Title: Comprehensive Sexuality Education in Six Southern Africa countries: Perspectives from Learners and Teachers

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Short Abstract

This paper explores issues around the content and delivery of Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health (SRH) commodity provision at schools from the perspectives of leaners and teachers in six Southern Africa countries. The paper is derived from the needs assessment conducted under the SRHR-HIV Knows no Borders Project in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa, and Zambia. The findings show that although Basic Education policies in Southern African countries are in tandem with international, regional and national policies. However, implementation of the policies regarding the full CSE content and SRH commodity distribution in schools is far from being fulfilled owing to conflicting policies and socio-cultural values of diverse stakeholders. The findings highlight the need for awareness campaigns and training in communities in order to promote positive perceptions among stakeholders toward teaching of sensitive CSE topics and the distribution of SRH commodities in schools.

Key words: Comprehensive Sexuality Education, Sexual and Reproductive Health commodities, policy

Draft paper

Introduction

Young people in Africa face several adverse sexual and reproductive health issues including teenage pregnancies, child marriages, gender based violence, sexually transmitted infections and HIV infections. For instance, it is estimated that 21 million girls aged 15 to 19 years give birth every year in developing nations (WHO, 2018; Darroch et al, 2016; UNFPA, 2015) and of the global estimate of 1.8 million HIV positive adolescents, 1.5 million (85 %) live in sub-Saharan Africa (UNAIDS, 2018; UNICEF, 2018; UNFPA, 2016). Comprehensive sexuality education (CSE) was introduced as a response to adverse sexual and reproductive health outcomes for adolescents. The provision of CSE ensures that leaners are equipped with knowledge, practical skills, attitudes and values required to make healthy informed choices about their sexual lives

and relationships (UNESCO 2018; UNFPA 2014; Kirby 2007). CSE programmes that focus on human rights, gender equality, diversity and empowerment can improve young people's knowledge, self-confidence, self-esteem; attitudes, decision-making and communication skills (Panchaud et al, 2019; Vanwesenbeeck et al, 2016; Haberland, 2015; Haberland & Rogow, 2015; UNESCO 2015; Fonner et al, 2014; Kirby 2011; UNESCO, 2009; Gallant & Maticka-Tyndale, 2004; Kirby, Obasi & Laris, 2006). Thus, the provision of CSE promotes positive health behavior among adolescents and young people which contributes to an increase in abstinence, condom use and a reduction in teenage childbearing, unsafe abortion, sexual violence and HIV infections (UNESCO, 2017; Vanwesenbeeck et al, 2016; WHO, 2011). However, in many African countries sexuality education remains controversial and the provision of CSE is not accompanied with the distribution of SRH commodities in schools.

Successful implementation of CSE can be achieved if there are sound policies and frameworks that guide, inform and support its implementation. Internationally, there are policies that promote implementation of CSE. These include the Convention on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination Against Women (CEDAW). In addition, the 1994 International Conference on Population and Development (ICPD), the Fourth World Conference on Women in 1995, the World Summit on Children in 2002, the Sustainable Development Goals and the 2016 Political Declaration on HIV and AIDS support the right for all children and adolescents to receive sexual and reproductive health information, education and services that fulfil the specific needs of adolescents (UNESCO, 2013b; UNESCO, 2013c; WHO, 2011a). In Africa, the Framework for Action in Sub-Saharan Africa, the Maputo Plan of Action, and the African Youth Charter further emphasized the need for education on reproductive health, HIV and gender (UNESCO, 2013b; UNESCO, 2013c). For Southern Africa to be consistent with the international, regional and national policies there is need to improve and implement effective, age-specific/appropriate and gender sensitive CSE programs that equip young people with the knowledge, skills and values to make responsible choices about their sexual and social relationships (UNESCO & UNFPA, 2012). Although Basic Education policies in Southern African countries are in tandem with international and regional policies, implementation of the policies regarding the full CSE content and SRH commodity distribution is far from being fulfilled owing to conflicting socio-cultural values of diverse stakeholders. This paper explores

issues around the content and delivery of CSE and SRH commodity provision at schools from the perspectives of leaners and teachers in six Southern Africa countries.

Methods

The paper is derived from the needs assessment conducted under the SRHR-HIV Knows no Borders Project (a collaboration of the International Organization for Migration (IOM), Save the Children Netherlands (SCNL) and University of the Witwatersrand's School of Public Health (WSPH) consortium partners) in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa, and Zambia. The aim of the project was to improve the sexual and reproductive health and HIV (SRH-HIV) related outcomes among adolescents & young people (AYP), sex workers (SW) as well as others living in 10 high migration communities in the selected countries. In order to establish a benchmark for the project's impact to be measured against, a needs assessments and baseline survey were conducted. The needs assessment preceded the baseline survey and aimed to provide contextual information to guide project interventions and ensure they are tailored to the needs of the target groups and inform targeted advocacy.

