4……. Observer comments…….	 [ ] [ ] [ ] [ ] [ ]
Section C: IEC Materials on School Related Gender-Based Violence		
13.	IEC materials available a. Yes b. No Observer comments……..	 [ ] [ ] [ ]

14.	Type of materials available on SRGBV 1……. 2…….. 3…….. 4…….. Observer comments……	 [ ] [ ] [ ] [ ]
15.	IEC SRGBV materials are gender appropriate **[Observer to take pictures]** a. Yes b. No Observer comments……	 [ ] [ ]
16.	IEC SRGBV materials are age appropriate **[Observer to take pictures]** a. Yes b. No Observer comments…….	 [ ] [ ]
17.	Language for the IEC SRGBV materials; 1…… 2…… 3…… 4…… Observer comments……..	
18.	Other materials available on SRGBV; 1…….. 2……. 3……. 4……. Observer comments…….	 [ ] [ ] [ ] [ ] [ ]
19.	SRGBV recorded; a. Yes	

<table>
<tr><td></td><td>b. No
Observer
comments……</td><td></td></tr>
<tr><td>20.</td><td>Types of SRGBV recorded;
1……..
2…….
3…….
4…….
Observer
comments…….</td><td></td></tr>
<tr><td>21.</td><td>Number of cases recorded
<table>
<tr><th>S/N</th><th>Type of SRGBV</th><th>Number</th><th>Victim (Male/female</th><th>Action taken</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
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Observer
Comments……</td><td></td></tr>
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