



COLLEGE OF MEDICINE

**CATCH THEM YOUNG: ASSESSMENT OF IMPLEMENTATION OF
SEXUALITY EDUCATION FOR VERY YOUNG ADOLESCENTS AGED
BETWEEN 10 AND 14 YEARS IN LILONGWE, MALAWI**

By

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(Bachelor of Science in Community Health Nursing)

**A Dissertation Submitted in Partial Fulfillment of the Requirement of a Master
of Global Health Implementation Degree**

October 2020

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DECLARATION

I, Esther Latif, hereby declare that this thesis is my original work and has not been presented for any other awards at the University of Malawi or any other university.

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A handwritten signature in black ink, appearing to read 'Esther Banda Latif', enclosed within a rectangular box.

Date:

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ACKNOWLEDGEMENTS

I am greatly indebted to the following;

1. My research supervisor, Dr N. Kalanga for dedicating his time offering guidance throughout the whole research project. I could not have imagined having a better advisor and mentor for my dissertation.
2. Members of staff of the Health Systems and Policy Research department for imparting in me knowledge over the past two years.
3. The Lilongwe District Education Office and Chowo, Chimbalinga and Kalamba School
This study would not have been possible if the administration denied to do this study in these schools.
4. My study participants, without them this study could not have taken place.
5. I also acknowledge F. Mwale and G. Aaron who helped me with data collection
6. Mr Hussein Latif, Ms G. Siyasiya, Andrew Makwinja, Dr Linda Nyondo Mipando, Tommy Mthepheya and Aisha Twalibu for their input and proof reading the final dissertation.
7. Nkhoma Hospital for financial support towards this research project.

DEDICATION

To my husband and children. Thank you for being always there for me supporting throughout this academic journey and forever believing in me. I am who I am today because of your unconditional love. May God bless you abundantly.

Above all I thank and dedicate this work to God for making me reach this far and for being with me throughout the study period.

ABSTRACT

Background: Despite the introduction of sexuality education (SE) in primary schools in Malawi, a significant number of very young adolescents still experience early marriages, high teenage pregnancies and high school drop-outs. The extent to which SE is being provided is not known. This study aimed at assessing implementation of SE in rural primary schools in Lilongwe District.

Methodology: This was a qualitative case study, which purposively selected three schools with registered high school drop-out numbers due to teenage pregnancies in Chowo Education Zone. We conducted 12 Focus Group Discussions with very young adolescents aged between 10-14 years, 20 parents and 8 religious/traditional leaders. We also conducted in-depth interviews with 12 teachers, to explore their perception towards sexuality education. In addition, we reviewed Education and Curriculum documents and conducted classroom observations. We used thematic content approach to analyze all the collected data.

Results: Most very young adolescents knew sexuality as boy/girl sexual relationships, and described the importance of SE in prevention of early pregnancy and sexually transmitted infections. However, some out of school Very Young Adolescents (VYAs) expressed lack of knowledge about sexuality issues. There were mixed reactions on how study participants perceived SE provided in primary schools; Some participants supported the teaching of SE in schools while others, mostly traditional and religious leaders felt SE in schools is not culturally and age appropriate. During classes, most teachers were observed to be uncomfortable in teaching SE; they lamented the lack of skills and resources, culture, religion as barriers to effective implementation of SE.

Conclusion: Comprehensive sexuality education in Chowo education zone is not implemented according to the International Technical Guidance for Sexuality Education, 2018. Comprehensive sexuality education curriculum available in the country is a good opportunity for improvement.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
COMREC	College of Medicine Research Ethics Committee
CSE	Comprehensive Sexuality Education
DHS	Demographic Health Survey
FGDs	Focus Group Discussions
HIV	Human Immunodeficiency Virus
KII	Key Informants Interviews
ITGSE	International Technical Guidance for Sexuality Education
JPAG	Joint UN Programme on Adolescent Girls
LMICs	Lower and Middle Income Countries
MoEST	Ministry of Education Science and Technology
SBSE	School-Based Sexuality Education
SE	Sexuality Education
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
VYA	Very Young Adolescents

WHO

World Health Organization

YFHS

Youth Friendly Health Services

CHAPTER ONE: INTRODUCTION

1.1 Background

An adolescent is any person between ages 10 and 19 according to World Health Organization (WHO) [1]. Adolescence can be broken into three stages: Very young adolescence ages 10 to 14, middle adolescence ages 15 to 17, and late adolescence ages 18 to 21 [2]. This study focused on very young adolescents (VYAs).

Early adolescence remains a crucial time since it is a period of rapid physical, social, emotional and cognitive changes [3]. During early adolescence, major changes in health and health related behavioral changes occur that may have implications later in life. The period of early adolescence is especially challenging for the provision of information and health services enabling boys and girls to “deal in a positive and responsible way with their sexuality” [3] as recommended in international agreements. More than 33% of the global burden of disease and almost 60% of premature deaths among adults can be associated with behaviors or conditions that began or occurred during young adolescence such as sexual abuse, and risky sex [3]. Evidence from the study findings done by Uwiragiye [4] on youths’ knowledge of HIV/AIDS, conducted in Gisozi district (Rwanda), pointed out that 22% of girls interviewed have never heard of the sexually transmitted illnesses or the consequences of being sexually active, 35% of girls knew nothing of the symptoms of STIs for women, and 42% knew nothing about any symptoms of STIs for men [5]. In addition, in 2016 alone, 777,000 births were from 10-14 -year old mothers in developing countries and 58% of the births took place in Africa [3].

In Malawi, like some other parts of the world, adolescents face a number of challenges ranging from early marriages, high teenage pregnancies, gender-based violence, early sexual debut, high school drop-out, high abortion complications leading to maternal deaths. Sex-related risky practices among adolescents indicate lack of knowledge about sexuality and reproductive health [2] hence the reason for introducing comprehensive sexuality education (CSE) in both primary and secondary schools in Malawi. In this study, comprehensive sexuality education (CSE) will be used interchangeably with sexuality education (SE).

1.2 Literature Review

1.2.1 Very Young Adolescents

Very Young Adolescents (VYA) is defined as adolescents within 10 to 14 years age bracket [5] and are now recognized as a specific age group with special programming needs [2]. This period is especially challenging for the provision of information and health services enabling boys and girls to “deal in a positive and responsible way with their sexuality”, as recommended in international agreements [6].

1.2.2 Comprehensive Sexuality Education (CSE)

The International Planned Parenthood Federation (IPPF) defines sexuality education as a rights-based approach to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality: physically and emotionally, individually and in relationships [7]. Adding to the IPPF’s definition, United Nations Population Agency Fund defined Comprehensive Sexuality Education as a right-based and gender-focused approach to sexuality education, whether in school or out of school [8]. Comprehensive Sexuality Education (CSE) is a

curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality [9]. It serves as a key component in a multifaceted approach to address the sexual and reproductive health needs of adolescents around the world [10].

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 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 [10].

Health risks arising from unsafe sexual practices contribute to the global burden of disease. Evidence shows that effective and comprehensive delivery of comprehensive sexuality education (CSE) plays a pivotal role in preparing adolescents for a safe, productive, fulfilling life [11]. In the very beginning CSE was used as one of the HIV prevention strategy among adolescents in general. However, while HIV prevention remains important, evidence and practice demonstrate that sexuality education has a much broader relevance to other issues, not only for young people's sexual and reproductive health but also for their overall wellbeing and personal development [9].

The introduction of sexuality education in primary schools in Malawi aimed at providing sexual and reproductive health information to very young adolescents who are believed to be in primary school at this age. Comprehensive sexuality education has proved to impact the very young adolescents with positive behaviours to protect their own health [12].

1.2.3 Why Sexuality Education is Important to Very Young Adolescents

A study by Kågesten that used national survey data and literature review found that there is little information on CSE and its quality for 10 to 14 year olds in developing countries [13]. This is despite the existence of national policies and curricula on CSE in primary schools. Furthermore, the study found that most very young adolescents had reported that they had not started sexual intercourse with others reporting that they had engaged in intimate relationships. The study also reported that more adolescent females than males had experienced sexual violence in the past year. On child marriage and very young adolescents giving birth, the study reported that this was different depending on country, region, residence and wealth. However, more child births were reported in Africa followed by Asia and then Latin America and the Caribbean. The study concluded that CSE was among the strategies that helped reduce child marriage and sexual violence [13]. In addition, a study which was conducted in Burkina Faso, Ghana, Malawi and Uganda found that among those aged 10-14 years, 66% of boys and 58% of girls in Western/Middle Africa and 74% of boys and 71% of girls in Eastern/Southern Africa were currently attending school: these high levels of attendance mean that the school is well placed to provide information on sexual and reproductive health to young adolescents, and as the gender gap in school participation has been narrowing over time, it is a good avenue to reach both boys and girls [14].

Sexuality Education (SE) is a lifelong purposeful process that should begin earlier on in life [10]. The motivation for providing SE to in and out of school adolescents is to give precise information about human sexuality including but not limited to issues regarding sexual relationships, sexual abstinence and the use of contraception [10]. Sexuality education also helps young people

develop skills in communication, decision-making, assertiveness, peer refusal skills, and the ability to create satisfying relationships [15]. Furthermore, sexuality education helps many young people not to receive confusing and conflicting information about relationships and sex, as they make the transition from childhood to adulthood [10]. This has led to an increasing demand from young people for reliable information, which prepares them for a safe, productive and fulfilling life [9]. When delivered well, CSE responds to this demand, empowering young people to make informed decisions about relationships and sexuality and navigate a world where gender-based violence, gender inequality, early and unintended pregnancies, HIV and other sexually transmitted infections (STIs) still pose serious risks to their health and well-being. Equally, a lack of high-quality, age- and developmentally-appropriate sexuality and relationship education may leave children and young people vulnerable to harmful sexual behaviours and sexual exploitation [16]. When CSE is not well delivered, there are negative implications which may arise as cited in some literature [16]. There are some research papers which have criticized sexuality education that it perpetuates sexual activity in young ones. These papers based CSE on four premises which were developed in around 1950s in Sweden that: teenage sexual activity is inevitable, educators should be value-neutral regarding sex, schools should openly discuss sexual matters and sex education should teach students about contraception [17].

A study in Kenya [18], involving more than 6,000 students who had received sexuality education led to delayed sexual initiation, and increased condom use among those who were sexually active once these students reached secondary school compared to more than 6,000 students who did not receive sexuality education. In addition, in the same country, the programme reduced pregnancy by 28% [19]. However, there is not much statistical evidence to show how much more CSE

provision in primary schools has contributed towards gender equality and empowerment, sexual and reproductive health and rights and healthy decision making for this age group (10 to 14) specifically.

Despite the widely documented importance of CSE, it remains a delicate and often times controversial. The social conflicts that surround sex education programmes such as the role of government in family life and sex education; parental control of the content of sex education and core values to be included in sex education happen to be the cause of this controversy [16].

1.2.4 How Sexuality Education Programmes are Being Implemented

Comprehensive Sexuality Education takes place through a myriad range of programmes both formal and informal including: schools, community settings, religious centres, within families, among peers, and through media [20]. There are different types of sexuality education globally and different ways of implementation. There are mainly three types namely: (i) Abstinence-Only-Until-Marriage Programmes, sometimes called Sexual Risk Avoidance Programmes, teach abstinence as the only morally correct option of sexual expression for teenagers. They usually censor information about contraception and condoms for the prevention of sexually transmitted diseases (STDs) and unintended pregnancy. (ii) Comprehensive Sexuality Education teaches about abstinence as the best method for avoiding STDs and unintended pregnancy, but also teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with STDs, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals, and options and (iii) Abstinence-Plus Education—Programmes which include information about contraception and condoms in the context of strong abstinence

messages [19]. In Malawi, integrated programme is a preferred model of implementation for comprehensive sexuality education in primary schools [16]. For the in-schools, very young adolescents, teachers and mother groups teach life skills and social studies subjects and act as local counsellors respectively. Teachers take a major role in the implementation of sexuality education.

1.3 Problem Statement

There is clear evidence that sexuality education has a positive impact on sexual and reproductive health, notably in contributing to reducing sexually transmitted infections, HIV and unwanted pregnancies among other strategies [21].

Comprehensive Sexuality Education (CSE) has demonstrated impact in terms of improving knowledge and self-esteem, changing attitudes and gender and social norms and building efficacy [21]. Furthermore, knowing where the problems with the current intervention is, it is possible to redirect resources and fine tune greater effectiveness in efforts to reduce sexual health related problems faced by the very young adolescents. However, there is little evidence on how sexuality education is being implemented in primary schools among 10 to 14-year-olds. It is in this context that this research was conducted to try and find out how the implementation of sexuality education in the selected primary schools is done.

1.4 Justification for the Study

Malawi adopted the United Nations Educational, Scientific and Cultural Organization (UNESCO), International Guidance for Sexuality Education in 2009 which aimed at reducing early school dropout due to pregnancies and as a response to HIV prevention [16]. Despite this, teenage

pregnancies are still on the rise (29%), and 50% of all HIV new infections are among adolescents in Malawi [22]. In addition, school dropout rate is at 10.5%, early marriage is at 28%, abortion rate 23/1000 women, and 20% of all the maternal deaths are from 10-14-year-olds in Malawi [23, 24].

There is evidence that some programmes, such as those that embedded sexuality education within a broader life skills curriculum, may be designed to promote a set of values that dovetail unevenly with those needed to underpin successful CSE – creating an awkward balance between, for example, respect, assertiveness, critical thinking, democracy, equality, obedience, patriotism, compassion or faith [25]. Furthermore, to take note is that when sexuality education is integrated or infused, it is mainstreamed across a number of subject areas, such as biology, social studies and life skills. While this model may reduce pressure on an overcrowded curriculum, it is difficult to monitor or evaluate, and may limit teaching methodologies to traditional approaches [26]. This being the case in Malawi, this study aimed at assessing how the implementation of CSE using integrated programme is done.

Findings from this study will help in identifying challenges in the implementation of CSE, re-direct resources and fine-tune greater effectiveness in efforts to reduce maternal/neonatal mortality, high school dropout due to teenage pregnancies and poverty levels in the communities.

1.5 Conceptual Framework

1.5.1 Information Consistency and Desired Action Model

This model is derived from Cognitive Consistency (Social Psychology) Theories.

This model assumes that “those information systems which have a high frequency of distribution and which are consistent in meaning, stand a better chance of achieving the desired reaction within the community than those with low frequency and of distribution and which are inconsistent” [4]. Consistency means both the frequency of the supply of information (the number of times people receive or access information); and the reliability of the content of that information; in other words, whether or not it remains constant when it is accessed [4]. A lack of consistency may occur when there is no coordination in the construction of information and contradictory information, or messages are transmitted. In case that there is inconsistency in the information supplied, the utilisation of that information by the receiver becomes more difficult and affects the decision-making accordingly [27].

Further, with regard to the frequency of distribution of information, it is argued that when information reaches the target groups frequently and consistently, it may influence decision making and behaviour change more positively than when it is not [28]. However, other researchers argued that the information frequency and consistency do not automatically affect a positive decision-making and behaviour change [27]. They claim that other factors such as literacy levels, and technological, social, cultural and economic development, etc. also influence both the information transmission and the utilisation of that information and the decision-making [28].

The information consistency and desired action model constitutes a relevant framework to analyse the consistency of the content of information and frequency of the information supply supplied by teachers who teach sexuality subjects, media, health care providers, peers, parents and religious/traditional as custodians of cultural norms. It is in this context that the above theory is

used in the current study. The author argues that by understanding such (in) consistency helped to assert whether or not the very young adolescents receive adequate sexuality information progressively based on what is stipulated in the curriculum and in the environment they stay and how this affects the way the latter youths interpret the message in question [29]. This framework did not guide the conduct of the study since in studies like this, the phenomenon must be explored from the perspectives of those that experienced it [30]. Therefore, it was not essential to have the framework in guiding the study. However, it was used in the explanation of the discussion.

