Comprehensive Sexuality Education

AN ASSESSMENT OF THE IMPACT OF THE IMPLEMENTATION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) IN ZAMBIA

FINAL IMPACT REPORT

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Research Team

This assessment of the impact of the implementation of Comprehensive Sexuality Education is as a result of a collaborative working process that took place among Lutandi, Make Way and Forum for African Women Educationalists of Zambia (FAWEZA). The research team was comprised of Tasila Mbewe-Lead Consultant; Liseteli Ndiyoyi-Data Analyst; Thandiwe Moomba and Pressly Sialwaambi -Research Assistants.

Executive Summary

The main purpose of the study was to assess the impact of the implementation of comprehensive sexuality education (CSE) in Southern, Eastern, Lusaka, Copperbelt and North Western provinces. The schools selected were from Lusaka, Kazungula, Kalomo, Monze, Kitwe and Zambezi districts. The study further examined the gaps that still exist and determine why teenage pregnancies continue increasing despite Zambia implementing CSE and provide recommendations to the ministry of education, implementing partners and the community.

The study employed a mixed method approach to collect both qualitative and quantitative data from the male and female pupils, teachers trained in CSE, guidance and counseling teachers, district resource center coordinators, headteachers and the parents. A total of 315 (54.8%) females and 260 (45.2%) male pupils from grade 5 to 12 were selected using stratified random sampling. 20 focus group discussions were carried out with the male and female pupils; 4 interviews were conducted at district and school level; while 24 in-depth interviews were held with the guidance and counseling, teachers trained in CSE, head of departments (HODs) and club patrons.

The study shows that CSE is being implemented in the selected schools and teachers have been trained and oriented to ensure effective delivery in the carrier subjects. This has resulted in male and female pupils opening up to their teachers who are trained in CSE and guidance and counseling, reporting cases of harassment. These teachers are able to offer direction to the pupils when approached for help.

The study further establishes that CSE has enabled both male and female pupils understand the dangers of pregnancy (57%), Sexually transmitted infections (STIs) (56.7%) and early and forced marriages (51.8%). The introduction of Comprehensive Sexuality Education (CSE) in schools was meant to ensure that learners do not get confusing and misleading messages concerning their sexuality, gender issues and relationships. Pupils should not only have knowledge on pregnancy prevention and safe sex, but also understanding their bodies, boundaries, relationships and respect.

Overall, male and female pupils (65.6%) have access to sexual and reproductive health services and information. This is accessed through health facilities and information is obtained mostly from the schools. Majority of the pupils (81.6%) indicated that adolescent sexual and

reproductive health (ASRH) services are appropriate for both male and female as well 75.4% of the respondents stated that information obtained from the school is suitable for both sexes. Comprehensive sexuality education aims at empowering learners with necessary skills, right attitudes, and values relevant to help them make informed decisions concerning their sexual life. It also helps to impart critical information and skills for life.

The major sources of ASRH information among the male and female pupils is television (41.1%), teachers (31.2%) and the radio (31.2%).
There are gaps in the implementation of comprehensive sexuality education and this is due to the religious and cultural beliefs among the teachers. The teachers are apprehensive and uncomfortable discussing sex, sexuality and reproduction with the young people for fear of encouraging more promiscuous behaviour. Age was also cited as a hindrance especially for the grade fives who are coming from different backgrounds, socio-economic status and when they attain puberty. From the pupils, the study shows that the males and female are also not comfortable with certain topics to be delivered in the CSE framework. Topics such as sexual behaviour (43.7%) and relationship (38.6%) are not appropriate with the religion and culture.

Key findings from the study shows that male and female pupils talk to their friends about sex (39.5%), sexual & reproduction health (40.5%), feelings for the opposite sex (60.9%), relationships (62.7%) and body changes (46%). Despite the Ministry of Education using comprehensive sexuality education (CSE) as a way of reducing various challenges faced by learners with regards to their sexuality education, the effectiveness and mode of implementing CSE is a source of concern.

From the study 72.3% indicated that school related gender-based violence still exists in the selected schools and cited bullying as the major problem. Factors associated with adolescent pregnancy are complex and often intertwined and driven by various social, economic, and sexual-relations patterns that are further influenced by other underlying issues such as age, peer-group experiences, gender dynamics, and vulnerabilities created by various circumstances in which adolescents find themselves.

The study reveals that teenage pregnancy is high at national level with 12,330 reported cases in 2020 and 5,078 readmissions. Factors contributing to teenage pregnancies include, poverty, lack of guidance from the parents, socio-economic status of the parents/guardians, peer pressure, lack of security for the weekly boarders and this increases the girls' vulnerability.

Further, male and female pupils indicated that they have unprotected sex (71.1%). Engaging in sexual risk behaviours has contributed to the teenage pregnancies. In the peri-urban areas like Lusaka, bars are not enforcing the age limit and some of the girls engage in transactional sex in exchange for money, goods, and services.

The best practice identified in the study include the training and orientation of teachers in the schools; partnership with the communities; links between the schools and health facilities as well as the establishment of the guidance and counseling units in schools. The continued training and orientation of teachers to deliver CSE will ensure that information and education is being delivered in a standardized, effective, high-quality manner as well as ensuring that the content of CSE is informed by the lived experiences of the pupils.

The study concludes that comprehensive sexuality is being implemented in the selected schools and delivered by the teachers trained and oriented. However, there are still gaps that need to be addressed. Based on the findings, the study concludes that there are various factors that are contributing to the teenage pregnancies stemming from the homes where the pupils come from and also the environment in which they live. If left unchecked, this has potential to comprise both the health and education outcomes of the young people.

Table of contents

List of Tables

List of Charts

List of figures

Acronyms

ADH	Adolescent Health
AIDS	Acquired immunodeficiency syndrome
ASRH	Adolescent Sexual Reproductive Health
AIDS	Acquired immunodeficiency syndrome
AGM	Annual General Meeting
CSE	Comprehensive Sexuality education
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
DEBS	District Education Board Secretary
DRCC	District Resource Center Coordinator
EUP	Early and unplanned Pregnancy
FAWEZA	Forum for African Women Education of Zambia
FGD	Focus Group Discussion
FLHE	Family Life & HIV/AIDS Education
GPS	Global Positioning System
HIV	Human Immunodeficiency Virus
HOD	Head of Department
IDIs	In-depth interviews
IPPF	International Planned Parenthood Federation
IWHC	International Women's Health Coalition
KIIs	Key Informant interviews
L-SHE	Life Skills and Health Education
MCDMCH	Ministry of Community Development, Mother and Child Health
MOE	Ministry of Education
MoES	Ministry of Education and Sports
MoH	Ministry of Health
NGOs	Non-Governmental Organisation
RE	Religious Education
RHSE	Reproductive Health and Sexuality Education
SAT	SRHR Africa Trust
SDGs	Sustainable Development Goals
SHARE	Safe, Happy and Responsible
SRGBV	School-related gender-based violence
SRHRs	Sexual Reproductive Health Rights

SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Diseases
TORs	Terms of Reference
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
WHO	World Health Organisation

1.0 Basic Information about the research

This part of the report provides the basic information on the research that was conducted in Lusaka, Kazungula, Kitwe, Kalomo, Monze and Zambezi. It contains the background information, objectives, research questions, purpose of the study and the findings on the impact of comprehensive sexuality education (CSE) since it was introduced in 2014. The study also aims to provide the Ministry of Education, FAWEZA, SAT and Plan International with recommendations on what has to be done going forward, including implementation and advocacy efforts.

1.1 Introduction

The report provides the findings on the impact of the implementation of CSE, best practices adopted in the schools, assess the existing gaps in the implementation of CSE, investigate the reasons for continued increases of teenage pregnancies regardless of the implementation of CSE in the primary and secondary schools selected in Lusaka, Kazungula, Kitwe, Kalomo, Monze and Zambezi respectively. A total of thirteen (13) schools were selected in the study with four (4) from Lusaka - Chawama Primary, Timothy Mwanakatwe Basic School, Kanyama and Kamulanga; two (2) from Kazungula -Nyawa Secondary and Malimba Basic; two (2) from Kalomo- Njezya and Chibomboma; two (2) from Monze- Mwanza Basic and Bbwantu Primary School; two (2) from Kitwe - Chamboli Secondary School and Chimwemwe Secondary School and one (1) from Zambezi -Zambezi Secondary School.

A total of five hundred and seventy-five (575) questionnaires were administered to the pupils with 315 being females and 260 males.

Ten (10) interviews were conducted with the headteachers and six (6) with the guidance and counseling in the selected schools. Six (6) teachers trained in CSE were also interviewed, two (2) club patrons and one (1) Head of Department (HOD). Focus groups were also conducted with male and female pupils. A total of 10 FGDs with females and 10 with the male pupils were conducted.

The report has been prepared as part of the Terms of Reference (ToR) guiding this assignment. The conclusion and recommendation are included in the report.

1.2 Project background and context

Adolescents and young people in Zambia face sexual and reproductive health (SRH) challenges.[1] The magnitude of the problem is evidenced by high teenage pregnancies, early marriages and sexually transmitted infections (STIs).

The Ministry of Education, with collaborating partners, developed CSE policies, and a comprehensive curriculum to address the challenges faced by learners in their day-to- day lives.[2] In 2014, Zambia introduced a nation-wide program for comprehensive sexuality education (CSE) to be implemented in schools by teachers. The curriculum is firmly based on a discourse of sexual and reproductive rights, not commonly found in the public debate on sexuality in Zambia. Sexuality in the Zambian education system has been shrouded in silence as it is viewed as inappropriate to openly discuss issues of sexuality in public.[3]

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

The introduction of Comprehensive Sexuality Education (CSE) in schools was meant to ensure that learners do not get confusing and misleading messages concerning their sexuality, gender issues and relationships. It also aimed at empowering learners with necessary skills, right attitudes and values relevant to help them make informed decisions concerning their sexual life. It also helps to impart critical information and skills for life. These not only include knowledge on pregnancy prevention and safe sex, but also understanding bodies and boundaries, relationships and respect, diversity and consent.[4]

The interventions include core CSE content, delivery methods, training materials and resources and teacher-training. Broad system characteristics of CSE include strengthening links between

[1] Chavula, M.P. (2019) Factors influencing the integration of comprehensive sexuality education into educational systems in low- and middle-income countries: a systematic review. Retrieved from https://pubmed.ncbi.nlm.nih.gov/36175901/
[2] Ministry of Education, Science, Vocational Training and Early Education (2013)
[3] Zulu, M et.al. (2019) Why teach sexuality education in school? Teacher discretion in implementing comprehensive sexuality education in rural Zambia. Retrieved from https://pubmed.ncbi.nlm.nih.gov/31558168/
[4] Ministry of General Education (2015)

schools and health facilities, school and community-based collaboration, coordination, and the monitoring and evaluation of CSE.

The report highlights the impact of the implementation of comprehensive sexuality education (CSE) in Southern, Lusaka, North-western and Copperbelt provinces in Zambia. The overall purpose of the study was to assess the impact of the implementation of CSE since it was introduced in Zambia in 2014 as well as examine the gaps that still exist and investigate reasons why numbers of teenage pregnancies continue increasing and make recommendations to the Ministry of Education, FAWEZA, SAT and Plan International as cooperating partners

2.0 Description of Assignment

2.1 Main purpose

The main purpose of the survey was to assess the impact of the implementation of CSE in Zambia since it was introduced in 2014 as well as examine the gaps that exist and investigate reasons why numbers of teenage pregnancies continue increasing despite the country implementing a robust CSE programme.

2.2 CSE Assessment objectives

1. To determine the impact of the implementation of CSE and document best practices
2. To assess the existing gaps in the implementation of CSE
3. To Investigate the reasons for continued increase in cases of teenage pregnancies regardless of the implementation of CSE in the schools.
4. To provide the Ministry of Education, FAWEZA, SAT and Plan International with recommendations on what has to be done differently going forward, including implementation and advocacy issues

2.3 Key Questions

1. What is the impact of the implementation of CSE and what are the best practices in Zambia?
2. What are the existing gaps in the implementation of CSE?
3. What are the reasons for continued increase in incidences of teenage pregnancies regardless of the implementation of CSE in Zambia?
4. What recommendations can be provided to the MoE and other stakeholders such as FAWEZA on what has to be done going forward, including implementation and advocacy issues?

2.4 Structure of Report

This report is structured as follows:

Section 1: Executive Summary – This chapter presents a summary of the findings at school and community levels as well as the conclusion and recommendations.

Section 2: Introduction – This chapter provides a general background to the study together with study objectives and purpose of the assessment of the impact of comprehensive sexuality education (CSE).

Section 3: Literature review – This chapter provides a global, Sub-Saharan Africa as well as the country context discussion of the impact of CSE.

Section 4: Methodology – This chapter provides a detailed account on the approach adopted in handling the assignment. It also provides details on mobilization as well as the targeted communities, participants and challenges during data collection.

Section 5: Findings: The Chapter presents findings from the survey. That is from the pupils, headteachers, teachers trained in CSE, Guidance and Counseling teachers as well as the parents/guardians through questionnaires, in-depth interviews and focus group discussions.

Section 6: Conclusion and Recommendations – This Chapter presents recommendations on what has to be done going forward, including implementation and advocacy issues.

Finally, the report contains annexes as follows:

Annex I Terms of Reference
Annex II School Questionnaire
Annex III Interview Guides
Annex IV Focus Group Discussion Guide

2.5 Literature Review

This section of the report presents literature review. Secondary data analysis was undertaken to analyse and explore the impact of comprehensive sexuality education with insights from the global perspective, Sub-Saharan Africa and Zambia. This was undertaken to help in understanding how CSE is implemented in various countries and determine the best practices to recommend and carry forward.

2.5.1 Global Perspective

Comprehensive sexuality education (CSE) has strong support in the international discourse and is supported by a relatively robust evidence base. Bonjour & Vlugt reveals that sexuality education has a long history in most of the Western European countries, the United States of America (USA) and the Global South.[5] Sexuality education has been developed by responding to emerging issues in society. The attention to sexuality education is constantly being influenced by norms and values on sexuality and young people and the current political climate in a given country including Zambia.[6]

According to the American College of Obstetricians and Gynecologists, sexuality education programs vary widely in the accuracy of content, emphasis, and effectiveness.[7] Data have shown that not all programs are equally effective for all ages, races and ethnicities, socioeconomic groups and geographic areas. The United Nations Populations Fund (UNFPA) adds that the right of access to comprehensive sexuality education is grounded in fundamental human rights and is a means to empower young people to protect their health, well-being, and dignity.[8] The United Nations Populations Fund expands the concept and adds that sexuality education should be included in the education programmes and curricula and should include respect for human rights and diversity with sexuality education affirmed as a right; critical thinking skills, promotion of young people's participation in decision making and strengthening of their capabilities for citizenship; fostering of norms and attitudes that promote gender equality and inclusion; addressing vulnerabilities and exclusions; local ownership and cultural relevance and a positive life cycle approach to sexuality.[9]

[5] Bonjour & Vlugt (2018)
[6] Bonjour & Vlugt (2018)
[7] American College Obstetricians and Gynecologist (2016)
[8] UNFPA (2014)
[9] UNFPA (2014)

Ketting & Ivanova observes that the delivery of CSE differs widely between and even within countries.[10] Despite the differences, the assessment in sexuality education in Europe and Central Asia has become the norm in most countries. Remarkable progress has been made in the European region in developing and integrating sexuality education curricula in formal school settings. Bonjour & Vlugt explains that formal CSE occurs in an education or training institution, and provides structure in terms of learning objectives, learning time/support and delivery which can, but doesn't have to, lead to a recognized qualification. In school, this can be implemented as part of the school curriculum or other activities within the school timetable.[11]

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

2.5.2 Sub-Saharan Africa (SSA)

Rutgers reports that in Burundi and Uganda, the space for civil society is shrinking and opposition to CSE growing.[12] IPPF emphasizes that, attention should be paid on who delivers CSE, where it is delivered, what is delivered, when it is delivered and how it is delivered.[13] Without paying close attention to pedagogy, countries will not be able to ensure that they reach young people in a considered and participatory way. Without training educators to deliver CSE, it is difficult to ensure that information and education is being delivered in a standardized, effective, high-quality manner as well as ensuring that the content of CSE is informed by the lived experiences of young people.[14]

In Nigeria, the creation of the National Guidelines on Sexuality Education set the stage for the Federal Government's forward movement on sexuality education, including the adoption of the Guidelines and their subsequent delivery of CSE in schools.[15] Ford Foundation reports that the delivery of CSE varies across schools in Nigeria..[16] A study by researchers at the University of Ibadan found that the percentage of secondary schools within states providing Family Life and HIV/AIDS Education (FLHE) ranged from 13.5 to 100%, and most states have no budget line for

[10] Ketting & Ivanova (2018)
[11] Bonjour & Vlugt (2018)
[12] Rutgers (2018)
[13] IPPF (2016)
[14] IPPF (2016)
[15] Schiffman et. al. (2018)
[16] Ford Foundation (2014)

the program.[17] A study on program delivery of CSE found multiple challenges, including a limited number of trained teachers, leading to the curriculum being delivered by untrained teachers; crowded classrooms; insufficient learning materials; and inadequate monitoring mechanisms.[18]

In Uganda, the Ministry of Education and Sports (MoES) developed the National Framework on Sexuality Education through wide consultations with a cross section of stakeholders. The framework is intended to create an over-arching national direction for providing young people with sexuality education in the formal education setting.[19] The delivery of CSE in Uganda is organized into four key themes, each of which encompasses one essential area of learning for young people. The themes include Human Development, Relationships, Sexual Behaviour and Sexual Health. Each key theme is broken down into a number of specific topic areas i.e. individual subjects that need to be covered in order to sufficiently address each key theme so that the learners may achieve the desired education and health outcomes.[20] The framework particularly targets at learners in educational institutions, and these are categorized into five separate age-groupings. The levels are: 1) Early Childhood: - 3 to 5 years; for pre-primary learners in nursery. 2) Lower Primary: - 6 to 9 years; from Primary 1 to 4. 3) Upper Primary: - 10 to 12 years; from Primary 5 to 7. 4) Lower Secondary: - 13 to 16 years; from Senior 1 to 4. 5) A-level/Tertiary Institutions: - 17+ years; senior 5 to 6 students, tertiary institutions of learning i.e. colleges, institutes and universities. Family Watch International proposes that Uganda should establish a sex education framework that seeks to ensure that the primary approach to sex education is abstinence based and reflects the strong religious and cultural values and morality of the Ugandan people.[21]

According to Kalembo, Zgambo, and Yukai CSE programs in SSA are predominantly school based, both in primary and secondary schools.[22] UNESCO adds that the delivery of CSE requires a specially trained teacher to teach CSE as a stand-alone subject. Stand-alone CSE classes are taught in South Africa, Namibia, and Zimbabwe.[23] CSE is integrated into one or more carrier subjects in Madagascar, Mauritius, Mozambique, Rwanda, and Zambia.[24]

[17] Ford Foundation (2014)
[18] Esiet (2012)
[19] Ministry of Education and Sports, 2018).
[20] Ministry of Educations and Sports (2018).
[21] Family Watch International (2018)
[22] Kalembo, Zgambo, and Yukai (2013)
[23] UNESCO (2015)
[24] UNESCO (2015), Health Education Clearing house (2016).

Sani et al. reports that CSE programs in SSA covers topics on Sexually Transmitted Infections (STIs), safer sex, and prevention of STIs and unwanted pregnancies. CSE also focuses on abstinence, promoted as the only method of contraception, or the main method.[25] Topics touching on gender and power relations and culture are the least frequently addressed among CSE programs.

2.5.3 Zambia

According to Wekesah the integrated CSE curriculum in Zambia was officially rolled out in 2014.[26] CSE is covered under six topics distributed across six carrier subjects indicated in the table below. Home economics is a carrier subject into which CSE has been integrated and is optional and learners who choose not to take it are likely to miss out on its content.[27]

Table 1: CSE topics and Subtopics

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

Source: Wekesah, 2019

[25] Sani et al. (2018)
[26] Wekesah (2019)
[27] (UNESCO 2016)

According to Moate and Cox both pre-service and in-service teachers are trained to deliver CSE in Zambia. Teacher training is focused on amplifying CSE content in the curriculum, emphasizing a learner-centered approach in teaching and helping teachers to reconcile their own values and attitudes and to feel confident delivering CSE as expected. Wakesah reveals that, to reach many in-service teachers faster with limited resources, a cascade model of training was used.[28] It is reported that approximately 60 percent of the nation's over 100,000 teachers (or about 67,000 teachers) have been trained or oriented in the delivery of CSE at school level. [29] Although the initial approach was using the cascade model to train teachers, at evaluation stage, the model proved expensive and the content and quality of the training was compromised or diluted at every stage going down to lower stages of the cascade.[30]

2.5.4 Impact of Comprehensive Sexuality Education (CSE)

Rutgers observes that impact evaluations of CSE are complex as well as very costly and is seldom conducted in a randomized controlled trial (golden standard).[31] Research on the effectiveness of CSE is not widely available and mostly focuses on the reduction of risky behaviour like STIs or unwanted pregnancies due to the predominant focus of CSE on public health.[32] According to Ketting et al. there is very limited use of indicators that focuses on positive aspects of sexuality.[33] Even though, indicators such as the ability to communicate about feelings and wishes or self-efficacy are often used, they are usually only considered in respect to the desired behaviour.

Studies show that CSE has great potential to provide young people with the necessary information about their bodies and sexuality, to reduce misinformation, shame and anxiety, and to improve their abilities to make safe and informed choices about their sexual and reproductive health.[34] There is growing evidence that good quality CSE has positive impact on sexual knowledge, attitudes, communication skills and certain sexual behaviours.[35] In comparison to less comprehensive programmes, CSE has been shown to contribute more adequately to gains in young peoples' sexual health.[36]

[28] Wakesah (2019)
[29] Wakesah (2019)
[30] UNESCO (2017)
[31] Rutgers (2018)
[32] Rutgers (2018)
[33] Ketting et al., (2016)
[34] Boonstra (2011); UNFPA (2015).
[35] Kirby et al., (2011); UNESCO (2009)
[36] Fine and McClelland, 2006; Haberland and Rogow, 2015; Kirby, 2008; McCave et al., 2007; Trenholm et al., 2007 Underhill et al., 2007; Santelli et al., (2017).

One major study reviewed sexuality education programs and STI/HIV education, conducted in the United States of America and in some other countries between 2000 and 2014. 15 out of the 17 reviews reported significant positive behavioural outcomes for comprehensive sexuality education or abstinence plus programs.[37] There is clear evidence that CSE has a positive impact on Sexual and Reproductive Health (SRH), notably contributing towards reducing Sexually Transmitted Infections (STIs), the Human Immunodeficiency Virus (HIV) and unintended pregnancy. Comprehensive sexuality education (CSE) has demonstrated impact in terms of improving knowledge and self-esteem, changing attitudes and gender and social norms, and building self-efficacy. Sexuality education does not hasten sexual activity but has a positive impact on safer sexual behaviours and can delay sexual debut and increase condom use.[38] However, the challenge remains. For as long as the number of teenage girls who drop out of school due to pregnancy continue to remain high as provided for by the Ministry of Education Statistical Bulletin, it is still very difficult to see and appreciate tangible benefits of CSE at personal level in a life of a young person or indeed a family.[39]

Rutgers reports that several West European countries have already a long tradition with national comprehensive sexuality education in schools.[40] Looking at the teenage birth rate in European countries, there tends to be a relationship between comprehensive sexuality education and a low rate of teenage pregnancies. The teenage pregnancy rate tends to be very high in central Asian countries (such as Georgian, Russian Federation, Tajikistan) where sexuality education programs are still in an early stage of development.[41] Beyond medical health outcomes, sexuality education can lead also to happier relationships by increasing confidence and strengthening skills. It also has an impact on positive attitudes and values and it evens out the power dynamics in intimate relationships resulting in mutually respectful and consensual partnerships.[42] Also, in schools, learners and teachers feel more at ease to talk about sexuality. There tends to be a more open atmosphere for young learners to pose questions or ask for help regarding sexuality and relationships.[43]

The American Academy of Pediatrics reveals that there has been a decline in sexual activity among adolescents15 to 19 years of age in the United States.[44] However, initiation of sexual

[37] Fonner et al., (2014)
[38] UNFPA (2010); UNFPA (2015).
[39] Ministry of Education Statistical Bulletin (2019)
[40] Rutgers (2018)
[41] IPPF & BZgA (2018).
[42] UNESC (2018).
[43] (Bachus et al.,(2012), Schutte (2016).
[44] American Academy of Pediatrics (2001)

intercourse during adolescence remains the norm for American youth (Ibid). The report further reveals that rates of hormonal contraception and condom use have risen and adolescent birth rates have been decreasing, yet the percentage of births to unmarried women of all ages, including adolescents, remains high. Among women 15 to 19 years of age, most pregnancies are unintended and approximately 1 in 3 results in abortion.[45]

The American Academy of Pediatrics adds that overall rates of Sexually Transmitted Infections (STIs) in the United States are among the highest in the industrialized world. Every year, an estimated 1 in 4 (approximately 3 million) sexually active adolescents acquire an STI. Additionally, only 57% of the 1 in 3 adolescents who reported having been sexually active in the past 3 months reported that they had used barrier contraception the last time they had intercourse.[46] Advocates for Youths in a 2012 study examined 66 comprehensive sexual risk reduction programs and found them to be an effective public health strategy to reduce adolescent pregnancy, HIV, and STIs in the United States of America. Although this is categorically stated for the United States, it is not clear why the results are not the same in the Sub Saharan African.[47]

The International Women's Health Coalition (IWHC) reveals that programs that address issues of gender and power (and were thus closest to true CSE) are markedly more likely to demonstrate significant positive effects on health outcomes—such as reductions in STIs and unintended pregnancy— than programs that ignore gender and power.[48] For example, the Horizons Project conducted with African American adolescent girls in the United States emphasized ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships.[49] According to the International Women's Health Coalition the project resulted in a 35 percent lower risk of acquiring chlamydia.

In Kenya, a sample, targeted intervention in schools used interactive and critical thinking methods to increase girls' understanding of the significantly higher rates of HIV infection amongst adolescents and of the consequences of "sugar daddy" relationships.[50] It saw a 28 percent reduction in teenage pregnancy, indicating a significant drop in unprotected sex. The Steppingstones curriculum used in South Africa, which relies on gender equality and

[45] The American Academy of Pediatrics (2001).
[46] American Academy of Pediatrics (2001)
[47] Advocates for Youths (2015)
[48] The International Women's Health Coalition (2015).
[49] The International Women's Health Coalition (2015).
[50] The International Women's Health Coalition (2015).

empowerment, resulted in a 33 percent reduction in the incidence of herpes simplex virus and reduced reports of intimate partner violence.[51]

The impact of CSE was explored on the sexual knowledge and skills in England. Stephenson et al., conducted a school-based randomised trial of over 8000 pupils aged 13 to14 years to evaluate the long-term effect of pupil-led sex education.[52] The programme showed some positive impact on self-reported knowledge of methods to prevent STIs and skills in using condoms at age 16. In Scotland, the Sexual Health and Relationships: Safe, Happy and Responsible (SHARE) programme was developed for 13-15-year-olds. Respondents (n=2,689) in the intervention group scored significantly higher on knowledge about sexual health than those in the control group.[53] According to Yu 'Healthy Respect' was part of the SHARE project as implemented in 10 schools in Lothian.[54] Tucker et al., reports that among 2,796 pupils in the intervention groups, there was a significant increase in confidence about getting and using condoms, and in believing that 'condom use reduces the chance of contracting (STIs).[55]
Yu further reveals that sexually active respondents were also found to be more likely to use birth control if taught at home about delaying sexual activity and contraception. Similarly, a study of 894 pupils in Ghana showed that family communication about HIV/AIDS was significantly associated with condom use although it did not result in sexual abstinence.[56]

The impact of family communication appeared to depend on what parents talked about. A longitudinal study by Romo et al., documented matters of talking about dating and sex among 55 Latino mothers and their children.[57] Dialogue about values and beliefs was found to have a positive impact on attitudes to premarital sex and sexual initiation; however, talking about everyday activities had no effect.[58] The generalisability of this longitudinal study is limited due to its small, non-randomised sample, yet it did show the importance of parental values and support findings reported by others.[59]

A large survey of 14,287 adolescents in nine European countries showed that in fact, family was a key protective factor for early sexual engagement, while close parent-adolescent relationships

[51] The International Women's Health Coalition (2015).
[52] Stephenson et al., (2004)
[53] Wight et al., (2002).
[54] Yu (2010)
[55] Tucker et al., (2007)
[56] Adu-Mireku 2003).
[57] Romo et al., (2002)
[58] Yu (2010)
[59] McNeely et al.,(2002); Somers and Gleason (2001); Somers and Paulson (2000).

and high levels of parental monitoring were less protective.[60] According to Yu, the studies conducted in various countries confirmed these findings.[61] In England, Bonell et al., followed 8,766 pupils for two and half years (29 months), reporting that respondents from lone parent families were more likely to report having had sex in the subsequent two and half years.[62] In the US, analysing a subset of sample from a longitudinal survey (n=497), Upchurch et al., found that Hispanic adolescents who lived with one sole parent or non-biological parents held more permissive sexual attitudes and lost virginity at a younger age.[63] A longitudinal study of 567 Swedish girls revealed a similar pattern.[64] In addition, Moore and Chase-Lansdale found that living in any type of married family protected African American females from getting pregnant.[65] Yu reports that CSE has a positive impact on religious commitment and participation in religious activities.[66]

In a New Zealand longitudinal study of a cohort of 1,020 participants, Paul et al., found that religious beliefs/practices were an important factor enabling them to sustain sexual abstinence to age 21.[67]

A study of 1,153 adolescents in Nigeria by Odimegwu revealed its positive effect on both sexual attitudes and initiation.[68] In addition, its positive impact on condom use was reported in a US study of 230 first year students at a Catholic university.[69]

Yu in a qualitative study of Chinese-British teenagers and parents in Scotland reported that religious practice reinforced the quantity and quality of parent-child interactions and may have made the young people more willing to share parental values.[70] Religious practices also offered the teenagers more opportunities to make friends who hold similar sexual values. Christian parents highlighted the value of providing sex education within a moral and religious context by teaching young people the option of sexual abstinence.

Friends were also seen as the major source of information about sex and relationships. The effect of dialogue about sex with friends appeared to depend on the content of such

[60] Lenciauskiene and Zaborskis (2008).
[61] Yu (2010)
[62] Bonell et al., (2006)
[63] Upchurch et al., (2001)
[64] (Magnusson 2001).
[65] Moore and Chase-Lansdale (2001)
[66] Yu (2010)
[67] Paul et al., (2000)
[68] Odimegwu's (2005)
[69] Zaleski and Schiaffino (2000).
[70] Yu (2007b)

communication.[71] In a small US study of 157 school teenagers, Somers and Gleason found that gaining more information about sexual intercourse from friends was related to more liberal sexual attitudes in respondents.[72] A US survey by Lefkowitz and Espinosa Hernandez explored sex-related communication with mothers and close friends among 182 first-year college students aged 17-19 years.[73] More frequent discussion about behaviours and feelings and more open and comfortable communication with friends correlated with respondents being non-virgins. Similarly, Amoran, Onadeko and Adeniyi in a community-based study (n=274) in Nigeria found that significantly more respondents who sought sexual information from peers had sex compared to those who sought information from parents, teachers and other sources (43.2%, 25.2%, 14.4%, 17.1%).[74] On the other hand, Potard, et al., in a French study found that respondents (n=1000) who perceived a high prevalence of sexual initiations of peers tended to have greater intentions to have sex.[75] Such perception was also related to earlier sexual debut, as reported by Babalola in a survey of 1,327 youth in Rwanda..[76]

A review on the impact of CSE worldwide show somewhat different regional trends.[77] In South and South East Asia, there have been declines in early marriage and early childbearing (6–7% and 6–10% points, respectively); in Sub-Saharan Africa, there has been a small decline in multiple partner relations (4% points) and a substantial increase in condom use (18% points); and in Eastern and Southern Europe there has been a corresponding increase in condom use (15% points).[78]

Santhya and Jejeebhoy further report that, Latin America and the Caribbean, changes are observed in the opposite direction: for example, pre-marital sex increased considerably (14% points), but condom use and multiple partner relations remained unchanged and unintended pregnancy increased substantially. In other regions, trends did not suggest notable changes.[79]Young people learn better when the learning is institutionalised, detaching it completely from individual biases which affect the way human beings think and feel at each given point.[80]

[71] Chung et al., (2005); Currie et al., (2008); Yu (2008).
[72] Somers and Gleason (2001)
[73] Lefkowitz and Espinosa Hernandez (2007)
[74] Amoran, Onadeko and Adeniyi (2004)
[75] Potard, et al., (2008)
[76] Babalola (2004)
[77] (Santhya and Jejeebhoy (2015)
[78] (Santhya and Jejeebhoy (2015)
[79] Santhya and Jejeebhoy (2015)
[80] Wekesa (2019)

2.6 Gaps in the literature

From the literature reviewed there is lack of evidence showing that classroom CSE is effective. Comprehensive sexuality education (CSE) was introduced in 2014 and it might be early to expect major shifts in the cultural and religious beliefs among teachers and pupils in Zambia. Further, there is lack of relatable evidence to argue that CSE has visible impact. There is no standard manual for teacher training, adequate materials are lacking to support learning and teaching at school level. Among the parents and teachers, there is opposition to CSE (push back) by those who feel different about the topics.