Study population and sample size

The study population comprised of learners aged between 8 to 24 years (boys and girls) and teachers from selected schools. The target population for learners was 20 learners per school per site (community) and 10 schools per site (community). Non-random probability sampling technique was applied and participants were purposively selected. The total sample for this study were 182 leaners and 96 teachers.

Data collection

Data collection was conducted between April and December 2018 in all the six countries using semi structured questionnaires (leaner's checklist and school's checklist). The school's checklist was an enquiry to ascertain the CSE topics that are covered and to know whether CSE formed part of the school curriculum. The learners' checklist was an enquiry on their perception of CSE topics that are taught in school, their preferred mode of delivery and their access to SRH commodities during and after school.

Ethical considerations

Ethical approval was obtained in each of the six countries. Approval to conduct the study at the project sites was also obtained from the provincial authorities as well as Ministries of Education and Health and permission from the schools. Written consent was also obtained from all participants and written consent for leaners below the age of 18 was obtained from the parents.

Findings from survey

Of the 96 schools that were surveyed in the six Southern Africa countries, 82.3% provide CSE as shown in Figure 1. In all the six countries, CSE is provided from Grade one. In the schools where CSE is not taught, the reasons reported for not providing CSE are that it contradicts with religious beliefs, teachers feel uncomfortable to teach CSE and the belief that CSE encourages learners to be sexually active..

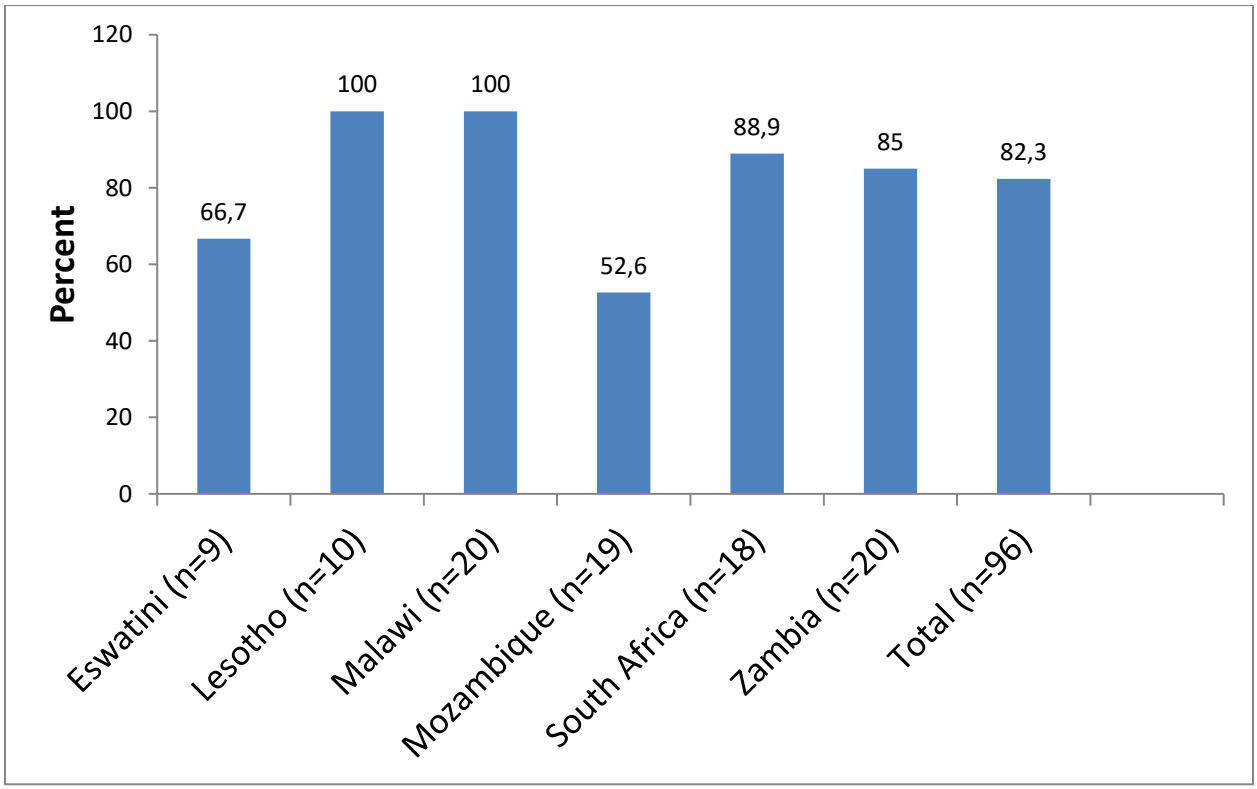

Figure 1: Percentage of schools providing CSE in the six Southern African countries

Table 1 shows that the most common CSE topics (taught as reported by the teachers) in all the countries are HIV & AIDS (81.3%), substance abuse (80.2%), abstinence (79.2%), puberty (78.1%) adolescent (77.1%) and reproduction (75.0%). On the other hand, the learners reported the top six CSE topics as follows: HIV & AIDS (97.5%), substance abuse (92.1%), puberty (91.9%), STDs (92.6%), human rights (92.0%) and gender equality and gender roles (88.1%). The CSE topics that were reported to be offered in schools from both the teachers and the leaners are HIV & AIDS, substance abuse and puberty. See detailed results by country in Appendix 1 and 2. Consistent with literature, the least CSE topics covered are termination of pregnancy, sources of SRH services, romantic relationships, condom use, pregnancy and prenatal care.