1.5.2 The Graphic Presentation of the Conceptual Framework

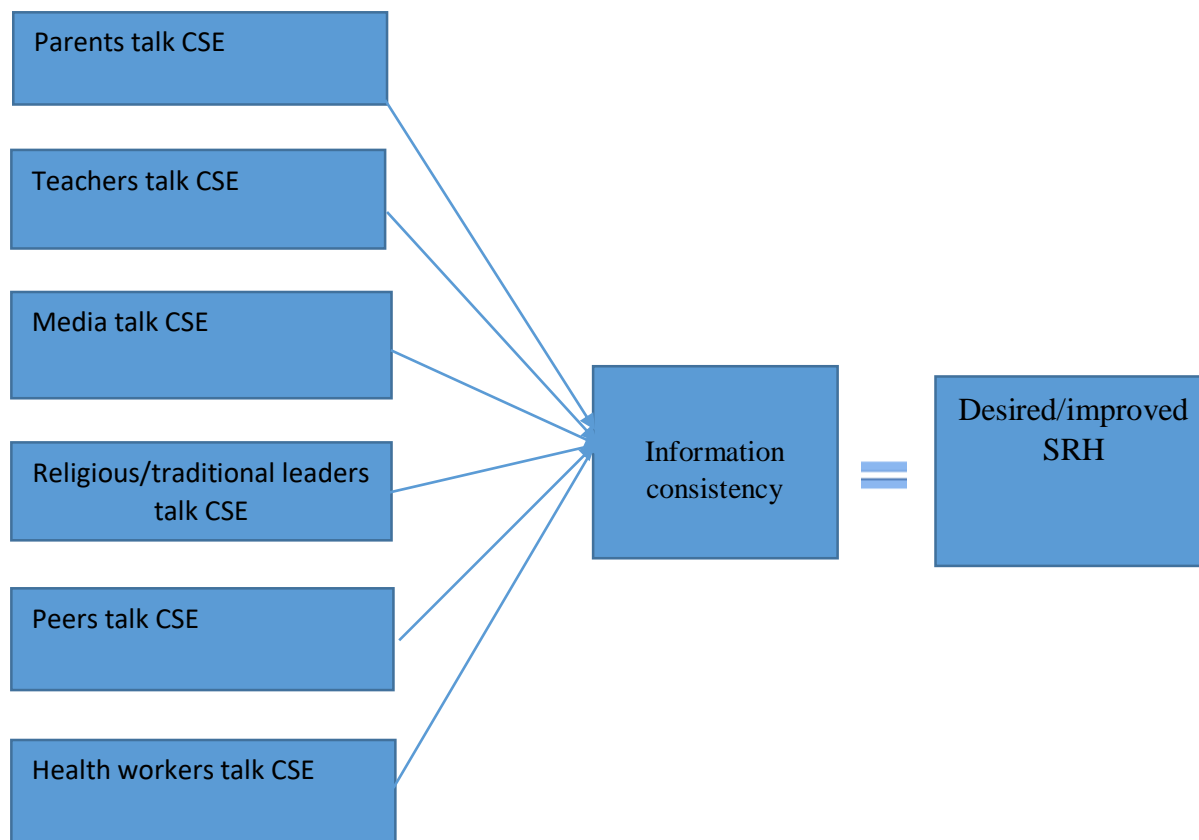


Figure 1: Graphic Presentation of the Conceptual Framework

1.6 Objectives

1.6.1 Broad Objective

The main aim of this study is to assess the implementation of sexuality education (SE) among adolescents aged 10 to 14 years in Chowo education zone, Lilongwe rural in Malawi.

1.6.2 Specific Objectives

Specifically the study aimed:

1. To explore the knowledge, perceptions and experiences of the very young adolescents about sexuality issues.
2. To explore the teachers' capacity in delivering sexuality subjects to the very young adolescents
3. To explore parents' and local leaders' perceptions towards SE of very young adolescents
4. To identify barriers to effective implementation of SE to very young adolescents in the area.

CHAPTER TWO: METHODOLOGY

2.1 Introduction

This chapter will discuss the methodology that was followed in this study. The chapter addresses the following: the study type, site, population, size, inclusion and exclusion criteria and study period. Other sections include data collection, management, analysis and ethical considerations.

2.2 Study Type

This is a qualitative case study research design. This type of design was chosen because a case study seeks to answer the question how and the focus of study is a contemporary phenomenon [30].

2.3 Study place

This study was conducted in Chowo education zone, in rural East of Lilongwe district [Appendix 6]. The school records 2015 to 2017 revealed that the three primary schools namely; Chowo, Chimbalanga and Kalamba, had experienced high school dropout attributed to early pregnancies. Lilongwe district is situated in the central region of Malawi with a population of 905,000 people with 234,763 very young adolescents [31]. Lilongwe rural is divided into three education zones, of which one was sampled for this study. The district is dominated by Chewa tribe with Chewa culture and Christianity being the religion of most of the population.

2.4 Study Population

The study's population was in-school and out of school very young adolescents (boys and girls aged 10 to 14 years), teachers, both males and females, teaching life skills and social studies,

parents and traditional/religious leaders, both males and females. This was decided upon because it was assumed that they would be the best groups to contribute to the information needs of the study. Purposive sampling was done for the identification and selection of information-rich cases related to the phenomenon of interest [30]

2.4.1 Inclusion Criteria

The following inclusion criteria were used for the study:

- Boys and girls aged 10 to 14 years old, who were in school, from standard five to eight and were willing to participate in the study.
- Girls aged 10 – 14 years old, who dropped out of school due to teenage pregnancy or early marriages and were willing to participate in the study.
- Teachers, male or female, who taught life skills and social studies subjects from standard five to standard eight.
- Parents to very young adolescents within the schools' surrounding villages and willing to take part in the study.
- Leaders, male or female, who were in the school management committee and willing to participate in the study.

2.4.2 Exclusion Criteria

- Very young adolescents who were not willing to participate in the study.
- Very young adolescents who dropped out of school due other reasons apart from early pregnancy or marriage.

2.5 Study Period

The study was conducted from August 2018 to January 2020. It started with proposal writing and is ending with defense of dissertation and dissemination of research findings.

Table 1: Gantt chart

Activity	Aug-18	Sep-18	Feb- 19	Apr-Jun19	Oct-19	Dec-19	Jan-20
Proposal development							
Proposal submission							
Data collection							
Data entry and cleaning							
Data analysis							
Thesis submission							
Defense							
Dissemination							

2.6 Sample Size

A total sample size of 96 participants was used. Of these, 36 were in-school very young adolescents (12 from each school selected); 20 were out of school very young adolescents; 12 were school teachers (4 from each school); 8 were religious leaders and 20 were parents from all 3 selected sites.

2.7 Data Collection

Data was collected through focus group discussions (FGDs), in-depth interviews, review of documents and classroom observations. FGDs aimed at exploring the knowledge, perceptions and experiences of VYAs about sexuality issues.

The in-school VYAs within the age range of 10 and 14 years were identified by the teachers while those out-of-school were identified by both teachers and the Health Surveillance Assistants working in the areas.

12 FGDs were conducted in total. Out of the 12 FGDs, 6 were for the in-school VYAs, 2 from each school: girls and boys were put into two different groups because it was observed that boys were dominating the discussion while girls were shy to respond. 10 to 12 year olds took long time much effort was put in order for them to respond to the discussions. 3 FGDs were for the out-of-school VYAs: 1 group from each area; these were girls only. FGDs for the in-school VYAs were conducted within the school premises, in the headmasters' offices in all 3 schools; while those of out-of-school were conducted right in their villages. Lastly, 3 FGDs were for parents,

religious/traditional leaders, 1 group from each area where the study was conducted and this was a combination of females and males.

12 in-depth interviews were done with teachers, both males and females, 4 from each school. The in-depth interviews aimed at exploring teachers' capacities in delivering sexuality subjects among very young adolescents and identifying barriers to effective implementation of SE to very young adolescents in the area. The interviews were one-on-one in order to get rich information from each key informant without interference from other participants and also this provided room for free expression of what they were asked.

Responses from both FGDs and in-depth interviews were recorded using an audio recorder and also written in the notepad.

The researcher conducted 9 classroom observations, 3 from each school, while Life Skills and Social Studies subjects were taught using a checklist [Appendix 12] in order to gain a first-hand insight into classroom discussions, classroom practices and curriculum enactment. Posters on the walls with messages of sexual health were checked for their availability as visual aids in all three schools. The researcher compared what was observed with what was on the adopted standard checklist. Similarities and differences were noted and written down in a notepad.

Review of education documents was the last method of data collection which was used. Documents, like International Technical Guidance for Sexuality Education 2018 [16], were reviewed in order to see if Malawi is implementing according to the prescribed standards. The

National Education Policy 2007-2017 was also reviewed for the presence of strategies on how to successfully implement CSE in primary schools. The Initial Primary Training Education syllabus was also reviewed to see how primary school teachers are equipped with knowledge and skills on how to teach sexuality subjects. And Teachers' Guide and Learners' Textbooks for standard 5, 6, 7 and 8 were reviewed to look at the content and depth of the information provided [Appendices 8, 9 and 10].

2.8 Data Management and Analysis

Qualitative data through focus group discussions and in-depth interviews were manually analyzed using Thematic Content Analysis (ACT) to ensure that findings are based on data collected. The researcher listened to, and read all scripts and thereafter analyzed them using the 5 steps of content analysis according to Graneheim & Lundman [32].

Step 1: Transcription of raw data

The researcher identified meaning units from words, sentences or paragraphs containing aspects that are related to each other. Those statements related were grouped as meaning units.

Step 2: Condensation of data

This is a process of shortening the text while still preserving the central content. This was done by paraphrasing the material and reducing the data into basic content so that they are easy to understand.

Step 3: Grouping data into codes

The condensed meaning units were grouped into codes according to their differences and similarities making it possible for the researcher to understand them in a new way but making sure they are relating well to context.

Step 4: Creating categories

Creating categories is the main aspect of qualitative content analysis where the researcher groups the content that shares a commonality, hence data were grouped according to similar and dissimilar units. When the categories were being created, the researcher made sure that the categories were comprehensive and communally exclusive meaning that no data related to the purpose were omitted due to lack of a suitable category.

Step 5: Development of themes

The researcher developed themes and sub-themes from the categories based on four (4) content areas which are: knowledge about sexuality issues, perceptions towards sexuality education in primary schools, teachers' capacities to teach sexuality subjects and barriers to effective implementation of sexuality education. Finally, the researcher merged the data set to look for convergences and similarities of the data from all the sources.

2.9 Ethical Considerations

The following ethical considerations were observed: ethical approval, justice, informed consent, confidentiality, beneficence and non-maleficence.

i. Ethical Clearance

Approval was sought from College of Medicine Research Ethics Committee (COMREC) to conduct this research and was granted in October 2018, Ref: P.5/18/2475 [Appendix 13]. Additionally,

written permission was given from Lilongwe District Education Office since the primary schools chosen belong to Ministry of Education Science and Technology but under Lilongwe district office [Appendix 5 and 6].

ii. Informed Consent

Informed consent for the study was sought from the parents of the very young adolescents who were involved, since they were minors and could not give consent on their own [Appendices 1a, and 1b for Chichewa version of the same]. Consent was also sought from the VYAs in and out of school through their parents, teachers, parents and religious leaders [Appendices 2a, 2b, 3a,3b and 4]. Seeking consent was done before the commencement of interviews for all. For illiterate participants, a witness read out the informed consent document and a thumb print was used as a signature.

iii. Confidentiality

FGDs and in-depth interviews which were conducted within the school premises were done in closed rooms, with windows and doors closed, a **Do Not Disturb meeting in progress** written notice was pasted on the doors of the Head Teachers' offices in order to ensure verbal and physical privacy. For the out of school VYAs FGDs a village clinic shelter was used which had closed windows and doors. Participants' confidentiality was ensured by conducting using anonymized data set. This was with codes, not names, which were recorded in digital formats. Interview guides were kept in a safe locker accessed only by the researcher. All data that were entered on a computer with a passwords.

iv. Risks and Benefits

The involvement of parents and teachers ensured that there were no risks for all participants especially the very young adolescents. On benefits, there were no monetary benefits; only soft drinks and snacks were offered during discussion sessions. Additionally, the results from the study are expected to contribute to CSE particularly its implementation in primary schools.

CHAPTER THREE: RESULTS

3.1 Introduction

The findings reported in this paper are derived from participants' narratives of their knowledge, experiences and perceptions about comprehensive sexuality education offered in primary schools at the selected primary schools where the study was conducted. These findings are split into four main themes and these are; knowledge about sexuality issues, experiences and perceptions of learners, teachers and parents about sexuality education offered in primary schools, capacity of teachers to teach sexuality subjects and barriers to effective implementation of CSE in primary schools.

3.2 Socio-Demographical Characteristics for Study Participants

The study participants were 36 in-school boys and girls and 20 out of school girls, aged 10 to 14 years, 12 teachers both males and females teaching life skills and social studies, and 28 parents and traditional/religious leaders both males and females who were in the school management committee. More than half of the participants were females with Chewa tribe being the most. Christianity was the largest religion found as compared to others, and most of them were educated to primary school level.

From the in-depth interviews, key informants comprised of teachers, parents and religious/traditional leaders. Most key informants were males, Chewa by tribe, with Christian faith. All teachers had attained tertiary education while more than half of the parents and religious/traditional leaders had primary school education.

3.3 Study Findings

3.3.1 Knowledge about Sexuality Issues

The study reveals that all teachers and most in- school VYAs had knowledge on sexuality education that was acquired from school. When asked the common issues associated with sexuality, most participants mentioned HIV/AIDS, sexually transmitted infections (STIs) and premarital abstinence:

“Sexuality education is learning about sexual relations among males and females and all issues associated with it”. [In-school VYA 11, FGD].

Likewise, another participant said:

“It is about avoiding sexual intercourse to prevent pregnancy and HIV infection” [in-school VYA 3, FGD].

Since the VYAs mentioned that pregnancy prevention was one of the sexuality issues, they were asked to mention some contraceptives they knew one could use to prevent pregnancy. Most VYAs were able to mention some types of contraceptives. Interestingly, it was noted that VYAs who were out of school knew about contraception but after they dropped out of school due to pregnancy.

“We heard some of the names of the contraceptives from the hospital when we started attending under five clinic with our babies; otherwise we wouldn’t have been in the

situation we are now (out-of-school participants responded altogether”. [**out-of-school VYA-1,5,9,10 &15 FGD**]).

However, some VYAs who were out of school expressed lack of knowledge about sexuality issues.

One out-of school participant narrated:

“I had no idea that having sex with my boyfriend once could make me pregnant. I thought we were just playing; it was out of childish thinking.” (**out-of-school VYA-22 [FGD]**).

Teachers admitted to have knowledge about sexuality education and that they have been involved in planning and teaching CSE in schools.

“As teachers we have knowledge about what sexuality is all about. We have subjects like life skills and social studies that sexuality topics are incorporated in. So, as we prepare for the lessons to teach, we read.” (**Male Teacher-1[KII]**).

Another teacher narrated:

“I know sexuality education from my secondary school education. It is about sexual relationships, human growth and physical development, healthy decision making, assertiveness etc.” (**Male Teacher-4 [KII]**).

However, some teachers who were trained long time ago expressed lack of knowledge about sexuality education as they said that these sexuality subjects were not there during their training in college.

“We were not trained neither oriented to life skills and social studies. We saw them for the first time in schools when they were introduced,” (Female Teacher-2 [KII]).

There are various sources of information about sexuality issues. The participants’ narratives show that information about sexuality issues comes from a number of sources.

Learners responded together as:

“We hear about sexuality issues from friends, media and school”. [in-school VYA-1, 3, 4, 6, FGD].

Concurring with their friends, the other two expressed the following sentiments:

“We hear from school, parents and the community health worker”. [in-school VYA -12, 13 FGD].

3.3.2 Perceptions towards Sexuality Education

Parents expressed mixed reactions towards the sexuality education provided in primary schools to VYAs. Some were in support of the SE which is taught in school as they acknowledged that it is difficult for parents to teach their own children about sexuality at home.

“Sexuality education taught in schools is good and important; however emphasis should be placed on abstinence until marriage”. (Parent- 4 [FGD]).

Another parent in support to the above response, expressed the following sentiments:

“I feel good because as a parent I cannot tell my children everything about sexuality so I am very thankful that other trusted people like teachers can tell them. So it is good that it is provided in primary schools”. (Parent- 11 [FGD])

VYAs too verbalized that sexuality education is good since it gives them the right information on how their body works, how to prevent STI and HIV infections and also it teaches about abstinence.

In agreement to this one VYA concurred with the parents’ sentiments above:

“It is good that we learn sexuality in school because our parents cannot talk about these things with us at home.” (In-school VYA-30, 36 &13 [FGD]).

However, others expressed dissatisfaction towards SE provided since young girls are still dropping out of school and they wondered if SE provided in schools has impact on behaviour at all. To the

extreme, some parents even voiced that they think CSE in primary schools has contributed a lot to teen pregnancies. One parent responded in a questioning manner:

“VYAs are still dropping out of school due to pregnancy, what is happening?” (Parent 6 [FGD]).

Another participant gave the following account:

“These children learn about sexuality education but teen pregnancies are on the rise,” (clapped hands in disbelief) (Parent- 10 FGD).

Another parent added in agreement to the other parents’ sentiments.

“They still get pregnant and some get infected with STIs.” (Parent 11 [FGD]).