3.0 Methodology

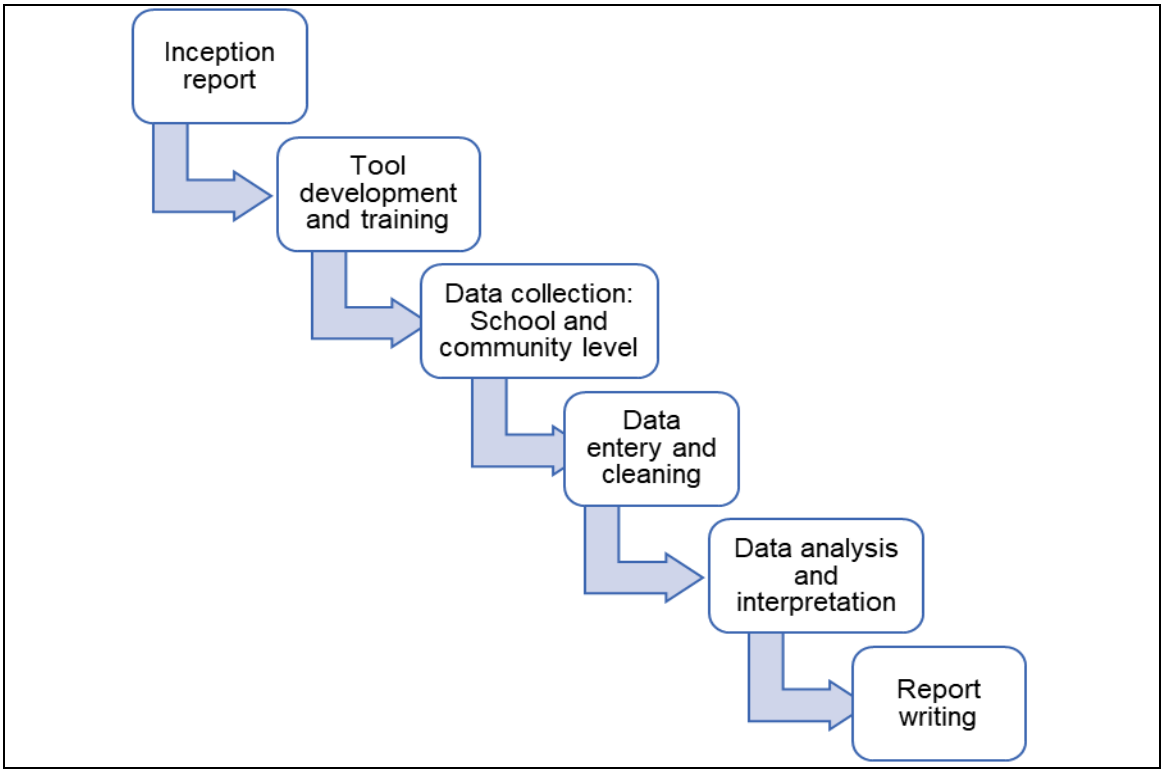
This section presents the research design, the study sites and the population as well as the sampling design and sample size. The data collection procedure and the ethical considerations are also presented.

3.1 Overview

The quantitative approach was used to gather quantifiable data from the male and female pupils in the schools. This research methodology was used to allow the assessment to understand the impact of CSE on each of the target groups in the selected schools. The quantitative research adopted a scientific approach to data collection and it leveraged deductive reasoning in order to arrive at useful insights that can inform practical decision making for the Forum for African Women Educationalists of Zambia (FAWEZA) and its partners

The survey was carried out based on the main tasks in the TORs. An overview of the tasks is depicted in figure 1 below:

Figure 1 Main tasks for the assignment



3.2 Study Design

The assessment employed a mixed method approach and according to Creswell this involves combining or integrating qualitative and quantitative data in a research study[81]. The design was used because mixed method resides in the idea that both methods have bias and weaknesses and therefore, the collection of both quantitative and qualitative data neutralizes the weakness of each form of data[82].

With the mixed method approach data triangulation was employed. This means that multiple sources of data were used from the secondary and primary sources. Secondary data was obtained from journals, reports from the implementing partners, Ministry of Education and the Ministry of Health at provincial and district levels. The primary sources of data were male and female learners from primary and secondary schools, parents/guardians, headteachers, guidance and counseling, teachers trained in CSE, health workers, representatives from ministry of education, ministry of health and school clubs. Data triangulation was adopted to test validity through the convergence of information from different sources.

The convergent approach was used and Creswell (2014) explains that the research merges qualitative and quantitative data in order to provide a comprehensive analysis of the research problem. The study collected both forms of data at the same time and integrated the information in the interpretation of the results.

The Qualitative approach used interviews and focus group discussions and the tools were open-ended without predetermined responses. Under quantitative, the questionnaire was administered and included close-ended responses containing close-ended questions.

3.2 Population, study settings, sampling procedure and sample size

3.2.1 Population

The population of this study targeted male and female pupils selected from grade 5 to grade 12. The Ministry of Education indicates that Chawama has 4,122 pupils, Kamulanga-2,823, Timothy Mwanakatwe-815 and Kanyama-4,395. In southern province, the schools selected have the population of 265 pupils from Nyawa Secondary; 360 – Malimba; 659 -Njezya; 892-Chibomboma; Mwanza-670; Bbwantu-320. From Kitwe, the selected schools had the population of 1, 321 from Chamboli and 1,204-Chimwemwe; while Zambezi Day has 394 pupils.

[81] Cresswell (2014)
[82] Ibid.

Table 2: School Population

Province	District	School	Population
Lusaka	Lusaka	Chawama	4,122
Lusaka	Lusaka	Kamulanga	2,823
Lusaka	Lusaka	Timothy Mwanakatwe	815
Lusaka	Lusaka	Kanyama	4,395
Southern	Kazungula	Nyawa Secondary	265
Southern	Kazungula	Malimba	360
Southern	Kalomo	Njezya	659
Southern	Kalomo	Chibomboma	892
Southern	Monze	Mwanza	670
Southern	Monze	Bbwantu	320
Copperbelt	Kitwe	Chamboli	1, 321
Copperbelt	Kitwe	Chimwemwe	1,204
North-Western	Zambezi	Zambezi Day Secondary	394
Total			**16,894**

Source: Ministry of Education (2022)

3.2.2 Study settings

The study was conducted in the selected schools from Lusaka - Chawama Primary, Timothy Mwanakatwe Basic School, Kanyama and Kamulanga; Kazungula -Nyawa Secondary and Malimba Basic; Kalomo- Njezya and Chibomboma; Monze- Mwanza Basic and Bbwantu Primary School; Kitwe - Chamboli Secondary School and Chimwemwe Secondary School and Zambezi -Zambezi Secondary School. The selection of the schools was based on the Ministry of Education's mandate to introduce CSE in the primary and secondary government schools. Further, the selection of schools was informed by the high prevalence of teenage pregnancies, training of teachers in CSE and school dropouts. The targeted population comprised of male and female pupils that have started learning CSE which is implemented from grade 5 to grade 12.

3.2.3 Sampling procedure

The scientific formula was used to select the targeted population of male and female pupils from grade 5 to grade 12 in the schools to ensure that the sample is representative of each group.

$$\frac{Z^2 \times (P)(1-P)}{e^2}$$

Z=The value corresponding to level of confidence (e.g., Z value for 95% confidence level is 1.96)

P = Estimated percentage of a sample having a characteristic (0.5)

e = Margin of error (the level of precision suggested is 0.05 for ± 5%)

n = 763

The statistical estimation of a minimum of (n=30) respondents was factored into the sample size calculation formula, and this is where the necessary adjustments were made in order to be able to measure the impact across individual areas; hence, the resulting sample size increased to (n= 860). The overall sample size for the survey was therefore the sum of the samples across all the areas specified for the survey.

3.3.3 Sample size

With the initial 860 sample size, only 575 were sampled and this was split between male and female pupils. The sample size was reduced to 575 because six schools in Eastern province, namely- Chipangali primary, Dwankhonzi Day secondary, did not participate in the survey and in Zambezi out of 3 schools only 1 was surveyed. Gondar Day secondary and Malola pimary did not participate in the study. This means that 240 questionnaires were not administered in eight (8) schools. However, a total of 315 females and 260 male pupils were sampled in the selected schools.

Below is the presentation of the sample size from the selected schools in Lusaka, Kazungula, Kalomo, Monze, Kitwe and Zambezi;

Table 3: School sample size

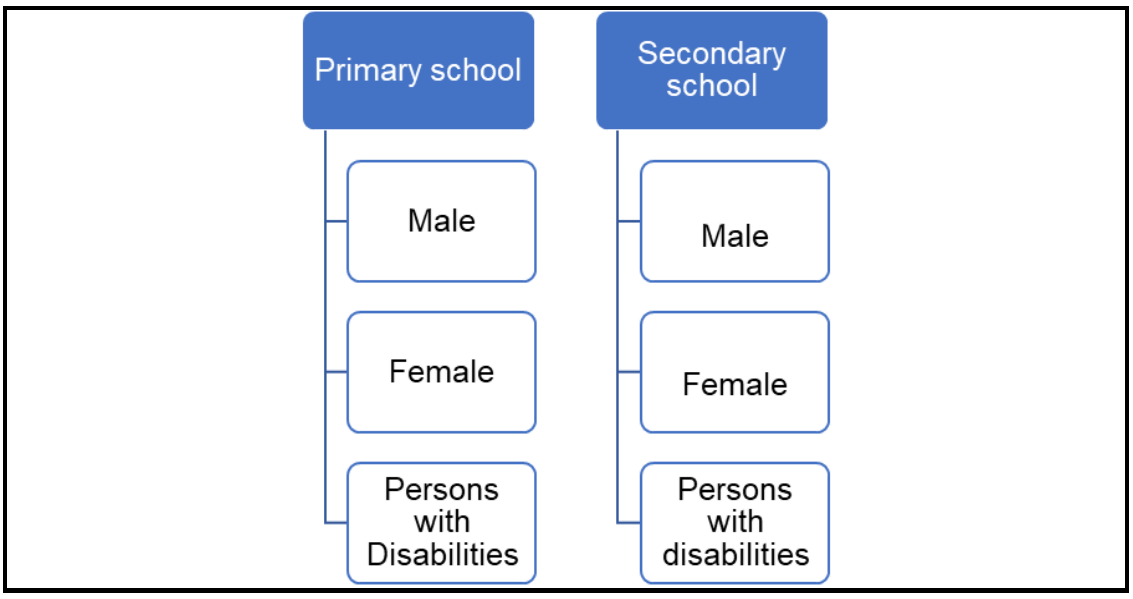
School	Sample size allocation	Achieved Sample size
Chawama	80	80
Kamulanga	80	75
Kanyama	80	80
Timothy Mwanakatwe	80	77
Malimba	30	29
Nyawa Day	30	30
Chibomboma	30	30
Njezya	30	30

Bbwantu	30	29
Mwanza Basic	30	30
Chamboli Primary	30	28
Chimwemwe Secondary	30	28
Zambezi Day Secondary	30	29
Total	**560**	**575**

Source: Fieldwork Data, 2023

The schools were divided into primary and secondary, male and female pupils. Stratified random sampling was used to sample the pupils in the schools following the three strata to identify the boys, girls and persons with disabilities that participated in the evaluation. Unfortunately, there were no pupils with disabilities in the schools selected. The sampling technique was used because the targeted population is heterogeneous, also by dividing the population into strata, the consultants ensured that the sample is representative of the population to avoid sampling biases.

Figure 2: Stratified random Sampling



Selection of male and female pupils

The school interviews targeted male and female pupils where CSE is being implemented in the selected districts of Kazungula, Kalomo, Monze, Zambezi and Kitwe. Purposive sampling was used to select the schools in the districts. In each of the selected schools, gender was considered with an equal number of male and female pupils.

Before fieldwork commenced, the schools were informed about the study through the District Resource Center Coordinators (DRCCs) in Lusaka, Kazungula, Kalomo and Monze. When the research team visited the selected school, all pupils (boys and girls) were listed, and a random table (the KISH grid) was used in the selection of the participating respondents. In primary schools, male and female pupils were selected from grades 5 to 9; in secondary schools the selection was from grades 8 to 12. Using the stratified random approach, the approximate proportion of females and males in the schools were selected to achieve the sample.

Focus Group Discussions

Focus group discussions were conducted with the pupils selected from grades 5 to 12 and the boys were separated from the girls. This approach was adopted to allow each group feel free and comfortable in discussing comprehensive Sexuality education (CSE) and sexual reproductive health issues. Teachers were not included in the groups because pupils might feel uncomfortable giving their opinions and perceptions on the implementation of CSE in the schools.

Each focus group had six (6) pupils. This approach was adopted because it works well with a small but highly validated sample size in order to gather objective data that will translate to insightful information. Below is the table indicating the focus groups conducted;

Table 4: Sample size for the focus group discussions conducted

District	School	Number of focus groups conducted	
		Male pupils (n =10)	Female pupils (n = 10)
Lusaka	Chawama	1	1
	Kamanga	1	1
	Kanyama	1	1
	Timothy Mwanakatwe	1	1
Kazungula	Nyawa High School	1	1
	Malimba	1	1
Kalomo	Njezya	1	1
	Chibomboma	1	1
Monze	Mwanza Basic	1	1
	Bbwantu	1	1

Source: Fieldwork Data, 2023

The table above indicates that two (2) focus groups were conducted in each selected school and a total of twenty (20) FGDs were carried out with the male and female pupils. The focus groups were carried out in English and Tonga in Southern province as well as Nyanja in Lusaka. The purpose of using the local language was to enable the pupils express themselves freely in the case of those with challenges to speak English fluently.

The interactions in the focus groups were conducted by the lead consultant who ensured that the conversation remained within the boundaries of the research purpose and scope.

Inclusion criteria

The inclusion criteria for the targeted location were based on the following:

- Primary and secondary schools in the rural areas known to have high prevalence of teenage pregnancies among the female pupils in schools where CSE is being implemented
- Male and female pupils in grade 5 to 12
- Primary and secondary schools where CSE is implemented by FAWEZA, SAT and Plan International
- Male and female pupils living with parents and guardians (i.e., grandparents, brothers, sisters, aunties and uncles)
- Male and female pupils with disabilities

Exclusion criteria

- The study excluded learners from grade 1 to 4
- The study excluded mission schools as they have not ascribed to the delivery of CSE at school level. In Zambia CSE is curriculum based and is delivered through a school system
- Teachers that have not received training in CSE did not participate in the study

Key informant and in-depth interviews

Key Informant Interviews (KIIs) with the authorities from the districts and schools was undertaken. Purposive sampling was used to select the key stakeholders within the districts and schools to help gather insights on the implementation of CSE in the selected schools. The consultants used *'expert sampling'* to gather information that would provide a better cross-section of information. Key informant interviews were conducted to provide insights on the

implementation of CSE in the districts, the successes and challenges encountered during implementation.

Table 5 above shows that the key informant interviews (KIIS) were conducted with the District Resource Center Coordinator (DRCC) in the selected districts of Lusaka, Kazungula, Kalomo and Monze. The in-depth interviews were held with the headteachers in ten (10) selected schools, with four (4) in Lusaka, two (2) in Kazungula, Kalomo and Monze.
Below is a summary of the KIIs with the key stakeholders;

Table 5: Sample size for the key informants and in-depth interviews conducted

Position	Sex	Institution/School	District	Number of interviews conducted (14)
District Resource Center Coordinator	Female	Ministry of Education	Lusaka	1
District Resource Center Coordinator	Male	Ministry of Education	Kazungula	1
District Resource Center Coordinator	Male	Ministry of Education	Kalomo	1
District Resource Center Coordinator	Male	Ministry of Education	Monze	1
Headteacher	Female	Chawama	Lusaka	1
Deputy Headteacher	Female	Kamulanga	Lusaka	1
Deputy Headteacher	Female	Kanyama	Lusaka	1
Headteacher	Female	Timothy Mwanakatwe	Lusaka	1
Headteacher	Male	Nyawa	Kazungula	1
Headteacher	Male	Malimba	Kazungula	1
Headteacher	Male	Njezya	Kalomo	1
Headteacher	Male	Chibomboma	Kalomo	1
Headteacher	Male	Mwanza Basic	Monze	1
Headteacher	Male	Bbwantu	Monze	1

Source: Fieldwork Data, 2023

The survey also targeted the teachers in the selected schools that had been trained in CSE and the guidance and counseling. The study triangulated to get more insights from the health facilities that offer sexual and reproductive health services to the adolescents and young people in the targeted districts.

Table 6: In-depth interviews conducted in the school

Position	Sex	Institution/School	District	Number of interviews (24)
Teacher trained in CSE	F	Chawama	Lusaka	1
Guidance and Counseling	F	Chawama	Lusaka	1
Guidance and Counseling teacher	F	Kamulanga	Lusaka	1
Teacher trained in CSE	M	Kamulanga	Lusaka	1
Guidance and Counseling teacher	F	Kanyama	Lusaka	1
Teacher trained in CSE	F	Kanyama	Lusaka	1
Teacher trained in CSE	F	Timothy Mwanakatwe	Lusaka	1
Guidance and Counseling	F	Timothy Mwanakatwe	Lusaka	1
Head of Department	M	Nyawa	Kazungula	1
Guidance and Counseling	F	Nyawa	Kazungula	1
Teachers trained in CSE	M	Nyawa	Kazungula	1
Guidance and counseling	F	Malimba	Kazungula	1
Teachers trained in CSE	M	Njezya	Kalomo	3
Guidance and Counseling	F	Njezya	Kalomo	1
Teacher trained in CSE	M	Chibomboma	Kalomo	1
Guidance and counseling teacher	F	Chibomboma	Kalomo	1
Club Patron	M	Mwanza Basic	Monze	1
Teacher trained in CSE	M	Mwanza Basic	Monze	1
Club Patron	M	Bbwantu	Monze	1
Teachers trained in CSE	F	Bbwantu	Monze	2
Guidance and counseling teacher	F	Bbwantu	Monze	1

Source: Fieldwork Data, 2023

3.4 Data collection

Both primary and secondary data was collected. Qualitative and quantitative primary data was collected from the male and female pupils, teachers trained in CSE, guidance and counseling teachers, headteachers as well as the district education board secretaries (DEBS).

Qualitative and quantitative secondary data was also collected from the published peer-reviewed papers, reports as well as government policies on CSE and SRH.

3.4.1 Data collection tools

For the quantitative approach, data was collected using the questionnaire. The tool was scripted on the tablets. This technology enabled us to get real-time data, GPS coordinates, live streaming and real time monitoring of fieldwork progress and quality. The questionnaire contained mostly closed and open-ended questions.

The key informant interview guide was designed to provide detailed information and a unique perspective on CSE and how it is being implemented in the schools as well as insights on the

impact. The tool was used to gather qualitative information to enhance the understanding of the quantitative data collected from the male and female pupils.

The purpose of using the interview guides was to collect information from key stakeholders at district at district and school levels. The interview guides were structured in a systematic format with clear and specific goals. In-depth interviews were conducted with the headteachers, guidance and counseling and teachers trained in CSE.

The focus group discussion guide was designed for the male and female pupils that did not participate in answering the questionnaire. The discussion guide contained main topics and it served as a road map to guide the facilitator in covering the list of topics and keeping the discussion on track. The number of items in the guide were kept to a minimum to leave enough time for in-depth discussions. It focused only on relevant research issues and moved from general to specific.

3.5 Data Quality and Management

Field management is a key component in research and this was done for the purpose of planning, monitoring and overseeing primary data collection in Lusaka, Kazungula, Kalomo and Monze.

3.5.1 Recruitment

Research assistants were hired to assist in collecting data in the selected schools. Care was taken to ensure that the research assistants had knowledge of the local languages used in Lusaka, Kazungula, Kalomo and Monze. The research assistants have a background in gender, Sexual and reproductive health and human rights. The research team selected had at least two (2) years of experience in quantitative data collection in Zambia.

Enumerator training packages were developed to ensure that the information collected is relevant and that quality data was obtained to address the study objectives and parameters and in keeping with what the project set out to achieve. Male and Female research assistants were hired to collect the data in the schools.

3.5.2 Training and Preparation

The training was conducted for two (2) days and information was given on the background of the project, CSE and the implementing partners, the purpose, objectives and key questions of

the assignment. Other information provided during the training include the study sites, sample size and the targeted population in each district.

After the training was conducted, the research team carried out the pilot study at Lusaka Girls High School. The purpose of the pilot was to identify possible flaws in measurement procedures such as instructions, time limit and flow of the questions. It was important to identify unclear or ambiguous items in the questionnaire. The non-verbal behaviour of the pupils in the pilot study also provided important information about any embarrassment or discomfort experienced concerning the content or wording of questions in the questionnaire. Also, the feedback structure to the pupils had to be piloted to clear out practical difficulties, like duplication of information to the respondents. The pilot also enabled the research team to come up with a strategy on how to administer the questionnaire in the selected schools.

The questionnaire was also pre-tested and debugged to ensure that there were no coding issues remaining when the research assistants started collecting data. After the pilot, changes were made to the questionnaire, removed questions that were duplicated and the phrasing of the questions was adjusted where it was required.

Before fieldwork commenced, the Lead Consultant prepared the quality control plan for fieldwork. The Lead Consultant prepared the route plan for all the areas for the research team. This was to help the research team prepare for any anticipated challenges and take proactive action to avoid delays in completing fieldwork in Lusaka, Kazungula, Kalomo and Monze.

3.5.3 Monitoring and Quality Control

In order to ensure that there is excellence in data collection, the study combined technology and on the ground field supervision in managing quality by using CSPro. The technology-based field monitoring platform has a fully integrated fieldwork management with scripting, data collection and back-checking functionality. It also reinforces qquality control with silent voice recording, integrated back-checking module flags interviews for independent back-checks. The technology gives a clear overview of completed interviews by updating field progress and generating quota reports by sample point.

A satellite function was activated when field work commenced and with GPS, we were able to track the interviewers. This was to ensure that the interviewing process and locations are captured. The satellite tracking system allowed the Principal Investigator to monitor field progress, as well as plot where all interviews have taken place. This also provided additional

check on interviewer movement. Using geo-fencing, we created an alert system indicating where one should be geographically and if it is the planned school and participant location.

3.6 Data Analysis

The questionnaire was scripted from paper to the tablets using CSPro. The use of tablets allowed data to be uploaded to the server immediately the interview was completed. When the network was not available, data was stored and uploaded as soon as the network was regained.

The output from the results were interpreted using descriptive analysis which involved creating tables, charts and summary statistics from the raw data. Additionally, the quantitative measurement involved cross tabulation among core variables relevant to the study among the male and female pupils in schools. This included looking for relationships among different respondent segments to identify trends, patterns, similarities, and differences between the boys and girls.

For the qualitative approach, all interviews and discussions were audio-recorded and analyzed. Content summaries from the interviews and discussions were created around major themes and sub-themes. The resulting matrices were used to explore themes based on the information collected from the teachers, guidance and counseling, headteachers, DRCCs as well as male and female pupils to identify common issues related to the study objectives and questions.

3.7 Ethical Considerations and Informed Consent

The principle of child participation is a cornerstone of the United Nations (UN) Convention on the Rights of the Child (CRC). The principle holds that children (defined as those under the age of 18) have the right to express their views if they so choose, and that, in accordance with the children's age and maturity, these views should be taken into account for all matters that affect them.

To ensure that the male and female pupils were able to participate in the study, permission was obtained from the District Resource Center Coordinator (DRCC) who informed the headteachers. Consent was obtained from the headteachers and guidance and counseling teachers to allow the participants to take part in the quantitative and qualitative survey.

This research adhered to the process of conducting research which includes confidentiality of the participants and the signed consent. To this regard, the following ethics were adhered to:

i. Introductory letters were presented to the DRCC in each district to conduct research in the schools. The letter was presented to the respondents answering the questionnaires to encourage their participation in the research. Information was also provided to the participants concerning the nature of the study, participation requirements (e.g. activities

and duration), confidentiality and contact information of the researcher. Permission was obtained from the DRCC of the Ministry of Education in each district;

ii. Consent, permission, and approval for the research was obtained from the Headteacher of each selected school.

iii. Informed consent for learners was obtained at two levels and these were: for participants and respondents under the age of 16, consent was provided by the school. Besides that, children also provided assent on their own before the focus group discussions and interviews.

iv. Participants and respondents were not subjected to any risk of unusual stress, embarrassment, or loss of self-esteem. Their safety was guaranteed and protected by ensuring that there is gender representation in the research team in order to protect the interest of the female learners especially.

v. The research team ensured that participants and respondents remained anonymous.

vi. The right to professional privacy and confidentiality of information obtained was guaranteed by a written statement in the cover letter; and

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

3.8 Limitations of the Assessment

The omission of certain schools, specifically those in North Western and Eastern Provinces, from the original coverage plan arise from the challenge of their late inclusion, which was requested by the client after the initial agreement had been established. As a result, the research team was able to administer questionnaires in Southern and Lusaka. On the Copperbelt and North Western Provinces FAWEZA partners administered the questionnaires. No questionnaires were received from Eastern Province. This limitation was primarily due to the logistical timeframe constraints associated with adding these regions to the survey, resulting in incomplete coverage in these areas.

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

The study was supposed to include interviews from the heath facilities. However due to distance in Kazungula, Kalomo and Monze, the research team could not reach the places. In Lusaka, the health workers were always busy and could not find time to be interviewed.

4.0 Findings

This section of the report presents both qualitative and quantitative findings from the male and female pupils, headteachers, guidance and counseling, parents/guardians as well as the district resource center coordinators (DRCC) from the selected districts, schools and communities.

Quantitative data is presented in charts and tables, while qualitative data includes verbatims in the appropriate sections. The chapter begins with a section on demographic data followed by a presentation on the impact of the implementation of CSE, the best practices in Zambia, the existing gaps in the implementation of CSE, reasons for continued increase in incidences of teenage pregnancies regardless of the implementation of CSE in Zambia.

The quantitative data was obtained from questionnaires, while qualitative data was from the interviews with the DRCC, headteachers, parents, teachers trained in CSE, guidance and counseling as well as parents.

Two evidence reviews commissioned by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2008 and 2016 informed the development of the original and the revised edition of the International Technical Guidance on Sexuality Education (the Guidance) published by UNESCO with the United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations International Children's Emergency Fund (UNICEF), United Nations (UN) Women and World Health Organization the World Health Organization (WHO).[83] The results of these studies, along with recommendations from experts in sexuality education development, implementation and evaluation, indicate that comprehensive sexuality education (CSE) contributes to a range of positive health and well-being outcomes, including: preventing HIV and unintended pregnancy; reducing risky sexual behaviour; preventing and reducing gender-based and intimate partner violence and discrimination; increasing gender equitable norms, self-efficacy and confidence; and, building stronger and healthier relationships.[84]

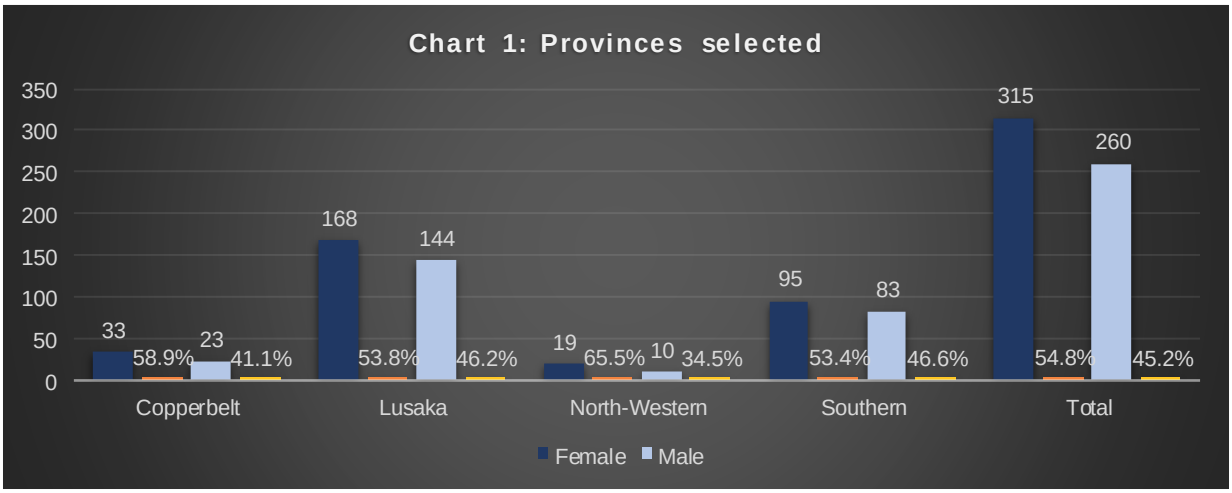
[83] UNESCO (2018)
[84] Ibid

4.1 Provinces and districts selected

The assessment on the implementation of comprehensive sexuality education (CSE) was conducted in the selected provinces of Lusaka, Southern, North-Western and Copperbelt provinces.

Chart 1 shows that 33 (58.9%) female pupils were from the Copperbelt; 168 (53.8) from Lusaka; 19 (65.5% from North-western and 95 (53.4%) from southern province. Majority of the female participants were from Lusaka. Male pupils were 23 (41.1%) from the Copperbelt; 144 (46.2%) from Lusaka; 10 (34.5%) from North-western and 83 (46.6%) from southern province. This shows that the majority of the male pupils were also from Lusaka.

Six districts were selected for the assessment and from Kitwe 33 (58.9%) female pupils participated in the survey; 168 (53.8%) from Lusaka; 19 (65.5%) from Zambezi; 33 (55%) from Kalomo; 33 (55.9%) from Kazungula and 29 (49.2%) from Monze. The male pupils selected from the districts were 23 (41.1%) from Kitwe; 144 (46.2%) from Lusaka; 10 (34.5%) from Zambezi; 27 (45%) from Kalomo; 26 944.1%) from Kazungula and 30 (50.8%) from Monze. Majority of the male pupils were from Lusaka.