Table 1: The most covered CSE topics in the six countries

	Teachers	**Learners**
Topics covered	**% of school covering the topic**	**% of leaners reporting the topics covered**
HIV & AIDS	81.3	97.5
Substance abuse	80.2	92.1
Abstinence	79.2	-
Puberty	78.1	91.9
Adolescent	77.1	-
Reproduction	75.0	-
STDs	-	92.6
Human rights	-	92.0
Gender equality and gender roles		88.1

According to the teachers, the three main CSE teaching methods used across the six countries are shown in Table 2. These are textbooks/teaching guide (77.1%), face to face (76.0%) and Peer educators (41.7%).

Table 2: CSE teaching methods in the six countries.

Mode of delivery (Teachers)	**Eswatini n (%)**	**Lesotho n (%)**	**Malawi n (%)**	**Mozambique n (%)**	**South Africa n (%)**	**Zambia n (%)**	**Total n (%)**
	N=9	**N=10**	**N=20**	**N=19**	**N=18**	**N=20**	**N=96**
Face to face	5 (55.6)	9(90.0)	19 (95.0)	10 (52.6)	13 (72.2)	17 (85.0)	73 (76.0)
Videos/movies	0(0.0)	1 (10.0)	0(0.0)	2(10.5)	0(0.0)	4 (20.0)	7 (7.3)
Textbooks/teaching guide	6 (66.7)	6 (60.0)	18 (90.0)	9(47.4)	17(94.4)	18(90.0)	74 (77.1)
Information pamphlets	2(22.2)	5(50.0)	4(20.0)	5(26.3)	7(38.9)	12(60.0)	35(36.5)

Peer educators	3(33.3)	2(20.0)	4(20.0)	4(21.1)	10(55.6)	13(65.0)	40(41.7)

Percentages do not add up to 100 as multiple responses were allowed

Table 3 shows that learners prefer CSE to be taught using face to face mode of delivery (79.4%), textbook/teacher's guide (69.8%), videos (64.9%) and in Lesotho, Malawi, South Africa and Zambia learners highlighted that they prefer provision of information pamphlets (40.9%) to be part of CSE teaching method.

Table 3: Learner's preferred method of CSE teaching

Mode of delivery	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Textbooks/teacher's guide	3(37.5)	5(83.3)	36(100.0)	1(16.7)	10(52.6)	5(45.5)	60(69.8)
Face to face	11(68.8)	3(75.0)	36(100.0)	15(75.0)	19(67.9)	16(72.7)	100(79.4)
Videos	1(16.7)	2(66.8)	14(100.0)	14(73.7)	5(35.7)	12(66.7)	48(64.9)
Magazine	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(14.3)	1(3.7)
Information pamphlet	0(0.0)	1(50.0)	2(100.0)	0(0.0)	7(43.8)	8(57.1)	18(40.9)
Radio	0(0.0)	1(50.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	2(7.1)
Tests & Homework	0(0.0)	0(0.0)	0(0.0)	0(0.0)	4(30.8)	0(0.0)	4(13.3)
Text messages	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(14.3)	1(3.7)

In many schools, the learners reported that CSE is taught by the life orientation teacher (42.1%) or a general class teacher (38.5%).

Table 4: CSE teacher in the six countries

CSE teacher (Learners)	Eswatini n (%)	Lesotho n (%)	Malawi n (%)	Mozambique n (%)	South Africa n (%)	Zambia n (%)	Total n (%)
	N=16	N=8	N=46	N=34	N=33	N=34	N=171
Life orientation teacher	1(6.3)	4(50.0)	0(0.0)	24(70.6)	32(97)	11(32.4)	72(42.1)
Health education teacher	1(6.3)	3(37.5)	1(2.2)	3(8.8)	0(0.0)	10(29.4)	18(10.5)
Principal/ headmaster	1(6.3)	0(0.0)	1(2.2)	5(14.7)	0(0.0)	1(2.9)	8(4.7)
Social worker	0(0.0)	0(0.0)	0(0.0)	2(5.9)	0(0.0)	0(0.0)	2(1.2)
Class teacher	9(56.0)	1(12.5)	44(95.6)	0(0.0)	0(0.0)	12(35.3)	66(38.5)
Career guidance	2(12.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	2(1.2)
Police Officer	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(3.0)	0(0.0)	1(0.6)
Volunteers	1(6.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(0.6)

Save the children	1(6.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(0.6)

Table 5 provides a list of the preferred CSE provider/teacher as reported by the learners. Most learners indicated that they prefer CSE to be taught by the teacher (93.5%), parent/guardian (91.7%), Health worker (66.7%), elders/grandparents and sisters (65.0%). This establishes the role and importance of the family in the provision of CSE.