On the same other participants perceive as the content and depth of the CSE information taught is not culturally and age appropriate. The study findings showed that most learners were older for class meaning that the information they were receiving was not enough to help them make an informed decision concerning sexuality issues.

“Most children here start school late and they repeat classes a lot therefore in standard five we have those who are 15 to 16 years old unlike in the cities where childrens’ age correlate with class”. [Male Teacher 1 KII].

3.3.3 Teachers' Capacity to Teach Sexuality Subjects

The study findings reveal that teachers lack appropriate skills to teach sexuality subjects in primary schools. Teachers were observed not to be confident and male teachers were very uncomfortable. Thus, most teachers accepted that teaching sexuality education is difficult, and they had some reservations mentioning some human private body parts because they do not have the skills to teach comfortably such topics. It was also observed that topics which were taught were those which do not mention any human private body parts. In addition, learners revealed to have observed some discomfort in their teachers' behaviour when teaching sexuality subjects.

A teacher mentioned this:

“There was no practical part of teaching sexuality subjects hence now difficult to implement on the ground.” (Male Teacher- 3 [KII]).

Another teacher added more information to the above response.

My experience has been, one has to be very cautious when teaching sex and sexuality because sometimes teachers get aroused and learners also get aroused in the course of teaching and learning respectively.” (Male Teacher-9 [KII]).

One teacher mentioned this:

“The only thing which worry us most are the terms used in some topics like, The Reproductive System sound obscene culturally”. **(Female Teacher- 7 [KII]).**

Another learner commented that;

“They just give us notes to read by ourselves when it comes to teaching topics like reproductive system because they do not want to mention private parts.” **(in-school VYA-29 [FGD]).**

From the timetables [Appendix 10] made, the researcher observed that Life Skills and Social Studies appeared every day; but they were taught once or twice in a week. Upon inquiring from them, they accepted that the observation was correct. Teachers responded that they give priority and more time to other subjects like Mathematics, English and Agriculture because they can teach comfortably.

A learner had to say this:

“My experience is that teachers are not comfortable when teaching; they are not free or I can say they do not open up; as a result they don't like teaching these subjects with obscene language in them, they prefer teaching other subjects like Mathematics, English and others ” **(Out-of-school VYA- 18 [FGD]).**

3.3.4 Barriers to Effective Implementation

The study also reveals that poor coordination among stake holders resulted into the ineffective implementation of CSE in primary schools. They mentioned lacking support from parents, leaders in the communities, and health workers as the responsibility seems to be left to them alone. Furthermore, cultural and religious beliefs impacted negatively on the implementation together with lack of resources.

One teacher explained:

“There is poor, or I can say, weak collaboration between the schools, the communities and the health sector because we need to be speaking the same language when it comes to sexuality issues to these adolescents. When we tell them the truth about reproductive system and how a girl can become pregnant, parents tend to hide the information; so, these learners are confused, and they do not know who to believe. Colleagues from the health sector should be able to assist teaching these sensitive topics since it is their area of expertise. It would be helpful for parents, traditional/religious leaders and health workers to complement one another.” (Female teacher 2 [KII]).

Realizing that in the rural areas there are few teachers, one teacher is allocated a lot of other subjects to teach hence one prefers to teach what seems easier and comfortable.

Another teacher explained:

“As teachers we have too much workload as a result, priority is given to other basic subjects like English, Mathematics and Chichewa and not to elementary subjects like social and life skills; hence no enough time is given to these subjects.” (Male Teacher 5 [KII]).

The researcher asked the teachers about the training they had in college regarding sexuality education. This was asked in order to know if they were prepared to deliver Life Skills and Social studies subjects.

A teacher responded:

“It was a general training. Basic primary school teacher training where the focus is on teaching methodology only not specialized as is the case with secondary school teacher training.” (Male Teacher-10 [KII]).

From the review of documents, the researcher looked at the initial primary education curriculum which revealed that sexuality subjects are included; however, the emphasis is on teaching methodologies and not the actual content taught. The study further shows that lack of skills to teach affects the implementation of SE. Teachers suggested that health care workers should be joining them to teach when it comes to sensitive topics because they have a lot of knowledge and skills to deliver such information.

One teacher explained like this:

“We had good training in college; but the focus was on teaching methodology only and not how to teach sexuality subjects specifically, as is the case with secondary school teachers.” (Male Teacher-6 [KII]).

Another teacher suggested this in his response:

“Lack of skills among teachers pose a big challenge to sexuality education implementation. Since it is integrated into Life Skills and Social Studies, the other topics can be taught very well; but when it comes to sensitive topics, I would love health care workers to be asked to be teaching those parts so that they complement to what we have taught, the less sensitive ones.” (Male Teacher 12 [KII]).

Lack of resources was mentioned as one of the barriers in the implementation of sexuality education by teachers. It was observed that there were no posters in the classrooms which could be used as visual aids for teaching and not enough textbooks, as 1 book was shared among 7 learners. Lack of textbooks made teachers to prefer lecture method of teaching compared to group discussions as recommended by the international standards of teaching. In addition, it was also observed that some classes took place under a tree.

Another teacher had to say this:

“Lack of resources is big barrier, there are no enough learners’ textbooks to use since some things learners need to see with their own eyes what a teacher is talking about.” (Male Teacher 8 [KII]).

A standard 7 teacher commented:

“We mostly use lecture method of teaching, no discussions because of inadequate books in our school, even the District Educational Manager knows about this problem”. (Female Teacher11 [KII]).

Additionally, another teacher lamented;

“Most of our classes take place under the trees, how can one confidently teach sexuality outside where passersby hear everything said? Sexuality subjects require privacy.” (Male Teacher 4 [KII]).

Culture has been found to be one of the barriers too in the implementation of comprehensive sexuality education in Malawi. Some traditional leaders stated that such information should be culturally sensitive. In Chewa culture, such information is offered in other avenues like initiation ceremonies.

A traditional leader commented:

“The child must be told about sexuality things only after she has started menstruations and not before that, it is a taboo, it is against our culture.” a Chief stated. (Traditional leader- 3 [FGD]).

The study findings reveal that religious beliefs were mentioned to be barriers during the discussion as most participants confessed to have Christian values.

“Religion is one of the barriers. The terms used in sexuality issues to mention private parts mainly in vernacular language sound obscene and one being a Christian you fail to mention.” [Male teacher 7 IDI].

Another teacher admitted that they are unable to teach effectively due to role conflict as teachers, they are also appointed as deacons and church elders in the society in addition to being parents.

“As a parent but I’m also a church elder, I cannot mention those private parts, it is not allowed, it is sin as far my faith confesses.” [Religious leader’s sentiments 16 FGD].

In addition, another teacher said:

“Religion plays a bigger role as a barrier. As a teacher, I also go to the same church as the learners, we all hear what is in the bible. You shall not swear. How

can I teach such subjects full of foul language? How will learners look at me in church?” [Female Teacher 4- KII].

Lack of political will poses a barrier to CSE implementation. The study found that National Education Policy (NEP) has no statement which talks about the provision of CSE in primary schools [Appendix 8]. In addition, it found that the guidance which is provided in the ITGSE is not followed during implementation.

CHAPTER 4: DISCUSSION

4.1 Introduction

This was a qualitative case study which aimed at assessing how comprehensive sexuality education (CSE) is being implemented in primary schools among VYAs in Lilongwe. The primary objective of this study was to explore the knowledge, perceptions and experiences of the VYAs about sexuality issues. The other objectives included to explore the teachers' capacity in delivering sexuality subjects among VYAs, to explore parents' and local leaders' perceptions towards CSE of VYAs and to identify barriers to effective implementation of CSE to VYAs in the area. Data was collected through focus group discussions with VYAs and parents (school management committee), in-depth interviews with key informants in this case teachers, classroom observations while teachers were teaching and documents like policies and primary school curricula and syllabi were reviewed.

From the FGDs findings, VYAs were aware about comprehensive sexuality education that is provided in primary schools. However, in-depth knowledge was lacking as evidenced by their responses of "it is when a boy and a girl, or a man and a woman have sexual relationship." These findings show that VYAs need to be given comprehensive information for them to be able to make healthy and informed decision in issues regarding sexuality. This is in agreement with a study that spotted the need for SRH information and education that is medically accurate, complete and age appropriate among VYAs [3]. On the same, another study emphasized that if young people are to protect themselves against negative sexual and reproductive health outcomes, and develop the capacity for healthy, safe and enjoyable sexual lives as they mature, they must have comprehensive and accurate information [33]. On the contrary, other studies have concluded that CSE contributed

to early sexual activities among VYAs [34] while others have said the information given to VYAs is too much and not cultural and age-appropriate [35].

While VYAs and teachers believe CSE to be important, many teachers said that they do not know how to teach it. In this study, teachers expressed to be lacking skills to teach sexuality subjects due to the fact that they were not specifically trained to teach these subjects but they had a general training on teaching methodologies for all subjects. Teacher training is one of the most important factors to effective implementation of sexuality education [36] This is in agreement with the study which was conducted in Malaysia which found that the effectiveness of school-based sexuality education programmes depend highly on teachers [37]. Other studies have shown that instructors' commitment to, as well as comfort with, the delivering of sex education, impacted on ones' teaching ability [38]. Religion was noted as another barrier to effective implementation of CSE. Some teachers, most parents and traditional/religious leaders were not in support of providing CSE to VYAs due to the fact that they felt it is contradictory to their religious beliefs. Religion plays a key role in producing and reproducing moral arguments against CSE which affects implementation of CSE programmes and people's perceptions about them [39]. Ibid found religion as a barrier to effective implementation of CSE because most organized religions, matters of sexuality and family formation are paramount concerns, as they represent fundamental human behaviours that religions attempt to shape and control [39].

Culture emerged to be one of the barriers too. For effective implementation, comprehensive sexuality education should target to engage with, and include, the wider community to reduce conflicting messages and increase programme backing. Another study on culture and CSE found

that if CSE is to be accepted by all implementers, it has to be culturally and age-appropriate [40]. This concurred with another research which found that there were a number of challenges experienced by VYAs and among them are the reluctance of some teachers to talk about topics that are considered culturally sensitive, such as sex and sexuality, and the attitude of some parents [33]. All of the above showed that there is inconsistency in information given to VYAs as a result the young ones are confused hence easily deceived with wrong information ending up contracting STIs, getting teen pregnancies and being forced into early marriages. This is in agreement with the Information Consistency and Desired Action Model.

However, to deliver age-appropriate comprehensive sexuality education in Malawi, mainly in rural areas, could be very challenging. In the study area most learners were older for class, meaning that the information they were getting was below their physical and psychological development. As was the case in Chowo zone, most learners were older for the class; for example standard five children from all schools there, were very few who were between 10 and 11 years old as it is supposed to be; however, most learners were between 14 and 15 years old [41]. This could be because of the high number of students that repeat grades or are otherwise behind in school, relative to their age as is the case in most rural areas.

Review of documents was one of the data collection method. One of the documents reviewed was the ITGSE. This document serves as a reference manual as to how sexuality education is supposed to be implemented. It was reviewed in order to have a picture of what is expected in the implementation of comprehensive sexuality education in an ideal situation and what has been adopted according to context. It gives a description of what comprehensive sexuality education is,

key consideration in the evolving field of comprehensive sexuality education, importance of sexuality education and how comprehensive sexuality education can be effectively delivered [36]. Malawi has adopted the Comprehensive sexuality education programmes which is integrated in Life Skills and Social Studies subjects.

Malawi national education policy has no policy statement to support the implementation of comprehensive sexuality education provision in primary schools. Comprehensive sexuality education programmes, just like any other intervention, tend to flourish in an enabling policy and legal environment, and well-established advocacy coalitions can play a key role in ensuring strong policies [8].

Time-tables were checked where the researcher saw the number of periods allocated for each subject. It was revealed that life skills and social studies subjects which include sexuality topics appeared every day, five times in a week but taught once to twice in a week, and not as indicated on the time-tables. There is abundant evidence that in many sites sexuality education was or is not being delivered as intended [41, 44 , 45]. In most of the implementation sites studied, certain lessons have been skipped or shortened, especially those on sensitive topics such as masturbation, homosexuality and abortion [44] and this was also the case in the area where the study took place. In addition, several practical issues may hamper programme fidelity. Teachers mentioned lack of materials for teaching, like visual aids and negative attitude as some of the factors contributing to ineffective implementation of CSE. This was in agreement with another study which identified a complex network of school-level elements affecting programme fidelity, such as inefficient

schedules and planning of lessons, lack of available teacher time, lack of availability of materials and computers, and negative attitudes of staff [36].

Initial Primary Teacher Education syllabus was another document which the researcher reviewed. This was done to find out how primary school teachers are prepared during their training. Some studies have cited that teacher training remains a weak point in most school-based sexuality education programmes [45]. However, from the teacher training syllabus, this study found that teachers are prepared on the methodologies to deliver sexuality education among other subjects which they are expected to teach when they qualify. This being the case, it means the training may require specific adjustments to the delivery of sexuality subjects.

The researcher had classroom observations as an additional data collection method to see how sexuality subjects are taught. It was observed that teachers used mainly lecturing and rarely group discussions as the methods of teaching. United Nations Fund for Population Agency operational guidance stated that as important as what information is taught is how we teach it [25]. The manual recommended that the most effective methods for teaching about sexuality, HIV, gender, and rights are participatory, learner-centered educational methods [8]. In order to enable young people to personalize what they learn and apply it in their lives CSE should use diverse and interactive methods of teaching [8].

Teachers often eschew or limit activities related to skills building, such as role plays because they think that students will find them difficult, or because they lack confidence in facilitating them well enough and in most cases because of large class sizes [42]. In all three primary schools, classes

were large, exceeding the recommended sizes of one to seventy [46], class size has a bearing too on the education system. When classes are large, teaching often reverts to lecturing and rote learning and this was similar to the findings of this study. Research by the Centre for Social Research, revealed that life skills education is not consistently taught in some schools; not taught in others; and taught after classes in still others [33] in Chowo zone it is not consistently taught as evidenced by the responses of VYAs, who revealed that they don't learn life skills every day and teachers who said priority is given to other more important subjects, like Mathematics, English and Agriculture. Among the reasons were that some church-run schools believed the subject goes against the church's moral teaching, and overcrowded timetables [ibid] as 2 of the schools that the study took place.

4.2 Strengths of the Study

This study has added to the current knowledge on how implementation of comprehensive sexuality education is done in primary schools. In addition, it has identified barriers to the effective implementation of comprehensive sexuality education. Furthermore, the findings will inform policy makers and the education sector as a whole to fine-tune the implementation strategies which are currently being used mainly to suit rural settings.

4.3 Limitations of the Study

The three primary schools sampled could not be a representation of all primary schools in the district and Malawi as a whole.

The study took place in a rural setting, issues affecting the implementation of comprehensive sexuality education may be different from those in urban settings.

The views presented by the purposively selected study participants could not represent all people in the area, others could have given different opinions.

4.4 Areas for Further Research

The study was conducted in Chowo education zone which is a rural area. There is need to conduct a similar study in urban area to establish other factors that may influence CSE implementation in primary schools among VYAs. In addition, it will be good to do a study on SRH needs on the most marginalized/vulnerable groups of VYAs, for example, VYAs living with HIV, disabled, refugees, street VYAs and married VYAs. To conduct a study evaluating the implementation of CSE in secondary schools since secondary school teachers undergo a specific training to deliver CSE.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

Generally, the implementation of CSE in Chowo education zone was found not to be according to the ITGSE recommended standards due to various reasons from the implementers.

From this study, most of the out of school VYA dropped out due to lack of in-depth sexual and reproductive health information hence unwanted teenage pregnancies and early marriages took place. It is confirmed that the age 10–14 years is critical as this age marks a key transition between childhood and older adolescence [47] and therefore offers an opportunity to intervene early by providing supportive policies, programmes and interventions that give adolescents the tools they need to grow well. In addition, the successful achievement of the Sustainable Development Goals—most notably on health (Goal 3), education (Goal 4) and gender equality (Goal 5)—will depend in part on improvements in the lives and health of very young adolescents [13]. Furthermore, the age range 10–14 years is a period when antecedents for adverse sexual and reproductive health outcomes emerge, and opportunities for the formation of healthy sexuality are the greatest [3]. In Malawi, there is an increasing prevalence of early pregnancy [22], which suggests limitations and failures in efforts aimed at addressing sexual and reproductive health challenges among adolescents. To address this problem, CSE is needed; but as this study has shown, it requires repackaging of both the content and mode of delivery with the support of teachers and other stakeholders.

It is important to note that the presence of a national policy or curriculum that supports CSE does not necessarily associate with effective implementation of CSE especially for VYAs.