Source: Fieldwork Data, 2023

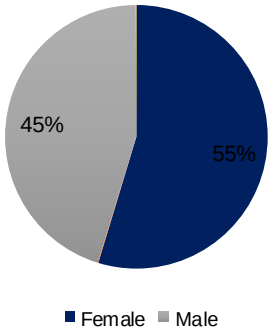
4.2 Demographic Characteristics of the participants, parents/guardians

4.2.1 Sex of the participants

The study results reveal a slight gender disparity among the participants. Females comprised the majority, accounting for 315 (54.8%) of participants, while males were 260 (45.2%). Although the difference is relatively modest, the higher representation of female pupils highlights their predominance compared to the males. This gender distribution underscores the

importance of ensuring that sexual and reproductive health education addresses the needs, concerns, and perspectives of both genders equally, acknowledging that both boys and girls require comprehensive information and support for their well-being and informed decision-making.

Chart 2: Sex of the participants



Source: Fieldwork Data, 2023

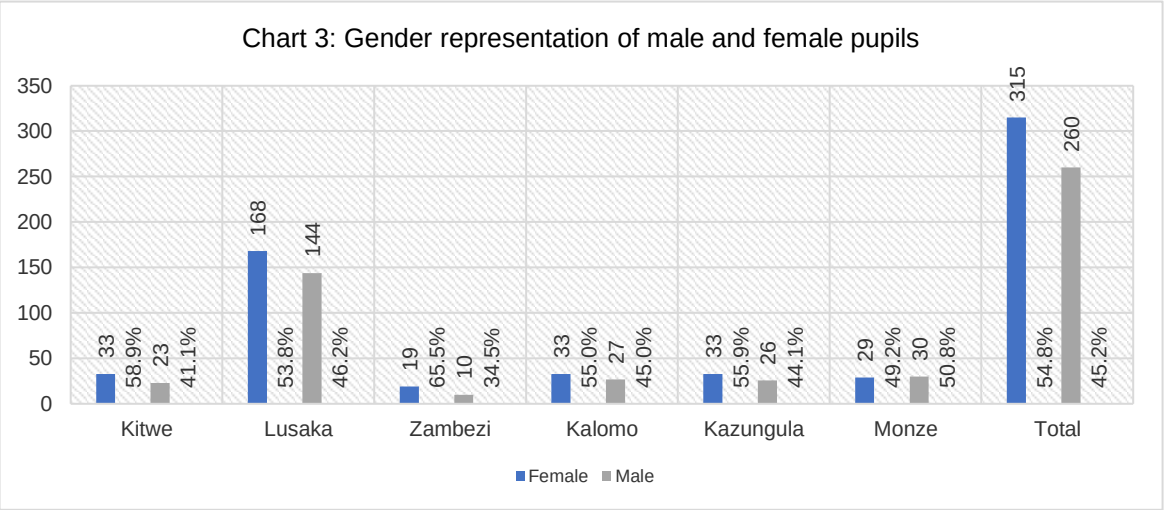
4.2.2 Gender representation from the schools selected

A gender representation was important for the assessment as male and female pupils were selected from thirteen (13) schools. The female pupils selected in Kazungula from Nyawa Secondary were 15 (50%), 18 (62.1%) from Malimba primary school; Kalomo was represented by 17 (56.7%) from Chibomboma, 17 (53.3%) from Njezya. From Monze, 5 (62.5%) the female pupils were from Mwanza while 14 (48.3%) from Bbwantu primary school. In Kitwe 18 (64.3%) were from Chimwemwe secondary and 15 (53.6%) were selected from Chamboli Secondary school; Zambezi was represented by 19 (65.5%) from Zambezi Secondary school.

Majority of the female participants were selected from Lusaka with 45 (58.4%) from Timothy Mwanakatwe Basic; 42 (52.5%) from Kanyama Primary; 42 (52.5% from Chawama Primary and 42 (52.5%) from Kamulanga Secondary school.

The male pupils from Kazungula were 15 (50%) from Nyawa secondary, 11 (37.9%) from Malimba; in Kalomo 14 (46.7%) were from Njezya, 13 (43.3%) from Chibomboma; Monze had 3 (37.5%) from Mwanza and 15 (51.7%) from Bbwantu primary school. In Kitwe, 13 (46.4%) male pupils were selected from Chamboli secondary and 10 (35.7%) from Chimwemwe secondary school. Zambezi secondary school had 10 (34.5%) male pupils.

From Lusaka, the majority of the male pupils were from Kanyama Basic 38 (47.5%), Chawama 38 (47.5%). This was followed by Kamulanga with 36 (48%) males and 32 (41.6%) from Timothy Mwanakatwe. Below is a summary of the male and female pupils selected in the primary and secondary schools.



Source: Fieldwork Data, 2023

4.2.4 Grades selected in the districts

The study's findings reveal distinct participation levels across different grade levels. Grade seven learners constituted the highest proportion at 20.9%, followed by grade eight learners at 18.1%. This trend is supported by the representation of grade nine learners at 14.3%.

However, there is a notable decrease in participation as the grade levels progress through the senior secondary phase, with figures of 10.4%, 10.1%, and 9.0% for the respective levels. Interestingly, this aligns with Ministry of Education Statistical Bulletin data of 2018, 2019 and 2020, which consistently reports a higher number of teenage pregnancies in lower-grade levels, including primary and junior secondary schools.

This pattern underscores the need for targeted sexual and reproductive health education efforts, especially in the early years, to address the factors contributing to these trends and to equip learners with the necessary knowledge and skills for responsible decision-making.

Table 7: Grades selected

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Grade 5	-	-	50	16%	-	-	10	16.70%	-	-			60	10.40%
Grade 6	-	-	34	10.90%	-	-	19	31.70%	-	-	5	8.60%	58	10.10%
Grade 7	1	1.80%	77	24.70%	-	-	20	33.30%	9	15.30%	13	22%	120	20.90%
Grade 8	27	48.20%	52	16.70%	-	-	10	16.70%	10	16.90%	5	8.50%	104	18.10%
Grade 9	-	-	50	16%	17	58.60%	-	-	10	16.90%	5	8.50%	82	14.30%
Grade 10	13	23.30%	17	5.40%	-	-	-	-	10	16.90%	10	16.90%	50	8.70%
Grade 11	14	25%	14	4.50%	-	-	1	1.70%	9	15.30%	11	18.60%	49	8.50%
Grade 12	1	1.80%	18	5.80%	12	41.40%	-	-	11	18.60%	10	16.90%	52	9.20%

Source: Fieldwork Data, 2023

4.3. Socio-economic status of the households

Recognising and acknowledging the importance of social and economic factors is critical for sustainable CSE integration in the schools. Parents/guardians have a pivotal role to play in providing good-quality CSE at home. A key strategy to address potential opposition to providing CSE in a community is to listen to parents' concerns and to incorporate their suggestions, where feasible or appropriate. In parallel, strategies to sensitize parents and provide them with accurate information on the benefits of CSE are critical. For this study it was important to determine who the male and female pupils live with, the heads of households, the level of education of the parent/guardian, employment status and the sector.

4.3.1 Who the Participants live with

Based on the data presented, the study found that a substantial majority of respondents, at 61%, live with both their mother and father. Those living solely with their mothers constitute 15.5%, followed by 6.4% living with their grandmothers. The remaining categories each hold a representation of less than 5%.

This data shows that the majority of participants live with their biological parents, which could impact their openness to discussing Comprehensive Sexuality Education (CSE). In the context of Zambia, it's widely believed at the community level that young people might feel more comfortable discussing sexuality matters with their grandparents.

This points towards the importance of recognizing family dynamics and relationships in approaching CSE discussions, highlighting the need to create an inclusive environment where

all learners, regardless of their living arrangements, can engage in open and informed conversations about sexual and reproductive health.

Table 8: Who respondents live with

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Mother	10	17.9%	60	19.2%	5	17.2%	6	10.0%	4	6.8%	4	6.8%	89	15.5%
Father	4	7.1%	6	1.9%	3	10.3%	7	11.7%	4	6.8%	5	8.5%	29	5.0%
Mother & Father	34	60.7%	187	59.9%	15	51.7%	38	63.3%	44	74.6%	33	55.9%	351	61.0%
Grandmother	1	1.8%	26	8.3%			4	6.7%	1	1.7%	5	8.5%	37	6.4%
Grandfather	1	1.8%			1	3.4%			1	1.7%			3	0.5%
Grandparents	4	7.1%	14	4.5%			3	5.0%	1	1.7%	6	10.2%	28	4.9%
Brother			6	1.9%	1	3.4%			2	3.4%	2	3.4%	11	1.9%
Sister			7	2.2%	4	13.8%			1	1.7%	2	3.4%	14	2.4%
Any other	2	3.6%	6	1.9%			2	3.3%	1	1.7%	2	3.4%	13	2.3%

Source: Fieldwork Data, 2023

4.3.2 Head of households where participants live

The majority of the participants identified fathers as the head of the household, accounting for 64%. Mothers followed at 17.2%, while grandmothers and grandfathers held lower percentages at 6.4% and 5.6%, respectively.

Table 9: Household heads

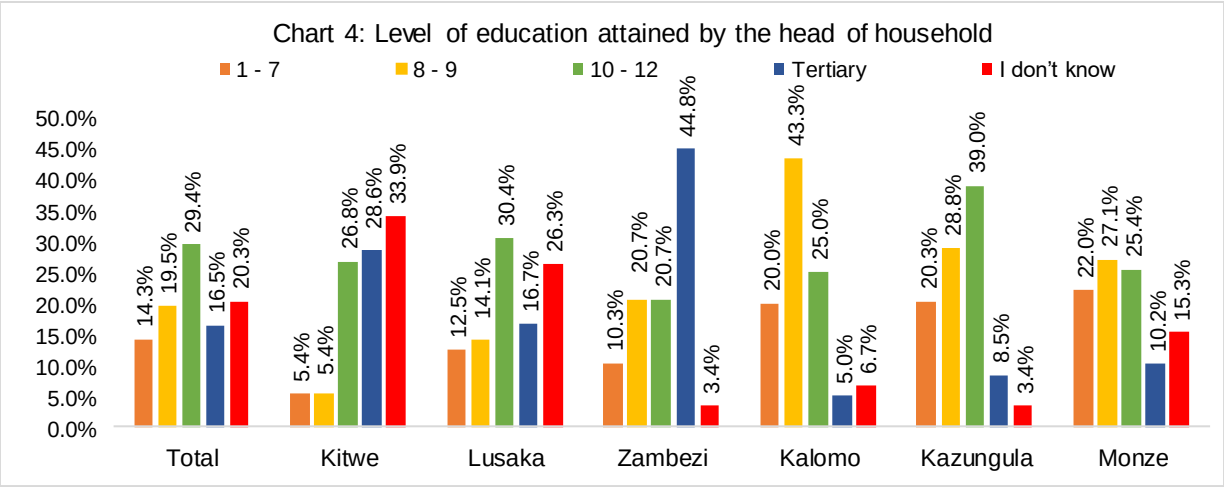
	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Mother	11	19.6%	68	21.8%	5	17.2%	7	11.7%	4	6.8%	4	6.8%	99	17.2%
Father	37	66.1%	181	58.0%	17	58.6%	47	78.3%	48	81.4%	38	64.4%	368	64.0%
Grandmother	1	1.8%	26	8.3%	1	3.4%	4	6.7%	1	1.7%	4	6.8%	37	6.4%
Grandfather	5	8.9%	15	4.8%	1	3.4%	2	3.3%	2	3.4%	7	11.9%	32	5.6%
Brother			8	2.6%	1	3.4%			2	3.4%	2	3.4%	13	2.3%
Sister			8	2.6%	4	13.8%			1	1.7%	2	3.4%	15	2.6%
Any other	2	3.6%	6	1.9%					1	1.7%	2	3.4%	11	1.9%

Source: Fieldwork Data, 2023

4.3.3 Level of education for the household heads

Based on the study's findings, the academic achievement levels of heads of households exhibit distinct patterns. The majority, at 29.4%, attended grade 10 to 12, while 19.5% had education

up to grade 8 to 9. Tertiary education was reported by 16.5% of respondents, and grade 1 to 7 education by 14.3%.



1 - 7	82	3	39	3	12	12	13
8 - 9	112	3	44	6	26	17	16
10 - 12	169	15	95	6	15	23	15
Tertiary	95	16	52	13	3	5	6
I don't know	117	19	82	1	4	2	9

Source: Fieldwork Data, 2023

This data highlights significant variation in education levels among households, which subsequently impacts their ability to provide comprehensive sexuality education information within the family setting. The lower levels of knowledge due to social barriers and limited exposure to information could hinder these families from engaging in open conversations about sexuality.

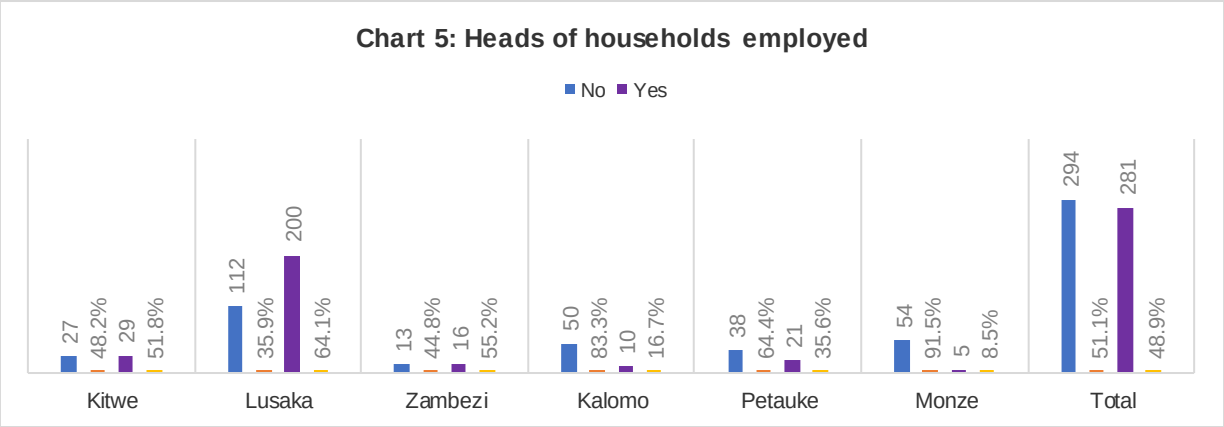
Consequently, learners may not have the privilege of accessing such information at home, reinforcing the important role of schools in providing comprehensive and accurate sexuality education to bridge the gap in knowledge and understanding.

4.3.4 Employment of the household heads

The study's findings on the employment status of heads of households reveal significant disparities. Notably, 48.9% were engaged in formal employment, while a considerable 51.1% were not employed at the time of the study. These statistics highlight social inequalities, indicating that a majority of household heads lack access to economic opportunities thereby rendering them socially and economically marginalized. This reality underscores the vital role of sound economic backgrounds in shaping young people's assertiveness levels and their access

to information without undue control. Economic stability can empower families to engage in open and informed discussions, enabling adolescents to navigate their sexual and reproductive health with confidence.

The study underscores the importance of addressing socioeconomic disparities to ensure comprehensive well-being and informed decision-making among adolescents.

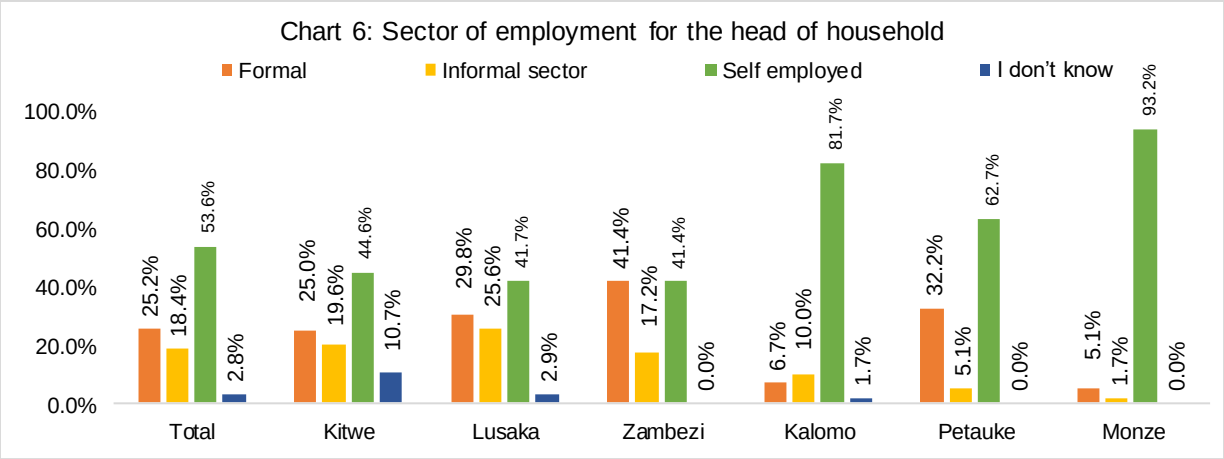


Source: Fieldwork Data, 2023

4.3.5 Employment sector for the head of household

This speaks to socio economic exclusion and does not guarantee easy access to information as heads of households maybe poor or not. Formal employment guarantees a particular lifestyle and young people raised in such households are more likely to have good access to information on adolescent sexual reproductive health which is also CSE.

This study has established that majority of the heads of household are self-employed at 53.6% whereas only 25.2% are in formal employment. The study shows that 18.4% are in informal sector where they are earning their own living.



Formal	145	14	93	12	4	19	3
Informal sector	106	11	80	5	6	3	1
Self employed	308	25	130	12	49	37	55
I don't know	16	6	9	0	1	0	0

Source: Fieldwork Data, 2023

During the focus group discussions, both male and female participants stated that their parents/guardians do not have money to provide for the family.

> *"My father is not working, so sometimes it's hard for me to come to school. I need clothes and shoes. Due to these challenges men take advantage and want to buy me clothes and give me money. It's hard."* **Female pupils, Chawama School**

> *"I live with my grandfather and he is a farmer. I am a weekly boarder and most of the times I run out of food."* **Male pupil, Nyawa School, Kazungula**

> *"These children come from very poor homes. They have to cook for themselves because they are weekly boarders. So, there was a case, one of the girls was dating a married man and the wife came to the school, wanted to beat her up. I had to intervene and talked to the girl."* **Guidance and counseling teacher, Nyawa Day secondary school, Kazungula**

> *"I have a friend who is dating a Rwandese. Her parents cannot buy her the things that she wants and she's only in grade 7. She tells me that he buys her anything that she wants. She has even started smoking shisha. I don't play with her anymore."* **Female pupil, Kanyama Basic school, Lusaka**

4.4 Impact of the implementation of CSE and documenting best practices in Zambia

Comprehensive sexuality education is central to the male and females' health and well-being, equipping them with the knowledge and skills they need to make healthy, informed, and responsible choices in their lives, including to prevent HIV, STIs and unplanned pregnancies among the females.

From the interviews with the guidance and counseling as well as teachers trained in CSE, they stated that CSE has had positive impacts.

> *"Children have started opening up especially some that have undergone abuse. A child is able to approach you and tell you something which is sensitive that's a win for them."* **Guidance and Counseling teacher, Chawama Primary School**

> *"Personal hygiene and menstrual hygiene most girls have improved because you would find that sometimes they're smelling but even for the boys, personal hygiene has improved." Guidance and Counseling teacher,* **Nyawa Day Secondary School, Kazungula**

> *"It has created room for teachers to talk openly. We are able to tell children that you should shave unlike back in the days. It has given us the courage and confidence as teachers to talk about personal hygiene like you should be bathing in the morning and etc. Teachers trained in CSE,* **Timothy Mwanakatwe Primary School, Lusaka**

> *"It has helped in teaching the science subject because back then they used to shy away and now they are able to get to the point."* **Njezya School, Lusaka**

> *"Sometimes they would come and say that this one is harassing this girl and you follow it up and now they're even able to report what is happening. I had a session where I was teaching the boys about GBV awareness, and I have trained more than 80 learners. There was an incident where a grade 8 was kissing a grade 5 but now there has been some changes after some punishment and engagement in the CSE lessons."* **Guidance and counseling teacher, Kanyama School**

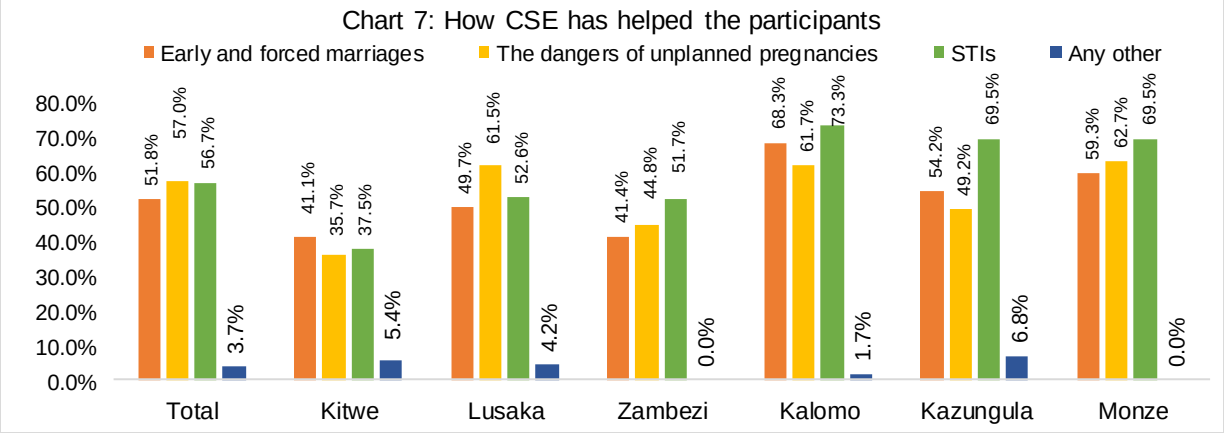
4.4.1 What participants have learnt from CSE

The study's findings show the impact of Comprehensive Sexuality Education (CSE) on learners. Notably, the data reveals that learner particularly value CSE for its contributions to preventing early and forced or early marriages, with 51.8% expressing this sentiment. Additionally, the

awareness of the dangers associated with unplanned pregnancies scored 57.1%, while the prevention of sexually transmitted infections (STIs) resonated with 56.7% of respondents. This clear appreciation from learners indicates that CSE is beneficial in addressing critical issues that directly affect their lives.

The study further highlights the desire among learners to continue benefiting from CSE and emphasizes the importance of maintaining and enhancing the quality and relevance of CSE programs to ensure comprehensive and effective education on sexual and reproductive health matters. A good CSE program is one that does not only impart knowledge about sexual and reproductive health but also effectively connects young people with the necessary support services. Beyond providing information, a good CSE program empowers learners to access healthcare, counseling, and resources that cater for their unique needs and advocating for a holistic approach to sexuality education and well-being.

The chart below is a depiction on what learners said about the impact of CSE on their lives.



Early and forced marriages	298	23	155	12	41	32	35
The dangers of unplanned pregnancies	328	20	192	13	37	29	37
STIs	326	21	164	15	44	41	41
Any other	21	3	13	0	1	4	0

Source: Fieldwork Data, 2023

In the focus group discussion, the female pupils stated that CSE has enabled them to understand how to prevent unplanned pregnancies.

> *"Our R.E, History and Mathematics teachers take us to the field and talk to us about puberty, hygiene, how to dispose the sanitary pads and bathing 2 times a day. If they didn't teach us these things we would have been aborting anyhow. But now we can prevent pregnancies by staying away from the boys and the big men."* **Female pupils, Kanyama School, Lusaka**

> *"Because of CSE, we have learnt how to prevent pregnancies and diseases. We have also been told that we don't have to get married at a young age."* **Female pupil, Njezya School, Kalomo**

CSE has also enabled the teachers to help the pupils in the schools. The guidance and counseling teacher from Chawama school reported that she was able to help a male pupil.

> *"I have not received any cases of STIs. But last month, I saw a boy who was struggling to walk. So, I called him to the office and he opened up to me and said that he had an STI. I had to refer him to the youth friendly corner at the clinic because we are working hand in hand with the health facility."* **Guidance and Counseling teacher, Chawama school**

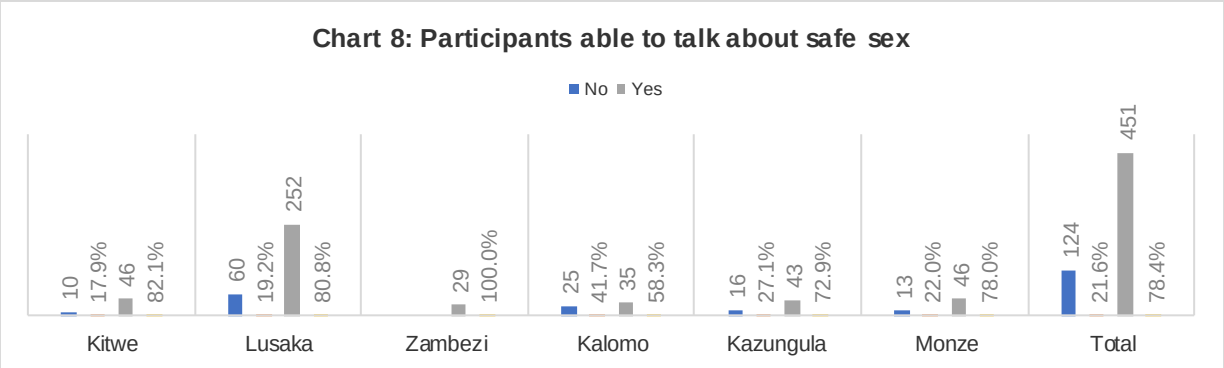
The male and female pupils indicated that they have learnt the dangers of unplanned pregnancies. The teacher trained in CSE from Nyawa Day Secondary school stated that teenage pregnancies have reduced at the school.

> *"At least now when you're talking about CSE in the classroom they're some positive changes. They're now few pregnancies, the numbers are not that big."* **Teacher trained in CSE, Nyawa Day Secondary, Kazungula**

4.4.2 CSE and the ability to freely talk about safe sex

The study's findings indicate a significant positive outcome in terms of learners' ability to openly discuss safe sex following their exposure to Comprehensive Sexuality Education (CSE). Impressively, 78.4% of respondents affirm that they can indeed converse freely about safe sex, with a minority of 21.6% indicating otherwise. This considerable margin underscores the efficacy of CSE in empowering learners with the knowledge and confidence to engage in open conversations about sexual and reproductive health matters.

The data implies that CSE is playing a crucial role in fostering a more informed and comfortable environment, enabling learners to address critical issues surrounding safe sex and overall well-being with greater openness and assertiveness.



Source: Fieldwork Data, 2023

4.4.3 Who participants talk to about safe sex after learning about CSE

The study's findings shed light on the significant influence of peer relationships in discussions about safe sex among learners after receiving Comprehensive Sexuality Education (CSE). Table 9 below shows that 39.5%% report that they talk about sex with their friends. This was followed by the grandmothers at 13,7%, with parents/guardians at 11.8% and female teachers 10.2%. Considering that CSE is delivered in the schools by the trained teachers, the study shows that about 8.9% talk about sex with the male teachers and 7.5% with the guidance and counseling. About 5.1% indicated that they talk to their cousins, brothers and sisters.

Table 10: Who participants talk to about sex

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Parents/ Guardians	12	26.1%	32	12.7%	1	3.4%	5	14.3%	2	4.7%	1	2.2%	53	11.8%
Grandmother	1	2.2%	28	11.1%	10	34.5%	11	31.4%	8	18.6%	4	8.7%	62	13.7%
Grandfather			3	1.2%	4	13.8%	6	17.1%	2	4.7%	1	2.2%	16	3.5%
Aunt			21	8.3%			3	8.6%			2	4.3%	26	5.8%
Uncle	2	4.3%	9	3.6%	3	10.3%	3	8.6%			1	2.2%	18	4.0%
Male teacher	2	4.3%	31	12.3%			4	11.4%	2	4.7%	1	2.2%	40	8.9%
Female teacher	3	6.5%	29	11.5%	5	17.2%	7	20.0%			2	4.3%	46	10.2%
Guidance & Counseling teachers	17	37.0%	12	4.8%	1	3.4%			4	9.3%			34	7.5%
Friends	8	17.4%	89	35.3%	9	31.0%	10	28.6%	29	67.4%	33	71.7%	178	39.5%
Any other	1	2.2%	18	7.1%	1	3.4%	1	2.9%			2	4.3%	23	5.1%

Source: Fieldwork Data, 2023

This data underscores the pivotal role that peers play in disseminating accurate information among themselves. The emphasis of CSE on fostering open and informed discussions about sexuality is reflected in these results, as learners gain the skills and confidence to engage in meaningful conversations about safe sex within their peer networks.

This underscores the importance of cultivating a supportive environment that empowers young people to share and seek reliable information from each other in a responsible and informed manner. On any other, the participants indicated that they are comfortable to talk to their best friends, sister, boyfriend and girlfriend.

During the focus group discussions with the male and female pupils, they stated that they are able to talk about sex with friends, sisters, grandmother and grandfather but not with the parents/guardians.

> *"When I learnt about sex at school, I was curious, and I wanted to learn more. The teacher told us that when you sleep with a man you can become pregnant, so I wanted to see whether it was true or not. I asked my sister and she said yes, So, in the evening I went and asked our neighbour, he is not married and lives alone. I told him to come and sleep with me. My mother was upset and I explained to her what the teacher had said. I thought that if you sleep in the same bed then you get pregnant. Then my sister explained to me that it was about sexual intercourse. I was shocked."* **Female pupil, focus group member, Kanyama Primary School**

> *"When the teacher was teaching us on puberty he talked about wet dreams. I went and asked my grandmother to explain more on what that meant. Learning about it at school has helped me understand that this is normal for boys."* **Male pupils, Nyawa Secondary School**

During the interviews with the teachers trained in CSE and guidance and counseling, it was reported that it is not easy to talk about sex or even say the word sex to pupils. It is hard to say it in the local languages, but in English it sounds much easier.

> *"There are certain terminologies that are a taboo to mention to the learners such as sexual intercourse."* **Guidance and counseling teacher, Chibomboma School, Kalomo**

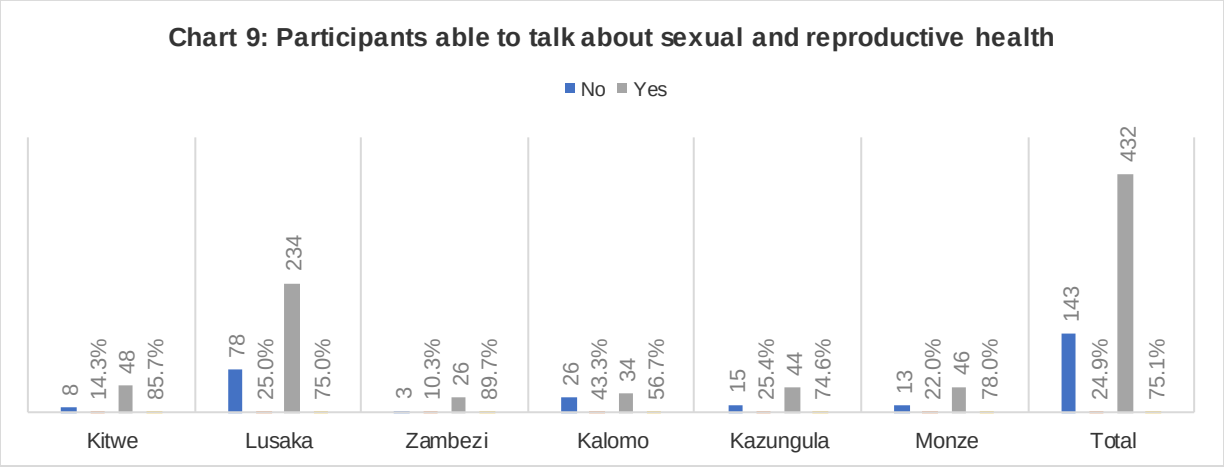
> *"I teach the grade fives and that is where my daughter is as well. So, when the topic of puberty, reproduction came up, I had to ask my fellow teacher to take up my class."* **Teacher trained in CSE, Bbwantu Primary school, Monze**

4.4.4 Participants able to talk about sexual and reproductive health

The data presented in chart 10 underscores a positive outcome in terms of learners' ability to discuss their sexual reproductive health following their engagement with Comprehensive Sexuality Education (CSE). Impressively, 75.1% of respondents express that they can engage in such conversations, while 24.9% indicate that they find it challenging.