Table 5: Preferred CSE Provider by learners

Preferred provider	**Eswatini**	**Lesotho**	**Malawi**	**Mozambique**	**South Africa**	**Zambia**	**Total**
Parent/guardian	9(100.0)	5(100.0)	10(100.0)	18(94.7)	17(73.9)	18(100.0)	77(91.7)
Aunt				1(50.0)	4(40.0)		5(41.7)
Peer educator		1(100.0)	2(100.0)	0(0.0)	2(25.0)	3(100.0)	8(53.3)
Elders/grandparents	2(100.0)	1(100.0)			5(45.5)	5(100.0)	13(65.0)
Teacher	3(100.0)	3(100.0)	38(100.0)	10(90.9)	21(77.8)	25(100.0)	100(93.5)
Friends	2(100.0)		6(100.0)	0(0.0)	0(0.0)	5(100.0)	13(65.0)
Youth club leader	2(100.0)		1(100.0)	0(0.0)	0(0.0)	1(100.0)	4(36.4)
Health worker	1(100.0)	4(100.0)		0(0.0)	1(14.3)	8(100.0)	14(66.7)
Sisters				0(0.0)	11(64.7)	2(100.0)	13(65.0)
Pastor/Priest				0(0.0)	4(40.0)	1(100.0)	5(41.7)
Brothers				0(0.0)	3(33.3)		3(30.0)
Uncle				0(0.0)	3(33.3)		3(30.0)
Counsellor				0(0.0)	2(25.0)	1(100.0)	3(30.0)
Police		1(100.0)		0(0.0)	0(0.0)		1(12.5)
Social Worker				0(0.0)	1(14.3)		1(12.5)

The teaching of CSE in many schools is not accompanied with the provision of SRH commodities. Table 6 shows that of the 96 schools that were surveyed, only 7.2% provide

condoms. All schools in Lesotho, Malawi and Swaziland do not distribute condoms. Similarly, only 3.6% of all schools surveyed provide contraceptive pills. All schools in Lesotho, Malawi, Swaziland and Zambia do not provide contraceptive pills. Sanitary pads are provided in all the countries but in less than half of the schools surveyed.

Table 6: SRH commodities provided at schools

Commodities	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Condoms	0(0.0)	0(0.0)	0(0.0)	1(9.1)	3 (16.7)	2 (11.1)	6 (7.2)
Contraceptive pills	0(0.0)	0(0.0)	0(0.0)	1(11.1)	2 (11.1)	0(0.0)	3 (3.6)
Sanitary pads	2 (28.6)	3 (30.0)	2(10.0)	3(27.3)	15(83.3)	14(70.0)	39(45.4)

The main SRH commodities that are not provided but teachers reported that they are required are shown in Table 7. These include sanitary pads (44.1%), condoms (17.5%), contraceptive pills (16.1%) and CSE teaching materials (13.0) changing room and tissue paper.

Table 7: SRH commodities required that are not provided at schools: reported by teachers

Commodities	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
HTC	0(0.0)	1(12.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(2.1)
Sanitary Pads	4(44.4)	2(22.2)	12(66.7)	3(20.0)	8(44.4)	8(53.3)	37(44.1)
Condoms	0(0.0)	0(0.0)	8(57.1)	0(0.0)	0(0.0)	2(22.2)	10(17.5)
Contraceptive pills	0(0.0)	0(0.0)	8(57.1)	0(0.0)	0(0.0)	1(12.5)	9(16.1)
Circumcision	0(0.0)	0(0.0)	1(14.3)	0(0.0)	0(0.0)	0(0.0)	1(2.1)
Teaching materials	0(0.0)	0(0.0)	1(14.3)	5(29.4)	0(0.0)	1(12.5)	7(13.0)
Uniforms, changing room, toilet paper	1(16.7)	0(0.0)	4(40.0)	0(0.0)	1(9.1)	1(12.5)	7(13.0)
Pregnancy test	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(12.5)	1(2.1)
HIV testing & treatment	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(12.5)	1(2.1)

Varies by what was on offer at each school at time of enquiry

Table 8 shows a list of the SRH commodities that learners would like to be provided at schools. Top on the list are CSE materials, sanitary pads and panty liners, toiletries, condoms, HIV testing kits, and contraceptive pills.