There is a dire need to equip implementers, for example teachers, parents as well as influential community members like chiefs and religious leaders, with the necessary information and skills to enhance the effectiveness of sexuality education programmes.

In Malawi, initial primary education training focuses only on teaching methodologies. The need to develop and update training curricula and support teachers to examine their own values and biases remains a priority in the success of CSE implementation in primary schools [48].

This study makes the following recommendations:

1. Ministry of Education

The study findings revealed that teacher lack proper skills to deliver CSE, therefore, primary school teacher training curriculum should be revised in a way that teachers must be trained how to specifically deliver CSE. This is in agreement with the study findings which recommended that training of teachers remains a priority in the success of CSE implementation in primary schools [50]. Making strong coalitions between parents, religious and traditional leaders in teaching VYAs about sexuality. Well-established advocacy coalitions can play a key role in ensuring strong policies [8].

- The Ministry of Education should reinforce back to school programmes for VYAs who dropped out of school due to pregnancy or marriage by creating an enabling environment for these girls and boys. Enabling environment in this case shall mean; qualified and mature teachers who can be able to accommodate these VYAs without bullying them.

2. Other partners/Non-Governmental Organisations

- The researcher recommends an intervention research which will have specific programmes to teach parents, community and faith leaders on how to teach VYAs sexuality issues so that there is consistency in the information that will be given to the young ones. This is in agreement with the Information Consistency and Desired Action model which assumes that “those information systems which have a high frequency of distribution and which are consistent in meaning, stand a better chance of achieving the desired reaction within the community than those with low frequency and of distribution and which are inconsistent”[4]. Further, with regard to the frequency of distribution of information, it is argued that when information reaches the target groups frequently and consistently, it may influence decision making and behaviour change more positively than when it is not [28].

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APPENDICES

Appendix 1a: Assent Form for the Very Young Adolescents

Assent to Participate in a Research Study: English

Title of Study: Catch them young- An assessment of implementation of sexuality education for In and Out of School very young adolescents (10-14 years) in Lilongwe, Malawi.

Principal Investigator: Esther Latif, BSc Community Health Nursing

Phone number: +265999406981

Study Contact email: latif.esther@gmail.com

To be read (aloud) and offered to consenting participants to take home with them.

General information about study

We would like to invite you to participate in a research study assessing the implementation of sexuality education for school going young adolescents (10-14 years old). The study is about exploring factors which can help in preventing early pregnancies and early school dropouts in the area with high school dropout rate. This study is conducted in Chowo Education Zone at Chowo, Chimbalinga and Kalamba primary schools.

What is the purpose of this study?

The overall aim of this study is to assess the implementation of sexuality education in primary schools among young adolescents aged 10 to 14.

Where is the study being conducted?

The study will take place in Lilongwe Rural South East, Chowo Zone in three primary schools which ranked high in school dropouts from 2015 to 2017 and the surrounding communities.

What will you have to do if you take part in this study?

You will be requested to answer questions about the study from our research team.

Study risks

We do not anticipate any risks associated with this study. You are free not to participate in the study if you prefer not to. All the information you give will be kept confidential. We will not share the information you give us with anyone not involved in the study.

What are the benefits of your participation?

You may not directly benefit from your participation in the study, however you will contribute to how SE is being implemented in primary schools hence help in reduction of early school

dropout, teen pregnancies and maternal/neonatal morbidity and mortality. No monetary benefits will be acquired only soft drinks and snacks will be offered during discussion sessions. The discussions will take place in the schools and right in their homes of the VYAs adolescents for the out of school ones hence no travel costs will be incurred by the participants.

Study participation

Your joining in this study is voluntary. You can refuse to participate or decide to withdraw from the research at any time, in which case any data collected for you.

Thank you very much.

If you have questions or require more information about this study please contact:

The Chairperson,
College of Medicine Research and Ethics Committee,
P/Bag 360,
Blantyre.
Telephone: 01 871911

Esther Latif
Nkhoma Hospital
Box 48
Nkhoma
Cell: +265999406981
Email: latif.esther@gmail.com

Signature page

Study title:

Catch Them Young-An Assessment of Implementation of Sexuality Education for In and Out of School Very Young Adolescents (10-14 years) in Lilongwe, Malawi.

Subject's Agreement:

I have read the information sheet / the information sheet has been read to me. I have been told what is involved in this study. By signing below, I give assent to take part in this research study. I understand that I can withdraw at any time and will not suffer any disadvantage in doing so. I understand that my learning will not be impacted by my participation or refusal to take part in this study. All of my questions have been answered and I have been offered a copy of the information sheet to take home for reference.

Do you agree to be interviewed?

Yes

No

Name of participant

Signature

Date

Name of study staff

Signature

Date

Appendix 1b: Assent to Participate in a Research Study: Chichewa Version

Title of Study:

Catch Them Young-An Assessment of Implementation of Sexuality Education for In and Out of School Very Young Adolescents (10-14 years) in Lilongwe, Malawi.

Principal Investigator: Esther Latif, Senior Nursing Officer, Nkhoma Hospital

Phone number: +265999406981

Study Contact email: latif.esther@gmail.com

Iwerengedwe (mokweza) ndi kuperekedwa kwa otenga nawo mbali mu kafukufuku kuti atengere kunyumba

Mawu otsogolera okhudza kafukufukuyi

Tikukukupemphani kuti mutenge nawo mbali mukafukufuku ofuna kuona mmene maphunzitsidwe a za ubereki akuchitikira mu sukulu za pulayimale makamaka pakati pa achinyamata azaka pakati pa khumi ndi khumi ndi mphambu zinayi.

Kodi cholinga cha kafukufukuyu ndi chiyani?

Cholinga chenicheni cha kafukufukuyu ndi kuunika mmene maphunzitsidwe a zokhudza zogonana a kuyendera mu sukulu za pulayimale poona kuti ana ambiri a zaka a pakati pa khumi khumi ndi mphambu zinayi akusiya sukulu msanga kamba koti ali ndi mimba komanso ambiri akupezeka ndi kachiroambo koyambitsa matenda ka HIV.

Kodi kafukufuku akuchitikira kuti?

Kafukufukuyu akuchitikira ku Chowo m'boma la Lilongwe.

Kodi kafukufukuyu achitika bwanji?

Pofuna kukwaniritsa zolinga za kafukufuku, muzapemphedwa kuti muzayankhe mafunso omwe akonzedwa ndi cholinga chopereka chithunzithunzi cha mmene maphunzirowa akuchitikira.

Zovuta kapena zosowetsa mtendere mu kafukufuku

Sitikuyembekezera zovuta zina zirizonse zokhudzana ndi kafukufukuyu. Mfundo kapena mayankho onse omwe mudzapereke inu zidasungidwa mwa chinsinsi. Palibe wina aliyense amene sali wakafukufuyi amene azadziwe Mfundo kapena zoyankha zomwe tidzazipezo.

Kodi phindu lotenga nawo mbali mu kafukufuku ndi chiyani?

Potenga nawo mbali mukafukufukuyi, mukuthandizira kupereka ukadawuro wapamwamba umene ungathandize kuti maphunzitsidwe a za ubereki akhale abwino othandiza achinyamata kudziwa zenizeni za mmene matupi awo amagwirira ntchi..to ndi kupewa kutenga mimba msanga komanso matenda opatsirana pogonana ngati HIV. Izi zizathandizira kuti achinyamata apitilize maphunziro awo popanda chowasokoneza komanso kawateteza kuzovuta zimene zimabwera chifukwa chakutenga mimba akadali achichepere monga, matenda otaya mikodzo and chimbudzi kuchokera malo osayenera, cancer wa khomo la chiberekero, imfa za a mai Kamba ka uchembere, kumwalira kwa mwana wobadwayo komanso umphawi chifukwa choti saphunzire.

Kutenga nawo mbali mu kafukufuku

Kutenga nawo mbali mukafukufukuyu ndi kodzipereka nokha. Ngati mutasankha kusatenga nawo mbali mukafukufuyi mudzapitilabe kulandila chinthandizo chomwe chimapelekedwa pa sukulu pano.

Zikomo kwambiri

Ngati muli ndi mafunso kapena mukufuna kudziwa zambiri zokhudza kafukufukuyi chonde funsani:

The Chairperson

College of Medicine Research and Ethics Committee

P/Bag 360

Blantyre

Telephone: 01 871911

Esther Latif

Nkhoma hospital

P. O Box 48

Tel +265999406981

latif.esther@gmail.com

Tsamba losayinila

Mutu wa kafukufuku:

Catch Them Young-An Assessment of Implementation of Sexuality Education for In and Out of School Very Young Adolescents (10-14 years) in Lilongwe, Malawi.

Chivomerezo cha otenga nawo mbali:

Ine ndawerenga chikalatachi / chikalatachi chawerengedwa kwa ine. Ndauzidwa,zonse zokhudzana

ndi kafukufuku ndipo ndikusaina kapena kuika chidindo changa mmusimu kusonyeza kuti ndavomera kuti ine nditenga nawo mbali mukafukufukuyu. Ndamvetsa kuti ine ndikhoza kusiya nthawi ina iriyonse ndipo sipadzakhala chovuta pakutero. Mafunso anga onse ayankhidwa ndipo ndapatsidwa imodzi mwa chikalata kupita nacho kunyumba ngati umboni wanga.

Inde Ayi

Dzina la otenga nawo mbali Saini Tsiku

Dzina laogwira ntchito ya kafukufuku Saini Tsiku

Wotenga nawo mbali ndi : Wodziwa kulemba Wosadziwa kulemba

For illiterate participants, name and date to be completed by study staff below:

Dzina la otenga nawo mbali Tsiku

Dzina la otenga nawo mbali lalembwedwa ndi Tsiku

Witness name, signature and date are required only when the consenting participant is illiterate

Dzina la mboni Saini ya mboni Tsiku

Appendix 2a : Parental Consent for Their VYAs to Participate in the Study

Informed Consent Form for _____ PARENTS/GUARDIANS FOR VERY YOUNG ADOLESCENT GIRLS AND BOYS participating in the research titled: **Catch them young- An assessment of implementation of sexuality education for In and Out of School very young adolescents (10-14 years) in Lilongwe, Malawi.**

My name is Esther Latif currently registered as a student at college of medicine for Master degree in Global Health Implementation and I am conducting a research project on the assessment of the implementation of sexuality education among very young adolescents 10-14 years old in the selected primary schools (Chowo, Chimbalanga and Kalamba) and I would like to ask if you can give permission to interview your child

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you agree that your child may participate)

You will be given a copy of the full Informed Consent Form

Information Sheet

Introduction

My name is Esther Latif currently registered as a student at college of medicine for Master degree in Global Health Implementation and I am conducting a research project on the assessment of the implementation of sexuality education among very young adolescents 10-14 years old in the selected primary schools (Chowo, Chimbalanga and Kalamba) and I would like to ask if you can give permission to interview your child. You may talk to anyone you feel comfortable talking with about the research and you can take time to reflect on whether you want your child to participate or not. Be assured that if you do not understand some of the words or concepts, I will take time to explain them as you go along and that you may ask questions now or later.

What is the purpose of this study?

The overall aim of this study is to assess the implementation of sexuality education in primary schools among young adolescents aged 10 to 14.

Where is the study being conducted?

The study will take place in Lilongwe Rural South East, Chowo Zone in three primary schools which ranked high in school dropouts from 2015 to 2017 and the surrounding communities.

What will your child have to do if you allow him/her take part in this study?

She/he will be requested to answer questions about the study from our research team.

Study risks

There are no anticipated any risks associated with this study. You are free not to participate in the study if you prefer not to. All the information you give will be kept confidential. We will not share the information you give us with anyone not involved in the study.

What are the benefits of your participation?

You may not directly benefit from your participation in the study, however you will contribute to how SE is being implemented in primary schools hence help in reduction of early school dropout, teen pregnancies and maternal/neonatal morbidity and mortality.

Selection of Participants

We want to talk to many teenagers about their health and what information they receive from school. One part of health that we want to talk to them about is sexuality. We would like to ask your daughter/son to participate because she/he is a teenager and lives in this area.

Voluntary Participation

You do not have to agree that your daughter/son can talk to us. You can choose to say no and that will not change anything. We know that the decision can be difficult when it involves your children. And it can be especially hard when the research includes sensitive topics like sexuality. You can ask as many questions as you like and we take the time to answer them. You don't have to decide today. You can think about it and tell me what you decide later.

Procedure

Your daughter/son will take part in a discussion with 10-11 other teenagers, those in the age range of 10-12 together and 13-14 years together for better understanding in the discussions groups. The girls and boys will be in the same groups. This discussion will be guided by one of the moderators.

The group discussion will start with me, or the group discussion leader, making sure that the participants are comfortable. We will also answer questions about the research that they might have. Then we will ask questions about what do they know sexual and reproductive health. We will talk about where they got the information from. We will encourage them to talk about sexual and reproductive health things like premarital sex abstinence and contraceptive use. These are the types of questions we will ask. We will not ask them to share personal stories or anything that they are not comfortable sharing.

The discussion will take place in the school (chowo/chimbalanga/kalimba) and in the villages surrounding these mentioned schools and no one else but the people who take part in the discussion and the guide. The researcher and one data collector will be present during this discussion. The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept in a lockable cupboard. The information recorded is confidential, and no one else except the researcher will be allowed to listen to the tapes. The tapes will be destroyed after 5 years.

Reimbursements

Your daughter/son will not be provided with any payment to take part in the research. However, she/he will be given some soft drinks and snacks during the time of discussions since it will be after classes. The researcher will be visiting them in their respective schools so that they do not incur any travel costs. In addition, this research project is not funded by any organisation so the researcher will not manage to find money to compensate the participants for their time.

Confidentiality

We will not be sharing information about your son or daughter outside of the research team. The information that we collect from this research project will be kept confidential. Information about your child that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about your child will have a number on it instead of his/her name. Only the researchers will know what his/her number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the researcher, COMREC and my supervisor will have access to the information.

Sharing of Research Findings

At the end of the study, we will be sharing what we have learnt with all the participants and with the community. We will do this by meeting first with all the participants and then with the larger community. Nothing that your child will tell us today will be shared with anybody outside the research team, and nothing will be attributed to him/her by name. A written report will also be given to the participants which they can share with their families. We will also publish the results in order that other interested people may learn from our research.

Right to refuse or withdraw

You may choose not to have your child participate in this study and your child does not have to take part in this research if she/he does not wish to do so. Choosing to participate or not will not affect either your own or your child's education from the involved schools in any way. You and your child will still have all the benefits that would otherwise be available at these primary schools. Your child may stop participating in the discussion/interview at any time that you or she/he wish without either of you losing any of your rights here.

Who to Contact

If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact any of the following:

The Chairperson,

College of Medicine Research and Ethics Committee,

P/Bag 360,

Blantyre.

Telephone: 01 871911

Esther Latif

Nkhoma Hospital

Box 48

Nkhoma

Cell: +265999406981

Email: latif.esther@gmail.com

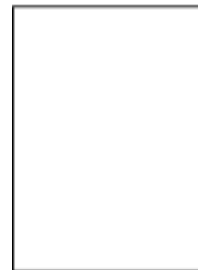
Signature Page

I have been asked to give consent for my daughter/son to participate in this research study which will involve her completing one interview and one questionnaire I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study.

Print Name of Parent or Guardian _____

If participant is illiterate:

Thumb print of participant



Signature of Parent of Guardian _____

Date _____

Day/month/year

If illiterate

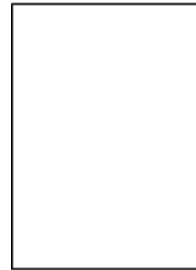
A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have witnessed the accurate reading of the consent form to the parent of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness _____

AND

Thumb print of participant



Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the parent of the potential participant, and to the best of my ability made sure that the person understands that the following will be done:

- 1.
- 2.
- 3.

I confirm that the parent was given an opportunity to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the parent or guardian of the participant. ____

Print Name of Researcher/person taking the consent _____

An Informed Assent Form will ____ OR will not ____ be completed.

Appendix 2b: Parental Consent for their VYAs to Participate in the Study- Chichewa

Version

Iwerengedwe (mokweza) ndi kuperekedwa kwa otenga nawo mbali mu kafukufuku kuti atengere kunyumba.

Mawu otsogolera okhudza kafukufukuyi.

Tikukukupemphani kuti mwana wanu adzatenge nawo mbali mukafukufuku ofuna kuona mmene maphunzitsidwe a za zogonana akuchitikira mu sukulu za pulayimale makamaka pakati pa achinyamata azaka pakati pa khumi ndi khumi ndi mphambu zinayi.

Kodi cholinga cha kafukufukuyu ndi chiyani?