This highlights a good outcome of CSE, as most learners exhibit a positive effect from their school-based learning. However, there still remains a substantial portion of learners at 25.6% who still struggle in this regard and this raise concerns that need addressing.

Ensuring that all learners have the skills and confidence to discuss their sexual reproductive health openly remains a priority, demonstrating the importance of continuous improvement and reinforcement of CSE programs to benefit all students effectively.



Source: Fieldwork Data, 2023

4.4.5 Who participants talk to about sexual and reproductive health

Table 10 below shows that pupils feel very comfortable to talk to their friends about reproductive health at 40.5% followed by grandmothers at 17% and parents/guardians at 16% respectively.

This data therefore suggests that parents or guardians are not the most common choice for discussions about safe sex. This could indicate a need for increased parental involvement in conversations about children's sexual health and education.

Table 11: Who participants talk to about sexual and reproductive Health

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Parents/ Guardians	13	27.1%	50	21.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	66	16.0%
Grandmother	7	14.6%	38	16.4%	14	53.8%	14	53.8%	0	0.0%	5	10.9%	70	17.0%
Grandfather	0	0.0%	3	1.3%	3	11.5%	3	11.5%	0	0.0%	0	0.0%	6	1.5%
Aunt	0	0.0%	13	5.6%	0	0.0%	0	0.0%	0	0.0%	2	4.3%	16	3.9%
Uncle	1	2.1%	9	3.9%	1	3.8%	1	3.8%	0	0.0%	1	2.2%	12	2.9%
Male teacher	2	4.2%	14	6.0%	1	3.8%	1	3.8%	0	0.0%	2	4.3%	19	4.6%
Female teacher	4	8.3%	25	10.8%	4	15.4%	4	15.4%	0	0.0%	0	0.0%	33	8.0%
Guidance & Counseling teachers	12	25.0%	11	4.7%	1	3.8%	1	3.8%	1	3.8%	4	8.7%	29	7.0%
Friends	10	20.8%	73	31.5%	2	7.7%	2	7.7%	25	96.2%	32	69.6%	167	40.5%
Any other	0	0.0%	24	10.3%	1	3.8%	1	3.8%	0	0.0%	0	0.0%	25	6.1%

Source: Fieldwork Data, 2023

During the focus group discussions, the male and female participants stated that they are scared to talk to the parents for fear of being beaten or scolded. Others said that it is not in their culture to talk to parents about sexual issues.

> *"At home it's my grandmother that talks about puberty. When I started my period, it was my grandmother who told me that I should not have sex with boys."* **Female pupil, Chawama Primary School, Lusaka**

> *"I am comfortable to talk to my mother. She tells me that I should not be moving in the night. It's dangerous for girls, I might get raped."* **Female pupil, Timothy Mwanakatwe Primary School, Lusaka**

Efforts could be made to encourage parents to engage in open and informed discussions with their children. Further, the fact that friends are the most common choice for discussing safe sex might indicate the influence of peers on individuals' behavior and attitudes. Peer education can be both positive and negative. Encouraging accurate and responsible information sharing among friends can be beneficial, but it's important to ensure that the information shared is accurate and safe.

The teachers, particularly guidance and counseling teachers though not preferred, play a significant role in providing information about safe sex. This highlights the importance of comprehensive sexuality education programs in schools and the role of teachers as trusted sources of information. Different generations (represented by grandparents) are not commonly chosen as confidants for discussions about safe sex. This could suggest a potential gap in communication and understanding between generations regarding contemporary sexual health practices and attitudes.

The varying preferences for who to talk to about safe sex in different provinces might reflect differences in cultural norms, educational programs, and access to resources. Tailoring educational initiatives to the specific needs and preferences of each region could be more effective.

Overall, the data suggests the importance of a multifaceted approach to comprehensive sexuality education that involves parents, peers, teachers, and other trusted individuals. It's important to ensure that accurate and respectful information is provided to individuals across different age groups and regions.

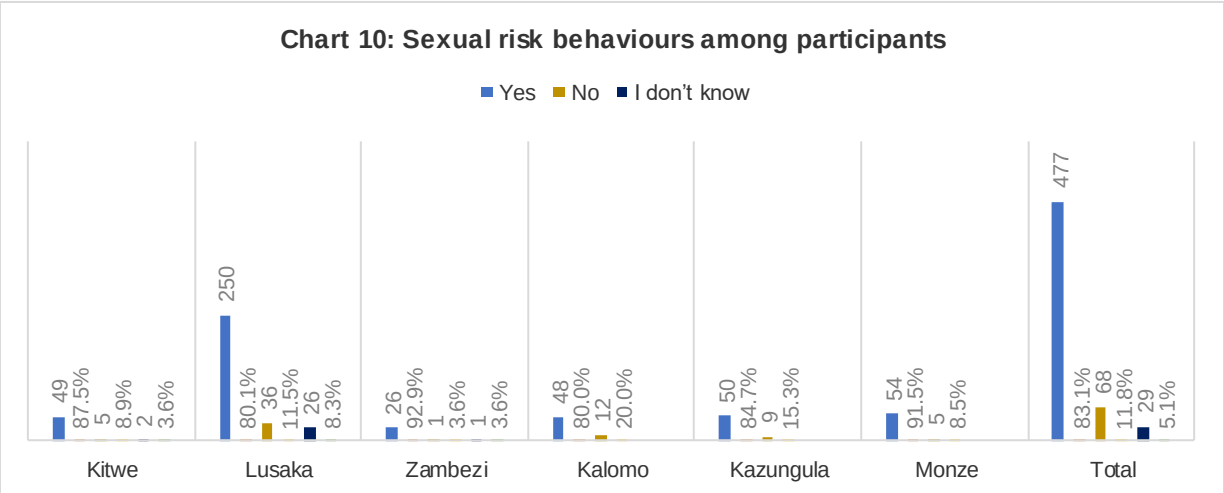
4.4.6 Knowledge about sexual risk behaviour

This study has established that learners understand what sexual risk behaviour is at 83.1% while 11.8% said they don't understand. If learners can understand risk, it should be easy for them to apply knowledge learnt to avoid risky sexual behaviour that has potential to affect their lives. This is a direct attribution to the positive effect of CSE which learners are accessing through the school system. One of the main goals of learning CSE is the understanding of sexual reproductive health.

The knowledge about sexual risk behavior is so invaluable in fostering healthy and informed decision-making. By understanding the potential risks and consequences associated with sexual activity, individuals can make informed choices that prioritize their well-being and that of their partners. This knowledge empowers individuals to engage in safer practices, such as using contraceptives where possible and practicing safe sex, thereby reducing the transmission of sexually transmitted infections (STIs) and unplanned pregnancies.

Moreover, the awareness of sexual risk behavior encourages open conversations about consent, communication, and boundaries thereby ensuring healthier relationships and

promoting respect. Ultimately, a strong foundation of knowledge in this area equips individuals with the tools to lead safer and more responsible sexual lives.



Source: Fieldwork Data, 2023

4.4.7 Sexual behaviour risk participants engage in

The study found out that adolescents engage in sexual risky behaviour that include unprotected sex at 71.1%, forced relationships at 36.2% and GBV at 22% as well as bullying other opposite sex. Other risky behaviour includes sexual favors for good academic results at 25.1% and sexual coercion at 6.1%.

The implications of sexual risky behaviors among young people are far-reaching and multifaceted. Engaging in unsafe sexual practices, such as unprotected sex or multiple partners, can increase the risk of contracting sexually transmitted infections (STIs) like HIV, as well as lead to unintended pregnancies.

These consequences can have profound physical, emotional, and psychological impacts on individuals, often disrupting their education, career prospects, and overall well-being. Additionally, risky behaviors can strain personal relationships and erode trust. The societal impact includes the burden on healthcare systems, as well as potential transmission of infections to broader populations. This study notes and recommends that addressing and educating young people about sexual risks is essential to promoting their health, well-being, and prospects, while also contributing to the broader public health goals of disease prevention and healthy communities.

Table 12: Sexual Risks behaviours

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Unprotected sex	39	81.3%	196	70.3%	6	23.1%	40	83.3%	35	70.0%	43	79.6%	359	71.1%
Forced relationships	2	4.2%	96	34.4%	14	53.8%	29	60.4%	18	36.0%	24	44.4%	183	36.2%
Fight for the opposite sex	2	4.2%	69	24.7%	3	11.5%	13	27.1%	2	4.0%	22	40.7%	111	22.0%
Bullying of opposite sex	1	2.1%	62	22.2%	1	3.8%	15	31.3%	5	10.0%	16	29.6%	100	19.8%
Sexual coercion	2	4.2%	12	4.3%	1	3.8%	8	16.7%	7	14.0%	1	1.9%	31	6.1%
Sexual favors for good grades			57	20.4%	3	11.5%	26	54.2%	21	42.0%	20	37.0%	127	25.1%
I don't know	2	4.2%	21	7.5%									37	7.3%
Any other			13	4.7%									13	2.6%

Source: Fieldwork Data, 2023

4.4.8 Why adolescents engage in risky sexual behaviour

Based on the chart below, the study has established why adolescents engage in risky sexual behaviour with peer pressure leading the graph at 66.6% followed by poverty at 42.1% and lack of exposure to information at 38.3%. Others include not knowing how to handle stress that comes with adolescence at 32.2% and decision making at 27.1%.

Further, adolescents may engage in risky sexual behavior due to a combination of other factors, including curiosity, peer pressure, limited experience, and a desire for independence. The period of adolescence is marked by a search for identity and experimentation, which can lead some individuals to engage in behaviors without fully considering the potential consequences. Peer pressure and the desire to fit in can also play a significant role, as young people and indeed learners often seek acceptance from their peers.

Additionally, inadequate access to comprehensive sexuality education and accurate information about safe practices might contribute to uninformed decision-making. Addressing these factors through education, open communication, and support can help guide adolescents towards healthier and safer choices regarding their sexual behavior.

Table 13: Why participants engage in sexual risky behaviours

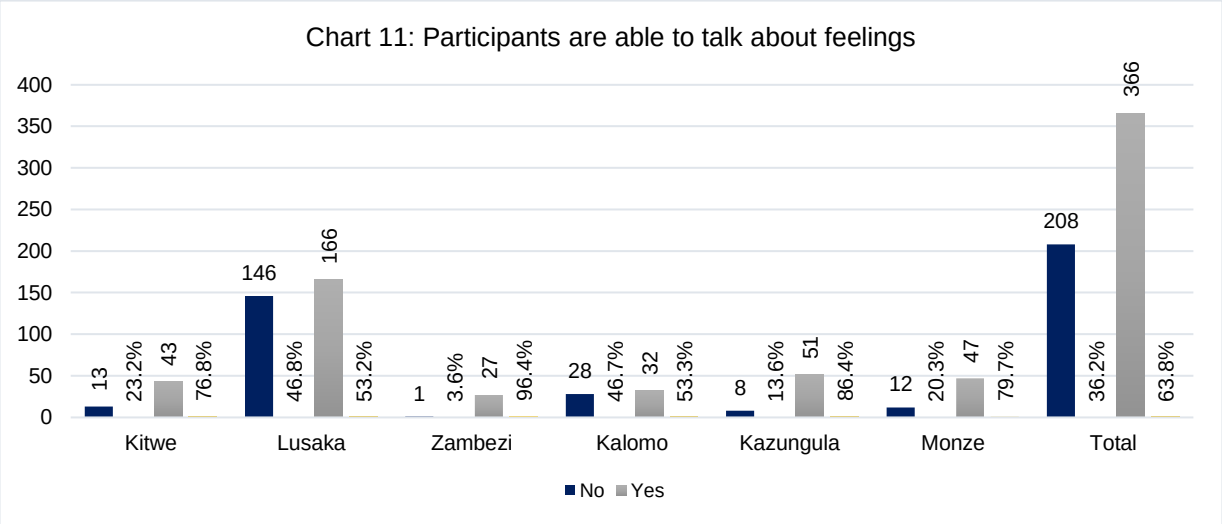
	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Peer Pressure	23	46.9%	181	64.9%	12	46.2%	42	87.5%	36	72.0%	43	79.6%	337	66.6%
Not knowing how to handle stress that comes with adolescence	7	14.3%	91	32.6%	7	26.9%	21	43.8%	12	24.0%	25	46.3%	163	32.2%
Lack of exposure to information	11	22.4%	91	32.6%	7	26.9%	38	79.2%	19	38.0%	28	51.9%	194	38.3%
Poor self-image	2	4.1%	47	16.8%	6	23.1%	16	33.3%	8	16.0%	14	25.9%	93	18.4%
Lacking decision making skills	5	10.2%	72	25.8%	2	7.7%	24	50.0%	15	30.0%	19	35.2%	137	27.1%
Poverty	6	12.2%	119	42.7%	14	53.8%	18	37.5%	33	66.0%	23	42.6%	213	42.1%
Parents/guardians failure to provide at home	1	2.0%	16	5.7%	4	15.4%	2	4.2%	1	2.0%	2	3.7%	26	5.1%
Any other	2	4.1%	26	9.3%									28	5.5%

Source: Fieldwork Data, 2023

4.4.9 Participants able to talk about feelings for the opposite sex

The study found out that 63.8% of the respondents said they are able to talk about their feelings for their opposite sex whereas only 36.2% said they are not able to. The bigger proportion in this response is that of those who are able to demonstrate the Positive effect of CSE. Comprehensive Sexuality Education (CSE) equips individuals with the ability to openly and confidently discuss their feelings for the opposite sex. By providing a foundation of understanding about relationships, consent, communication, and emotional well-being, CSE fosters a safe space for dialogue.

This education encourages young people to express their emotions, desires, and concerns in a respectful and informed manner. The knowledge gained from CSE empowers individuals to navigate relationships more effectively, make informed decisions, and establish healthier connections built on mutual respect, consent, and communication. Overall, CSE enables a more open and authentic discussion of feelings for the opposite sex thereby promoting and fostering healthier relationships.



Source: Fieldwork Data, 2023

4.4.10 Who participants are comfortable to talk about feelings

The study established that learners opted for others at 60% without clearly being descriptive. This was followed by grandmothers at 13.8% and parents/Guardians at 9.8. The rest of the responses are insignificant. Further, it is clear that learners often feel most comfortable talking about their feelings with people they trust and perceive as non-judgmental and understanding.

Table 14: Who participants are comfortable to talk to about feelings

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Parents/ Guardians	9	20.9%	21	9.3%			5	15.6%			7	14.9%	42	9.8%
Grandmother	8	18.6%	24	10.6%	7	25.9%	10	31.3%	8	15.7%	2	4.3%	59	13.8%
Grandfather	1	2.3%	14	6.2%	1	3.7%	4	12.5%	5	9.8%			25	5.9%
Aunt	3	7.0%	24	10.6%	1	3.7%	4	12.5%			1	2.1%	33	7.7%
Uncle	2	4.7%	10	4.4%	1	3.7%					3	6.4%	16	3.7%
Male teacher	1	2.3%	11	4.8%					2	3.9%	1	2.1%	15	3.5%
Female teacher	2	4.7%	16	7.0%	1	3.7%	2	6.3%	1	2.0%	1	2.1%	23	5.4%
Guidance & Counseling teachers	12	27.9%	9	4.0%	1	3.7%			2	3.9%			24	5.6%
Best friend	6	14.0%	148	65.2%	16	59.3%	18	56.3%	39	76.5%	33	70.2%	260	60.9%

Source: Fieldwork Data, 2023

The individuals the participants are referring to include close friends, family members like parents or siblings, supportive teachers or mentors, and sometimes even guidance and

counselling teachers. The sense of comfort comes from the assurance that their emotions will be heard, validated, and respected.

Establishing such a network of trusted individuals builds an environment where learners can openly express their thoughts, concerns, and experiences thereby enabling them to navigate the challenges of life more effectively and seek guidance when needed.

The findings show that CSE is being taught in the schools and teachers are key in the delivery of the topics in the carrier subjects. However, the response from the pupils that participated in the study clearly shows that teachers are not given the prominence in terms of preference when it comes to pupils talking about their feelings for the opposite sex. This should be a concern and a challenge worth establishing as to why teachers are not preferred as much as parents as well as guidance and counseling teachers. This is a challenge because teachers were trained to deliver CSE at classroom level. Therefore, efforts should be made to ensure that learners become comfortable to learn from teachers through effective methods because teachers were trained in participatory approaches.

In the focus group discussions, the male and female participants stated that they are comfortable to talk about their feelings with friends.

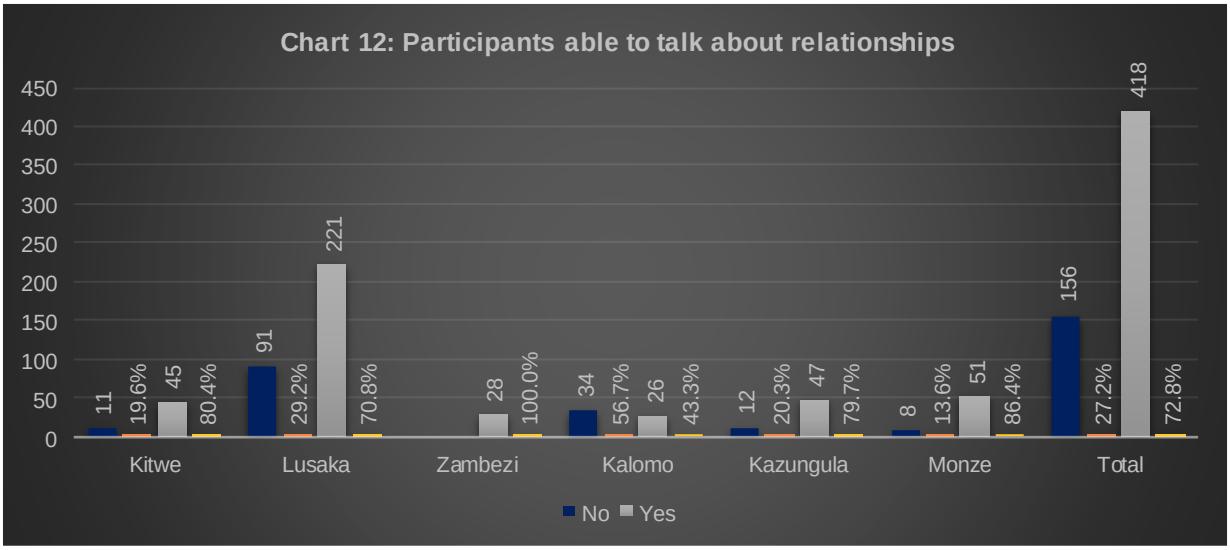
> *"I can't talk to my mother about feelings for the opposite sex, she will beat me and am scared that she will think am not a good girl. So, I feel more comfortable talking to my friends. They don't judge me."* **Female pupil, Kanyama Primary school, Lusaka**

> *"I am more comfortable talking to my friends because I'm scared that my mum will shout at me. I don't fully trust my friends, sometimes they give good advice, then there are times when I don't take their advice. For example, there was a boy that was asking me out and I told my friend. Her advice to me was that I say yes, but I was not comfortable because am still young and I want to finish school."* **Female pupil, Chawama primary school, Lusaka**

> *"I am comfortable to talk to my friends about sexual feelings. But when I want answers, I ask the female teachers. I asked the teacher whether boys and girls have the same feelings, what can I do as a boy to control the feelings for the opposite sex?'* ***Male pupil, Chibomboma School, Kalomo***

4.4.11 Participants talk about relationships after learning CSE

The study findings have established that learners are able to talk about their relationships after learning about CSE at 72.8% whereas only 27.2% said no.



Source: Fieldwork Data, 2023

4.4.12 Comfortable to talk to about relationships

The participants were asked to indicate who they are comfortable to talk to about relationships since they started learning CSE. Majority of the participants 360 (62.7%) indicated that they talk to their best friends, followed by 80 (13.9%) indicated grandmother, 66 (11.5%) said parents/guardians and 44 (7.7%) said their aunt.

Table 15: Who participants talk to about relationships

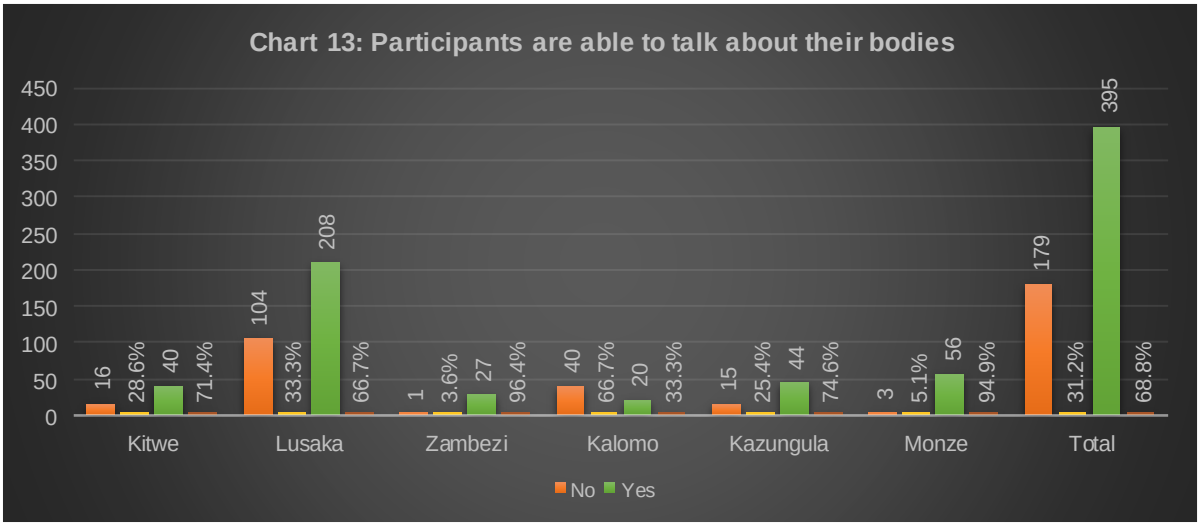
	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Parents/ Guardians	19	33.9%	39	12.5%	1	3.6%	2	3.3%	1	1.7%	4	6.8%	66	11.5%
Grandmother	11	19.6%	36	11.5%	10	35.7%	10	16.7%	11	18.6%	2	3.4%	80	13.9%
Grandfather	1	1.8%	16	5.1%	3	10.7%	3	5.0%	3	5.1%			26	4.5%
Aunt	8	14.3%	35	11.2%					1	1.7%			44	7.7%
Uncle			12	3.8%	1	3.6%			1	1.7%	1	1.7%	15	2.6%
Male teacher			10	3.2%									10	1.7%
Female teacher	1	1.8%	13	4.2%					2	3.4%			16	2.8%
Guidance & Counseling teachers	13	23.2%	7	2.2%	1	3.6%			1	1.7%			22	3.8%
Best friend	8	14.3%	194	62.2%	14	50.0%	48	80.0%	44	74.6%	52	88.1%	360	62.7%

Source: Fieldwork Data, 2023

This demonstrates that CSE is having a positive effect on the learners and helps them to freely interact. It is also true based on this finding that after undergoing Comprehensive Sexuality Education (CSE), individuals are better equipped to engage in open conversations about relationships. CSE provides learners with a solid understanding of key concepts such as consent, communication, boundaries, and emotional well-being which are essential in building positive relationships. This knowledge empowers individuals to discuss their expectations, concerns, and desires with greater confidence and clarity. As a result, they can navigate relationships more effectively, establish healthy boundaries, and address issues that may arise with better communication skills. CSE encourages a culture of respect, empathy, and understanding, enabling individuals to build stronger and more meaningful connections with others based on mutual trust and shared values.

4.4.13 Participants are comfortable to talk about their body after learning about CSE.

On whether respondents are comfortable talking about their bodies, 68.8% said yes, they are comfortable to talk about their bodies whereas 31.2% said they are not comfortable. While the question was too broad, it can be argued that the margin for those who said they are not is too big and creates a concern.



Source: Fieldwork Data, 2023

The reason for this variation is not clearly understood. After learning about CSE, pupils typically experience increased comfort when discussing topics related to their bodies. It is also clear that CSE provides them with accurate information about anatomy, puberty, and sexual health thereby helping to demystify the concept of CSE. Equipped with this knowledge, male and female pupils become more confident in their understanding of their bodies, enabling them to address questions, concerns, and curiosities openly.

This newfound comfort fosters a positive body image and a healthier perspective on physical changes. Furthermore, the ability to discuss these matters openly promotes a culture of self-awareness, self-care, and a sense of empowerment, which collectively contribute to a more informed and confident approach to personal well-being.

4.4.15 Who you are comfortable to talk to about your body

The participants were asked to state who they are comfortable to talk to about their bodies, 46% indicated that they prefer to talk to their best friends. If this is not about teachers who are trained to deliver CSE, it must be concerning. 18.1% for parents and guardians and 18.1% for grandmothers. Teachers both male and female including guidance teachers are way below the graph at 3.7%, 5.9% and 5% respectively.

Table 16: Who participants talk to about relationships

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Parents/ Guardians	12	30.0%	55	22.0%	2	7.4%	4	20.0%	3	6.8%	3	5.4%	79	18.1%
Grandmother	8	20.0%	40	16.0%	13	48.1%	3	15.0%	17	38.6%	1	1.8%	82	18.8%
Grandfather	3	7.5%	11	4.4%	3	11.1%	4	20.0%	11	25.0%			32	7.3%
Aunt	3	7.5%	30	12.0%	3	11.1%	2	10.0%	2	4.5%	4	7.1%	44	10.1%
Uncle	3	7.5%	18	7.2%			3	15.0%	4	9.1%	2	3.6%	30	6.9%
Male teacher	2	5.0%	12	4.8%			1	5.0%	1	2.3%			16	3.7%
Female teacher	5	12.5%	16	6.4%					2	4.5%	3	5.4%	26	5.9%
Guidance & Counseling teachers	11	27.5%	5	2.0%	1	3.7%			5	11.4%			22	5.0%
Best friend/s	5	12.5%	117	46.8%	11	40.7%	8	40.0%	17	38.6%	43	76.8%	201	46.0%

Source: Fieldwork Data, 2023

It is quite concerning that teachers, parents, and guidance counseling teachers, who are well-suited to provide support and accurate information, are not often preferred by learners as sources of discussion about their bodies. This hesitancy might stem from societal taboos, cultural barriers, or the fear of judgment. In some cases, learners might perceive these figures as authority figures rather than approachable individuals for personal discussions. Addressing this issue is crucial, as these trusted adults can offer essential guidance, ensure accurate information, and provide a safe space for learners to navigate questions about their bodies and overall well-being. Encouraging open and non-judgmental communication within these

relationships is vital to breaking down barriers and fostering an environment where learners feel comfortable seeking guidance and support from those who can provide it best.

During the focus group discussions with the male and female pupils, they stated that they are comfortable to talk about their bodies with their friends.

> *"It is embarrassing to talk about your body when there are boys and even with the girls because they judge and start talking about it. I can't even ask the teacher in class because I will be judged by my fellow students. So, I talk to my best friends because they will not judge me".* **Female pupil, Timothy Mwanakatwe Primary School, Lusaka**

> *"I can only ask questions about the body to the female teachers, it's embarrassing to ask the male teachers."* **Female pupil, Nyawa Day Secondary School, Kazungula**

4.4.15 School-related gender-based violence

School-related gender-based violence (SRGBV) describes physical, sexual and psychological acts of violence in and around schools, underpinned by unequal access to resources and power, and inequitable norms and stereotypes. While there is increasing recognition of SRGBV as a major issue globally, rigorous reviews of literature have concluded that evidence about effective ways to address it is lacking.

One of the key pillars of CSE is the prevention of violence among young people in schools. Mukonka states that gender-based violence is not just physical but psychological as depicted by this study. Bullies make the school environment unsafe and CSE should continue to aim at ensuring that schools become better places for all whether male or female[85].

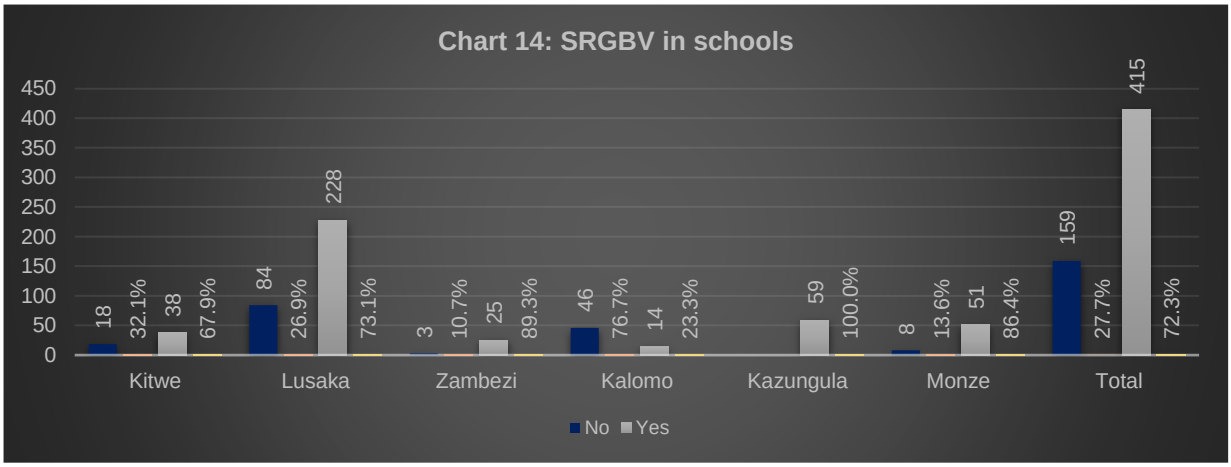
4.4.17 Violence targeted at girls/boys in school

This study found out that there is violence targeted at girls/boys in schools at 72.3% of respondents saying yes and 27.7% saying there is no violence targeted at girls/boys in schools. This confirms that schools may not be safe spaces for many learners and this calls for continued efforts to provide CSE which integrates information on prevention of violence.

[85] Mukonka (2022)

Preventing violence aimed at both girls and boys in schools holds immense significance. It is also vital for creating a safe and nurturing environment that supports learning and personal growth. Violence disrupts this atmosphere, impacting not only the victims but the entire school community. Ensuring the safety and well-being of all learners, regardless of gender, is essential for their mental, emotional, and academic development.

By addressing violence, schools can instill respect, empathy, and conflict resolution skills in students. This not only prevents immediate harm but equips them for a life where mutual understanding and peaceful coexistence are the norms.



Source: Fieldwork Data, 2023

4.4.18 Forms of violence is targeted at girls/boys

On forms of violence targeted at boys and girl learners with disabilities, this study found out that 70.2% of respondents said bullying while 42% said physical fights. Sexual harassment was rated 37.2% while sexual acts in exchange for good grades or paying school fees where this applies was rated 16% and 13.4% seduction or sexual harassment.

This outcome generates more concern especially that these are learners with disabilities. A protective and free from violence school environment should be guaranteed. Tolerating violence in schools for learners with disabilities undermines their right to a safe and inclusive education. These learners already face unique challenges in their educational journey and subjecting them to violence compounds their struggles. Therefore, creating a safe and inclusive learning environment is paramount, where every student can thrive without fear. Allowing violence to persist not only undermines their well-being but also contradicts the principles of equality and respect for human rights.

Table 17: School related gender-based violence

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Bullying	27	71.1%	179	77.2%	8	32.0%	7	50.0%	41	69.5%	32	62.7%	294	70.2%
Physical fighting	4	10.5%	113	48.7%	8	32.0%	9	64.3%	14	23.7%	28	54.9%	176	42.0%
Sexual harassment	6	15.8%	91	39.2%	3	12.0%	8	57.1%	35	59.3%	13	25.5%	156	37.2%
Sexual acts in exchange for good grades or for the paying of school fees	8	21.1%	29	12.5%	7	28.0%	4	28.6%	7	11.9%	12	23.5%	67	16.0%
Seduction or sexual harassment of learners by a teacher	4	10.5%	26	11.2%	5	20.0%	2	14.3%	4	6.8%	15	29.4%	56	13.4%

Source: Fieldwork Data, 2023

In the focus groups the male and female pupils stated that SRGBV exists in the schools.