Table 8: SRH commodities required that are not provided by schools: reported by learners

Commodities	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Toiletries	4(57.1)		16(100.0)	0(0.0)	1(7.7)	2(100.0)	23(51.1)
CSE materials	0(0.0)		20(100.0)	6(46.2)	0(0.0)	6(100.0)	32(59.3)
Sanitary pads & panty liners	7(70.0)		5(100.0)	0(0.0)	7(36.8)	12(100.0)	31(58.5)
Soccer balls	0(0.0)	1(100.0)		0(0.0)	0(0.0)	2(100.0)	3(12.0)
Condoms	1(25.0)	1(100.0)		6(46.2)	1(7.7)	7(100.0)	16(42.1)
HIV testing material	3(50.0)	1(100.0)		0(0.0)	4(25.0)		8(26.7)
Contraceptive pills	1(25.0)		1(100.0)		2(14.3)		4(15.4)
Pregnancy test kits		1(100.0)			0(0.0)		1(50.0)

Multiple responses permitted; Varies by what was on offer at each school at time of enquiry

Table 9 shows that besides obtaining SRH commodities at school, learners would want the commodities to be provided at home (88.2%), at the clinic/hospital (84.5%), at youth clubs and in the community (71.9%).

Table 9: Places learners would want to receive SRH commodities other than at school

Places	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Home	7(87.5)	3(100.0)	9(90.0)	19(100.0)	8(53.3)	21(100.0)	67(88.2)
Youth club	2(66.7)	1(100.0)	21(95.5)		1(12.5)	1(100.0)	26(74.3)
Radio/Television	0(0.0)	1(100.0)	10(90.9)		1(12.5)		12(57.1)
Church	1(50.0)		1(50.0)		13(65.0)	8(100.0)	23(71.9)
Clinic/hospital	4(80.0)	4(100.0)	1(50.0)	16(100.0)	10(58.8)	14(100.0)	49(84.5)
Groups	0(0.0)		1(50.0)		0(0.0)		1(10.0)
Friends	0(0.0)		5(83.3)		0(0.0)	3(100.0)	8(47.1)
Community	3(75.0)	3(100.0)	0(0.0)		3(30.0)	14(100.0)	23(71.9)
Chief's office	0(0.0)	2(100.0)	0(0.0)		0(0.0)		2(18.2)
Council	0(0.0)	1(100.0)	0(0.0)		0(0.0)		1(10.0)

Multiple responses permitted

Discussion (Incomplete – very first draft)

Status of CSE policies in the six countries

In the Kingdom of Eswatini, provision of CSE which is known as Life Skills Education (LSE) in schools received immense support from several policies and frameworks. The provision of LSE curriculum is aligned to the Swaziland Education Sector Policy (2011) which supports integration of LSE into the school curriculum and mandates the Ministry of Education and Training to ensure provision of age appropriate, evidence-based and comprehensive education on life skills and HIV and AIDS. The LSE curriculum is also aligned with several national policies which are the National Development Strategy, the HIV extended National Strategic Framework, the Sexual and Reproductive Health Policy and the Swaziland National Youth Policy.

The provision of CSE in Lesotho is supported by various policies which include Curriculum and Assessment Policy (2009), Education Sector HIV and AIDS Policy (2011), National Minimum Standards for Provision of Adolescent-Friendly Health Services, National Action Plan for Women, Girls and HIV and AIDS, Behaviour Change and Communication Strategy, Draft School Health and Nutrition Policy and Draft Adolescent Health Strategy (National Curriculum Development Centre, 2007). Lesotho CSE curriculum aims to equip learners with knowledge, skills, and values to enable them to exercise their human rights and adopt healthy lifestyles (UNESCO & UNFPA, 2012).

In Malawi, LSE and life skills-based HIV prevention are two key governmental strategies identified in education and health policies and strategic plans, namely; the National HIV and AIDS Strategy, National Education Sector Plan, Ministry of Education HIV and AIDS Mainstreaming Strategy, National Youth-Friendly Health Strategy, and the National Youth Policy (Ministry of Health, 2017). In addition, teaching of LSE in Malawi gained support from many stakeholders except teaching of Sex and Sexuality to very young learners and the promotion of condom distribution in schools (Algur et al, 2018; UNESCO, 2017).

In Mozambique, the provision of CSE is anchored by the Strategic Plan for the National Response to HIV and AIDS 2015-2019 and the Strategic Plan for Education 2015-2019 (Chandra-Mouli et al, 2015).

In South Africa, The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (1999), was the first policy which aimed to equip learners with knowledge and skills to protect themselves against HIV infection. Similarly, the National Integrated Plan of 2000-2005 supported the provision of LSE in primary and secondary schools. The 2007 Children's Act allows children aged 12 years and older to exercise their rights relating to reproductive health; including access to contraceptives and to information on sexuality and reproduction and the right of consent to HIV/AIDS testing and treatment (Han & Bennish, 2009). In addition, there are several policies that promote the provision of CSE in schools and these are: The Department of Basic Education Integrated Strategy on HIV, STI and TB 2012-2016 which aims to improve coordination and mainstreaming of the basic education sector's response, The National Strategic Plans (2007-2011; 2012-2016) which provide guidelines for a multi-sectoral response to HIV and AIDS, STIs and TB, The Integrated School Health Policy (2012) which seeks to address health problems of learners and promote health education on various topics, including SRH, The Adolescent Sexual and Reproductive Health and Rights Strategy Framework (2015-2019) which is a multi-sectoral framework aimed at scaling up access to CSE and SRH services by adolescents.