Cholinga chenicheni cha kafukufukuyu ndi kuunika mmene maphunzitsidwe a zokhudza zogonana a kuyendera mu sukulu za pulayimale poona kuti ana ambiri a zaka a pakati pa khumi ndi khumi ndi mphambu zinayi akusiya sukulu msanga kamba koti ali ndi mimba/pakati komanso ambiri akupezeka ndi kachirokoyambitsa matenda ka HIV.

Kodi kafukufuku akuchitikira kuti?

Kafukufukuyu akuchitikira ku Chowo m'boma la Lilongwe.

Kodi kafukufukuyu achitika bwanji?

Pofuna kukwaniritsa zolinga za kafukufuku, muzapemphedwa kuti mwana wanu adzayankhe mafunso omwe akonzedwa ndi cholinga chopereka chithunzithunzi cha mmene maphunzirowa akuchitikira.

Zovuta kapena zosowetsa mtendere mu kafukufuku

Sitikuyembekezera zovuta zina zirizonse zokhudzana ndi kafukufukuyu. Mfundo kapena mayankho onse omwe mudzapereke inu zidzasungidwa mwa chinsinsi. Palibe wina aliyense amene sali wakafukufuyi amene azadziwe Mfundo kapena zoyankha zomwe tidzazipezo.

Kodi phindu lotenga nawo mbali mu kafukufuku ndi chiyani?

Potenga nawo mbali mukafukufukuyi, mukuthandizira kupereka ukadawuro wapamwamba umene ungathandize kuti maphunzitsidwe a za ubereki akhale abwino othandiza achinyamata kudziwa zenizeni za mmene matupi awo amagwirira ntchito ndi kupewa kutenga mimba msanga komanso matenda opatsirana pogonana ngati HIV. Izi zizathandizira kuti achinyamata apitilize maphunziro awo popanda chowasokoneza komanso kawateteza kuzovuta zimene zimabwera chifukwa chakutenga mimba akadali achichepere monga, matenda otaya mikodzo and chimbudzi kuchokera malo osayenera, cancer wa khomo la chiberekero, imfa za a mai Kamba ka uchembere, kumwalira kwa mwana wobadwayo komanso umphawi chifukwa choti saphunzire. Palibe malipilo a ndalama yina yiliyonse yomwe mwana wanu adzapeze kamba kotenga nawo mbali mu kafukufukuyi. Adzapatsidwa zakumwa zoziziritsa kukhosi ndi zodyela zake panthawi ya zokambirana ku sukuluku ndi ku midzi komwe kafukufukuyi adzachitikire. Wopangitsa

kafukufuku ndi amene adzibwera ku sukulu kumene mwana wanu akuphunzirira kapena ku mudzi kumene mwana wanu amakhala ndiye chifukwa cha chimenechi sipadzakhala kumupepesa chifukwa choti wayenda kufika kumalo a kafukufuku. Komanso wopangitsa kafukufuku alibe bungwe lililonse lomuthandiza pakafukufukuyi akudalira ndalama zopeza yekha ndiye sangakwanitse kupereka ndalama mmene kufunikira.

Kutenga nawo mbali mu kafukufuku

Kutenga nawo mbali mukafukufukuyu ndi kodzipereka nokha. Ngati mutasankha kuti mwana wanu asatenga nawo mbali mukafukufuyi mudzapitilabe kulandila chinthandizo chomwe chimapelekedwa pa sukulu pano.

Zikomo kwambiri

Ngati muli ndi mafunso kapena mukufuna kudziwa zambiri zokhudza kafukufukuyi chonde funsani:

The Chairperson,

College of Medicine Research and Ethics Committee,

P/Bag 360,

Blantyre.

Telephone: 01 871911

Esther Latif

Nkhoma Hospital

Box 48

Nkhoma

Cell: +265999406981

Email: latif.esther@gmail.com

Tsamba losayina

Ndapemphedwa kupereka chibvomerezo choti mwana wanga atenge nnawo mbali mukafukufukuyi zimene zitamupatse kuthekere kopanga nawo zokambirana. Ndawerenga zones za nkafukufukumu ndiponso andiwerengeranso. Ndinapatsidwa mpata wofusa mafunso ndipo mafunso anga onse ayankhidwa ndipo ndakhutira ndimayankho operekedwawo. Ndapereka chibvomerezo kuti mwana wanga atha kutenga nawo mbali mu kafukufukuyi.

Tsindikizani dzina la kholo/woyang'anira _____

Siyini ya kholo/woyang'anira _____

Tsiku _____

tsiku/mwezi/chaka

Ngati ndiwosaphunzira;

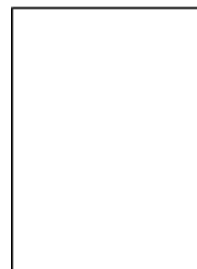
Mboni yodziwa kulemba yiwasayinile (ngati nkotheke, munthuyo asankhidwe ndi khololo ndipo asakhale wokhuzidwa ndi wina aliyense wopangitsa kafukufuku). Iwo amene sadziwa kulemba adindenso chibvomerezo ndi chala chachikulu.

Ine ndaonerera kuwerengedwa komveka bwino kwa chibvomerezo chotenga nawo mbali mukafukufuku ngati kholo la wachinyamata wa chichepere kwambiri ndipo mwai unalipo wofunsa mafunso. Ndikuperekeramba umboni kuti sanakakamizidwe mwanjira yiliyonse.

Dzina la mboni _____

NDI

Chala cha chikulu chodindira



Sayini ya mboni _____

Tsiku _____

Tsiku/mwezi/chaka

Zonena za wopanga kafukufuku kapena wotenga mbali

Ndawawerenga bwino lomwe ngati kholo zokhudza mwana wao mwai wotenga mbali mukafukufuku ndipo mwakuzindikira kwanga ndayesetsa kuti makolowo amvetsetse ndipo zochitika ngati izi:

- 1.-----
- 2.-----
- 3.-----

(mwachidule kusonyeza kuti amvetsetsadi)

Ndikutsindika kuti kholo kapena woyang'anira mwana anapatsidwa mpate wofunsa mafunso okhudza za kafukufuku ndipo mafunso onse omwe anafinsidwa ayankhidwa momveka bwino. Ndikutsimikizira kuti wina aliyense sanakakamizidwe kuti apereke chibvomerezo ndipo kuti chibvomerezo chaperekedwa mwaulere ndiponso mwakufuna kwa munthu aliyense.

Kalata ngati yomweyi ya chibvomerezo yaperekedwa kwa kholo/woyang'anira mwana _____

Dzina la ofufuza/kapena wotenga nawo mbali_____

Chibvomerezo choti kalatayi ndisayinira-----kapena ayi----- Form.

Appendix 3a : Traditional/ Local Leaders Informed Consent

TRADITIONAL/RELIGIOUS LEADER CONSENT FOR SEXUALITY EDUCATION ON VERY YOUNG ADOLESCENTS

LOCAL/RELIGIOUS LEADERS TO PARTICIPATE IN THE STUDY

I _____ (NAME OF A LEADER) is willing to take part in participating in the research titled: Catch them young- An assessment of implementation of sexuality education for In and Out of School very young adolescents (10-14 years) in Lilongwe, Malawi.

My name is Esther Latif currently registered as a student at college of medicine for Master degree in Global Health Implementation and I am conducting a research project on the assessment of the implementation of sexuality education among very young adolescents 10-14 years old in the selected primary schools (Chowo, Chimbalanga and Kalamba) and I would like to ask if you can give permission to be interviewed.

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you agree that you may participate)**

You will be given a copy of the full Informed Consent Form

Information Sheet

Introduction

My name is Esther Latif currently registered as a student at college of medicine for Master degree in Global Health Implementation and I am conducting a research project on the assessment of the implementation of sexuality education among very young adolescents 10-14 years old in the selected primary schools (Chowo, Chimbalanga and Kalamba) and I would like to ask if you can give permission to be interviewed. You may talk to anyone you feel comfortable talking with about the research and you can take time to reflect on whether you want to participate or not. Be assured that if you do not understand some of the words or concepts, I will take time to explain them as you go along and that you may ask questions now or later.

What is the purpose of this study?

The overall aim of this study is to assess the implementation of sexuality education in primary schools among young adolescents aged 10 to 14.

Where is the study being conducted?

The study will take place in Lilongwe Rural South East, Chowo Zone in three primary schools which ranked high in school dropouts from 2015 to 2017 and the surrounding communities.

What part will you take in this study?

You will be requested to answer questions about the study from our research team.

Study risks

There are no anticipated risks associated with this study. You are free not to participate in the study if you prefer not to. All the information you give will be kept confidential. We will not share the information you give us with anyone not involved in the study.

What are the benefits of your participation?

You may not directly benefit from your participation in the study, however you will contribute to how SE is being implemented in primary schools hence help in reduction of early school dropout, teen pregnancies and maternal/neonatal morbidity and mortality.

Selection of Participants

We want to talk to a few local/religious leaders about the adolescent's health and what information you would like your children to receive from school. One part of health that we want to talk about is very young adolescent's sexuality education. We would like to ask you to participate because you are a leader and lives in this area.

Voluntary Participation

You do not have to agree that you can talk to us. You can choose to say no and that will not change anything. We know that the decision can be difficult when it involves your contribution on the issue. And it can be especially hard when the research includes sensitive topics like sexuality. You can ask as many questions as you like and we take the time to answer them. You don't have to decide today. You can think about it and tell me what you decide later.

Procedure

You will take part in a discussion with 10-12 other local/religious leaders both males and females. This discussion will be guided by one of the moderators. It may take approximately 45 minutes.

The group discussion will start with me, or the group discussion leader, making sure that the participants are comfortable. We will also answer questions about the research that they might have. Then we will ask questions about what do they know regarding sexual and reproductive health in very young adolescents. We will ask about where they got the information from. We will encourage them to talk about very young adolescent's sexual and reproductive health things like premarital sex, abstinence, early school dropout and contraceptive use. These are the types of questions we will ask. We will not ask to share personal stories or anything that they are not comfortable sharing.

The discussion will take place in the school (chowo/chimbalanga/kalamba) and in the villages surrounding these mentioned schools and no one else but the people who will take part in the discussion and the guide. I and one data collector will be present during this discussion. The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept in a lockable cupboard. The information recorded is confidential, and

no one else except the researcher will be allowed to listen to the tapes. The tapes will be destroyed after 5 years.

Reimbursements

You will not be provided with any payment to take part in the research. However, you will be given some soft drinks and snacks during the time of discussions since it will be after lunch. The researcher will be visiting them in their respective villages so that they do not incur any travel costs. In addition, this research project is not funded by any organisation so the researcher will not manage to find money to compensate the participants for their time.

Confidentiality

We will not be sharing information about you outside of the research team. The information that we collect from this research project will be kept confidential. Information about you that will be collected from the research will be put away and no-one but the researchers will be able to see it. Any information about you will have a number on it instead of your name. Only the researchers will know what his/her number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the researcher, COMREC and my supervisor will have access to the information.

Sharing of Research Findings

At the end of the study, we will be sharing what we have learnt with all the participants and with the community. We will do this by meeting first with all the participants and then with the larger community. Nothing that you will tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. A written report will also be given to the participants which they can share with their families. We will also publish the results in order that other interested people may learn from our research.

Right to refuse or withdraw

You may choose not to participate in this study if you do not wish to do so. Choosing to participate or not will not affect you in any way. You and your family will still have all the benefits that would otherwise be available at these primary schools. You may stop participating in the discussion/interview at any time that you wish without either of you losing any of your rights here.

Who to Contact

If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact any of the following:

The Chairperson,

College of Medicine Research and Ethics Committee,

P/Bag 360,

Blantyre.

Telephone: 01 871911

Esther Latif

Nkhoma Hospital

Box 48

Nkhoma

Cell: +265999406981

Email: latif.esther@gmail.com

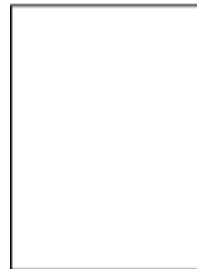
Signature Page

I have been asked to give consent for myself to participate in this research study which will involve attending one in-depth interview. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for myself to participate as a participant in this study.

Print Name of Local/religious leader _____

If participant is illiterate:

Thumbprint of participant



Signature of Local/religious leader _____

Date _____

Day/month/year

If illiterate

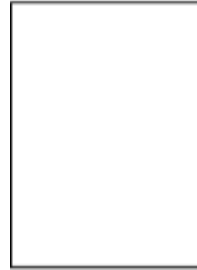
A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have witnessed the accurate reading of the consent form to the parent of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness _____

AND

Thumb print of participant



Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the parent of the potential participant, and to the best of my ability made sure that the person understands that the following will be done:

- 1.
- 2.
- 3.

I confirm that the local/religious leader was given an opportunity to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Print Name of Researcher/person taking the consent _____

An Informed Assent Form will ____ OR will not ____ be completed.

Appendix 3b: Traditional/Religious Leaders Consent for Sexuality Education in Very Young Adolescents to Participate in the Study – Chichewa Version

Iwerengedwe (mokweza) ndi kuperekedwa kwa otenga nawo mbali mu kafukufuku kuti atengere kunyumba.

Mawu otsogolera okhudza kafukufukuyi.

Tikukukupemphani kuti mwana wanu adzatenge nawo mbali mukafukufuku ofuna kuona mmene maphunzitsidwe a za zogonana akuchitikira mu sukulu za pulayimale makamaka pakati pa achinyamata azaka pakati pa khumi ndi khumi ndi mphambu zinayi.

Kodi cholinga cha kafukufukuyu ndi chiyani?

Cholinga chenicheni cha kafukufukuyu ndi kuunika mmene maphunzitsidwe a zokhudza zogonana a kuyendera mu sukulu za pulayimale poona kuti ana ambiri a zaka a pakati pa khumi ndi khumi ndi mphambu zinayi akusiya sukulu msanga kamba koti ali ndi mimba/pakati komanso ambiri akupezeka ndi kachiroombo koyambitsa matenda ka HIV.

Kodi kafukufuku akuchitikira kuti?

Kafukufukuyu akuchitikira ku Chowo m'boma la Lilongwe.

Kodi kafukufukuyu achitika bwanji?

Pofuna kukwaniritsa zolinga za kafukufuku, muzapemphedwa kuti mudzayankhe mafunso omwe akonzedwa ndi cholinga chopereka chithunzithunzi cha mmene maphunzirowa akuchitikira.

Zovuta kapena zosowetsa mtendere mu kafukufuku

Sitikuyembekezera zovuta zina zirizonse zokhudzana ndi kafukufukuyu. Mfundo kapena mayankho onse omwe mudzapereke inu zidasungidwa mwa chinsinsi. Palibe wina aliyense amene sali wakafukufuyi amene azadziwe mfundo kapena zoyankha zomwe tidzazipezo.

Kodi phindu lotenga nawo mbali mu kafukufuku ndi chiyani?

Potenga nawo mbali mukafukufukuyi, mukuthandizira kupereka ukadawuro wapamwamba umene ungathandize kuti maphunzitsidwe a za zogonana akhale abwino othandiza achinyamata kudziwa zenizeni za mmene matupi awo amagwirira ntchito ndi kupewa kutenga mimba msanga komanso matenda opatsirana pogonana ngati HIV. Izi zizathandizira kuti achinyamata apitilize maphunzirowo popanda chowasokoneza komanso kawateteza kuzovuta zimene zimabwera chifukwa chakutenga mimba akadali achichepere monga, matenda otaya mikodzo and chimbudzi kuchokera malo osayenera, cancer wa khomo la chiberekero, imfa za a mai kamba ka uchembere, kumwalira kwa mwana wobadwayo komanso umphawi chifukwa choti sanaphunzire. Palibe malipilo a ndalama yina yiliyonse yomwe mudzapeze kamba kotenga nawo

mbali mu kafukufukuyi. Mudzapatsidwa zakumwa zoziziritsa kukhosi ndi zodyela zake panthawi ya zokambirana ku midzi komwe kafukufukuyi adzachitikire. Wopangitsa kafukufuku ndi amene adzibwera ku midzi kumene mumakhala ndiye chifukwa cha chimenechi sipadzakhala kupepesedwa chifukwa choti mwayenda kufika kumalo a kafukufuku. Komanso wopangitsa kafukufuku alibe bungwe lililonse lomuthandiza pakafukufukuyi akudalira ndalama zopeza yekha ndiye sangakwanitse kupereka ndalama mmene kufunikira.

Kutenga nawo mbali mu kafukufuku

Kutenga nawo mbali mukafukufukuyi ndi kodzipereka nokha. Ngati mutasankha kuti kusatenga nawo mbali mukafukufuyi mudzapitilabe kulandila chinhandizo chomwe chimapelekedwa pa sukulu pano.