> *"There are girls at this school who are junkies. They write insults on the walls in the toilets and sometimes they say bad things to some of us. These are girls who are sleeping with big men. Some are in grade 5".* **Female pupil, Kanyama primary school, Lusaka**

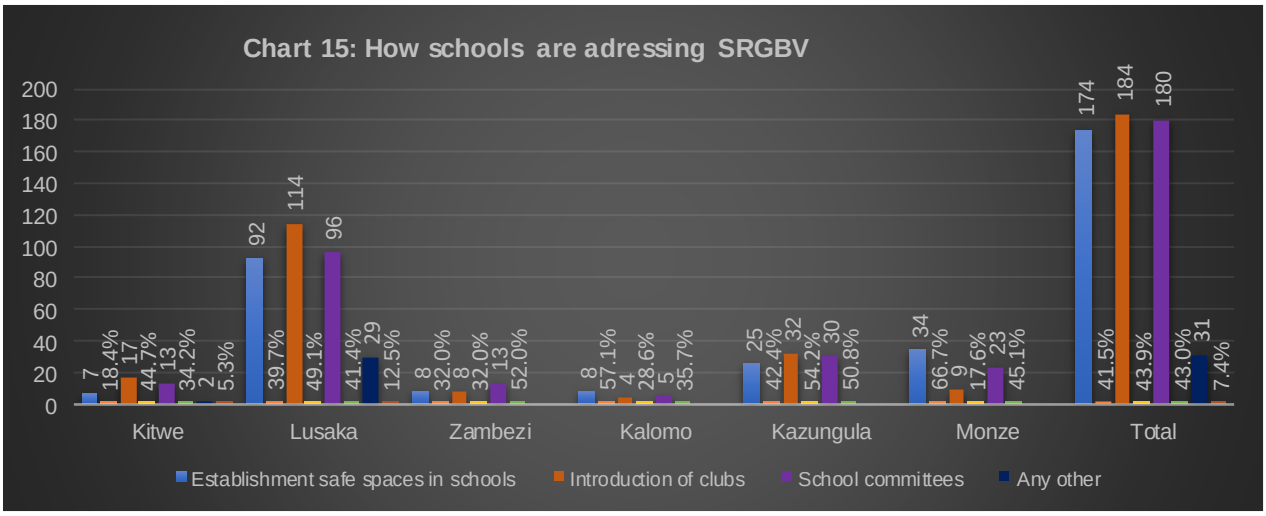
> *"We used to touch the girls' breasts and buttocks, but now we have stopped. Our teachers have told us that it is not good behaviour."* ***Male pupil, Timothy Mwanakatwe primary school, Lusaka***

> *"There are boys and girls that are in relationships. They hide from the teachers. I know some of the pupils in my class that have girlfriends, they kiss when the teachers are not around."* **Male pupil, Nyawa Day Secondary school, Kazungula**

4.4.19 How the schools are addressing violence

This study discovered that schools are taking measures to address violence aimed at learners. Specifically, 43.9% of respondents highlighted the importance of school clubs in spreading prevention information about school related violence. Additionally, 43% of respondents acknowledged the role of school committees, while 41.5% pointed out the positive impact of creating safe spaces within schools. These findings underscore the importance of diverse

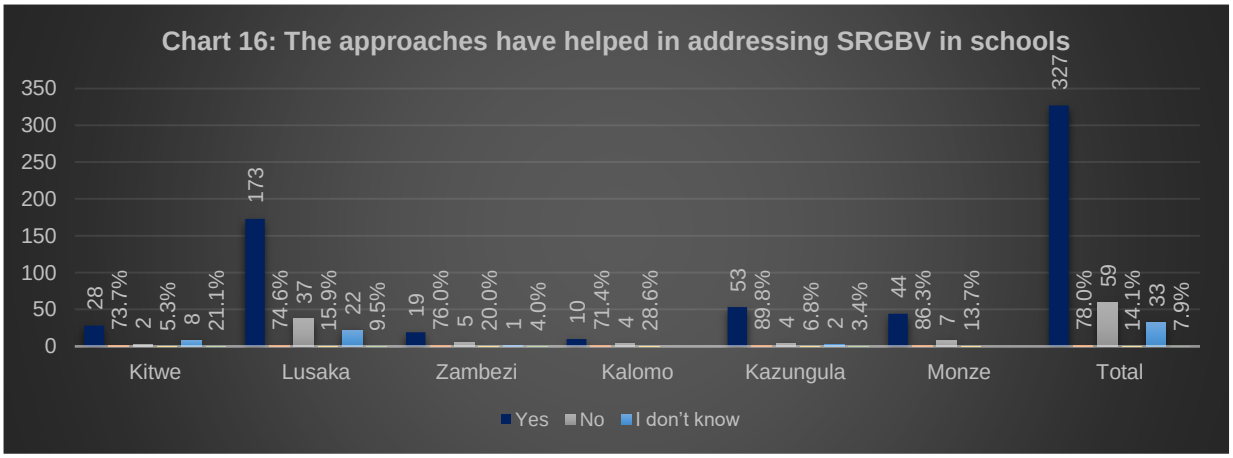
approaches in combatting violence and fostering secure and nurturing educational environments.



Source: Fieldwork Data, 2023

4.4.20 Approaches of addressing Gender-based violence at school level helped

The effectiveness of approaches aimed at addressing gender-based violence at school level was assessed, revealing compelling results. A significant majority, comprising 78% of respondents, expressed that these approaches have indeed proven helpful. In contrast, a minority of 14.1% indicated that they felt the approaches had not yielded the desired impact. These findings indicate a notable level of appreciation among learners for the preventive measures undertaken by schools. The clear support expressed by the majority underscores the importance of continuing and potentially expanding such efforts to ensure safer and more secure educational environments.



Source: Fieldwork Data, 2023

4.5 Existing gaps in the implementation of CSE

Debate among researchers and practitioners on effective approaches to measuring the impact of, and effective processes for delivering CSE has emerged in the past decade. The study aimed at establishing the existing gaps in the implementation of CSE in the schools.

During the interview with the guidance and counseling teacher, she pointed out that CSE text books and teaching aids are not available. The pupils are not able to grasp how the STIs affect the reproductive organs.

> *"There are sensitive issues where some teachers do not teach. So, if we expose the learners to the internet and tell them to go and research and all those things, I feel it would broaden their understanding of CSE and it can really help learners make better choices. For example there is this part where it is able to show the different parts of the sexually transmitted diseases if the learner is able to see rather than teaching them in abstract because the learner never comes in contact with a sexually transmitted disease and literally no matter how you teach about it the learner won't grasp the concept so when you give the learners time to research and let them see it and maybe you unveil the information that we have they are able to see that these are the repercussions, these are the symptoms. You're broadening their understanding of various topics in CSE. They don't have access to internet so everything is just theoretical. There isn't a practical part. With theory the retention is only about 30% they can easily forget."* **Guidance and counseling teacher, Chawama Primary School, Lusaka**

Other gaps in the implementation of CSE is that there are no specific reports on CSE provided to the district education board secretary. According to the head teachers they stated that they send reports, but there is no stand-alone report on CSE.

> *"Yes, there is coordination between the school and the ministry of education. Because we are implementing and teaching CSE. So, when the monitors come, they want to see the aspect of CSE in the lesson plan, they observe the lesson. So, this is done termly. They don't announce. They just come. We have the school in service provider, she's the one who's in charge of it. As a guidance teacher there's information that I give her in relation to CSE so I believe she's the one who forwards it to the DEBS. Headteacher, Timothy Mwanakatwe primary school, Lusaka*

Training is not adequate to equip the guidance and counseling teachers to handle certain issues that happens within the school premises;

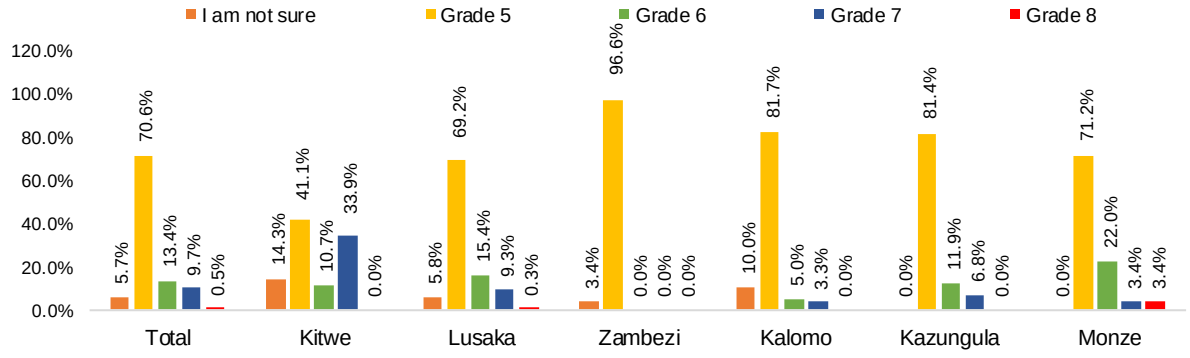
"I can give a rating of 8/10 mainly because sometimes I don't have enough information on what they're asking questions on abortion. I have to be careful on how to answer these things. There was a case where a grade 5 was tormented by friends and they ended up fighting and she started victimizing the friends. The child according to rumors was pregnant and she had an abortion and from that abortion they started laughing at her and she tried to commit suicide. So as a guidance teacher I need more information on abortion, mental health, suicide for me to be able to understand and be able deal with those issues." **Guidance and counseling teacher, Chawama Primary School, Lusaka**

"I was not trained in CSE, I was only oriented by my fellow teacher. She explained to us what CSE is all about. It has helped me to integrate it in R.E but there are certain questions that I can't ask." **Female teacher, Timothy Mwanakatwe School, Lusaka**

4.5.1 When Participants started learning CSE

The data in chart 18 below provides clarity regarding the point at which learners started learning about Comprehensive Sexuality Education (CSE). Remarkably, 70.6% of learners confirmed that they commenced learning about CSE in grade five, aligning with the Ministry of Education's CSE framework that stipulates CSE instruction from grade 5 to grade 12. However, variations in responses surfaced, with 5.7% of learners stating uncertainty about the start, 13.4% beginning in grade 6, and 9.7% starting in grade 7.

Chart 17: The grade when participants started learning CSE



I am not sure	33	8	18	1	6	0	0
Grade 5	406	23	216	28	49	48	42
Grade 6	77	6	48	0	3	7	13
Grade 7	56	19	29	0	2	4	2

Source: Fieldwork Data, 2023

These disparities raise concerns, given that CSE is a policy-mandated curriculum taught in schools. The presence of fragmented understanding among learners' hints at potential discrepancies among teachers responsible for delivering CSE lessons. Addressing these variations is imperative to ensure consistent and accurate CSE education, promoting comprehensive understanding among learners and educators alike.

Among the teachers trained in CSE they stated that CSE starts from grade 5 to grade 12. They are following the curriculum; however, they are not sure why CSE is not implemented in the lower grades.

> *"From grade 5 up to grade 9 that's where CSE is being taught. Grades 1-4 don't receive and I am not sure why. The books that we have in the school start from grade 5 so we just follow the books because we can't teach something that does not fit into the curriculum."* **Guidance and counseling teacher, Chawama Primary School, Lusaka**

> *Here we are also integrating CSE for the lower grades. We are in the rural areas and children start school when they are older, it's different with the urban areas. They already know about some of these things, especially puberty and hygiene. That is what we talk to them.* **Teacher trained in CSE, Bbwantu School, Monze**

The absence of a standard training manual for Comprehensive Sexuality Education (CSE) in Zambia is a critical issue that demands immediate attention. As research findings indicate, the current implementation of CSE without a standardized training manual leaves teachers heavily reliant on resources, primarily PowerPoint presentations shared during teacher training sessions. This ad-hoc approach not only undermines the consistency of the curriculum delivery but also compromises the quality of content presented to learners in schools. The lack of a standard training manual has created a situation where teachers may interpret and teach CSE differently, resulting in potential disparities in the depth and accuracy of information provided to learners. To ensure the effective and uniform delivery of CSE across schools in Zambia, it is imperative that a comprehensive and standardized training manual be developed and implemented. This manual would not only serve as a vital resource for teachers but also guarantee that learners receive accurate and well-structured information, promoting a more holistic and responsible approach to sexuality education.

4.5.2 CSE topics that pupils like

The findings of this study indicate that learners have a strong preference for topics related to values, attitudes, and skills, with 60.2% of respondents choosing this option. Additionally, culture, society, and human rights are also highly favored, with 59.1% of respondents showing interest. However, topics like sexual and reproductive health (43.3%), sexual behavior (28.7%), and reproduction and relationships (27.1% and 27.8%) received somewhat lower levels of interest.

Table 18: CSE topics participants like

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Relationships	8	14.3%	103	33.0%	14	48.3%	7	11.7%	16	27.1%	12	20.3%	160	27.8%
Values, attitudes, and skills	19	33.9%	172	55.1%	14	48.3%	54	90.0%	45	76.3%	42	71.2%	346	60.2%
Culture, society, and human rights	17	30.4%	198	63.5%	17	58.6%	43	71.7%	38	64.4%	27	45.8%	340	59.1%
Reproduction	2	3.6%	84	26.9%	14	48.3%	13	21.7%	30	50.8%	13	22.0%	156	27.1%
Sexual behavior	3	5.4%	105	33.7%	3	10.3%	13	21.7%	29	49.2%	12	20.3%	165	28.7%
Sexual and reproductive health	16	28.6%	154	49.4%	13	44.8%	11	18.3%	38	64.4%	17	28.8%	249	43.3%
Puberty	2	3.6%	9	2.9%									11	1.9%

Source: Fieldwork Data, 2023

These findings suggest that teachers and curriculum developers should prioritize values, attitudes, and skills, as well as culture, society, and human rights when designing CSE programs, while considering ways to make topics related to sexual and reproductive health more engaging to learners because they are the conner stones of the concept of comprehensive sexuality Education.

There were variations from the teachers concerning the topics that pupils like. Teachers from Lusaka stated that the pupils are interested in topics related to reproduction and sexuality. While the teachers from Monze, Kalomo and Kazungula stated these topics make the students uncomfortable. This is also consistent with Mukonka (2022) study that aimed at identifying CSE topics that were not a taboo with the culture. Male and female participants in the study were requested to make multiple choices on topics they considered not a taboo. The study established that topics like puberty and reproduction are still not viewed as taboo as well as

culture and relationships including HIV.[86] The challenge is the social construct developed by society. Therefore, the variations in this study are normal but would require further interrogation as to whether its culture or religious beliefs. Largely, what society considers a taboo is usually designed by the community itself. Thus, the work of CSE should also aim at deconstructing these perceptions that are affecting the welfare of young people.

> *"The students give feedback. It's very interesting especially when you're touching on sex related topics children pay attention and they become alert and enjoy the lesson more."* **Teacher trained in CSE, Kanyama School, Lusaka**

> *"Topics to do with menstrual hygiene, personal hygiene, making choices on whether to have sex or not. These are interesting to the pupils and can be taught to everyone because it's reality. If they don't discuss sex at home and someone ends up hearing from friends, they might have wrong information and start doing wrong things. So as a teacher I have a duty apart from the normal teaching I must impart good knowledge and morals and impart self confidence and self-esteem in the learners."* ***Teacher trained in CSE, Chawama, Lusaka***

4.5.3 Topics that participants do not like

Based on the responses provided, this study identified specific topics within the Comprehensive Sexuality Education (CSE) curriculum that are less favored by respondents. Notably, sexual behavior emerged as the least liked topic at 43.7%, followed by relationships at 38.6%. Reproduction garnered 28.7% of respondents' dislike, while sexual and reproductive health was at 21.6%.

[86] Mukonka (2022)

Table 19: CSE topics participants do not like

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Relationships	14	25.0%	95	30.4%	10	34.5%	38	63.3%	34	57.6%	31	52.5%	222	38.6%
Values, attitudes, and skills			32	10.3%	14	48.3%	4	6.7%	7	11.9%	9	15.3%	66	11.5%
Culture, society, and human rights	2	3.6%	41	13.1%	7	24.1%	8	13.3%	6	10.2%	7	11.9%	71	12.3%
Reproduction	7	12.5%	73	23.4%	11	37.9%	38	63.3%	14	23.7%	22	37.3%	165	28.7%
Sexual behavior	29	51.8%	127	40.7%	21	72.4%	31	51.7%	15	25.4%	28	47.5%	251	43.7%
Sexual and reproductive health	4	7.1%	58	18.6%	12	41.4%	27	45.0%	8	13.6%	15	25.4%	124	21.6%
Puberty	7	12.5%	49	15.7%	1	3.4%	2	3.3%	13	22.0%			72	12.5%

Source: Fieldwork Data, 2023

Mixed feelings among learners concerning various CSE topics are evident. To address this, teachers will need to take on the responsibility of deepening the teaching of learners about the significance of CSE within the classroom setting. This involves creating an inclusive and comfortable environment where learners understand the importance of these topics for their overall well-being and informed decision-making.

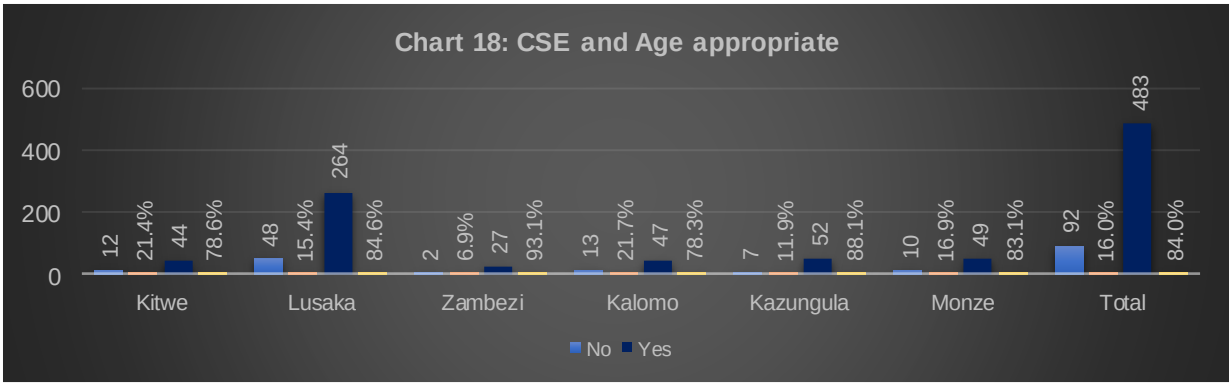
Teacher trained in CSE from Njezya stated the following;

> *"Anything to do with sex, sexuality and reproduction they're finding it a challenge. When you teach in vernacular it seems to be like an insult but at least in English. Some pupils don't understand it, they don't feel offended but once you mention it in the local language, they feel offended and even their behaviors change. I've seen it myself some even tend to sleep or even pretend they're dozing but they're just avoiding to hear what you're talking about".* **Teacher trained in CSE, Njezya Primary School.**

> *"Topics that are hard to talk about are family planning because it will be like encouraging the girls to go for family planning and have unprotected sex. I'm encouraging them to have sex anytime they feel like because nowadays teenagers fear to get pregnant than diseases. I feel like I'm encouraging them to avoid pregnancies but at the same time be prone to sexually transmitted diseases. When teaching it I just say if you have started having sex you must wear a condom because you're preventing a pregnancy and at the same time a disease because we can't run away from it."* **Guidance and counseling teacher, Chawama Primary School.**

4.5.4 Age and CSE

Chart 19 provides insights into learners' perspectives on the appropriateness of CSE topics with their respective ages. An encouraging 84% of respondents affirm that the topics align well with their age, while a smaller proportion of 16% hold the opposite view.



Source: Fieldwork Data, 2023

The predominantly positive response suggests that learners generally perceive the CSE framework to be suitable for their developmental stage. Despite the limited percentage of those who disagree, it's important to investigate their reasoning further, possibly uncovering how their faith or personal beliefs might influence their stance on CSE. This highlights the significance of understanding individual perspectives and ensuring that CSE programs are adaptable and respectful of diverse viewpoints while effectively addressing learners' age-specific needs.

In Njezya and Chibomboma the teacher trained in CSE said that CSE is appropriate;

> *"As a male teacher because I teach science, I don't have much of a challenge integrating CSE in the subjects that I teach. Even before I went for training, I didn't have any problems because I' m a science teacher. The learners ask questions like is there any possibility that after menstruation one can get pregnant and I'm able to answer without any problem."* **Teacher trained in CSE, Njezya School, Kalomo**

> *"Sensitive questions from a male pupil that can all these girls menstruate and how long do they take? Such questions have been coming and I'm okay with answering the questions but some girls aren't okay with the questions being asked and others feel shy.* **Teacher trained in CSE, Chibomboma, Kalomo**

> *"One time I was talking about how HIV/AIDS is contracted with the grade 5s. I ended the topic by stating that HIV/AIDs come as a result of sleeping with somebody. I never explained much and I just ended there. So, it's like when*

the pupils went home, they shared with the parents and this one pupil thought that it meant sleeping with anyone in bed, one would contract HIV but when they came back the following day, they said that their parents were annoyed. It's like the boy didn't want to sleep with somebody that night and some parents were bitter about it saying how can this teacher say this. So, I explained that no only when you sleep with an infected person that's when you get HIV." **Teacher trained in CSE, Bbwantu Primary School, Monze**

From Chawama school, the guidance and counseling teacher stated that;

"CSE is incorporated in most of the subjects like science, social studies, PE, CTS, English. It can be incorporated depending on the lesson that's being taught that day even in computer studies. You just pick a topic that's related to the topic of the day in that particular subject and then you incorporate it. For example, when I'm teaching about ports of a computer that's where I integrate it. I will say the female pins and the male pins or female ports or male ports that's where I enter now to say like your body makeup you need to take care the ports of the body, for example like I'm teaching about personal hygiene or menstrual hygiene which is under CSE that's how I incorporate it." **Guidance and counseling teacher, Timothy Mwanakatwe primary school, Lusaka**

Needs of the pupils were not considered before introducing CSE in the schools. According to the guidance and counseling teacher, she stated that;

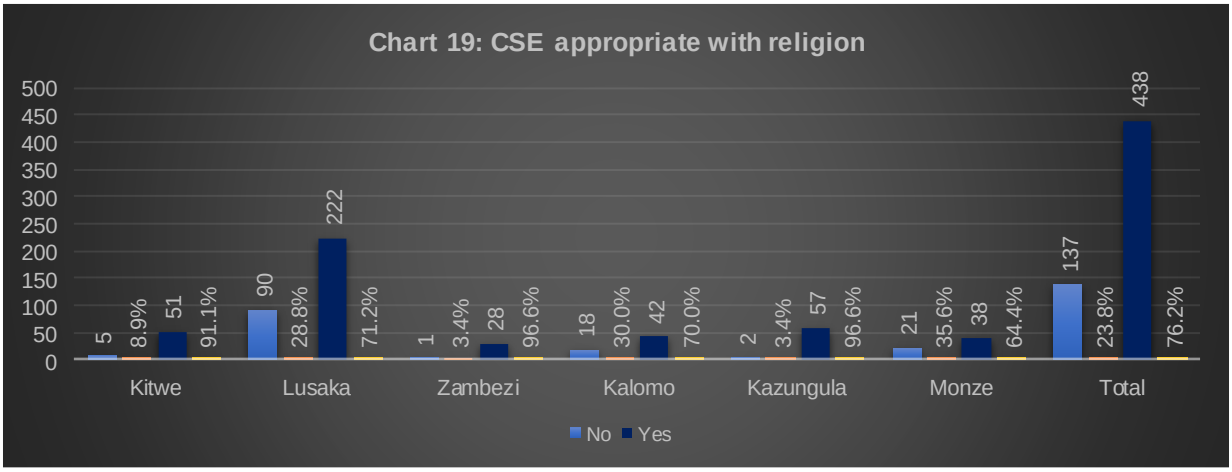
"You know we come from different backgrounds and different cultures and at the end of the day they play a very big role in someone's education. You'll find someone comes from a home where they don't talk about sex because it's a taboo for the parents to talk about pregnancy and here at school you just start talking about it. It becomes strange to them. And some children have never been exposed to that kind of life. In my opinion I feel like the learners' needs were not put into consideration." **Guidance and Counseling teacher, Chawama Primary School.**

"The ages vary in the grades. You may find that someone is 11 years old in grade 7. So, age is also a limiting factor. So, it isn't appropriate for the children who are 11 and below to learn about CSE. You can't exclude them when you're teaching because they'll still mingle with fellow learners so they're just included. As a teacher you need to know where to start from. You'll know that they're others that have started and those that haven't started yet so maybe you can exclude them for certain parts of the topic maybe you can get the girls outside and talk about it and nowadays you teach the boys. Even when we receive pads, we use the boys to offload them some would even ask what they were and you would explain so that even as they grow, they should know

that a woman needs this." **Guidance and counseling teacher, Timothy Mwanakatwe school, Lusaka**

4.5.5 Religion and CSE

To understand if religion is a factor in the implementation of CSE in the schools, the pupils were asked if CSE is appropriate with their religion. The data presented in chart 20 below highlights learners' perceptions regarding the alignment of Comprehensive Sexuality Education (CSE) topics with their religious beliefs. Impressively, 76.2% of respondents agree that the topics harmonize with their religion, whereas 23.8% express a differing opinion. The significant proportion of dissenting views warrants further exploration to ascertain the underlying basis for their responses.

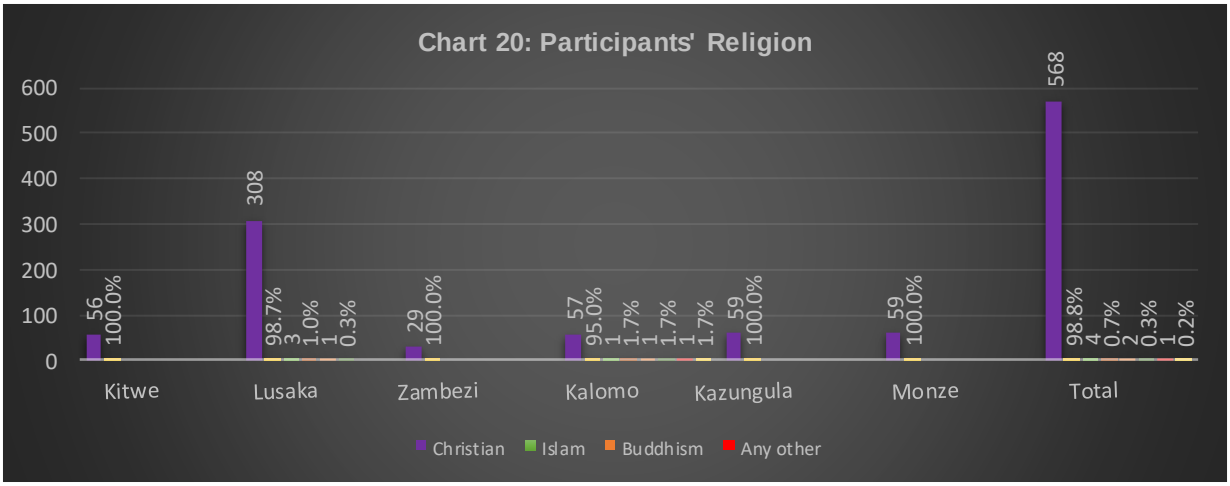


Source: Fieldwork Data, 2023

This observation emphasises the importance of addressing concerns and understanding how learners' faith influences their stance on the compatibility of CSE topics with religious values. Such insights are valuable for refining CSE curricula and ensuring they are inclusive, respectful, and sensitive to learners' diverse beliefs while still delivering comprehensive and accurate sexual and reproductive health education.

4.5.6 Religion of the participants

The study's findings reveal a significant religious composition among the respondents, with the overwhelming majority, accounting for 98.8%, identifying as Christians. Conversely, other religious affiliations collectively make up less than 1.5% of the respondents. This distribution underscores the prevalence of deep-seated religious values within the respondent population.



Source: Fieldwork Data, 2023

These values can significantly influence how learners interact with others, particularly concerning CSE topics within the school context. One's religious beliefs can impact their approach to accessing information and services related to Sexual and Reproductive Health and Rights (SRHR), and it might even contribute to resistance or reluctance towards certain aspects of CSE. It is therefore important for teachers and policymakers to recognize these religious dynamics and address them sensitively when developing and implementing CSE programs to ensure effective communication and understanding among all learners, regardless of their religious background.

From Nyezya, the teachers trained in CSE and the headteacher stated that;

> *"They're children that have complained that the topics aren't in line with their religion/ church. Like the SDAs, if you talk about puberty, they say those things should not be exposed. The lower grades feel like it's insulting and if they have to talk about it in churches or other areas, they feel like they're offending their parents and the culture of the home."*

> *"I have just been appointed as the headteacher; I was teaching the grade 5s. It was hard for me to implement CSE, I am SDA and this is in conflict with my religion."*

4.5.7 Denomination & place of worship

The study findings reveal distinct affiliations among the respondent's denomination or place of worship. The majority, comprising 46.6% of respondents belong to the Pentecostal churches. Following closely are the Seventh Day Adventists (SDA) at 22.8%, and the Roman Catholic Church at 16%.

Table 20: Place of worship/Denomination

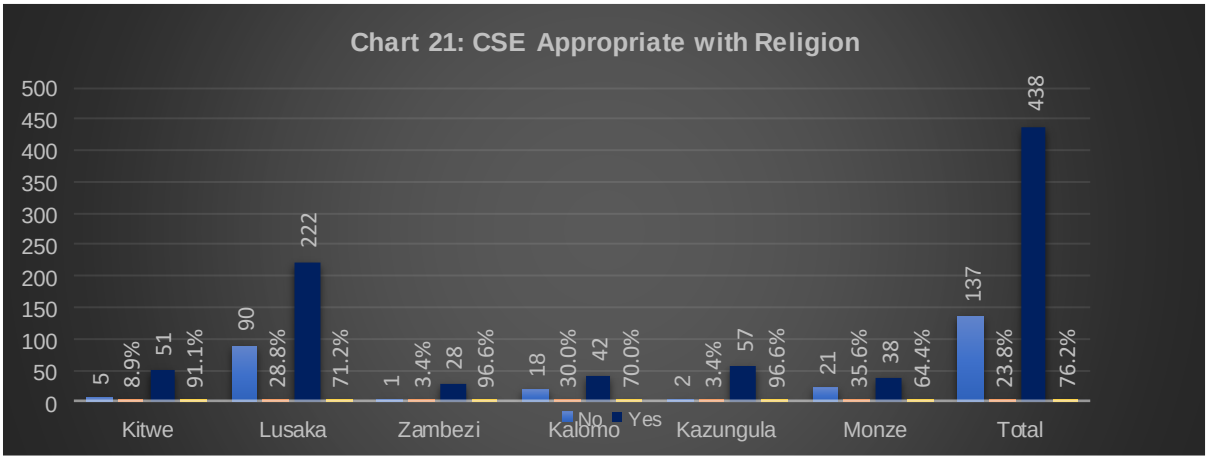
	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Roman Catholic	11	19.6%	54	17.3%	9	31.0%	6	10.0%	6	10.0%	9	15.3%	92	16.0%
Seventh Day Adventist (SDA)	12	21.4%	42	13.5%	1	3.4%	28	46.7%	28	46.7%	38	64.4%	131	22.8%
Jehovah's Witness (JW)	9	16.1%	33	10.6%			1	1.7%	1	1.7%			45	7.8%
Pentecostal	21	37.5%	165	52.9%	2	6.9%	24	40.0%	24	40.0%	12	20.3%	268	46.6%
Mosque			3	1.0%									3	0.5%
Any other	3	5.4%	15	4.8%	17	58.6%	1	1.7%	1	1.7%			36	6.3%

Source: Fieldwork Data, 2023

The diverse distribution of religious affiliations emphasizes the significance of accommodating various faith backgrounds when addressing topics such as CSE. Acknowledging these differences and incorporating religious sensitivity into CSE programs is essential to foster an inclusive environment where learners' diverse beliefs are respected while ensuring comprehensive and accurate sexual and reproductive health education.