Provision of CSE in Zambia is anchored on several policies and have been institutionalized through the following policies, framework and strategies: Zambia Education Curriculum Framework, The Life Skills Based Comprehensive Sexuality Education Framework, Out of School CSE Framework, School Health and Nutrition Policy, Education Sector Policy on HIV and AIDS, National AIDS Strategic Framework (2011-2016 and 2017-2021, Adolescent Health Strategic Framework (2010-2016 and 2017-2021) and the National Strategy on Ending Child Marriage (2016-2020)

Analysis of policy and contraception distribution points

All the policies, frameworks and strategies highlighted support the notion that contraception should be distributed in health facilities, community health delivery points and health clubs. However, the policies do not mention schools as part of contraception distribution points. In Mozambique, literature has shown that condoms are provided in secondary schools and the country aims to reach 90% to 100% of schools providing contraceptive methods by 2021 (IOM, 2006). South African government policies including the 2007 Children's Act grants individual schools the authority to decide whether to distribute condoms (Han & Bennish, 2009). However, owing to contradictory government policies and public pronouncements regarding provision of condoms in South African public schools, few schools are providing condoms in South Africa (Han & Bennish, 2009).

Study findings and policy

In all the countries studied, policies have institutionalized and support the provision of CSE in schools. Although, the policies incorporate all aspects of CSE, there are certain topics which are not taught in schools thereby depriving and undermining the rights of learners. Similar to previous findings, the topics include romantic relationships, condom use, and contraception, termination of pregnancy, diversity and sources of SRH services (UNESCO, 2017; de Reus et al, 2015; UNESCO, 2013c; UNESCO & UNFPA, 2012). This is partly attributed to conflicting cultural and religious beliefs of parents, teachers, religious leaders and other community stakeholders (de Reus et al, 2015; Soon et al, 2013; Francis, 2012; Francis, 2010; Wilson et al, 2010; Goldman, 2008; Francis and Zisser, 2006; Posel , 2004). CSE topics on diversity have received resistance as heteronormativity is perceived as the norm in many African societies (Francis, 2017; Lees, 2017; de Reus et al, 2015; Chirawu et al, 2014; Francis, 2012). In addition, in almost all the schools investigated in this study, condoms and contraceptive pills are not provided. In Eswatini, Lesotho, Malawi, and Zambia, the policy prohibits distribution of condoms at schools and initiation ceremonies are still perceived as the legitimate way of teaching CSE thereby hindering provision of comprehensive CSE to the learners (UNESCO, 2017).

Recommendations

Socio-cultural beliefs around sexuality education affect teaching about diversity, termination of pregnancy and sexuality as well as provision of condoms and contraceptive pills. Awareness

campaigns and dissemination of findings from several studies in communities and with policy makers and teachers promote positive perceptions among stakeholders toward provision of CSE in schools.

Many schools have reported shortage of trained teachers in CSE and inadequate CSE teaching materials. Teachers that are not trained in CSE do lack the understanding and the ability to impart learning and develop skills on CSE. In-depth teacher training should be conducted especially in areas regarding sexual and gender diversity. This would assist teachers to overcome their own commonly held beliefs of heteronormativity as the norm and homosexuality as a taboo. Thus, CSE training will not necessarily change the teacher's beliefs but rather helps them to reconcile their personal and professional values. In addition to formal training, it is important to provide on-going in-service support and lessons learnt workshops for teachers.

The main teaching methods in schools are textbooks/teaching guide and face to face which can be described as authoritative and teacher centered. It is crucial to develop learner-centered or learner focused initiatives, for example, role-plays/drama where active dialogue and learner participation is encouraged. This would ensure that learners take control and ownership of their sexuality education and enhance stories and experiences to be shared in a non-judgmental and holistic way.

There is a need to link and promote collaboration between the education systems and the health care systems regarding provision of age-specific and appropriate SRH service and referrals.