Zikomo kwambiri

Ngati muli ndi mafunso kapena mukufuna kudziwa zambiri zokhudza kafukufukuyi chonde funsani:

The Chairperson,

College of Medicine Research and Ethics Committee,

P/Bag 360,

Blantyre.

Telephone: 01 871911

Esther Latif

Nkhoma Hospital

Box 48

Nkhoma

Cell: +265999406981

Email: latif.esther@gmail.com

Tsamba losayina

Ndapemphedwa kupereka chibvomerezo chotenga nawo mbali mukafukufukuyi zimene zitandipatse kuthekere kopanga nawo zokambirana. Ndawerenga zonse za nkafukufukumu ndiponso andiwerengeranso. Ndinapatsidwa mpata wofusa mafunso ndipo mafunso anga onse ayankhidwa ndipo ndakhutira ndimayankho operekedwawo. Ndapereka chibvomerezo kuti nditha kutenga nawo mbali mu kafukufukuyi.

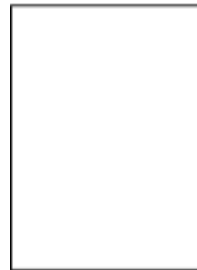
Tsindikizani dzina la mtsogoleri _____

Siyini ya mtsogoleri _____

Tsiku _____

tsiku/mwezi/chaka

Ngati ndiwosaphunzira; CHIDINDO CHA CHALA CHACHIKULU CHA KUMANJA



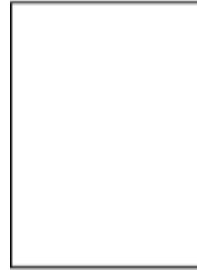
Mboni yodziwa kulemba yiwasayinile (ngati nkotheke, munthuyo asankhidwe ndi khololo ndipo asakhale wokhuzidwa ndi wina aliyense wopangitsa kafukufuku). Iwo amene sadziwa kulemba adindenso chibvomerezo ndi chala chachikulu.

Ine ndaonerera kuwerengedwa komveka bwino kwa chibvomerezo chotenga nawo mbali mukafukufuku ngati kholo la wachinyamata wa chichepere kwambiri ndipo mwai unalipo wofunsa mafunso. Ndikuperekera umboni kuti sanakakamizidwe mwanjira yiliyonse.

Dzina la mboni _____

NDI

Chala cha chikulu chodindira



Sayini ya mboni _____

Tsiku _____

Tsiku/mwezi/chaka

Zonena za wopanga kafukufuku kapena wotenga mbali

Ndawawerenga bwino lomwe ngati kholo zokhudza wotenga mbali mukafukufuku ndipo mwakuzindikira kwanga ndayesetsa kuti atsogoleriwa amvetsetse ndipo zochitika ngati izi:

1.-----

2.-----

3.-----

(mwachidule kusonyeza kuti amvetsetsadi)

Ndikutsindika kuti atsogoleri a mpingo kapena mmudzi anapatsidwa mpata wofunsa mafunso okhudza za kafukufuku ndipo mafunso onse omwe anafunsidwa ayankhidwa momveka bwino. Ndikutsimikizira kuti wina aliyense sanakakamizidwe kuti apereke chibvomerezo ndipo kuti chibvomerezo chaperekedwa mwaulere ndiponso mwakufuna kwa munthu aliyense.

Dzina la ofufuza/kapena wotenga nawo mbali _____

Chibvomerezo choti kalatayi ndisayinira-----kapena ayi-----

Appendix 4: Teachers Consent Form

Consent to Participate in a Research Study: English

Title of Study: Catch them young- An assessment of implementation of sexuality education for In and Out of School very young adolescents (10-14 years) in Lilongwe, Malawi.

Principal Investigator: Esther Latif, BSc Community Health Nursing

Phone number: +265999406981

Study Contact email: latif.esther@gmail.com

To be read (aloud) and offered to consenting participants to take home with them.

General information about study

We would like to invite you to participate in a research study assessing the implementation of sexuality education for school going young adolescents (10-14 years old). The study is about exploring factors which can help in preventing early pregnancies and early school dropouts in the area with high school dropout rate. This study is conducted in Chowo Education Zone at Chowo, Chimalanga and Kalamba primary schools.

What is the purpose of this study?

The overall aim of this study is to assess the implementation of sexuality education in primary schools among young adolescents aged 10 to 14.

Where is the study being conducted?

The study will take place in Lilongwe Rural East, Chowo Zone in three primary schools which ranked high in school dropouts from 2015 to 2017 and the surrounding communities.

What will you have to do if you take part in this study?

You will be requested to answer questions about the study from our research team.

Study risks

We do not anticipate any risks associated with this study. You are free not to participate in the study if you prefer not to. All the information you give will be kept confidential. We will not share the information you give us with anyone not involved in the study.

What are the benefits of your participation?

You may not directly benefit from your participation in the study, however you will contribute to how SE is being implemented in primary schools hence help in reduction of early school dropout, teen pregnancies and maternal/neonatal morbidity and mortality. No monetary benefits

will be acquired only soft drinks and snacks will be offered during discussion sessions. The discussions will take place in the schools and right in the VYAs' homes for the out of school ones hence no travel costs will be incurred by the participants.

Study participation

Your joining in this study is voluntary. You can refuse to participate or decide to withdraw from the research at any time, in which case any data collected for you.

Thank you very much.

If you have questions or require more information about this study please contact:

The Chairperson,
College of Medicine Research and Ethics Committee,
P/Bag 360,
Blantyre.
Telephone: 01 871911

Esther Latif
Nkhoma Hospital
Box 48
Nkhoma
Cell: +265999406981
Email: latif.esther@gmail.com

Signature page

I have been asked to give consent for myself to participate in this research study which will involve me attending one in-depth interview and I have read the foregoing information, and also it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this study.

Print Name of Teacher _____

Signature of Teacher-----

Date -----

Appendix 5: Request for Permission to Conduct Research in Lilongwe Rural East

APPENDIX C : REQUEST FOR PERMISSION TO CONDUCT A RESEARCH IN LILONGWE RURAL EAST.

College of Medicine,
P/B 360,
Chichiri,
Blantyre 3.

The District Education Office,
Lilongwe Rural East Zone,
Box 71,
Lilongwe.

Dear Sir/ Madam,

REQUEST TO CONDUCT A RESEARCH ON HOW SEXUALITY EDUCATION IS BEING IMPLEMENTED IN LILONGWE RURAL EAST, CHOWO EDUCATION ZONE (CHOWO, CHIMBALANGA AND KALAMBA PRIMARY SCHOOLS)

I am a postgraduate student pursuing Masters in Global Health Implementation at college of medicine and would like to request for permission carry out a research study titled; Catch Them Young-An Assessment of implementation of sexuality education for school-going young adolescents 10-14-years old in Lilongwe District.

Looking at the increase of teenage pregnancies and their adverse birth outcomes, high primary school drop-out rates in the mentioned area and increased HIV prevalence among adolescents in the country as a whole, gives the question of how much knowledge does this age group has about sexual and reproductive health. This study therefore will assess how implementation of sexuality education in primary schools among this age group is being done.

The study will focus group discussions with learners, in-depth interviews with key informants (teachers, parents and leaders of the communities involved), classroom observations as the teachers are teaching and review the Ministry of Education Science and Technology policy, primary school curriculum and other relevant documents.

The proposed study will be approved by College of Medicine Research and Ethics Committee.

I would like to assure you that names of study participants will not be revealed and the information provided will be treated with confidentiality.

Should you need more information, please contact the undersigned on the phone numbers below +265 999 406 981, +265 995 447 784 and +265 886 216 211.

Yours faithfully,

Esther Latif

University of Malawi
College of Medicine
2018 -08- 2 1
Health Systems Policy
Private Bag 360
Chichiri, Blantyre 3

Appendix 6: Approval Letter from the DEM, Lilongwe Rural East

APPENDIX D: APPROVAL LETTER FROM THE DEM, LILONGWE RURAL EAST.

The District Education Office
Lilongwe Rural East Zone
Box 71
Lilongwe.
23rd August 2018

Dear Esther Latif,

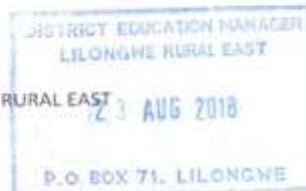
This is to inform you that our office has no objection for you to do your research on the assessment of the implementation of sexuality education among very young adolescents, 10 – 14 years of age as part of your research project in Chowo Education Zone (Chowo, Chimalanga and Kalamba Primary schools).

All the best in your studies.

Yours faithfully,


A.K.B Nandika

DEM – LILONGWE RURAL EAST



Appendix 7: Malawi National Education Policy 2013

1.2 Defining the Problem

Malawi has experienced some major changes in education over the past decade. Many of these changes were triggered by policy shifts, notably the introduction of Free Primary Education (FPE) which led to significant increase in school enrollment from 1.9 in 1993/94 to 2.9 million in 1994/95. Additionally, the FPE was instituted without an overall education policy framework.

Due to the transition to multiparty dispensation, the education sector experienced the emergence of private institutions many of which are substandard. This is the result of the absence of a comprehensive education policy to guide all stakeholders in the provision of education services and has adversely affected learning outcomes at all levels.

Furthermore, due to the absence of a well-defined education policy, different key players in the education sector have not been well coordinated. Additionally, their roles and responsibilities have not been clearly defined thereby prompting non-conformity to set standards among stakeholders.

It is against this brief background that the National Education Policy has been developed.

1.3 Purpose of the Policy

The purpose of the policy is to provide a coordinated approach to the development of the education system for relevant knowledge, skills, competencies and values necessary for the socio-economic development of the nation.

2.0 Broad Policy Directions

2.1 Policy Vision

To be a catalyst for economic growth and socio-economic development.

2.1 Policy Goal

To promote equitable access, relevance, quality and improved governance and management of the education sector. This will ultimately contribute to sustainable socioeconomic development and poverty reduction.

2.2 Policy Outcome

An equitable and relevant education system that is well governed and managed.

2.3 Policy Objectives

The objectives of the policy are:

- i To create an enabling environment for the expansion of equitable access to education for all Malawians;
- ii To improve quality and relevance of education to meet socio-economic development needs for the nation; and
- iii To improve the operations and efficiency of the education system through good governance and management in order to deliver education services effectively and effectively.

3.1.4 Primary Education

Primary education is the longest existing sub-sector attended by the largest number of learners. The fundamental objective of primary education is to inculcate basic literacy, numeracy and life skills, and it is recognized as the foundation for secondary and tertiary education levels. The official entry age to primary education is 6 years, meaning that the expected primary school going age population is within the range of 6 and 13 years. However, because of late entry into the system and high class repetition rates, the system is also characterized by a significant percentage of children who are over the official maximum age of 13.

The primary cycle is for eight years, from standard 1 to standard 8. At the end of standard 8, learners sit for a standardized national examination called the Primary School Leaving Certificate Examination (PSLCE) which determines their eligibility for secondary education. Historically the provision of primary education was solely undertaken by the government. In 2004, a national policy authorized primary education provision by private institutions; however, private schools play a small role in the provision of primary education as currently less than 10% of total primary education enrolment is attending private schools. The government is still the main provider of primary education.

Primary education in Malawi was made free in 1994 during which tuition fees in all public primary schools were abolished and wearing of school uniform in such schools was no longer compulsory. The introduction of free primary education in Malawi brought itself a lot of challenges in the education system, especially in the primary sub-sector itself. Enrolment figures tremendously increased, thereby putting a lot of pressure in the distribution of teaching and learning materials, availability of adequate qualified teachers, class space and provision of adequate sanitary facilities. After almost twenty years since the introduction of free primary education, the sub-sector has not fully overcome these challenges. The notable consequence of these challenges has been the low quality of primary education which has also negatively affected the learning outcomes, learner retention (especially girls), promotion rates to upper classes and the transition rate to secondary education.

Policy Statements

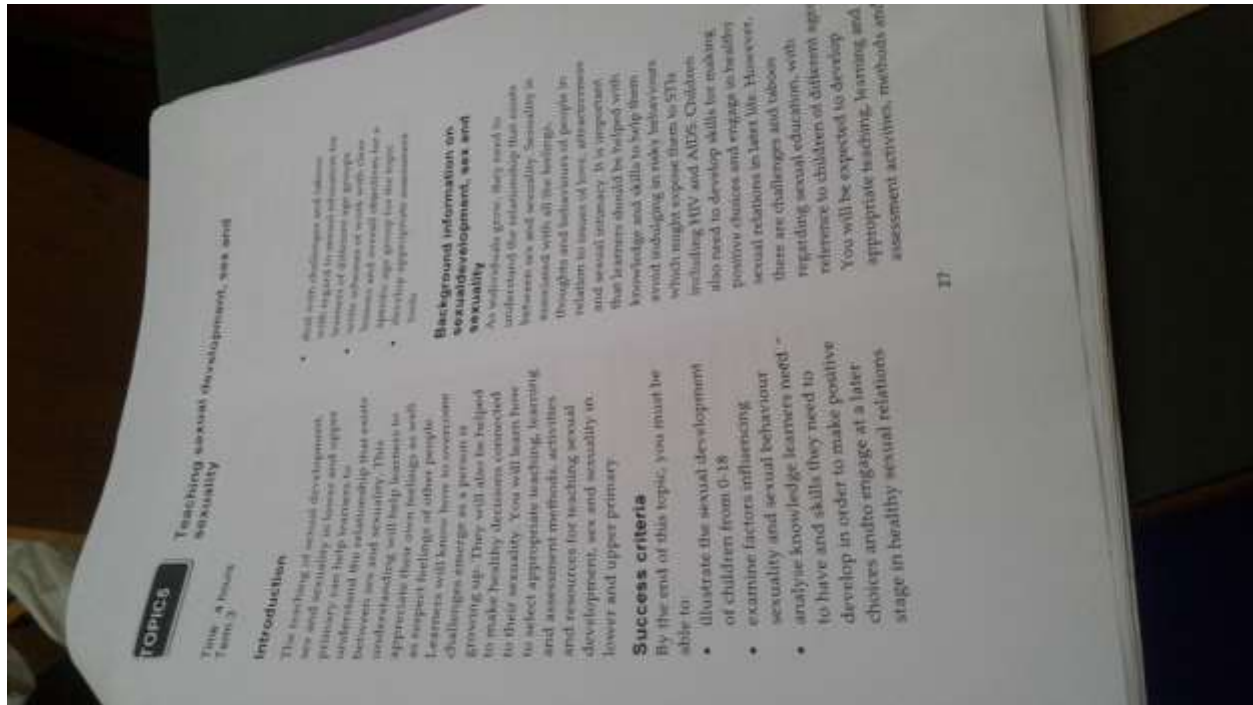
The policy will ensure that:

- i. national education standards are adhered to in all schools.

- ii. primary school curriculum is relevant and responsive to the needs of the country;
- iii. quality assurance is enhanced;
- iv. free primary education is compulsory and implemented incrementally;
- v. continuous assessment in primary education is enhanced;
- vi. teaching and learning materials are available to all learners;
- vii. a sustainable and effective school health and nutrition programme including HIV/AIDS education services is enhanced
- viii. increased numbers of girls equitably access, participate in, excel and complete primary education
- ix. equitable access to quality and relevant special and inclusive primary education is enhanced
- x. capacity development in primary education is strengthened; and

- xi. governance and management of primary education is enhanced.