4.5.8 CSE Appropriate with religion

The data presented in Figure 15 above highlights learners' perceptions regarding the alignment of Comprehensive Sexuality Education (CSE) topics with their religious beliefs. Impressively, 75.1% of respondents agree that the topics harmonize with their religion, whereas 24.9% express a differing opinion.



Source: Fieldwork Data, 2023

The significant proportion of dissenting views warrants further exploration to ascertain the underlying basis for their responses. This observation emphasizes the importance of addressing concerns and understanding how learners' faith influences their stance on the compatibility of CSE topics with religious values. Such insights are valuable for refining CSE curricula and ensuring they are inclusive, respectful, and sensitive to learners' diverse beliefs while still delivering comprehensive and accurate sexual and reproductive health education.

4.5.9 Topics appropriate with Religion

The survey generated a range of opinions regarding the alignment of Comprehensive Sexuality Education (CSE) topics with respondents' religious beliefs. The table highlights diverse sentiments, with respondents indicating that certain topics resonate more with their religion. Notably, 71.5% believe that values, attitudes, and skills correlate well with their faith, while culture, society, and human rights scored 50.8%. Similarly, topics related to relationships found approval from 36.2% of respondents.

Surprisingly, topics such as reproduction at 6%, sexual behavior at 11.4%, and sexual & reproductive health at 14% received lower scores, suggesting perceived incongruence with religious beliefs. Curiously, these topics form the core of CSE delivery, as outlined by the Ministry of Education's CSE framework (2014).

Table 21: Topics appropriate with participants' religion

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Relationships	11	21.6%	123	45.9%	16	57.1%	1	2.4%	12	21.1%	12	31.6%	175	36.2%
Values, attitudes and skills	25	49.0%	183	68.3%	22	78.6%	39	92.9%	45	78.9%	32	84.2%	346	71.5%
Culture, society, and human rights	14	27.5%	137	51.1%	19	67.9%	32	76.2%	23	40.4%	21	55.3%	246	50.8%
Reproduction			18	6.7%	4	14.3%	1	2.4%	5	8.8%	1	2.6%	29	6.0%
Sexual behavior	4	7.8%	31	11.6%	3	10.7%	2	4.8%	5	8.8%	10	26.3%	55	11.4%
Sexual and reproductive health	5	9.8%	45	16.8%	5	17.9%	5	11.9%	3	5.3%	5	13.2%	68	14.0%
Any other			6	2.2%			3	7.1%	4	7.0%			13	2.7%

Source: Fieldwork Data, 2023

The findings in table 19 above emphasises the importance of addressing the disparities to ensure that CSE programs not only provide accurate information but also consider the religious

sensitivities of learners, striking a balance between faith and comprehensive sexuality and reproductive health education.

4.5.10 Topics not appropriate with religious faith

The presented graph highlights topics that learners perceive as not aligning well with their religious faith within CSE. Surprisingly, sexual behavior at 57.8%, reproduction at 37.3%, sexual & reproductive health at 34.8%, and relationships at 28.2% are deemed inappropriate for inclusion in CSE. Interestingly, these topics constitute the foundational pillars of CSE delivery, as outlined in the Ministry of Education's CSE framework of 2014.

The disparity between learners' perceptions and the curriculum's intended content could stem from misunderstandings, misinformation, or even disinformation surrounding the concept of CSE. This prompts the need for a deeper exploration of whether learners require additional content to address their concerns or if teacher training in CSE should be enhanced through workshops to ensure high-quality delivery.

Table 22: CSE topics not appropriate with religion

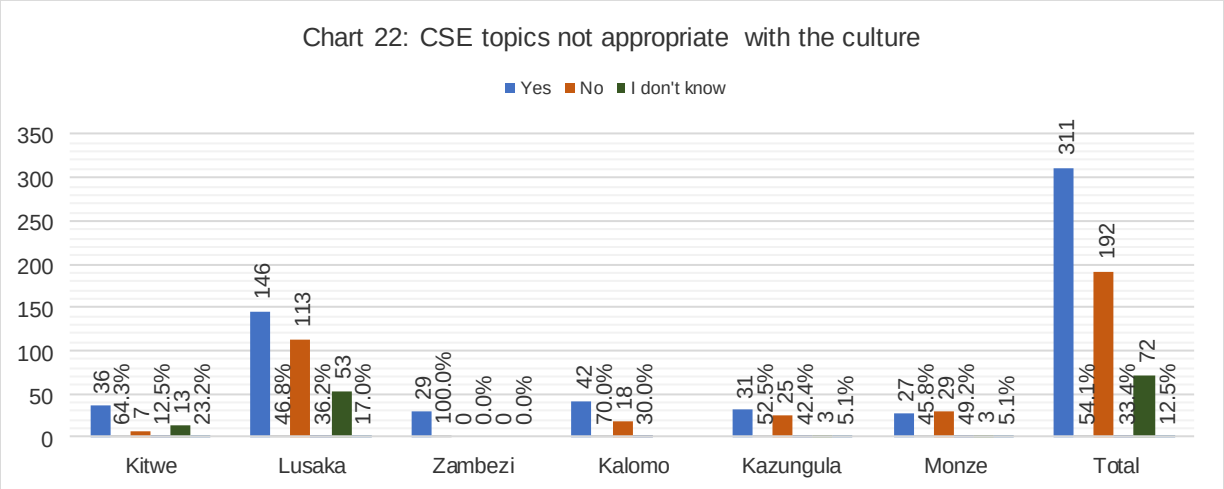
	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Relationships	10	19.6%	60	22.5%	7	25.0%	16	38.1%	30	52.6%	13	34.2%	136	28.2%
Values, attitudes and skills	3	5.9%	19	7.1%	3	10.7%	3	7.1%	1	1.8%	1	2.6%	30	6.2%
Culture, society, and human rights	2	3.9%	15	5.6%	5	17.9%	4	9.5%	7	12.3%	5	13.2%	38	7.9%
Reproduction	4	7.8%	100	37.5%	17	60.7%	13	31.0%	27	47.4%	19	50.0%	180	37.3%
Sexual behavior	28	54.9%	152	56.9%	23	82.1%	13	31.0%	43	75.4%	20	52.6%	279	57.8%
Sexual and reproductive health	5	9.8%	86	32.2%	19	67.9%	10	23.8%	34	59.6%	14	36.8%	168	34.8%
Any other	6	11.8%	18	6.7%			18	42.9%					42	8.7%

Source: Fieldwork Data, 2023

The table below shows the necessity for comprehensive and informed discussions to bridge this gap and ensure that CSE programs align both with learners' faith-based concerns and with the curriculum's educational objectives.

4.5.11 CSE Topics that are a taboo with the culture

The data presented in chart 23 highlights learners' perspectives on whether certain topics within Comprehensive Sexuality Education (CSE) are considered taboo within their cultural context. Notably, 54.1% of learners believe that some topics are indeed considered taboo, while 33.4% hold the opposing view. About 12.5% indicated that they don't know.



Source: Fieldwork Data, 2023

Remarkably, these variations in perceptions persist nearly a decade into CSE implementation, underscoring the ongoing challenges in aligning CSE with cultural norms and values.

These findings emphasize the importance of continuous efforts to engage communities, educators, and learners in open conversations about the relevance and significance of CSE topics in cultural contexts. Achieving this understanding is crucial to ensuring that CSE programs remain sensitive, relevant, and effective in addressing learners' sexual and reproductive health needs while respecting their cultural backgrounds.

4.5.12 Topics which are a taboo in CSE

The graph above shows that respondents indicated that topics like sexual behaviour (54.5%), relationships (33.5%) and reproduction (27.2%) are leading in being termed at taboos in CSE delivery.

Table 23: CSE topics that are a taboo with the participants' culture and religion

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Relationships	5	13.9%	64	31.7%	7	24.1%	21	50.0%	17	54.8%	9	33.3%	123	33.5%
Values, attitudes and skills	4	11.1%	17	8.4%	5	17.2%	9	21.4%	1	3.2%	1	3.7%	37	10.1%
Culture, society, and human rights	5	13.9%	16	7.9%	1	3.4%	4	9.5%	1	3.2%	1	3.7%	28	7.6%
Reproduction	5	13.9%	41	20.3%	8	27.6%	25	59.5%	7	22.6%	14	51.9%	100	27.2%
Sexual behavior	15	41.7%	108	53.5%	17	58.6%	23	54.8%	19	61.3%	18	66.7%	200	54.5%
Sexual and reproductive health	4	11.1%	36	17.8%	6	20.7%	14	33.3%	6	19.4%	9	33.3%	75	20.4%
Any other	1	2.8%	33	16.3%					1	3.2%			35	9.5%

Source: Fieldwork Data, 2023

It is not clear why learners feel that way when these are the topics contained in the CSE learning and teaching materials found in schools. This could either be the fact that CSE has not been well explained to learners or the negative reactions to the content being spread by the opposers is filtering through the school system thereby affecting the perceptions of learners.

According to the teachers from Nyawa Secondary School;

> *"Looking at the Zambian culture you'll see that certain things are not supposed to be taught at their age such as sex which is believed to be talked about by elderly people and not people who are 13 years and then when you start telling them how a child is made then it is like you're trying to teach them insults."*

> *"Teachers are more comfortable to teach in English than in local languages because some words seem to come out as very strong and may seem like an insult to the children. But with CSE they say that what you see is what you say so somehow some teachers are very shy to teach what is there."*

4.6 Access to Adolescent Sexual and Reproductive Health

The provision of comprehensive sexuality education (CSE) accords opportunities for scientifically accurate information about sexual and reproductive health (SRH). Linking provision of CSE with accessible SRH services that are receptive to needs of adolescents and young

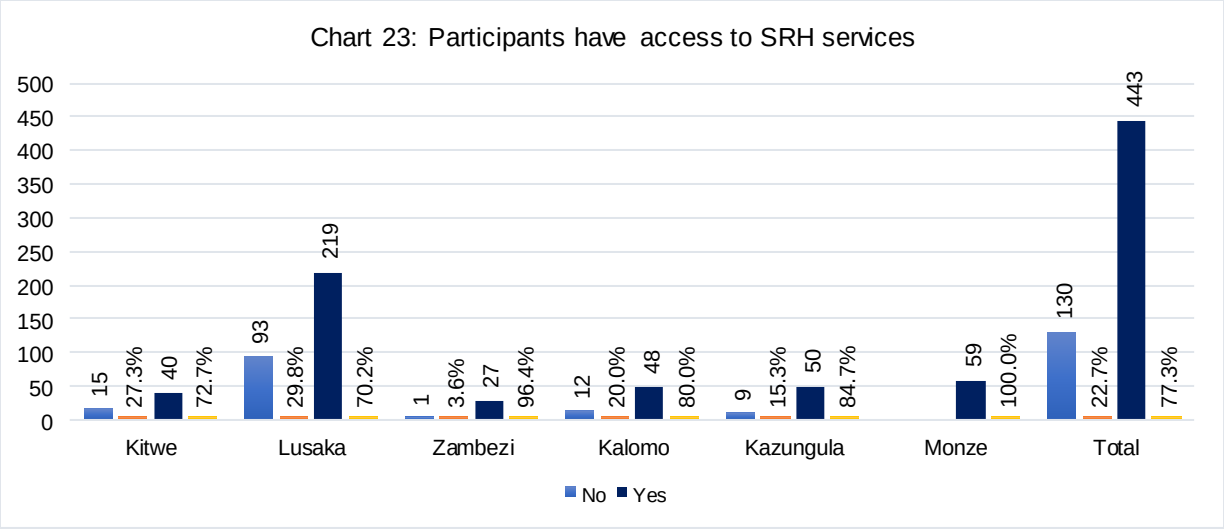
people reduces EUP, which provides the opportunity for higher retention in school for adolescent girls.

The study aimed at investigating if boys and girls have access to SHR services, the entities that provide the services and the types of services accessed by the targeted participants.

4.6.1 Participants have access to SRH services

The availability of adolescent sexual and reproductive health services was examined, and the outcome reveals insightful results. A significant proportion, accounting for 77.3% of respondents reported having access to these services. Conversely, 22.7% indicated a lack of access. This data suggests a positive trend in terms of accessibility, indicating that a substantial majority of learners can access these vital services. However, the fact that a significant minority at 22.7% still faces limitations in accessing such services underscores the need for continued efforts to ensure equitable availability and linkages to ASRH services.

This information emphasizes the ongoing importance of promoting comprehensive and accessible sexual and reproductive health resources for all adolescents, ensuring their well-being and informed decision-making.



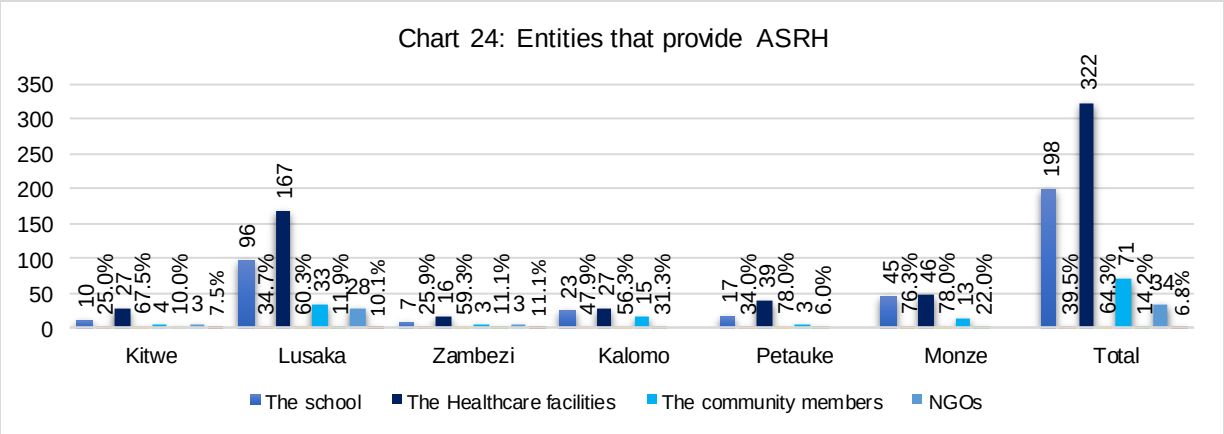
Source: Fieldwork Data, 2023

4.6.2 Entities that provide ASRH

In this study, an analysis was conducted to identify the providers of sexual reproductive health services. The majority of respondents highlighted that healthcare facilities, accounting for 64.3%, play a pivotal role in delivering these services. Following closely were schools,

contributing at 39.5%. A smaller but notable proportion, 14.2%, mentioned community members as providers, while 6.8% indicated other sources, albeit unspecified.

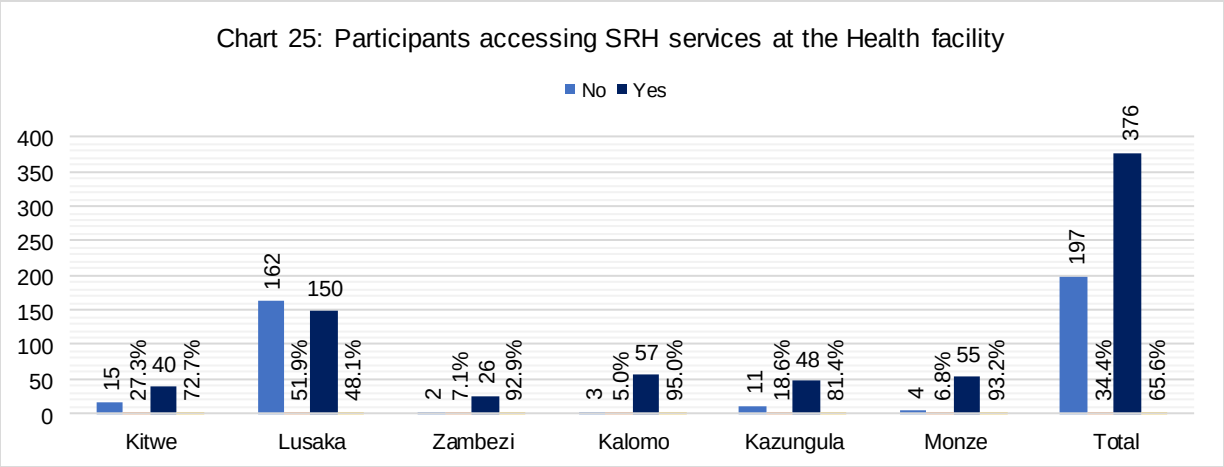
These findings underline the prominent role of healthcare facilities and schools in addressing sexual reproductive health needs, while also hinting at the potential contribution of community resources. It emphasizes the collaborative nature of delivering comprehensive services to ensure the well-being and informed choices of learners.



4.7 Health Facilities and ASRH services

4.7.1 Participants accessing SRH at the heath facilities

The analysis of whether respondents have accessed reproductive health services at a healthcare facility reveals a somewhat balanced distribution of responses. The fact that 65.6% of respondents have accessed such services indicates a significant portion of learners who have actively sought out reproductive health resources. On the other hand, the 34.4% of respondents who have not accessed SRHR services at a healthcare facility highlight a potential gap in access or utilization. This disparity could be influenced by factors such as geographical location, awareness, socio-economic status, and cultural norms. The data underscores the importance of continued efforts to ensure that comprehensive reproductive health services are accessible to all, as well as the need to address any barriers that might prevent certain individuals from seeking out these vital services.



Sources: Fieldwork Data, 2023

From Guidance and counseling teacher as well as the teacher trained in CSE from Chawama and Kanyama primary schools stated that;

> *"There are no problems working with the Chawama clinic. The introduction of health learners in schools has really helped us and it has strengthened our relationship with the Ministry of Health. So even when we have a case of a child that's sick the child is attended to quickly at the health facility. We even invite people from the youth friendly corner to just come and talk to the adolescents here in school and the learners are allowed to ask them questions. The teachers aren't involved. We leave them so that they can be free and not intimidated and to be able to have that freedom."* **Guidance and counseling teacher, Chawama Primary school, Lusaka**

> *"The adolescents are accessing the facilities. We've had reports that they go and access free condoms. We have received these reports from the health workers. The pupils go there to get more information and also access treatment, we also encourage those who are on medication to go to the clinic. So, if the learner is about to give up and they're referred to the hospital they're able to help and counsel them."*, **Teacher trained in CSE, Kanyama primary school, Lusaka**

In Kazungula, the teachers trained in CSE and the guidance and counseling teacher also confirmed that the school is working with the health facility.

> *"You can't really tell who's pregnant when being accepted into the school unless a medical checkup is done at the hospital. The matron takes the girls for checkups then you'll find that some are pregnant and those are the records*

that they have. But as a school teenage pregnancy is reducing." **Guidance and counseling teacher, Nyawa Secondary school, Kazungula**

"We are working with Nyawa clinic. Sometimes we have invited them to come to the school and sensitize the learners on preventing pregnancies, health talk, preventing HIV/AIDS and STIs. They get some information from the health workers on reproductive health and tetanus. They also conduct some talks with the learners." **Teacher trained in CSE, Nyawa Secondary school, Kazungula**

4.7.2 Sexual Reproductive Health Services provided at the health care facility

The analysis of services provided by healthcare providers revealed an interesting finding, with 45.4% of respondents indicating guidance and counseling. This outcome appears rather unusual, as guidance and counseling typically occur within the educational institutions like schools rather than healthcare facilities. In addition, pregnancy prevention was cited by 39.6% of respondents, followed closely by information sharing at 39.6%, and condom distribution at 31.8%. The implications of this finding suggest potential confusion or misperceptions among respondents regarding the nature of services provided by healthcare facilities. This might point to a need for clearer communication and education about the distinct roles of schools and healthcare providers in delivering sexual and reproductive health services. It also underscores the importance of ensuring that individuals have accurate information about the available resources and services to make informed decisions about their reproductive health.

Table 24: ASRH services at the health facilities

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Information sharing	7	17.5%	107	44.8%	9	34.6%	24	42.1%	7	14.6%	30	54.5%	184	39.6%
Guidance & Counselling	30	75.0%	91	38.1%	9	34.6%	21	36.8%	16	33.3%	44	80.0%	211	45.4%
Condom distribution	2	5.0%	61	25.5%	7	26.9%	26	45.6%	26	54.2%	26	47.3%	148	31.8%
Pregnancy prevention	3	7.5%	87	36.4%	8	30.8%	33	57.9%	36	75.0%	17	30.9%	184	39.6%
I don't know	4	10.0%	30	12.6%	2	7.7%	4	7.0%			1	1.8%	41	8.8%
Any other			14	5.9%					2	4.2%			16	3.4%

Source: Fieldwork Data, 2023

From the interviews with the school administrators, they pointed out that the schools are working with the clinics.

"Sometimes we usually call the health personnel from Simango to come and orient the pupils on sexual behavior and all these diseases that can be found in all these sexual activities. So, they usually come maybe 2 times in a term." **Teacher trained in CSE, Njezya**

"The clinic has their own programs with the pupils. They would want to meet the girls from grade 7-9." **Headteacher, Bbwantu Primary**

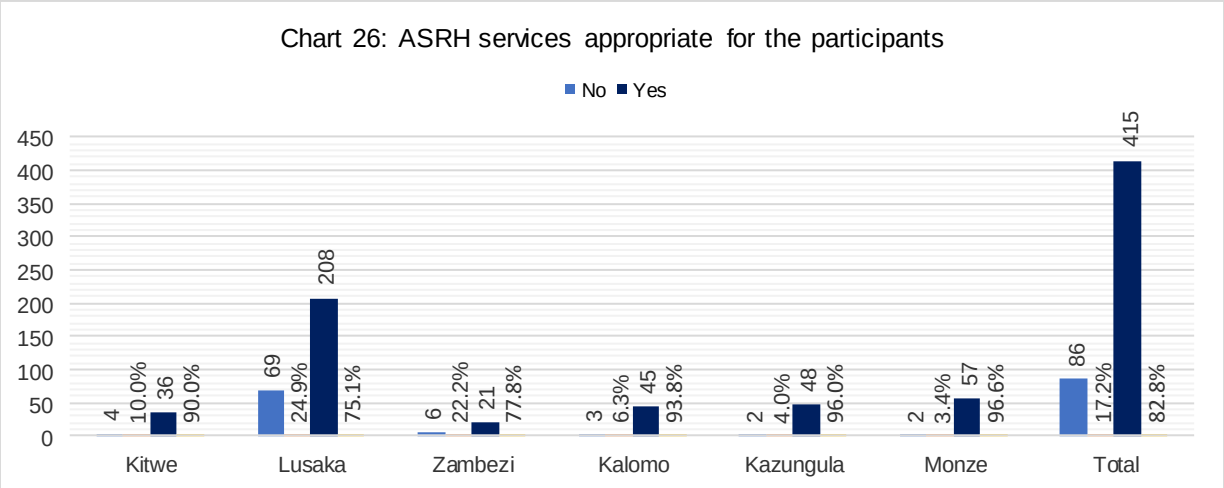
"They have talks about puberty and body changes and they had it twice last term with the guidance counselor who left especially after the girl in grade 8 fell pregnant." **Headteacher, Chibomboma Primary School.**

4.7.3 Adolescent Sexual Reproductive Health (ASRH) services appropriate for participants

The study examined the appropriateness of Adolescent Sexual and Reproductive Health (ASRH) services provided in the health facilities across different categories. Notably, a considerable majority of respondents, totaling 82.8%, indicated that the services are appropriate for both boys and girls. However, about 17.2% indicated that the ASHR services are not appropriate for the pupils.

These varying responses underscore the importance of inclusivity and comprehensive coverage in ASRH education. The predominant view that the services are fitting for both genders and align with the holistic nature of sexual and reproductive health.

The minor disparities might reflect cultural or gender-specific perspectives which emphasize the necessity for tailored approaches that cater for diverse backgrounds and needs. Overall, these responses underscore the importance of offering inclusive, well-rounded ASRH/CSE services to address the specific needs of all individuals involved.



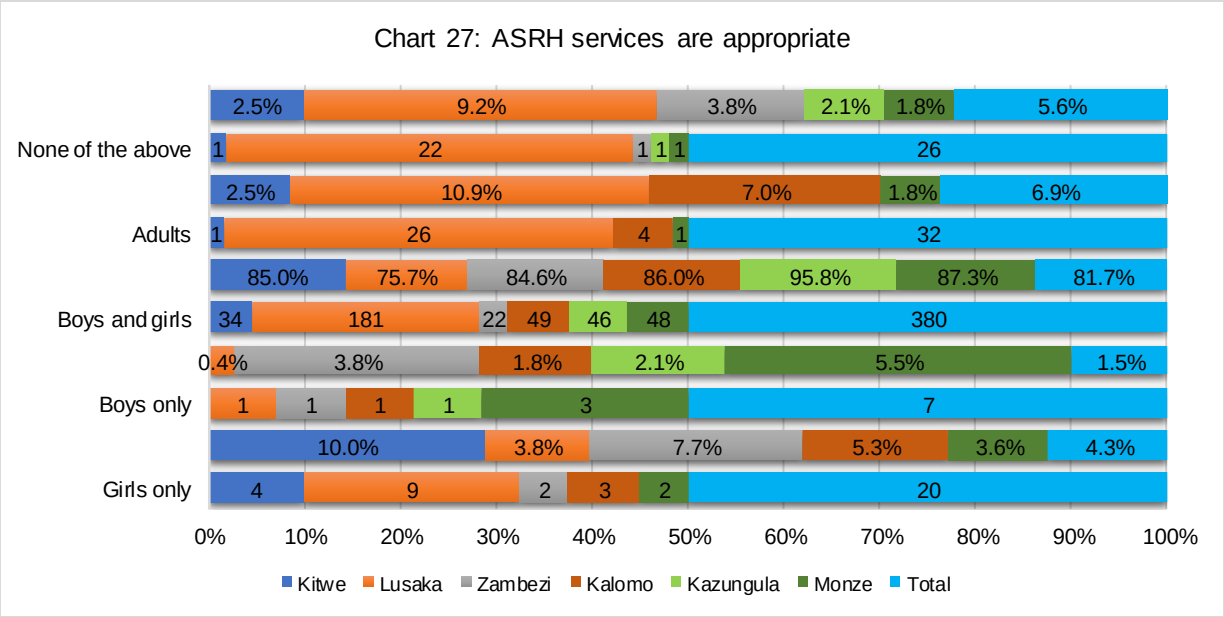
Source: Fieldwork Data, 2023

4.7.4 ASRH services are appropriate for male and female pupils

The analysis of whether sexual reproductive health services offered by health facilities are appropriate yielded notable insights. A significant majority, constituting 81.7% of respondents, affirmed that these services are indeed appropriate for both boys and girls. However, there were varying minor margins of response: 6.9% considered the services appropriate for adults, 4.3% for girls only, and 1.5% for boys only.

This range of perspectives underscores the need for comprehensive and inclusive sexual reproductive health services that cater for diverse needs of young people. The dominant view of services being suitable for both genders reflect the importance of addressing holistic health concerns, but the variations suggest that certain individuals may perceive specific aspects as more fitting for particular groups.

The implication of this finding is the importance of designing and delivering services that are not only medically accurate but also culturally sensitive, accommodating different perspectives and ensuring that all individuals can access relevant and appropriate information and care.

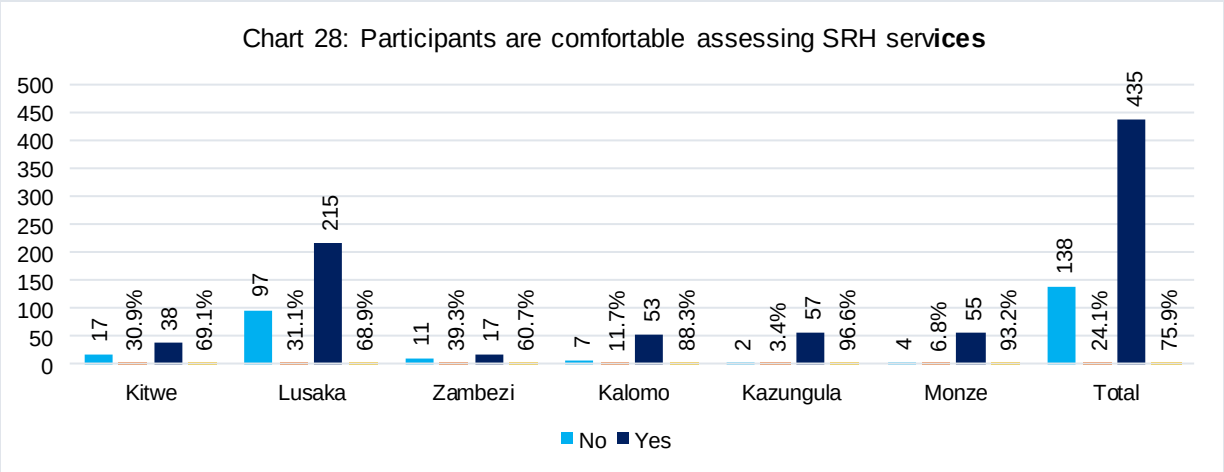


Source: Fieldwork Data, 2023

4.7.5 Participants comfortable to access ASRH services at health facility

The study's findings shed light on adolescents' comfort levels in accessing information on Sexual and Reproductive Health (SRH) at health facilities. The chart below reveals that 75.9% of respondents expressed feeling at ease in seeking SRH information within healthcare settings. On the other hand, 24.1% indicated discomfort in accessing such information at health facilities.

This variation in responses emphasizes the need for healthcare providers to foster an environment of trust and respect, ensuring that adolescents can access SRH information and services without hesitation. While the majority feels comfortable, the percentage of those who don't underscores the importance of addressing potential barriers, privacy concerns, or apprehensions to ensure that all adolescents can have the opportunity to access accurate and relevant SRH information at healthcare facilities.



Source: Fieldwork Data, 2023

From the guidance and counseling, there is a positive impact coordinating with the health facilities;

> *"It is just the nature of their job. The health workers are able to say that this is the truth unlike the teachers who are not trained in health issues and when we talk to the pupils, they think we are just trying to ban certain things but if it comes from a health worker then maybe it has an impact somehow."* **Guidance and counseling teacher, Chibomboma primary school, Kalomo**

> *"They have a program with the schools after lessons to talk to the adolescents. The pupils are accessing family planning, for those that have returned to school after having a child."* **Guidance and Counseling teacher, Chawama primary school, Lusaka**

The teacher trained in CSE from Kalomo stated the following;

> *They called them and counseled them and spoke to them about early pregnancies and they usually have talks with them. You'll find that they just laugh. They laugh a lot. They don't take them seriously. They know and they enjoy them.* **Chibomboma School.**

4.7.8 Schools as providers of information on ASRH

There are several factors that hinder adolescents and young people from accessing information on sexual and reproductive health. Lack of trust in services providers, lack of confidentiality and privacy by service providers, inadequate knowledge of where the services are provided, lack of youth friendly facilities, lack of information on SRH rights, Stigma and discrimination and

negative cultural norms that prevent adolescents from freely talking about sex and anything related to reproductive health are some of the fundamental reasons that hinder adolescents from accessing the sexual and reproductive health services. Some adolescents are shy while others lack awareness and lack of sexuality education information.

4.7.9 Schools providing information on SRH

This study also sought to categorize and prioritize the array of services offered by schools. The findings revealed that health talks held the top position at 58.5%, followed by HIV/STI prevention at 49.7%, and the prevention of early and unintended pregnancies at 43.3%. Abstinence was ranked at 42.9%. Other important topics included addressing early marriages at 36.9%, condom use at 24.2% and menstrual hygiene at 20.2%. It was strange to note that learners report access to condoms although these are not dispensed in schools.