References

Algur, E., Wang, E., Friedman, H.S. & Deperthes, B. (2019). A Systematic Global Review of Condom Availability Programs in High Schools. *Journal of Adolescent Health* vol 64 292-304

Chirawu, P., Hanass-Hancock, J., Aderemi, T.J., de Reus, L., • Anna Sophie Henken, A.S. (2014). Protect or Enable? Teachers' Beliefs and Practices Regarding Provision of Sexuality Education to Learners with Disability in KwaZulu-Natal, South Africa. *Sex Disabil* (2014) 32:259–277 DOI 10.1007/s11195-014-9355-7

Darroch J, Woog V, Bankole A, Ashford LS. (2016). *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute.

de Reus, L., Hanass-Hancock, J., Henken, S. & van Brakel, W. (2015). Challenges in providing HIV and sexuality education to learners with disabilities in South Africa: the voice of educators, *Sex Education*, 15:4, 333-347, DOI: 10.1080/14681811.2015.1023283

Fonner, VA., Armstrong, K.S., Kennedy, C.E., O'Reilly, K.R., & Sweat, M.D. (2014). School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *PLoS ONE* 9(3): e89692. doi:10.1371/journal.pone.0089692

Francis, D.A. (2017). Homophobia and sexuality diversity in South African schools: A review. *Journal of LGBT Youth* VOL. 0, NO. 0, 1–21. http://dx.doi.org/10.1080/19361653.2017.1326868

Francis, D. (2012). Teacher positioning on the teaching of sexual diversity in South African schools. *Culture, Health & Sexuality* 14: 597–611.

Francis, D.A. (2011). Wedged within a triad of contradictory values: Sexuality education in South Africa. African Journal of Psychology 21: 319–328. Francis, D. 2012. Teacher positioning on the teaching of sexual diversity in South African schools. *Culture, Health & Sexuality* 14: 597–611.

Francis, D. (2010). Sexuality education in South Africa: Three essential questions. *International Journal of Educational Development.* DOI: 10.1016/j.ijedudev.2009.12.003

Francis, D. & Zisser, A. 2006. Youth have a new view on Aids, but are they talking about it? *African Journal of Aids Research* 5: 189–196.

Gallanta, M., Maticka-Tyndaleb, E. (2004). School-based HIV prevention programmes for African youth. *Social Science & Medicine* 58 1337–1351

Haberland, N.A. (2015). The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review Of Evaluation Studies. *International Perspectives on Sexual and Reproductive Health*, 41(1):31–42, doi: 10.1363/4103115

Haberland, N. & Rogow,D. (2015). Sexuality Education: Emerging Trends in Evidence and Practice. *Journal of Adolescent Health* Vol. 56 Issue 1 S15 -S21

Han, J. & Bennish, M.L. (2009) Condom Access in South African Schools: Law, Policy, and Practice. PLoS Medicine Vol 6, Issue 1- e1000006

International Organization for Migration (IOM). (2006). *Mapping HIV Vulnerability along Northern Maputo and Nacala Transport Corridor in Mozambique*. PHARMSA. IOM

Kirby, D. (2011). *A Way Forward: Recommendations to the South African DBE to Design and Implement an Effective HIV Education Curriculum that Reduces Sexual Risk for HIV*. Scotts Valley, CA: ETR Associates

Kirby, Douglas. (2007). *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

Kirby, D., Obasi, A. and Laris, B.A. (2006). *The Effectiveness of Sex Education and HIV Education Interventions in Schools in Developing Countries*. World Health Organization Technical Report Series, 938, 103-150.

Lees, J. (2017). sexual diversity and the role of educators: reflections on a south african teacher education module. *South African Journal of Higher Education* Vol 31 No. 249–266 http://dx.doi.org/10.20853/31-4-820

Panchaud, C., Keogh,S.C., Stillman, M., Awusabo- Asare,K., Motta, A., Sidze E.& Monzón, A.S. (2019). Towards comprehensive sexuality education: A comparative analysis of the policy environment surrounding school-based sexuality education in Ghana, Peru, Kenya and Guatemala, *Sex Education*, 19:3, 277-296, DOI:10.1080/14681811.2018.1533460

Posel, D. (2004). *Getting the nation talking about sex: reflections on the discursive constitution of sexuality in South Africa since 1994*. Agenda 62, 53–63

Soon,C.N., Kaida, A., Nkala, B., Dietrich, J., Cescon, A., Gray, G. & Miller, C.L. (2013). Adolescent experiences of HIV and sexual health communication with parents and caregivers in Soweto, South Africa. *Journal of Social Aspects of HIV/AIDS*: 10:3-4, 163-169, DOI10.1080/17290376.2014.902769

United Nations Children's Fund (UNICEF)**.** (2018). Global and Regional HIV Trends. https://data.unicef.org/topic/hivaids/global-regional-trends/

United Nations Educational, Scientific and Cultural Organization (UNESCO). (2018). *International technical guidance on sexuality education: An evidence-informed approach.* UNESCO, 7, place de Fontenoy, 75352 Paris 07 SP, France.

United Nations Educational, Scientific and Cultural Organization (UNESCO). (2017). *CSE Scale-up in Practice Case Studies from Eastern and Southern Africa*. UNSCO, Paris, France.