Appendix 8: Life Skills Primary School Education Syllabus: Teacher's Competencies



Appendix 9: Time-table for 5 to 8. Kalamba Primary School

	7:15	7:30	8:05	8:40	9:15	9:50	10:05	10:40	11:15	11:50	12:25	12:45	1:20	1:55
	7:30	8:05	8:40	9:15	9:50	10:10	10:40	11:15	11:50	12:25	12:45	1:20	1:55	2:30
MOND	5	MATHS	CHICH	SES	ENG	CHICH	ENG	S4TEC	EXARTS	SES	LISKILLS	AGRIC		
	6	MATHS	ENG	CHICH	SES	CHICH	ENG	S4TEC	SES	EXARTS	AGRIC	LISKILLS		
	7	MATHS	EXARTS	ENG	SES	MATHS	EXARTS	ENG	SES	SES	AGRIC	LISKILLS		
	8	MATHS	ENG	SES	EXARTS	CHICH	S4TEC	SES	CHICH	LISKILLS	AGRIC	ENG		
TUES	5	S4TEC	MATHS	ENG	MATHS	SES	EXARTS	CHICH	LISKILLS	ENG	AGRIC	AGRIC		
	6	ENG	MATHS	S4TEC	MATHS	ENG	ENG	EXARTS	SES	AGRIC	AGRIC	LISKILLS		
	7	ENG	S4TEC	MATHS	CHICH	EXARTS	ENG	SES	LISKILLS	AGRIC	AGRIC	SES		
	8	ENG	MATHS	S4TEC	CHICH	EXARTS	SES	ENG	AGRIC	MATHS	B/K	LISKILLS		
WED	5	ENG	LISKILLS	CHICH	AGRIC	MATHS	ENG	S4TEC	SES	B/K	MATHS	EXARTS		
	6	ENG	CHICH	AGRIC	LISKILLS	MATHS	S4TEC	SES	ENG	B/K	MATHS	EXARTS		
	7	MATHS	ENG	MATHS	AGRIC	CHICH	S4TEC	ENG	B/K	LISKILLS	AGRIC	LISKILLS		
	8	MATHS	ENG	AGRIC	MATHS	ENG	EXARTS	B/K	LISKILLS	AGRIC	LISKILLS	S4TEC		
THURS	5	CHICH	ENG	AGRIC	MATHS	LISKILLS	S4TEC	SES	MATHS	CHICH	ENG	EXARTS		
	6	CHICH	MATHS	ENG	AGRIC	CHICH	SES	S4TEC	LISKILLS	MATHS	EXARTS	ENG		
	7	MATHS	CHICH	ENG	CHICH	AGRIC	SES	LISKILLS	S4TEC	EXARTS	ENG	MATHS		
	8	CHICH	MATHS	ENG	CHICH	AGRIC	SES	LISKILLS	S4TEC	EXARTS	ENG	MATHS		
FRID	5	MATHS	SES	ENG	EXARTS	CHICH	B/K	S4TEC	S4TEC	EXARTS	ENG	MATHS		
	6	MATHS	ENG	EXARTS	SES	ENG	B/K	CHICH	AGRIC	LISKILLS	S4TEC	S4TEC		
	7	CHICH	ENG	MATHS	MATHS	B/K	SES	AGRIC	CHICH	LISKILLS	S4TEC	S4TEC		
	8	ENG	CHICH	MATHS	MATHS	ENG	CHICH	MATHS	LISKILLS	S4TEC	S4TEC	S4TEC		

KALAMBA SCHOOL
MASTER TIME
TABLE

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Appendix 10: Standard 8 Learner's Text Book: Table of contents

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DATA COLLECTION TOOLS

Appendix 11: Focus Group Discussion Guide and Interview Guide

Level of knowledge about sexuality among in-school very young adolescents

1. Have you heard about sexuality? Y N
If yes, explain what you know
2. Where did you get the information from?
3. What have you heard about Premarital sexual abstinence?
4. Where do you and your friends get information about sex, HIV, STDs, and pregnancy?
5. To what extent do you think HIV/AIDS is a risk to people of your age?
6. May you explain what you know about contraceptive use and where did you get such information?
7. Are people of your age more worried about pregnancy or HIV/AIDS or STI? Why?

Level of knowledge about sexuality among out of school very young adolescents

1. What do you know about sexuality education?
2. Where did you get this information from?
3. What do think about the depth of knowledge you have?
4. Why did you drop out of school so early?
5. What do you know about contraceptives and pregnancy prevention?
6. What do you think about the sex education that is provided in school?
7. what can you advise the school authorities about how sexuality education is being implemented?

8. What are your plans for the future now that you have had the experience of being out of School?
9. What proportion of young men/women of your age do you think are sexually active?
10. What can you tell other very young adolescents about sexuality education?

Parents, religious and local leaders' perceptions

1. What are parents', religious and local leaders' perceptions and concerns about very young adolescents' pregnancy in their community?
2. What do parents want for sexual and reproductive health education and programmes for their very young adolescents?
3. What do you think about the sex education that is provided in school?
4. How much information do parents, religious and local leaders want their very young adolescents to have about sexuality?
5. What concerns as guardians do you have over the very young adolescents regarding sexuality education?
6. As guardians to the very young adolescents, how do you feel when they are taught about sexuality in school?
7. What does your culture say about teaching sexuality education to VYAs?

Teachers capacities and level of knowledge

1. Have you ever taught subjects on sexuality among very young adolescents? Y N
If yes, what are your experiences when teaching these subjects?
2. What can you say about the training you received regarding sexuality education for VYAs?
3. What any other resources are available for the implementation of sexuality education?
4. See checklist for observations to be made during sexuality education subjects/lessons

Barriers

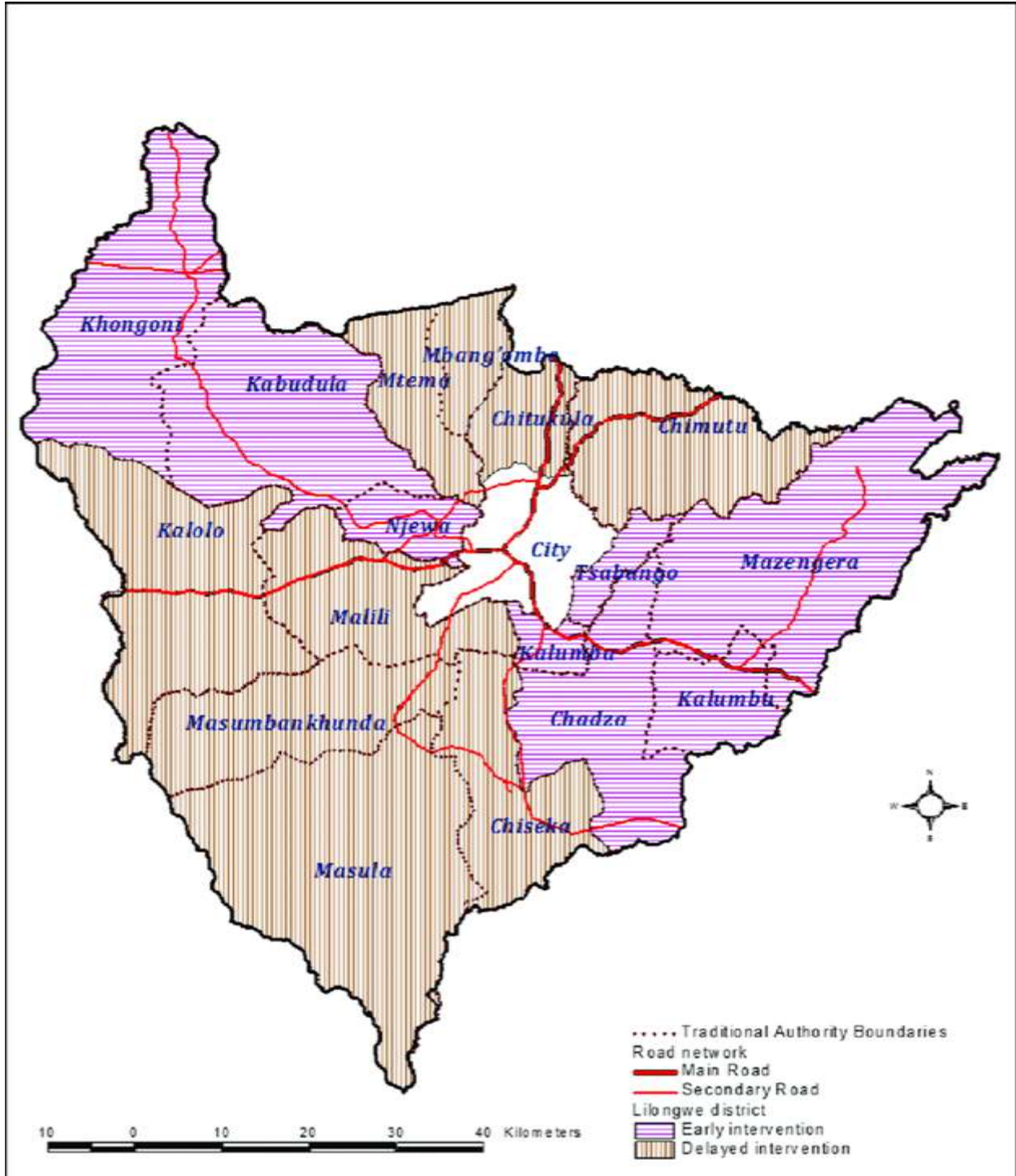
1. Are there any barriers to providing sex education in schools? If yes explain.

Appendix 12 : Classroom Observation Checklist

Time Table			Comments
DO Sexuality Education subjects appear on time-table	Yes	No	Yes they appear on the time tables
Are they taught	Yes	No	Yes
Frequency of teaching	Yes	No	1 to 2 times in a week
Skills			Comments
Preparation & organisation	Yes	No	No, 1out of 12 teachers had a lesson plan prior to teaching
Confidence	Yes	No	Yes
Friendliness	Yes	No	Yes
Clear Communication	Yes	No	No
Feedback to students	Yes	No	No
Resources			
Text books for learners	Yes	No	Yes but not enough for the whole class
Curriculum	Yes	No	Yes
Teaching manuals	Yes	No	Yes
Classrooms	Yes	No	Yes, though 1 school had no adequate school blocks. Learning under a tree.
Methods of teaching			
Discussions	Yes	No	Yes
Interactive	Yes	No	No
Demonstration	Yes	No	No
Gradable assignments	Yes	No	No

Adopted from International Guidelines for Effective Teaching

Appendix 13: Map of Lilongwe District



Appendix 14: COMREC Certificate of Approval



Appendix 15: Manuscript

Catch them young: Assessment of implementation of sexuality education for very young adolescents aged between 10 and 14 years in Lilongwe, Malawi: A qualitative case study

Esther Banda Latif¹, Aisha Twalibu², Noel Kalanga²

ABSTRACT

Background: Despite the introduction of sexuality education (SE) in primary schools in Malawi, a significant number of very young adolescents (VYAs) still experience early marriages, high teenage pregnancies and high school drop-outs. The extent to which SE is being provided is not known, hence this study assessed implementation of SE in rural primary schools in Lilongwe District.

Methodology: This was a qualitative case study, which purposively selected three schools from Chowo Education Zone, Lilongwe district. We conducted 12 Focus Group Discussions with VYAs aged between 10-14 years, 20 parents and 8 religious/traditional leaders. We also conducted in-depth interviews with 12 teachers, reviewed education and curriculum documents and conducted classroom observations. We used thematic content approach to analyze all the collected data.

Results: Most very young adolescents knew sexuality education topics such as importance of SE in prevention of early pregnancy and sexually transmitted infections. However, some out of school VYAs expressed lack of knowledge about sexuality issues. There were mixed reactions on how study participants perceived SE provided in primary schools; some participants supported the teaching of SE in schools while others, mostly traditional and religious leaders, felt SE in schools is not culturally nor age appropriate. Class observations revealed that most teachers were uncomfortable teaching SE and that lack of skills and resources, weak political will, culture and religion as barriers to effective implementation of SE.

Conclusion: Comprehensive sexuality education in Chowo Education Zone is not implemented according to the International Technical Guidance for Sexuality Education (2018).

PLAIN ENGLISH

Background: Malawi adopted comprehensive sexuality education (CSE) in primary schools as additional intervention to curb early marriages, pregnancies and school drop-out among young boys and girls. Despite the introduction of this, the extent to which it is provided is not known. A good number of very young boys and girls still experience early marriages, early pregnancies and early school drop outs. This study seeks to know how CSE implementation is done in rural primary schools in Lilongwe, Malawi.

Methodology: This qualitative case study selected three primary schools in Lilongwe rural. 12 focus group discussions done with learners and school drop outs (10 – 14 years of age), parents and religious/traditional leaders. 12 in-depth interviews with teachers, review of education documents was done and classroom observations conducted. Thematic content used to analyze data.

Results: Some very young boys and girls knew what sexuality is and its importance while others expressed lack of knowledge. Some parents supported the teaching of SE while religious/traditional leaders did not. Weak political will was among the contributing factors to its flourish. Classroom observations revealed teachers lacking teaching skills, resources of SE subjects.

Conclusion: CSE is not implemented according to International Technical Guidance for Sexuality education (2018).

Background

An adolescent is any person between ages 10 and 19 [1] and is further categorised into three stages: very young adolescence ages 10 to 14, middle adolescence ages 15 to 17, and late adolescence ages 18 to 21 [2]. Early adolescence entails rapid physical, social, emotional, and cognitive changes with major changes in health and health-related behavioral that have implications later in life [3] . Evidence suggests that the early adolescence period is when health information and services to enable boys and girls to navigate positively and responsibly with their sexuality [3]. Efforts such as youth friendly health services, improved access to family planning services and introduction of comprehensive sexuality education (CSE) in primary schools by the Malawi government have yielded very little. Early marriages, high teenage pregnancies and high school drop-outs are still common among very young adolescents. For example, in 2016 alone, there were 777,000 births from 10 to 14 year old adolescents in developing countries and 58% of these births took place in Africa [3].

In Malawi like some other parts of the world, adolescents face several challenges ranging from early marriages, high teenage pregnancies, gender-based violence, early sexual debut, high school drop-out, high abortion complications leading to maternal deaths [2].

Sexuality Education (SE) is a lifelong purposeful process that should begin earlier on in life [3]. The motivation for providing SE to in and out of school adolescents is to give precise information about human sexuality including but not limited to issues regarding sexual relationships, sexual abstinence and the use of contraception [10]. Sexuality education also helps young people develop skills in communication, decision-making, assertiveness, peer refusal skills, and the ability to create satisfying relationships [15]. Malawi introduced it in 2002 with the aim of

empowering pupils, students and their teachers with life skills for HIV prevention, sex and sexuality issues.

However, there is little evidence on how sexuality education is being implemented in primary schools among 10 to 14 year olds. The purpose of this study is to assess the implementation of sexuality education in the selected primary schools in Lilongwe district. The study was anchored by the Information Consistency and Desired Action Model, which assumes that “those information systems which have a high frequency of distribution and which are consistent in meaning stand a better chance of achieving the desired reaction within the community than those with low frequency and of distribution and which are inconsistent” [4].

Methods

2.1 Study Design

This is a qualitative case study research design. This type of design was chosen because a case study seeks to answer the question how and the focus of study is a contemporary phenomenon [30]

2.2 Study Setting

This study was conducted in Chowo Education Zone in Lilongwe Rural East Education Division between August 2018 and January, 2020. Chowo, Chimbalanga and Kalamba primary schools were purposefully selected due to high school dropout recorded, about 50 out of 100 of the total number of girls who were in standard 7 and 8 between 2015 and 2017 [School registers]. Lilongwe district is situated in the central region of Malawi with a population of 905,000 people with 234,763 very young adolescents [22].

2.3 Sample sampling

Our research was conducted within the constraints of a low budget for a student researcher and different schedules of participants (teachers, parents, VYAs, traditional and religious leaders) which meant that sampling and recruitment of study participants to be focused and flexible. All the study participants were purposively selected so that they could provide the relevant information regarding their experiences and perceptions on SE [30]. Learners, teachers, religious and traditional leaders were included bearing in mind that each group will provide different responses regarding the subject matter. Learners showed to have some knowledge about SE and it is important to learn in school while drop outs had no prior knowledge to help them prevent pregnancy. Teachers had knowledge but lacked skills to teach while parents and religious leaders had mixed reactions, some were for it while others were not.

The sample included 36 in-school very young adolescents (12 from each school selected), 20 out of school very young adolescents, 12 school teachers (4 from each school), 8 traditional/religious leaders and 20 parents of VYAs from all 3 selected sites were randomly selected and interviewed for the study. Thus, the final sample was 96 participants. 96 was thought to be a good representation because the study took place in three primary schools [three different cases] involving six groups of study participants mentioned above. The sample size was reached after reaching saturation point where no new information was provided by participants [49].

2. 4 Data collection

We collected data through focus group discussions (FGDs), in-depth interviews, classroom observations and review of documents. Using an open-ended FGD and interview guides, we conducted 12 FGDs with in-school and out-of school VYAs, parents, and traditional/religious leaders and 12 in-depth interviews with teachers respectively. The participating in-school VYAs

were identified by the teachers while those out-of-school were identified by both teachers and Health Surveillance Assistants (HSAs) working in the areas. The interviews with VYAs and parents were conducted in Chichewa upon translation of the guides from English. Interviews with teachers were conducted in English as teachers could easily comprehend the English language. Responses from both FGDs and in-depth interviews were recorded using an audio recorder and notes were taken.

We also conducted 9 classroom observations, 3 from each school while Life Skills and Social Studies subjects were taught using a checklist to gain a first-hand insight into classroom discussions, classroom practices, and curriculum enactment. The checklist included availability of posters that have messages of sexual health in all three schools. The observations were recorded using our checklist and thereafter compared to what was on the adopted standard checklist.