These proactive initiatives underscore schools' dedication to the effective implementation of CSE and their commitment to ensuring that learners derive significant benefits from the program. By addressing a range of critical topics, schools are playing a crucial role in equipping students with the knowledge and skills necessary for their well-being and informed decision-making.

Table 25: SRH information given to the pupils

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
Health talks	12	30.0%	171	61.7%	8	29.6%	32	66.7%	16	32.0%	54	91.5%	293	58.5%
Early marriages	4	10.0%	104	37.5%	7	25.9%	7	14.6%	11	22.0%	47	79.7%	180	35.9%
Sex education	2	5.0%	85	30.7%	3	11.1%	11	22.9%	21	42.0%	38	64.4%	160	31.9%
Prevention of Early and Unintended Pregnancies	12	30.0%	120	43.3%	4	14.8%	29	60.4%	10	20.0%	42	71.2%	217	43.3%
Prevention of HIV/STIs	4	10.0%	147	53.1%	8	29.6%	39	81.3%	17	34.0%	34	57.6%	249	49.7%
Abstinence	6	15.0%	139	50.2%	4	14.8%	11	22.9%	24	48.0%	31	52.5%	215	42.9%
Condom use	1	2.5%	68	24.5%	1	3.7%	16	33.3%	15	30.0%	20	33.9%	121	24.2%
Menstrual Hygiene	7	17.5%	50	18.1%	3	11.1%			10	20.0%	31	52.5%	101	20.2%

Source: Fieldwork Data, 2023

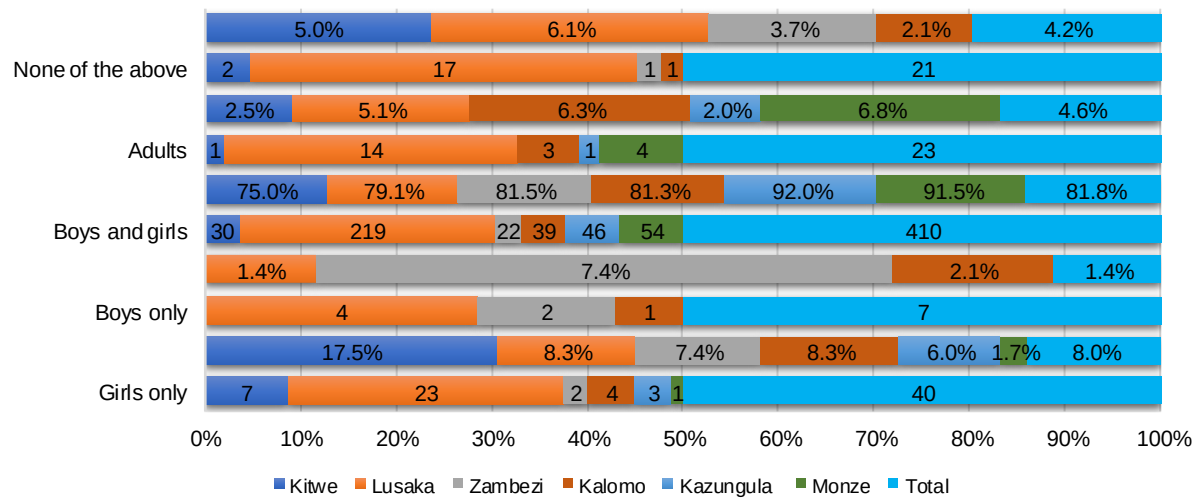
4.7.10 The Sexual Reproductive health information is appropriate for male and female pupils

The question of whether the information on sexual & reproductive health offered in schools are suitable for adolescents was explored in this study. Impressively, a substantial majority, comprising 81.8% of respondents, affirmed that these services are indeed appropriate for adolescents. In contrast, a smaller percentage of 4.2% expressed the view that the services might not align well with adolescent needs.

> *"In the lower grades it's not very effective. The negativity among the young ones. They feel as if when you talk about CSE it's almost like insulting to them."* **Guidance and counseling teacher, Timothy Mwanakatwe School, Lusaka**

This notable divergence in responses underscores the efficacy of the services being provided. It also reflects how these services are effectively tailored to address the specific requirements of learners, highlighting the importance of offering comprehensive and relevant sexual reproductive health education to ensure the well-being and understanding of adolescents.

Chart 29: ASRH information is appropriate

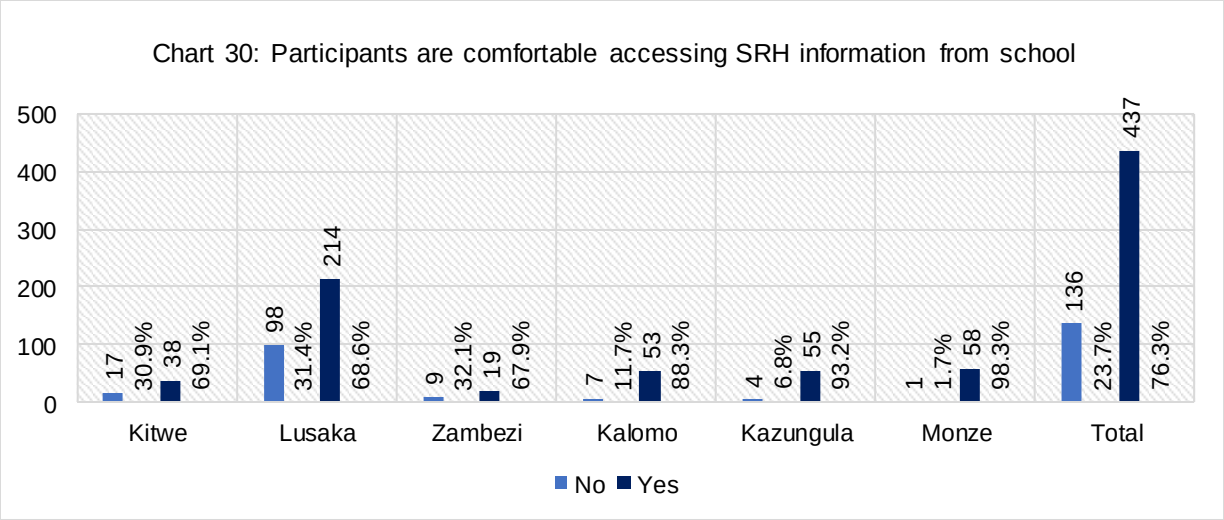


Source: Fieldwork Data, 2023

4.7.11 Participants are comfortable to access information on ASRH from school

Chart 31in the study sheds light on adolescents' comfort level in accessing information on Adolescent Sexual and Reproductive Health (ASRH) at school. Remarkably, the findings reveal that a significant 76.3% of learners feel comfortable seeking out ASRH information within the school environment. However, a noteworthy 23.7% express discomfort in accessing such

information at school. This division in responses underscores the importance of cultivating a supportive and non-judgmental environment around ASRH discussions within schools. While the majority expresses ease, the proportion of those who feel uncomfortable highlights the need to address potential barriers, stigma, or concerns that might hinder some adolescents from seeking the information they need to make informed decisions about their sexual and reproductive health.



Sources: Fieldwork Data, 2023

It was also found that the pupils are not comfortable to ask questions from the guidance and counseling teachers and this was reported in Nyawa

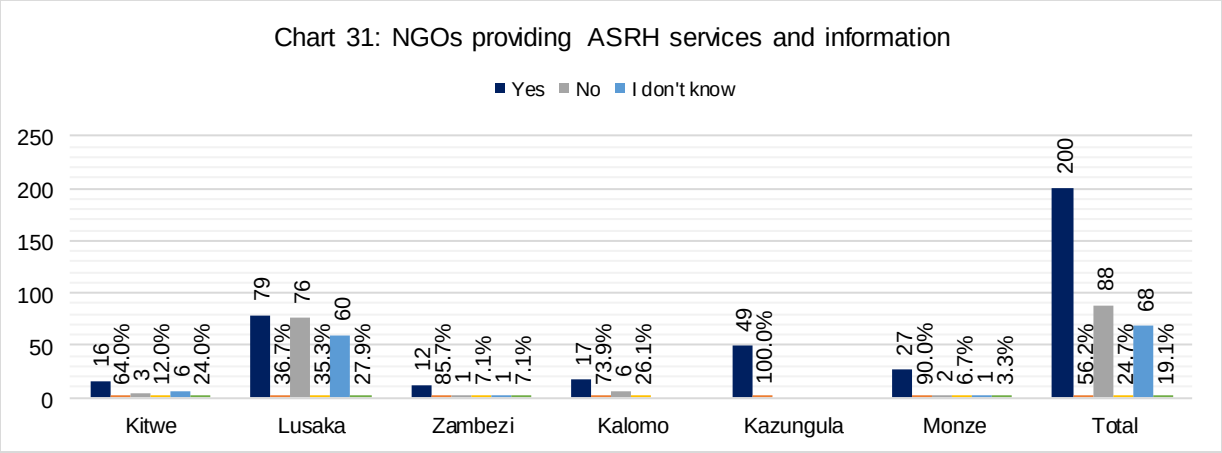
> *"With the orientation that I received in CSE, I'm able to answer any questions from the pupils. But, no one comes to ask me any questions. When someone is new, the pupils are not free with them but with the previous guidance counselor they were free. She had been here for almost 10 years, but she was transferred."* **Nyawa, Guidance and Counseling teacher**

4.8 Non-Governmental Organisations

4.8.1 NGOs providing ASRH services

The study delved deep into checking the presence of Non-Governmental Organizations (NGOs) in the area providing Adolescent Sexual and Reproductive Health (ASRH) services. The data revealed a diverse range of responses, with 56.2% of respondents acknowledging the existence of NGOs offering ASRH services in the area. Conversely, 24.7% indicated a lack of NGOs providing such services.

This fragmentation in responses underscores the varying levels of awareness among respondents regarding the presence of these vital organizations that provide ASRH service. The discrepancy might arise from differences in access to information or local knowledge. The finding also exposes and emphasizes the need for enhanced communication and awareness activities to ensure that all individuals, especially adolescents, are well-informed about available resources and can make informed decisions regarding their sexual and reproductive health.



Source: Fieldwork Data, 2023

The headteachers and the teachers trained in CSE were asked if there are NGOs supporting the schools in the implementation of CSE.

> *"There isn't any other NGO apart from FAWEZA. Helping with the re-entry policy and helping with the girl child. Supporting those who are coming back into school. They're helping 10 girls currently. They do it every year."* **Headteacher, Njezya School**

> *"We only have Innovation Africa. They're the ones that put up solar."* **Teacher trained in CSE, Chibomboma School**

In Lusaka, the teachers as well as guidance and counseling teachers reported that;

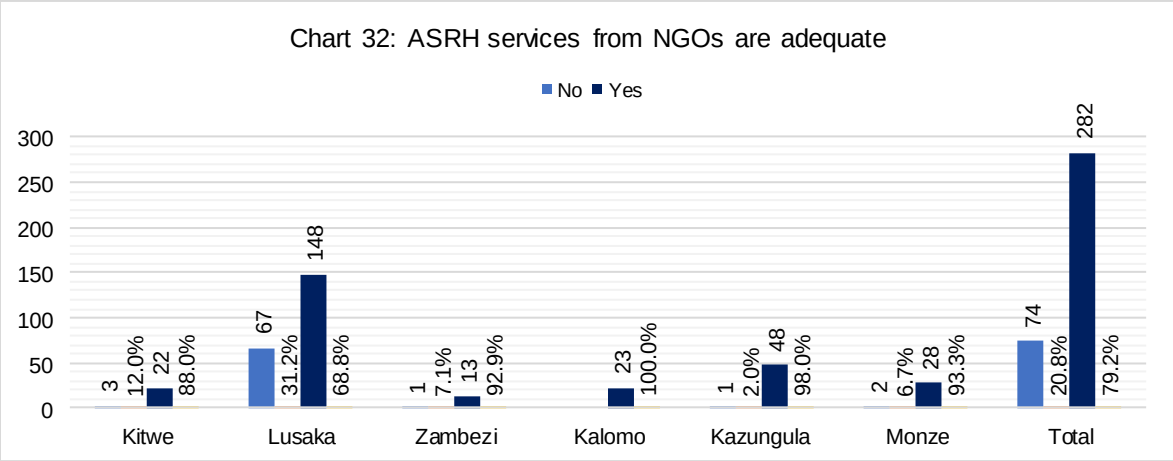
> *"We are working with Dreams. With Dreams they come here and hold sessions with the learners. Dreams is long term and they are more into girls but they have included boys now and they're teaching them about gender-based violence. The girls are being taught gender-based violence, menstrual hygiene most of the things related to CSE. Other NGOs, its short term, we are*

working with Change lives. Change lives is helping with the morals of the learner and supporting the learners that aren't able to do well by helping with Tuitions. They even invite the girls to their center to learn skills and give certificates on ICT, tailoring depending on what the learner will choose. Dreams started in 2020 and changing lives is 2023. **Chawama Primary School**

4.8.2 The ASRH services provided by the NGO are appropriate for male and female pupils

The study assessed the suitability of services provided by Non-Governmental Organizations (NGOs) for adolescents. Notably, the findings indicate a significant consensus, with 79.2% of respondents affirming that the services offered by NGOs are indeed appropriate for adolescents. However, 20.8% expressed the view that these services might not align well with the specific needs of adolescents.

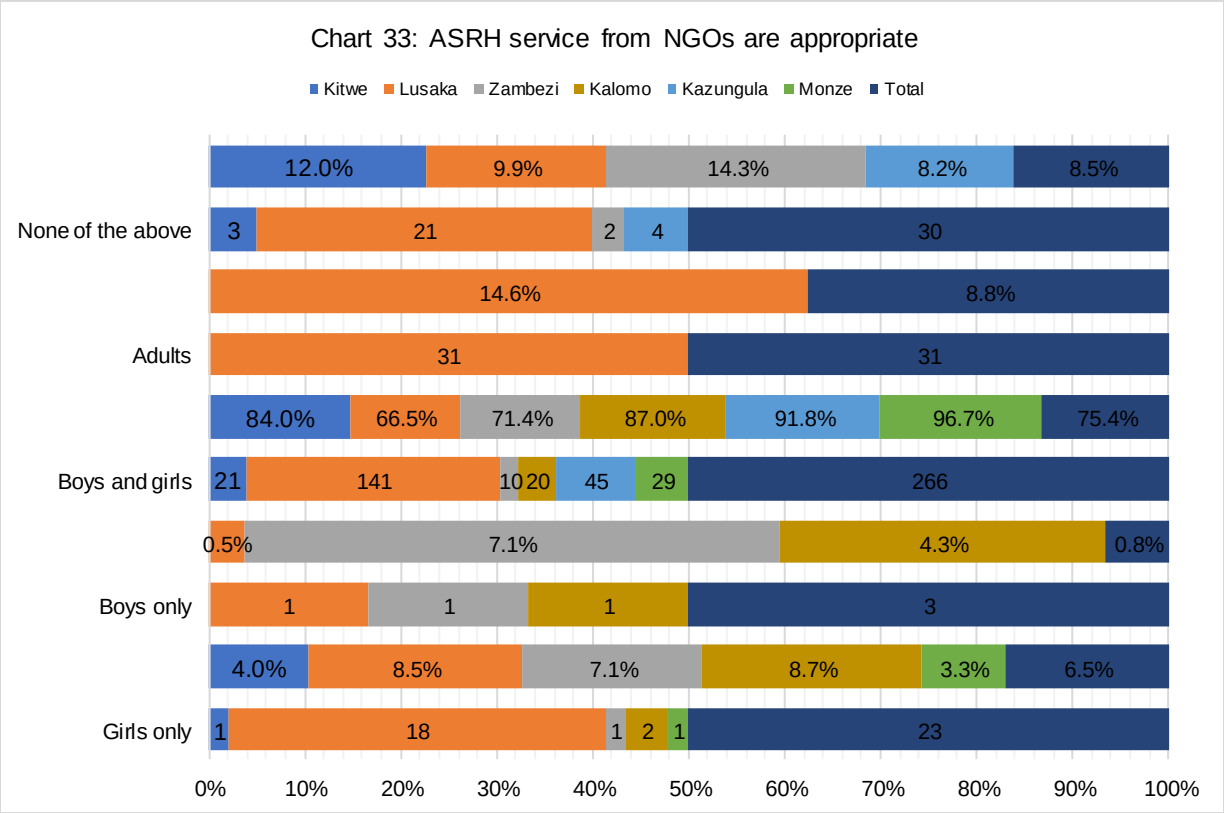
This diversity in responses highlights the importance of further evaluation and adjustment of services to better cater for the diverse needs of adolescents. While the majority view supports the effectiveness of these services, the responses that suggest otherwise underscore the need for continued efforts to ensure that NGOs are offering services that are both informative and relevant, fostering a holistic and effective approach to adolescent sexual and reproductive health.



Source: Fieldwork Data, 2023

4.8.3 ASRH services are appropriate for male and female pupils

Chart 33 shows that the male and female pupils are accessing ASRH from the NGOs and 75.4% stated that the services are adequate for both boys and girls.

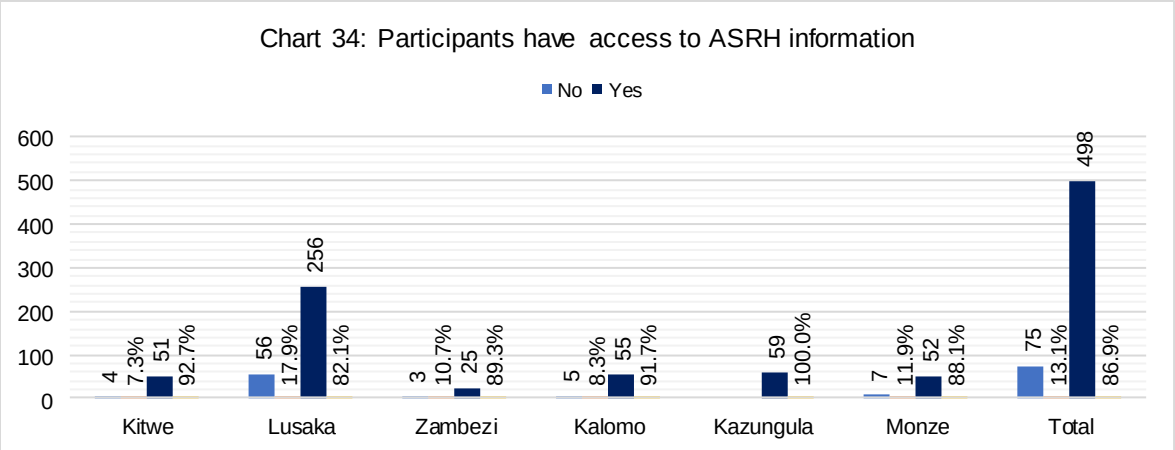


Source: Fieldwork Data, 2023

4.8.4 Access to ASRH information

The study investigated the availability of information on sexual reproductive health services for respondents. Encouragingly, a substantial majority of 86.9% affirmed having access to such information and health services. However, a noteworthy 13.1% indicated a lack of access. These findings paint a positive picture of the impact of Comprehensive Sexuality Education (CSE), indicating that a significant proportion of learners are well-informed about sexual reproductive health services and do have access.

Nonetheless, the presence of those without access underscores the need to ensure standardized availability of services. The study suggests that while CSE has made a positive difference, continued efforts are needed to ensure that every individual, regardless of their circumstances, can access accurate and comprehensive information and services for their well-being.



Source: Fieldwork, Data 2023

4.9 Current sources of information on ASRH for adolescents

The study explored the current sources of information on Adolescent Sexual and Reproductive Health (ASRH) for adolescents. Among the multiple responses, television emerged as the primary source, with 41.1% of respondents indicating its significance. Following closely were teachers at 32.5%, and both teachers' and learners' books at 31.2%. Other notable sources included radio at 31.6%, and guidance and counseling teachers at 29.4%.

However, certain sources like mothers at 18.8%, brothers at 8.2%, movies at 24.2%, and friends at 27.3% held less significant influence in informing decision-making. This diversity in sources underscores the importance of providing accurate and comprehensive information through various platforms to ensure adolescents are well-informed about issues that affect them directly like SRH. Television and teachers appear as dominant channels, but it is crucial to continue utilizing multiple avenues to reach adolescents thereby promote their understanding of SRH and well-being.

Table 26: Sources of information

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
The radio	1	2.0%	81	27.4%	8	32.0%	34	61.8%	20	33.9%	26	50.0%	170	31.6%
Father			17	5.7%			10	18.2%	5	8.5%	5	9.6%	37	6.9%
Brother	1	2.0%	26	8.8%	1	4.0%	5	9.1%	6	10.2%	5	9.6%	44	8.2%
Sister	2	3.9%	43	14.5%	7	28.0%	3	5.5%	3	5.1%	6	11.5%	64	11.9%
Magazines			55	18.6%	4	16.0%	7	12.7%	12	20.3%	10	19.2%	88	16.4%
Books	5	9.8%	104	35.1%	4	16.0%	7	12.7%	33	55.9%	15	28.8%	168	31.2%
Movies	3	5.9%	81	27.4%	5	20.0%	14	25.5%	18	30.5%	9	17.3%	130	24.2%
Television	10	19.6%	154	52.0%	10	40.0%	15	27.3%	20	33.9%	12	23.1%	221	41.1%
Male teachers	1	2.0%	56	18.9%	3	12.0%	18	32.7%	8	13.6%	13	25.0%	99	18.4%
Female teachers	1	2.0%	84	28.4%	4	16.0%	16	29.1%	13	22.0%	11	21.2%	129	24.0%
Guidance and Counseling	25	49.0%	66	22.3%	6	24.0%	14	25.5%	18	30.5%	29	55.8%	158	29.4%
Traditional teachers			32	10.8%	3	12.0%	6	10.9%	14	23.7%	12	23.1%	67	12.5%
Friends	4	7.8%	81	27.4%	9	36.0%	5	9.1%	31	52.5%	17	32.7%	147	27.3%
Teachers	8	15.7%	111	37.5%	5	20.0%	17	30.9%	20	33.9%	14	26.9%	175	32.5%
Mother	1	2.0%	66	22.3%	3	12.0%	14	25.5%	9	15.3%	8	15.4%	101	18.8%
Cousins	1	2.0%	18	6.1%					1	1.7%			20	3.7%

Source: Fieldwork Data, 2023

4.9.1 Sources of information on SRH that is appropriate for adolescents

The study investigated the preferred sources of information on Sexual and Reproductive Health (SRH) that are appropriate for adolescents. Notably, television continues to be the preferred medium, with 42.4% of respondents favoring it. Radio follows at 31.2%, and books at 28.3, guidance teachers at 28.1%.

Teachers themselves play a pivotal role, with 25.7% of respondents indicating their significance. While other sources carry lower percentages, the prevalence of television, radio, books, and guidance teachers emphasizes the importance of utilizing diverse platforms to provide accessible, reliable, and appropriate SRH information to adolescents. This reinforces the need to align information dissemination with adolescents' preferences to ensure a comprehensive understanding of SRH topics.

4.9.2 Sources of information on SRH that is appropriate for adolescents

The study investigated the preferred sources of information on Sexual and Reproductive Health (SRH) that are appropriate for adolescents. Notably, television continues to be the preferred medium, with 42.4% of respondents favoring it. Radio follows at 31.2%, and books at 28.3,

guidance teachers at 28.1%. Teachers themselves play a pivotal role, with 25.7% of respondents indicating their significance.

Table 27: Sources of information on SRH that is appropriate for adolescents

	Kitwe		Lusaka		Zambezi		Kalomo		Kazungula		Monze		Total	
The radio	2	3.9%	89	30.1%	7	28.0%	27	49.1%	20	33.9%	23	44.2%	168	31.2%
Father			22	7.4%	1	4.0%	6	10.9%	6	10.2%	11	21.2%	46	8.6%
Brother			24	8.1%	1	4.0%	6	10.9%	4	6.8%	9	17.3%	44	8.2%
Sister			29	9.8%	4	16.0%	4	7.3%	2	3.4%	9	17.3%	48	8.9%
Magazines	2	3.9%	47	15.9%	3	12.0%	4	7.3%	14	23.7%	9	17.3%	79	14.7%
Books	7	13.7%	95	32.1%	3	12.0%	5	9.1%	29	49.2%	13	25.0%	152	28.3%
Movies	5	9.8%	81	27.4%	4	16.0%	12	21.8%	18	30.5%	12	23.1%	132	24.5%
Television	9	17.6%	164	55.4%	8	32.0%	11	20.0%	21	35.6%	15	28.8%	228	42.4%
Male teachers	2	3.9%	45	15.2%	1	4.0%	18	32.7%	5	8.5%	14	26.9%	85	15.8%
Female teachers			58	19.6%	2	8.0%	13	23.6%	9	15.3%	13	25.0%	95	17.7%
Guidance and Counseling	24	47.1%	64	21.6%	7	28.0%	12	21.8%	16	27.1%	28	53.8%	151	28.1%
Traditional teachers	3	5.9%	24	8.1%	4	16.0%	3	5.5%	7	11.9%	13	25.0%	54	10.0%
Friends	2	3.9%	55	18.6%	3	12.0%	5	9.1%	30	50.8%	13	25.0%	108	20.1%
Teachers	5	9.8%	77	26.0%	7	28.0%	15	27.3%	16	27.1%	18	34.6%	138	25.7%
Mother			63	21.3%	4	16.0%	7	12.7%	5	8.5%	5	9.6%	84	15.6%
Cousins	1	2.0%	9	3.0%	1	4.0%							11	2.0%

Source: Fieldwork Data, 2023

While other sources carry lower percentages, the prevalence of television, radio, books, and guidance teachers emphasizes the importance of utilizing diverse platforms to provide accessible, reliable, and appropriate SRH information to adolescents. This reinforces the need to align information dissemination with adolescents' preferences to ensure a comprehensive understanding of SRH topics.

4.10 CSE and teenage pregnancies in the selected schools

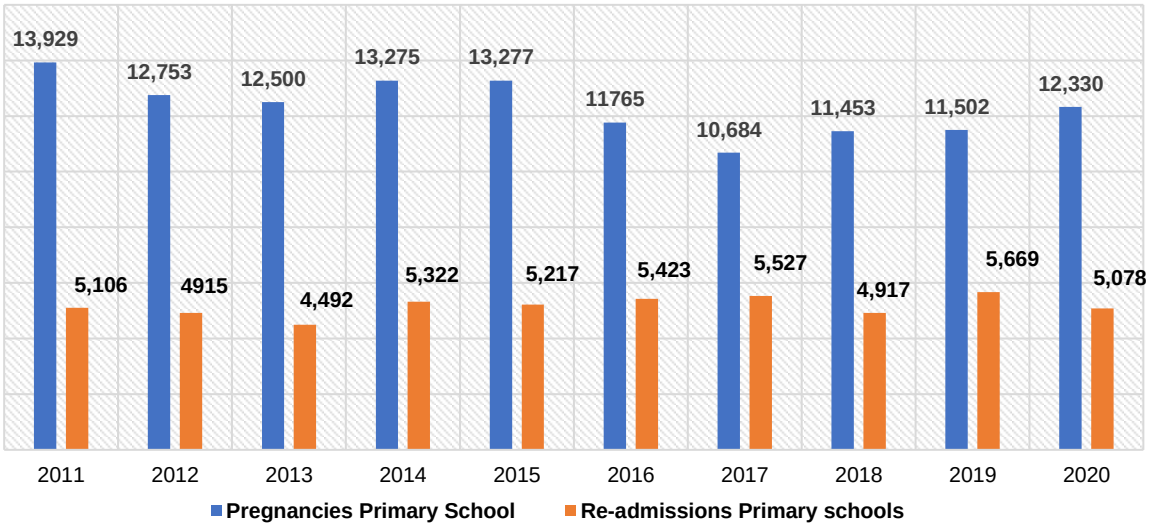
The American College Obstetricians and Gynecologist (2016) supports that Comprehensive Sexuality Education programs reduces the rates of sexual activity, sexual risk behaviors (e.g., number of partners and unprotected sexual intercourse), Sexually Transmitted Infections, and adolescent pregnancy.

To understand the prevenance of teenage pregnancy, a desk review analysis of statistics was done to determine whether the early and unintended pregnancies (EUPs) cases are increasing or decreasing. The graph below shows a 10-year trend analysis of the teenage pregnancies and the findings reveal that before CSE was introduced, teenage pregnancy cases recorded were

13, 929. When the CSE programme was introduced in 2014, statistics reveal 13, 275 school girls had dropped off school due to teenage pregnancies

From 2016 to 2019, pregnancy cases recorded were about 11,000, However in 2020 the number increased to 12, 330. All these cases recorded were from primary schools.

Chart 35: 10 Year Trend for Pregnancies and Readmissions



Source: Mukonka (2022)

As can be observed from the chart above, not all girls return to school. In 1997, Zambia instituted a School Re-Entry Policy, which officially states that girls who become pregnant while at school should be allowed to return to school after giving birth. This policy is part of the efforts by the Zambian government to increase education completion rates among the population thereby closing the gender gap in education by addressing one of the barriers to education that some girls face.

In Zambia a variety of policies were instituted to address pregnancy-related school dropouts. Some of these include giving adolescent mothers the legal right to return to school after giving birth.[87] However, a study by MaCCaden (2015) reveals that many girls continue to face social, financial, and practical challenges in returning to school after giving birth[88]. Mutombu and Muenda conducted 279 interviews with females in 12 districts who had left school due to pregnancy. The report shows that some of the challenges to returning to school was the "fear of scorn from fellow pupils" and inadequate resources to support both themselves and their

[87] Chilisa (2002)
[88] McCadden, D. T. (2015)

children.[89] Linking provision of CSE with accessible SRH services that are receptive to needs of adolescents and young people reduces EUP, which provides the opportunity for higher retention in school for adolescent girls.

From the study, there are factors that were identified which are contributing to teenage pregnancies among female pupils in the schools. Teenage pregnancy is associated with several social issues: poverty, low education levels and the lack of awareness about sex and pregnancy prevention.

The study found that adolescents engage in sexual risky behaviour that include unprotected sex, forced relationships and GBV as well as bullying other opposite sex. Other risky behaviour includes sexual favors for good results and sexual coercion. The implications of sexual risky behaviors among young people are far-reaching and multifaceted. Engaging in unsafe sexual practices, such as unprotected sex or multiple partners, can increase the risk of contracting sexually transmitted infections (STIs) like HIV, as well as lead to unintended pregnancies. These consequences can have profound physical, emotional, and psychological impacts on individuals, often disrupting their education, career prospects, and overall well-being.

Additionally, risky behaviors can strain personal relationships and erode trust. The societal impact includes the burden on healthcare systems, as well as potential transmission of infections to broader populations. Addressing and educating young people about sexual risks is essential to promoting their health, well-being, and future prospects, while also contributing to the broader public health goals of disease prevention and healthy communities.

The impact of family communication depends on what parents talk about in a household. Dialogue about values and beliefs have a positive impact on attitudes to premarital sex and sexual initiation; however, talking about everyday activities has no effect.[90]
The study establishes that lack of guidance from the parents contributes to teenage pregnancies.

> *Lack of guidance from the parents. The parents don't say anything or don't see the negative impact when the child gets pregnant. When you try and talk to the parents and encourage them to come back to school after child birth*

[89] Mutombu, N. & Mumbuna M. (2010).
[90] Yu (2010)

they say no let the child just stay home. They know about the re-entry policy. **Teacher trained in CSE, Bbwantu primary school, Monze**

The study shows that friends are seen as the major source of information about sex and relationships. The effect of dialogue about sex with friends appear to depend on the content of such communication. Lefkowitz and Espinosa Hernandez established that teenage girls that seek sexual information from peers have sex compared to those who get information from parents, teachers and other sources[91].