United Nations Educational, Scientific and Cultural Organization (UNESCO). (2013b). *Prevention Education in Eastern Europe and Central Asia: A Review of Policies and Practices*. Moscow, UNESCO. http://unesdoc.unesco.org/images/0022/002264/226426E.pdf

United Nations Educational, Scientific and Cultural Organization (UNESCO). (2013c). *Young People Today. Time to Act Now. Why Adolescents and Young People Need Comprehensive*

Sexuality Education and Reproductive Health Services in Eastern and Southern Africa. Paris, UNESCO. http://unesdoc.unesco. org/images/0022/002234/223447e.pdf

United Nations Educational, Scientific and Cultural Organization (UNESCO) and United Nations Population Fund (UNFPA). (2012). *Sexuality Education: A ten-country review of school curricula in East and Southern Africa*. Paris, UNESCO and UNFPA. Retrieved from http://unesdoc.unesco. org/images/0022/002211/221121E.pdf.

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, UNESCO. http://unesdoc.unesco. org/images/0018/001832/183281e.pdf

United Nations Population Fund.(UNFPA). (2015). *Girlhood, not motherhood: Preventing adolescent pregnancy.* New York: UNFPA

United Nations Population Fund (UNFPA). (2014). *UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender*. UNFPA. New York, USA.

United Nations Programme on HIV/AIDS (UNAIDS). (2018). *Global HIV & AIDS statistics: 2018 Fact Sheet*. https://www.unaids.org/en/resources/fact-sheet

United Nations Programme on HIV/AIDS (UNAIDS). (2016). *Ending the AIDS epidemic for adolescents, with adolescents: A practical guide to meaningfully engage adolescents in the AIDS response*. United Nations Programme on HIV/AIDS. GENEVA, Switzerland.

Vanwesenbeeck, I., Westeneng, J., de Boer, T., Reinders, J. & van Zorge, R. (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, DOI:10.1080/14681811.2015.1111203

Venkatraman Chandra-Mouli, V., Gibbs, S., Badiani, R., Quinhas, F. & Joar Svanemyr, J. (2015). Programa Geração Biz, Mozambique: How did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve? *Reproductive Health* 2015, 12:12. https://doi.org/10.1186/1742-4755-12-12

World Health Organization (WHO). (2018). *Adolescent Pregnancy Fact Sheet.* https://www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy

World Health Organization (WHO). (2011). *Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*. Geneva: WHO.

Wilson,E.K., Dalberth, B.T., Koo, H.P. & Gard, J.C. (2010.). Parent's Perspective on Talking to Preteenage Children About Sex. *Perspectives on Sexual and Reproductive Health Volume 42*, Number 1.

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Appendices

Appendix 1: Top six CSE topics by country as reported by teachers

Topics covered	**Eswatini n (%)**	**Lesotho n (%)**	**Malawi n (%)**	**Mozambique n (%)**	**South Africa n (%)**	**Zambia n (%)**	**Total n (%)**
Topic	**N=9**	**N=10**	**N=20**	**N=19**	**N=18**	**N=20**	**N=96**
HIV & AIDS	6(66.7)	10(100.0)	19(95.0)	10(52.6)	16(88.9)	17(85.0)	78(81.3)
Substance abuse	6(66.7)	10(100.0)	19(95.0)	10(52.6)	15(83.3)	17(85.0)	77(80.2)
Abstinence	5(55.6)	10(100.0)	20(100.0)	10(52.6)	17(77.8)	17(85.0)	76(79.2)
Puberty	6(66.7)	9(90.0)	18(90.0)	10(52.6)	15(83.3)	17(85.0)	75(78.1)
Adolescent	6(66.7)	8(80.0)	19(95.0)	8(42.1)	16(88.9)	17(85.0)	74(77.1)
Reproduction	6(66.7)	10(100.0)	19(95.0)	10(52.6)	12(66.7)	15(75.0)	72(75.0)

Appendix 2: Top six CSE topics by country as reported by learners

Top six topics covered (leaners)	**Eswatini**	**Lesotho**	**Malawi**	**Mozambique**	**South Africa**	**Zambia**	**Total**
HIV & AIDS	16(100.0)	7(100.0)	41(95.4)	29(100.0)	33(100.0)	31(94.0)	157(97.5)
STDs	15(93.6)	8(100.0)	36(80.0)	16(100.0)	30(96.8)	33(100.0)	138(92.6)
Substance abuse	14(87.5)	7(87.5)	40(88.9)	19(100.0)	31(96.9)	29(90.6)	140(92.1)
Human rights	13(81.3)	6(75.0)	40(88.9)	30(100.0)	31(96.9)	30(93.8)	150(92.0)
Puberty	15(93.6)	7(87.5)	35(76.1)	26(100.0)	36(100.0)	32(100.0)	148(91.9)
Gender equality and gender roles	7(43.8)	6(75.0)	43(97.7)	12(100.0)	31(96.9)	27(87.1)	126(88.1)