We also reviewed a number of education documents such as International Technical Guidance for Sexuality Education 2018 to see if Malawi is implementing according to the prescribed standards. The National Education Policy (2007-2017) was also reviewed to see the presence of strategies on how to successfully implement CSE in primary schools and the Initial Primary Training Education syllabus to see areas covered. Teachers' guide and learners' text books for standard 5, 6, 7 and 8 were also reviewed to look at the content and depth of the information provided. Notes were taken from observations and review of documents.

Methodological triangulation was achieved by gathering data by means of different data collection methods such as focus group discussions, in-depth interviews, education documents review and classroom teaching observations. Participants were repeatedly asked using probing questions in order to explain further and clearer on the subject under discussion to obtain credible data [50]. Responses from both FGDs and in-depth interviews were recorded using an audio recorder and

also written in the notepad. At the end of each FGDs and interview a summary was conducted to verify with the participants on information provided to achieve trustworthiness [50].

In addition, the researcher had a long-lasting engagement in the field with participants which gave enough time to become familiar with the study setting and context.

2.5 Data analysis

The audio recordings were transcribed verbatim, reviewed in comparison to field notes before translation (for the Chichewa FGDs and interview). During pre-analysis, the researcher and research assistant reviewed all transcripts and emerging themes were recorded.

The data analysis followed Graneheim and Lundman steps of thematic content analysis (TCA) from [32]. First, the researcher and her assistant listened to all interviews and reviewed all transcripts thereby getting a better understanding of the data set. Second, six codes were developed from both research objectives and FGD/interview guides. Third, all related words or statements were grouped into units and then the data was reduced into basic content for easy understanding, followed by coding the data and creating categories depending on commonality or dissimilarity. Fourth, researcher developed themes and sub-themes from the categories based on four (4) content areas which are: knowledge about sexuality issues, perceptions towards sexuality education in primary schools, teachers' capacities to teach sexuality subjects, and barriers to effective implementation of sexuality education. The analysis was carried out simultaneously with the collection of information. In the end the researcher merged the data set to look for convergences and similarities of the data.

2.7 Ethical considerations

Ethical approval was obtained from College of Medicine Research Ethics Committee (COMREC), reference number P.05/18/2475. To ensure the protection of participants, ethical principles were

followed. The researcher obtained informed consent from participants. Furthermore, participants were assured about confidentiality in that their names would not be revealed and that privacy would be respected. All interviews or discussions were held in closed rooms labeled “Do not disturb, meeting in progress” outside the door.

Results

In this section we will report the findings on our main outcomes: knowledge about sexuality issues, experiences, and perceptions of learners, teachers, and parents about sexuality education offered in primary schools, the capacity of teachers to teach sexuality subjects, and barriers to effective implementation of CSE in primary schools.

3.1 Socio-demographical characteristics for study participants

The study had 96 participants. Thirty six in-school boys and girls with 18 were between the ages of 10 and 12 while the other half were above 12 to 14 years of age. Twenty were out of VYAs (all girls). Ten were parents of which 4 were men and 6 were women all belonging to the school management committee. Ten were traditional leaders 6 men and 4 women, 8 were religious leaders all men and lastly 12 were teachers (6 males and 6 females). Most of the participants had attempted school up to the primary level and Christianity was the most common religion practiced by study participants.

3.2 Knowledge about sexuality issues

All teachers had comprehensive knowledge about sexuality while most in-school VYAs had some knowledge on sexuality education that was acquired from school unlike the out of school participants who were less knowledgeable. The in-school VYAs knew about HIV/AIDS, sexually transmitted infections (STI's), premarital abstinence and pregnancy prevention. In demonstrating knowledge on sexuality education, one VYA participant had this definition:

“Sexuality education is learning about sexual relations among males and females and all issues associated with it”. [In-school VYA 11 & 16 FGD].

VYAs had knowledge of some contraceptives that can be used to prevent pregnancy. Interestingly, it was noted that VYAs who were out of school knew about contraception but after they dropped out of school due to pregnancy. Participants shared their thoughts of how they could have prevented pregnancy had they known about contraceptives while still in school:

“We heard some of the names of the contraceptives from the hospital when we started attending under-five clinics with our babies` otherwise we wouldn` t have been in the situation we are no ”.

[Out-of-school VYA-1, 5, 9, 10 &15 FGD)].

Teachers acquired knowledge on sexuality education through reading in order to plan and teach CSE in schools.

“As teachers, we know what sexuality is all about. We have subjects like life skills and social studies that sexuality topics are incorporated in. So as we prepare for the lessons to teach, we read.” (Male Teacher-1[KII]).

Despite the teachers’ knowledge of sexuality education, it was observed that they were unable to put it across to the learners. The teachers felt uncomfortable to teach reproductive topics.

3.3 Perceptions of sexuality education

Participants had mixed reactions towards provision of sexuality education in primary schools to VYAs. VYAs verbalized that sexuality education gives them the right information on how their bodies work, how to prevent STI and HIV infections and also it teaches about abstinence. Furthermore, VYAs voiced out the importance of SE in schools as that seems to be one of the few

platforms that can provide information on such a subject. Parents for example were said to be uncomfortable in talking about sexuality as some participants remarked:

“It is good that we learn sexuality in school because our parents cannot talk about these things with us at home.” (In-school VYA-30, 36 &13 [FGD]).

In agreement to what the VYAs had said, some parents were in support of SE which is taught in school as they acknowledged that it is difficult for them to teach their children about sexuality at home. They also recommended the importance of highlighting abstinence before marriage.

“Sexuality education taught in schools is good and important. However, emphasis should be placed on abstinence until marriage”. (Parent- 4 [FGD]).

However, there were some parents who had reservations with SE in school. These parents considered VYAs as immature for such information. In addition, the perception was that SE in primary schools promotes teen pregnancies leading to more drop outs. They questioned the impact of SE in school on behavior.

“Such information is given to immature minds too soon, what do they expect a twelve-year-old to do with such information?”. (Parent- 9 [FGD]).

The documents showed that the content was age appropriate only that in rural settings this is not the case.

This perception by the parents can be attributed to increased cases of teen pregnancies in the schools. Our study also showed that some learners got pregnant because they wanted to experiment with what they had learned in class. It is these experiences that overshadow the importance of SE for VYAs in school.

“After I learnt, I went to experiment if what the teacher said was true.” (out-of-school VYA- 30 [FGD]).

While the parents considered VYAs as immature and very young to be introduced to SE, teachers had a contradictory view. They were of the view that many students learn SE a bit late. The curriculum is designed according to expected ages in these classes. In practice this is not the case at times. Although SE starts in middle primary school (standard five) and targets 10 or 11 year old students, in reality many of the students are advanced in age (14 to 16 years) due to repeating a class and late debut into school among other reasons. Document reviews showed that the SE material provided was age and class (grade) appropriate. The only challenge was the lack of consideration of those learners who delay in school due to repetitions and starting school late which is common in rural areas.

3.4 Teachers' capacity to teach sexuality subjects

The study findings reveal that teachers lack appropriate skills to teach sexuality subjects in primary schools as evidenced by the lecturing teaching method used in all three schools. There were some teachers who were trained a long time that expressed a lack of knowledge about sexuality education. At the time of their training, the teachers training colleges did not provide lessons on sexuality education subjects that are being taught in schools nowadays. Class observations showed that teachers were not confident and male teachers were very uncomfortable. They chose topics which they had taught in the past months about HIV mostly as opposed to reproductive health systems topics. It was also observed that the teachers avoided topics that were explicit such as reproductive health system that human private body parts. The teachers attributed this to lack of demonstration skills and cultural barriers.

“There was no practical part of teaching sexuality subjects hence now difficult to implement on the ground.” (Male Teacher- 3 [KII]).

“The only thing which worries us most is the terms used in some topics like, The Reproductive System sound obscene culturally”. (**Female Teacher- 7 [KII]**).

Further to this, through class observations and review of time tables, we discovered that Life Skills and Social Studies were taught once or twice in a week despite featuring everyday on the time table. This was confirmed by the teachers upon an inquiry. Their explanation was that priority and more time was given to other subjects like Mathematics, English, and Agriculture.

3.5 Perceptions of parents and local leaders on SE to VYAs

Most parents, religious and traditional leaders welcomed teaching of SE in schools. They entrusted teachers to take on this role of imparting sexuality knowledge on VYAs because of their training. They parents and leaders considered themselves under equipped in providing sexuality education to VYAs. However, they did not agree with the approaches used at the moment. They also thought that the taught content was advanced for standard three pupils whom they considered too young for such content.

“We don’t know how these people at the ministry of education think about teaching sexuality as early as in standard three, mmhu (clapped hands).” (**Religious leader- 15 [FGD]**).

In addition, some parents expressed fear of what they called dilution of culture since culturally sexuality issues are not discussed with children until they reach puberty age at about 12 years and above. Parents mentioned embarrassment when they hear what their children are discussing after learning SE in school.

3.6 Barriers to effective implementation

The study also revealed that poor coordination among stakeholders results into ineffective implementation of SE in primary schools. Teachers mentioned lacking support from parents, leaders in the communities, and health workers as the responsibility seems to be left to them alone.

Furthermore, cultural and religious beliefs, and lack of resources impacted negatively on the implementation. One teacher explained:

“There is poor or I can say weak collaboration between the schools, the communities and the health sector because we need to be speaking the same language when it comes to sexuality issues to these adolescents. When we tell them the truth about reproductive system and how a girl can become pregnant, parents tend to hide the information so these learners are confused and they do not know who to believe. Colleagues from the health sector should be able to assist teaching these sensitive topics since it is their area of expertise. It would be helpful for parents, traditional/religious leaders and health workers to complement one another.” **(Female teacher 2 [KII]).**

The study also found that teachers had huge workload, hence they concentrate on other simpler subjects and that training colleges prepared them to teach SE, while some teachers said their training was on methodology and not specialized. Another teacher explained:

“As teachers we have too much workload as a result priority is given to other basic subjects like English, Mathematics and Chichewa and not to elementary subjects like social and life skills hence no enough time is given to these subjects.” **(Male Teacher 5 [KII]).**

A review of the initial primary education curriculum revealed that sexuality subjects are included but emphasis is on teaching methodologies and not the actual content taught. The study further shows that lack of skills to teach affects the implementation of SE. One teacher explained like this:

“We had good training in college but the focus was on teaching methodology only and not how to teach sexuality subjects specifically as is the case with secondary school teachers.” (Male Teacher-6 [KII]).

Lack of resources was mentioned as one of the barriers in the implementation of sexuality education by teachers. It was observed that there were no posters in the classrooms which could be used as visual aids for teaching and no enough text books as one book was shared among 7 learners. Another teacher had to say this:

“Lack of resources is big barrier, there are no enough learners’ text books to use since some things learners need to see with their own eyes what a teacher is talking about.” (Male Teacher 8 [KII]).

Culture and religion have been found to be some of the barriers in the implementation of sexuality education in Malawi.

“As a teacher, I am also a church elder, it is very difficult mentioning these things to children in class and then on Sunday they hear me preaching the word of God.”

Male Teacher 11 [KII].

Some traditional leaders stated that such information should be culturally sensitive since in Chewa culture, such information is offered in other avenues like initiation ceremonies. Religious leaders and teachers said teachers who are also religious leaders get torn between abiding by their beliefs and teaching as per the syllabus. The study found that National Education Policy has no statement which talks about the provision of CSE in primary schools. Also, it found that the guidance which is provided in the ITGSE is not followed during implementation.

Timetables showed that sexuality subjects were appearing five times a week but it was observed that it was taught once or twice a week.

“We give priority to other important subjects like English and Mathematics, not these other subjects.” **Female Teacher 8 [KII]**.

4.0 Discussion

This was a qualitative case study that aimed at assessing how comprehensive sexuality education is being implemented in primary schools among VYAs in Lilongwe district. This study is among the few studies in Malawi to assess CSE among very young adolescents. The main findings from this study suggest that VYAs are aware about CSE provision in primary school.

The study highlights the importance of CSE to VYAs. While our results suggest that both VYAs and teachers consider CSE important, VYAs lack in depth knowledge on the subject. This can be attributed to teachers’ lack of skills to teach the detailed information as prescribed in the curriculum. In addition, the curriculum is not age appropriate according to rural settings where children start school late and there is a lot of class repetition. In the study area most learners were older i.e. aged 14 and 15 years old, for the assigned standard 3 class meaning that the lessons were getting was below their physical and psychological development. Teachers mentioned that they were not specifically trained to teach CSE but rather received general training on teaching methodologies. Since training of teachers is one of the most important factors to effective implementation of sexuality education [36], this result is not surprising. Further to this, a study which was conducted in Malaysia found that the effectiveness of school-based sexuality education programs depends highly on teachers [37]. Thus we can conclude that without well trained teachers on CSE, the delivery of CSE might not be as effective thereby resulting in lack of in depth knowledge of CSE among VYAs. Without the required training on CSE, teachers might not provide SRH information and education that is medically accurate, complete and age appropriate among VYAs as recommended by a study conducted in Malaysia [51].

The study also highlights religion and culture as barriers to effective implementation of CSE in primary schools in Lilongwe district. A considerable number of teachers, parents, traditional and religious leaders were not in support of providing CSE to VYAs because they felt it goes against their cultural and religious beliefs. Other studies have also found religion as a barrier to effective implementation of CSE because in most organized religions, matters of sexuality and family formation are paramount concerns, as they represent fundamental human behaviours that religions attempt to shape and control [39]. Another study on culture and CSE found that if CSE is to be accepted by all implementers it has to be culturally and age-appropriate [40]. However, recently some studies have shown that when young people have age-appropriate sexual information, their questions answered, and open communication with trusted adults, they are more likely to make healthy choices.

Religion being mentioned as one of the barriers to effective implementation of sexuality education, other recent studies have shown that when young people have age-appropriate sexual information, their questions and open communication with trusted adults, they are more likely to make healthy choices [38]

A review of the ITGSE showed that the document is key in the evolving field of comprehensive sexuality education, importance of sexuality education and how comprehensive sexuality education can be effectively delivered [44]. This document is a reference manual on how sexuality education is supposed to be implemented. Malawi has adopted the comprehensive sexuality education program which is integrated in Life Skills and Social Studies subjects. However, Malawi national education policy has no policy statement to support the implementation of comprehensive sexuality education provision in primary schools, which might be contributing towards the

challenges in implementation, since for a programme to flourish it needs a clear and enabling policy and legal environment [8].

Cross-checking teaching time-tables and class observations revealed that life skills and social studies subjects which include sexuality topics appeared every day, five times in a week but taught once to twice in a week. In all the research sites sexuality education was or is not being delivered as intended. In most of the implementation sites studied, certain lessons have been skipped or shortened, especially those on sensitive topics such as masturbation, homosexuality and abortion [42]. This was also evident with this study. Responses from VYAs also revealed that they don't learn life skills every day, while some teachers said priority is given to other more important subjects like Mathematics, English and Agriculture. In addition, teachers mentioned lack of materials for teaching like visual aids as one of the factors contributing to ineffective implementation of CSE.

Some studies have cited that teacher training remains a weak point in most school-based sexuality education programs [45]. However, from the teacher training syllabus, this study found that teachers are prepared on the methodologies to deliver sexuality education among other subjects which they are expected to teach. This being the case, it means the training may require specific adjustments to the delivery of sexuality subjects. Classroom observations revealed that teachers used mainly lecturing and rarely group discussions as the methods of teaching, which is contrary to UNFPA's operational guidance which recommends that the most effective methods for teaching about sexuality, HIV, gender, and rights are participatory, learner-centered educational methods [8]. .

Strengths and limitations of the study

This study has added to the current knowledge on how implementation of comprehensive sexuality education is done in primary schools. The use of multiple stakeholders in the issue gives a comprehensive picture of the matter. In addition, it has identified barriers to the effective implementation of comprehensive sexuality education. Furthermore, the findings will inform policy makers and the education sector as a whole to fine-tune the implementation strategies which are currently being used mainly to suit rural settings. However, this study also has limitations. First, the three primary schools sampled could not be a representation of all primary schools in the district and Malawi as a whole. Second, the study took place in a rural setting, issues affecting the implementation of comprehensive sexuality education may be different from those in urban settings and that the views presented by the purposively selected study participants could not represent all people in the area, others could have given different opinions.

Conclusion

The study has shown that in Malawi, initial primary education training focuses only on teaching methodologies. The need to develop and update training curricula and support teachers to examine their own values and biases remains a priority in the success of CSE implementation in primary schools [48]. It requires repackaging of both the content and mode of delivery with the support of teachers and other stakeholders. It is important to note that the presence of a national policy or curriculum that supports CSE does not necessarily associate with effective implementation of CSE especially for VYAs.

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