Broad system characteristics of CSE include strengthening links between schools and health facilities for collaboration, coordination, and the monitoring and evaluation of CSE. Despite the link between schools and health facilities, the pupils do not access the services.

"The pupils don't go to the clinics when they want more information. They rely on their friends." **Guidance and counseling teacher, Mwanza primary school, Monze**

"I would like to go the clinic and access the services, but the nurses refuse because I don't have an NRC." **Male pupil, Bbwantu primary school, Monze**

The male and female pupils in grade five stated that they do not access ASRH services at the health facility.

"I have never gone to the clinic to access the services because I fear that my mother will either beat or shout at me. Some people might report to my mother that I went to the clinic." **Female Pupil, Kanyama primary school, Lusaka**

"I don't go to the clinic because I'm young and I don't know what services they offer." **Female pupil, Chawama primary school, Lusaka**

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

[91] Lefkowitz and Espinosa Hernandez (2017)

Teenage pregnancy in Zambia is also influenced by the socio-demographic factors. Age is one of the factors that influence teenage pregnancy. Studies in Sub-Saharan Africa investigating the effects of socio-demographic factors on teenage fertility have shown that socio-demographic characteristics of teenage have an association with teenage fertility.[92]

Sexual activity before marriage is more the norm in Sub- Saharan African. Studies indicate that teenagers that are engaged in sexual activities have a higher risk of pregnancy which often leads to higher fertility.[93] In Zambia, teenagers, who give birth particularly at ages 15 to 17, are likely to be single and they are also in school.[94]

Region also affects teenage pregnancy in some way. In Zambian provinces, traditions might contribute towards teenage pregnancy. Girls are treasured as wealth and once they become of age, parents are willing to see them off to their husbands. This has been coupled with benefits yielding from dowry payments that may solve some of their problems.

> *"They want to marry off the girls because of culture and poverty."* **Teacher trained in CSE, Chibomboma primary school, Kalomo**

> *"Poverty is contributing to the teenage pregnancies. Our children here are in weekly boarding and most parents cannot afford to provide everything. Some of the girls start sleeping with married men so that can have food and other supplies needed.'* **Male parent, Kazungula**

> *"The girls want nice things like smart phones, nice clothes so they end up sleeping with the big men."* **Male pupil, Timothy Mwanakatwe primary school, Lusaka**

Teenagers from the poor households have high prevalence of teenage pregnancy compared to those from rich households. Teenage pregnancy also has economic consequences. Teenagers from the poor households have high prevalence of teenage pregnancy compared to those from rich households.[95] Teenage pregnancy also has economic consequences.

[92] Stone et.al. (2003)
[93] Palamuleni (2011)
[94] Sungwe (2015)
[95] Ibid

The study establishes that lack of care and support from parents, both emotionally and financially, has contributed to teenage pregnancies. Teenage pregnancies were reported at Nyawa secondary school.

> *"There is lack of security for the girls because they have to stay with the communities. The boarding houses are not safe for the pupils. Last term Nyawa recorded 10 pregnancies."* **Male parent, Kazungula**

Factors such as exposure to media, knowledge about sexual and reproductive health (SRH) and contraception as well as contraceptive use were found to be associated with teenage pregnancy.

> *"These pupils know a lot of things because of technology. They have access to the smart phones and the internet. So, when you are teaching in class, they cover their faces because they already know about sex."* **Guidance and counseling teacher, Kanyama primary school, Lusaka**

> *"The reason why the girls are getting pregnant is because the clinic is giving these family planning pills to the pupils. It is wrong".* **Female parent, Kazungula**

Peer pressure, socio-cultural, as well as environmental factors were identified as factors that are contributing to the teenage pregnancies.

> *"Most of these girls get pregnant because of peer pressure, their parents send them to school with no food."* **Teacher trained in CSE, Njezya primary school, Kalomo**

> *"There is not much to do here, as you can use this is rural area. So, some of the parents force the girls to get pregnant so that they can get some money."* **Female pupil, Chibomboma primary school, Kalomo**

> *"The community isn't helping. It's destroying the children. There are bars that do not have age restriction and minors just go there. There's a complex next to the police station and illegal things are happening there but the police are not doing anything."* **Guidance and Counseling teacher, Chawama primary school, Lusaka**

"There is a dam with a lot of gangs that prey on the young girls. They follow the girls and have sex with them by the dam. The girls are threatened in the presence of the parents, they don't report to the police. The only reason I found out was because of a certain issue that happened to a child in grade 7. When you see a child portraying a certain behavior you follow it up and that's how it came to light and a lot of things were revealed about what's happening in the community. Even if we teach them here as much as they would want to protect themselves, but the poverty levels are high. The girls who are just being kept by guardians are the most vulnerable." **Teacher trained in CSE, Chawama primary school, Lusaka**

Although teenage pregnancy is reducing in the schools, there are factors that contribute such as poverty, the environment, peer pressure, exposure to media, as well as the socio-economic status of the parents/guardians.

4.11 Best practices

Comprehensive sexuality education (CSE) lacked legitimacy in the community and was met with resistance from teachers tasked with its' implementation. In order to enhance ownership to the implementation of CSE, community concerns about the contents of the curriculum and the parent-teacher role dilemma must be taken into consideration. The study aimed at documenting the best practices adopted in the target schools.

1. **Training and orientation of teachers**

   Delivery of effective comprehensive sexuality education (CSE) requires skilled and motivated teachers. The study found that the trained teachers in CSE oriented the other members of staff. This has helped to address the teachers' negative attitudes towards CSE. The teachers interviewed stated that they had challenges to implement CSE when it was introduced due to the cultural and religious sensitivity of some of the CSE topics. However, due to the training and orientation, teachers have been able to examine their own attitudes toward sexuality, gender and behaviours regarding HIV prevention, pregnancies, understand the content they are teaching, learn participatory teaching skills, and gain confidence to discuss sensitive and controversial topics in a non-judgmental and rights-based manner.

2. **Partnership with the community**

   The study reveals that teachers, parents, chiefs, headmen, church leaders, and civic leaders are involved in the implementation of Comprehensive Sexuality Education (CSE). The school head teachers have created opportunities for community involvement in the implementation of Comprehensive Sexuality Education through the integration of Comprehensive Sexuality Education in other programmes in the schools such as

guidance and counselling, Annual General Meetings (AGMs), infrastructural development, re-entry policy, controlling of bad behaviour and motivational talks. The involvement of the community is aimed at building strong support, strengthen the relationship between school and the community. The pupils come from various households with different backgrounds and socialization, therefore, the schools are connected to the issues, which affect the community. As a result, strong, sustained community participation can enhance transparency and accountability in the education system and promote a sense of ownership, agency and responsibility for positive change among pupils.

3. **Links between the schools and health facilities**

   Adolescents in Zambia face numerous sexual and reproductive health (SRH) challenges, from HIV infection to unwanted pregnancy. The links between schools and health facilities accords the pupils opportunities to access scientifically accurate information about sexual reproductive health (SRH). Linking provision of CSE with accessible SRH services that are receptive to needs of adolescents and young people reduces EUP, which provides the opportunity for higher retention in school for adolescent girls. Health providers are more receptive to ASRH health needs, in addition they are encouraging teachers to ensure learners have access health services.

4. **Guidance and counseling teachers**

   The guidance and counseling teachers in the schools are implementing the reentry policy guidelines, conduct their counseling sessions with the girls and provide advice on the use of contraceptives to the reentered girls so as to help them prevent HIV, STIs and future unplanned pregnancies. The Ministry of Education has ensured that guidance and counseling departments are established in educational institutions at all levels of the education system so that counseling could be offered to the girls who fall pregnant while at school. However, the teachers also provide sanitary pads to the pupils and they also talk to them about body changes and abstinence.

5.0 Discussion of the findings

The Ministry of Education launched integration of Comprehensive Sexuality Education (CSE) into the National Education Curriculum for grades 5 to 12 learners in 2014 in order to provide the platform for learners to have access to information on sexuality education in schools,[96]

[96] Ministry of General Education (2013)

under the guidance of teachers. CSE empowers adolescents by providing information and knowledge about reproductive health and rights.

Comprehensive Sexuality Education (CSE) framework in Zambia was developed to guide the provision of Reproductive Health and Sexuality Education (RHSE), which features as a cross cutting theme in the Zambia Education Curriculum Framework. The implementation of Reproductive Health and Sexuality in Zambian schools is not meant to be a standalone subject, but integrating its content in subjects such as; Integrated Science at Primary and Junior Secondary level, Biology at Senior Secondary level and Civic Education at Senior Secondary level. Other subjects include Home Economics and Religious Education. The subjects are stand alone and examinable.

The pupils in secondary school and school administrators reported that they have seen changes among boys and girls.

- **Behavioural change:** *"Male and female pupils who take CSE seriously are able to refrain and change their behavior."*
- **Sexual harassment:** *"There are no issues of sexual harassment."*
- **Sexual relations:** "*We have seen that there are reduced sexual relations between male and female pupils. There may be a few pupils in relationships but, now they are able to report to the guidance and counseling teacher to get help if need be."*
- **Substance abuse:** *"There are no reports of substance abuse within the school premises. There was one boy who was a problem, smoking weed, but after I started talking to him, he changed and he is now in grade 12."*

Among the male and female pupils in the lower grades, the school administrators reported that there has been changes since CSE was introduced.

- **Cleanliness:** *"Some have improved especially on cleanliness. They've improved in the way they come to school; they now look clean."*
- **Body-care:** *"Since we have talked about sexual health, learners have improved in the way they clean themselves. Even girls advise each other the way they should care for their bodies as females. As teachers we talk to them about these things."*
- **Boy-girl relationships:** *"I have observed that the way boys and girls interact now has changed, especially after learning about puberty and body changes. That is for in the upper grades where it's working."*

- **Respect for elders:** *"We had seen that children were not respecting the elderly, their parents and grandparents in the community. The topic on culture, society and human rights has helped a lot."*

Early marriages and teenage pregnancies

The study aimed at investigating the teenage pregnancies in the schools for the last five years. However, the schools visited did not have the records, due to transfers of guidance teachers and headteachers. In many cases, there had been no handovers. At Chibomboma school, the office was locked due to renovations and the file could not be retrieved. However, the teachers trained in CSE, guidance and counseling as well as the headteachers reported that the cases are reducing.

> *"CSE is effective and it is helping the pupils. I have been at Njezya for 11 years and in the past, we had high a number of pregnancies and now it has reduced. CSE has come also at the time when FAWEZA is following behind with the support of the re-entry policy implementation. Before CSE, we were recording between 3-5 pregnancies in a year but from 2021 up to this time, it has reduced to 1-2 a year."* **Teacher trained in CSE, Njezya Primary school, Kalomo**

Chawama school had records from 2020 to 2023. The table below shows that pregnancies among teenage girls at Chawama Primary school have been reducing. In 2020 the school recorded 10 pregnancies and this was high among the grade 9s; in 2021, 2 grade 9s were pregnant, in 2022, 5 pregnancies were recorded and in 2023, 3 grade 7s were made pregnant.

Table 28: Pregnancies at Chawama Primary School

Year	Age	No. of pupils pregnant
2020		
Grade 5	15 years	1
Grade 7	16 years	4
Grade 9	17 years	5
2021		
Grade 9	17 years	2
2022		
Grade 9	17 years	2
Grade 8	16 years	2

Grade 7	15 years	1
2023		
Grade 7	16 years	3
Total		**20**

Source: School file, Chawama School (2023)

Other impacts of CSE includes the reductions in early marriages among the male and female pupils.

> *"With CSE, the pregnancies have reduced and they don't force the boys to marry the girls now. We are allowed to go back to school."* ***Male pupils, Chibomboma Primary school***

> *"We have seen a reduction in child marriages. The early marriages are going down. We've preached much on the action when one is withdrawn from school. We've had cases like that but this time when a child is withdrawn from school, people will begin talking about it and after a week or so the girl comes back."* **Guidance and Counseling teacher, Njezya School**

The teachers also reported that CSE has helped address sexual harassment and they are able to talk to the pupils when there are issues to be addressed.

> *"There cases of sexual harassment. Sometime back we would get reports like certain boys were following girls on the way and those have reduced this time. They would be touching their breasts or buttocks."* **Guidance and counseling teacher, Chawama Primary School**

> *"As a guidance teacher there are those rare cases that I deal with. I don't encourage the pupils to use family planning. There was an instance where a girl had prolonged periods because of the use of contraceptives and it was later found out that it was the aunt who introduced it to her and I called the parents although they never came. I had to counsel her and I told her the repercussions. For the re-entries, I just tell them to start using contraceptives because they are sexually active and I am not with them all the time to monitor or see what they are doing."* **Guidance and counseling teacher, Timothy Mwanakatwe Primary School, Lusaka**

> *"To teach pupils that have re-entered school about all these things like you are teaching those who don't know anything can be awkward. I am privileged to*

be a guidance teacher because I can call them privately and counsel them and also speak to them one on one and not as a whole group." **Guidance teacher Bbwantu primary school, Monze**

It is perceived that when sexuality education is comprehensive, age-appropriate, gender-sensitive, rights-based, contextually adapted, and scientifically accurate and life skills based it can help learners develop and maintain safer behaviours toward HIV prevention and healthy lives for young people and that CSE provides a building-block approach to prepare adolescents and young people for puberty and beyond, helping them to understand their bodies, to make informed decisions about relationships and develop critical decision making skills.

School-based sexuality education is regarded as essential owing to the fact that most parents are unable to discuss sexual matters with their children. The study found out that school adolescents were having sexual relationships at increasingly young ages, often from as young as 15 years and boys of the same age were already sexually active. Parents are unable to discuss sexual matters with their children due to cultural and religious beliefs.

Beausang & Fowler argues that pupils need to learn about sexuality because it is part of their social, personal and health education, thus CSE provides them with structured opportunities to develop the knowledge, attitudes, values, beliefs and practical skills necessary to establish and sustain healthy personal relationships as children and adults.[97]

[97] Beausang & Fowler (2020)

6.0 Conclusion and Recommendations

6.1 Conclusion

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

The ZDHS (2018) indicates that about 32% of adolescents aged 15-17 years and 60% of those aged 18-19 years are sexually active, and therefore face risks of acquiring HIV and other (STIs). One in five adolescent girls are already married compared to only one in 100 adolescent boys aged 15-19; and one in four girls aged 17 and six in 10 girls aged 19 have already started child - bearing. This study found out that if CSE continues being properly integrated with good coordination, policy direction and support, it can help to develop adolescents, delay sex, and improve on school retention thereby improving on health and educational outcomes for adolescents. Adolescents and young people not only represent a significant and growing population in Zambia, but also, disproportionately bear the burden of CSE/SRHR issues including HIV. In Zambia adolescents and young people today are burdened with a cocktail of health problems mostly CSE/SRHR related that make it difficult for them to thrive.

The findings of this study are consistent with the CSE conceptual framework indicating that policy is key in the implementation of CSE. Comprehensive sexuality education (CSE) plays an important role in equipping young people with sexual and reproductive health knowledge. However, in Zambia and in the schools selected for this study, there is prevalence of early and unplanned pregnancies among teenagers, 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 content and mode of delivery with the support of teachers and other stakeholders at district level.

Parents/guardians and teachers trained in CSE preferred that the local community provide sexuality education, because of its cultural role in shaping behaviors and norms. Examples were

given of how elders in the community would guide youth regarding societal norms and expectations of gendered roles. However, it was noted that these relationships were collapsing, and that society was tending toward a more “individualistic” orientation. Community health workers and teachers to provide ASRH information and services because they can act as resource persons to link adolescents to ASRH services and accurate information.

6.2 Recommendations

The study on the implementation of comprehensive sexuality education (CSE) generated recommendations for the Ministry of Education and its partners on what has to be done going forward, including implementation and advocacy. The recommendations below are linked to the objectives of the study and are categorized at Policy and practice, Stakeholder roles and responsibilities as well as community or beneficiary action.

Ministry of Education

- Th findings shows that when the teachers are delivering CSE (now L-SHE) the students are uncomfortable. Ministry of Education should strengthen the training of teachers in L-SHE, so that they are able to deliver it in an interactive manner. Delivery of L-SHE should not be rigid.

National Level (Educational Policy and CSE)

- The study reveals two pertinent aspects that hinders the effective implementation of CSE at a national level namely lack of sustainable financing and ineffective coordination of the programme. Recommendation is thus made for sustainable local financing to support both teacher training and CSE material production. It is also recommended that coordination between stakeholders be strengthened. This is because integration of CSE requires effective co-ordination within the Ministry of Education departments and collaboration with the Ministry of Health and other stakeholders that include NGOs, CSOs and FBOs. The effective implementation of CSE is that which is linked to a health facility for many ASRH needs
- Teachers face significant challenges in the classroom, ranging from lack of time, materials or resources to perceived community opposition, their own discomfort, and lack of knowledge or training on the topics. This study recommends that there should be improvement in systematizing and scaling up of teacher training as this is essential to ensure that sexuality education is delivered accurately, appropriately and effectively.
- There is need for a standard teacher training manual t guide effective delivery of CSE training. This study has found out that currently, there is no training manual which

teacher trainers can leverage on. The study strongly recommends that the Ministry should ensure that a standard training guide for all the implementors of CSE are guided and are doing the same thing. There variations that exist affect the quality of information that teachers hold.

- It is clear from the study findings that the Ministry of Education has been open to educational reforms, and policies do exist to support the provision of school-based sexuality education However, the government has not been successful in ensuring the implementation of these policies. Because sexuality education is guided by policies at multiple levels—from national laws to local school administrative guidelines—political leadership is needed at each level to support implementation. Appropriate coordination and synergy are also needed among different government agencies involved to ensure uniformity and better utilization of the available resources for all.
- There is inadequate teacher training for implementing CSE, and the teachers are unprepared and lack sufficient knowledge or adequate support limits their teaching to topics with which they are comfortable. The Ministry of Education should create clear guidelines for the NGOs so that they are able to assist in capacity building of teachers in Comprehensive sexuality education (CSE).
- The comprehensive sexuality education topics that are integrated into carrier subjects are limited in scope; they are not examinable. The fact that CSE topics are not well integrated into compulsory and examinable subjects limits the information available to students and reduces the incentive for students and teachers to accord them high priority. Therefore, high-quality comprehensive sexuality education needs to be recognized as essential for the healthy development of adolescents and their transition to adulthood, and needs to become institutionalized within national systems of education if it is to be delivered at scale on a sustained basis.
- Strengthen coordination between NGOs and health facilities, so that the lessons learned from the NGO programmes can be applied to the design and implementation of the government programme at a national level.

Forum for African Women Educationalists of Zambia (FAWEZA) Make Way, SAT and Plan International

- Ensure stronger advocacy on the development of the programmes and that it should be based on empirical evidence documenting the characteristics of successful comprehensive sexuality education programs and the positive impact that it can have on

adolescents when designed and delivered appropriately. This study further recommends that partners like FAWEZA, Make Way, Plan International and SAT can advocate for a standard training manual and other related materials to reinforce smooth implementation of CSE at school level.

- Prioritize CSE at primary school level focusing on a comprehensive and rights-based approach for comprehensive sexuality education ensuring that pupils receive essential age-appropriate information in their local languages.

- Develop a comprehensive mechanism for monitoring and evaluating the integration of CSE in schools, and assessing the gaps between policies and classroom realities on a quarterly and yearly basis.
- Implementing partners should consider other forms of disseminating information on comprehensive sexuality education or facilitating discussions e.g., through digital media, traditional and contemporary songs or art should be explored in order to also reach the out-of-school youth.

School Level

- The finding reveals that topics such as reproduction accounted for 6%, sexual behavior at 11.4%, and sexual & reproductive health at 14% received lower scores, suggesting perceived incongruence with religious beliefs. It is recommended that Guidance and counselling teachers should be equipped with religious tools so that they are able to assist the learners and deal with the issues from a faith-based perspective.

Community level

- More sensitisation and awareness on the dangers of early marriages and pregnancies on the adolescents' health thereby affecting their education and health outcomes. The community should be encouraged to get concerned and join the campaign for the good of their children.
- The study recommends that the re-entry policy guidelines should be translated into the seven major languages for communities to easily understand the policy.
- The study shows that the pupils talk to their friends about sex, relationships and body changes. This was followed by the grandmothers. It is recommended that capacity building and sensitisation to the parents/guardians on L-SHE should continue so that they are given the right information and enable them promote the positive/good traditional practices.

Gender Division

- The study shows that Nyawa recorded 296 recorded in 2022 and 286 in 2023. Zambezi district recorded 1,074 in 2021, 1284 in 2022 and 1,094 in 2023. The 10-year trend analysis also shows that A 10-year trend analysis of the teenage pregnancies reveal that before CSE was introduced, teenage pregnancy cases recorded were 13, 929. When the CSE programme was introduced in 2014, statistics reveal 5,106 school girls had dropped out of school due to teenage pregnancies. From 2016 to 2019, pregnancy cases recorded were about 11,000, However in 2020 the number increased to 12, 330. All these cases recorded were from primary schools.
- It is recommended that the Provincial Gender officers should work with the NGOs to raise awareness on teenage pregnancies in the provinces and districts.

Further research

- This study recommends that more in-depth qualitative studies are needed to know more about the impact of comprehensive sexuality education (CSE) on young people, the phenomena of teenage pregnancy from the perspective of teenagers, their parents and families and the community as a whole is required.
- The assessment only targeted the government schools that are implementing CSE and this was provided by FAWEZA. It is recommended that future research should include missionary schools to get a perspective on L-SHE.
- The study did not include pupils with disabilities as they were not identified by the school administrators. The research on CSE should also include pupils with disabilities. This will enable the NGOs identify the challenges and gaps as well as design policy on how the pupil with disabilities can be included in the implementation of L-SHE in the schools.

Annex I: Terms of Reference for a Research on the Impact of the Implementation of Comprehensive Sexuality Education (CSE) In Zambia

1. Background of FAWEZA

The Forum for African Women Educationalists of Zambia (FAWEZA) is a gender justice organization with the mandate of promoting quality and inclusive education for women and girls. Formed on 8th March 1996, the organization advocates for gender-responsive policies and programmes so that women and girls have equitable access to education opportunities. Over the years the FAWEZA works to address all barriers to girls' access to education.

2.0 BACKGROUND

Inadequate knowledge on Sexual Reproductive Health Rights Information among adolescent girls has resulted in high teenage pregnancies and child marriages in Zambia. Teen pregnancies are currently above 15,000 per annum. Out of these, only 7,405 re-enter school according to Ministry of General Education Statistical Bulletin of 2018. Additionally, there is a high prevalence of Sexually Transmitted Infections (STIs) including HIV among the 15-24 age group (2013/2014 ZDHS); Furthermore, about 32% of adolescents aged 15-17 years and 60% of those aged 18-19 are sexually active (ZDHS) 2013/14. Statistics show that 16% of girls and 12% of boys experience sexual intercourse before the age of 15 (ZDHS2013/14).

In 2014, the government of the Republic of Zambia introduced Comprehensive Sexuality Education (CSE) to be part of the Zambian school curriculum for learners from grades five (5) to twelve (12). This was necessitated as a result of the increased number of girls dropping out of school due to teenage pregnancies. However, it is sad to note that over eight years since CSE was introduced, more than half of the teachers have not been trained to deliver CSE in schools. The situation is worse in rural areas. FAWEZA's experience during the training of teachers in Luapula province noted that from 360 teachers drawn from 12 Districts of the Province, only 5% of the target group acknowledged having undergone training facilitated by the Ministry of General Education while the rest had never been trained and were seeing the CSE framework for the first time.

The introduction of CSE was aimed at providing young people with age-appropriate, culturally relevant, and scientifically accurate information so that they can make informed decisions on their sexuality as well as reduce the incidences of teenage pregnancies. Unfortunately, only 42.3% of the learners have been reached with life skills-based HIV and sexuality education information.

After so many years of implementation of CSE, not much seems to improve especially in the number of teenage pregnancies among school-going girls. The number of teenage pregnancies

from 2018 has continued to rise with the number in 2022 being 16,419 learners who became pregnant and only 7,954 were re-admitted.

The situation presents a worrisome scenario among key stakeholders such as FAWEZA as it extremely disadvantages girls in having access to equitable education opportunities.

3.0 PURPOSE OF THE RESEARCH

In view of the foregoing, FAWEZA would like to engage a consultant to conduct an assessment of the impact of CSE in Zambia. The goal of the consultancy work is to assess implementation of CSE in Zambia, to ascertain what impact has been recorded, what gaps still exist and investigate why larger numbers of teenage pregnancies continue to increase in spite of the country implementing CSE. The research further aims to make recommendations on what has to be done going forward. It is envisaged that the findings of this research will be used by FAWEZA to influence the curriculum review process which is currently underway.

OBJECTIVE OF THE RESEARCH

The overall objective of the research is to generate evidence in order to influence effective implementation of CSE in Zambian Schools.

Specific objectives:

i. To determine the impact of the implementation of CSE and document best practices during the implementation of CSE in Zambia
ii. To assess the existing gaps in the implementation of CSE
iii. To investigate reasons for the continued increase in teenage pregnancy incidences regardless of the implementation of CSE in Zambia.
iv. To provide recommendations to MoE and other stakeholders such as FAWEZA on what has to be done going forward, including implementation and advocacy issues

3.0 SCOPE AND FOCUS OF THE RESEARCH

The consultant(s) will conduct the research in a representative selection of schools across the four (4) districts of implementation namely Lusaka, Monze, Kalomo and Kazungula.
Specifically, the consultant will be expected to:

a) Develop research tools for the study
b) Conduct a desk study to provide a concrete background with latest statistics;
c) Conduct interviews with key informants directly benefiting and those involved in delivery of CSE
d) Come up with a comprehensive report of findings and concrete recommendations for enhancing the delivery of CSE
e) Develop a short Policy brief with key findings and recommendations for policy direction to improve delivery of CSE in Zambian schools

EXPECTED DELIVERABLES

i. An inception report detailing a work plan of the assignment, including dates for the key milestones of the study
ii. Research tools which will be finalized after mutual agreement with FAWEZA Secretariat and Project partners
iii. First draft report to be submitted to FAWEZA Secretariat on dates to be agreed in the inception report

iv. Second draft report which will be presented to the project partners for joint feedback
v. Third and final draft
vi. A policy brief of not more than 6 pages with key findings and key recommendations for advocacy
vii. Make a presentation of the study findings at an engagement meeting to be organized by FAWEZA Secretariat

EXPRESSION OF INTEREST

Those interested in undertaking the assignment must submit a research proposal stating key methodologies to be employed in the research, proposed samples to be reached for the categories of key informants, work plan and proposed fees. The consultant will further be expected to show proof of experience and competence to deliver on similar work.

Annex II: School Questionnaire

Questionnaire serial #: _____

Lutandi Enterprises

An Assessment of the Impact of the Implementation of Comprehensive Sexuality Education (CSE) in Zambia

LEARNER QUESTIONNAIRE

2023

The questions in this survey are designed for the adolescent pupils in schools aged 12-19 years.

Guidance for introducing yourself and the purpose of the interview:

- My name is …… and I am representing Lutandi Enterprises Ltd. We are currently conducting a survey on Comprehensive Sexuality Education (CSE) in selected districts of Zambia, which includes Kazungula, Kalomo, Monze, and Lusaka. Your school has been selected for this survey because you are implementing CSE.
- **Purpose:** The purpose of this interview is to gather information on how CSE is delivered, the impact it has on learners' lives, the gaps in the implementation of CSE, and the reasons for the continued increase in the number of learners dropping out of school due to teenage pregnancies. Confidentiality: The survey is voluntary and the information that you provide will be confidential. The information will be used to prepare a report that will inform our partners about the success or lack of success of CSE implementation in Zambia. The report will not include any specific names, and there will be no way to identify that you provided this information.
- Time: Thank you for taking the time to speak with us today. The interview will take approximately 30 minutes. Please let me know if you have any questions or concerns.
- Consent: Before we begin, I would like to confirm that you consent to participate in this survey. If you do not consent, we will not proceed with the interview. Please indicate your response below. Consent given [ ] Consent not given [ ]

SECTION A: IDENTIFICATION PARTICULARS

[This section is for the school authorities] A.1. Province Name:	
A.2. District Name:	
A.4. Region (1. Rural, 2. Urban)	
A.5. Name of School	
A.6. Number of pupils in the school	Boys [ ] Girls [ ]
A.7 Year when the school opened	
A.9. Date of Interview:	Date MM / DD / YYYY [____/____/_____]
A10. Name of enumerator:	

SECTION B: DEMOGRAPHIC INFORMATION (I am now going to ask you questions about you)		
Respondents (BIO DATA) adolescents aged 12-17		√
B.1	Respondents gender a. Female b. Male	 [ ] [ ]
B.2	Age of respondent: a. 12 years b. 13 years c. 14 years d. 15 years e. 16 years f. 17 years g. 18 years h. 19 years	 [ ]
B3.	Grade of the respondent ……	
B.4	Who do you live with? a. Mother b. Father c. Mother and father d. Grandmother e. Grandfather f. Grandmother and Grandfather g. Any other, please specify……..	 [ ] [ ] [ ] [ ] [ ] [ ] [ ]
B.5	How many people live in your household including yourself? a. 1-5 b. 6-10 c.Other, please specify……..	[ ]
Head of Household (BIO DATA)		
B.6	Has the household head attended school? a. Yes b. No c. I don't know	 [ ] [ ] [ ]
B.7	What is the highest level of school attended by the head of household? a. 1-7 b. 8-9 c. 10-12 d. Tertiary e. I don't know	 [ ] [ ] [ ] [ ]
B.8	Is the head of the household employed a. Yes b. No	 [ ] [ ]
B9.	Is the head of the household in the following sector a. Formal b. Informal sector c. I don't know	
SECTION C: Approaches to delivering Comprehensive Sexuality Education		

C.1	Do you receive comprehensive sexuality education in school? a. Yes b. No	 [ ] [ ]
C.2	At what grade did you start learning Comprehensive Sexuality Education? a. Grade 5 b. Grade 6 c. Grade 7 d. I am not sure	 [ ] [ ] [ ] [ ]
C.3	Who teaches Comprehensive Sexuality Education (CSE)? a. Teachers b. Nurses c. Guidance couselling teacher d. Parents/Guardians e. Other, please specify…….	 [ ] [ ] [ ] [ ] [ ]
C.4	Is the time allocated for Comprehensive Sexuality Education sufficient? a. Yes b. No	
C.5	Explain, your answer …… … …… …	
C.6	Which topics are covered in Comprehensive and Sexuality Education? a. 1…… b. 2…… c. 3…… d. 4…… e. I don't know ……..	
C.7	Which topics do you find interesting in Comprehensive Sexuality Education? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure	
C.8	Please explain why do you find the topics mentioned above interesting …… …… …… ……..	
C.9	Which topics do you not like in Comprehensive Sexuality Education? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure	
C.10	Please explain why you do not like the topics mentioned above. …… …… ……	

C.11	Has Comprehensive Sexuality Education helped you as an adolescent? a. Yes b. No	 [ ] [ ]
C.12	If yes, please explain how Comprehensive Sexuality Education has helped you? …… …… …… ……	
C13.	If no, please explain how Comprehensive Sexuality Education has not helped you? …… …… …… ……..	
	What gaps are missing in Comprehensive Sexuality education for learners? …… …… …… ……	
SECTION D: Comprehensive Sexuality Education and Language, religion, culture and age		
CSE and Language		
D1.	Is the language used to teach Comprehensive sexuality education (CSE) appropriate for learners? a. Yes b. No	
D2.	What language is used to teach Comprehensive Sexuality Education? a. English b. Tonga c. Bemba d. Chinyanja e. Other, please specify……	 [ ] [ ] [ ] [ ] [ ]
D3.	Which topics are appropriate with your language? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……..	
D4.	Which topics are not appropriate with your language? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
CSE and Age		
D5.	Are the topics in CSE appropriate for your age? a. Yes	

	b. No	
	If no, please explain why the topics are not appropriate for you age …… …… …… ……..	
CSE and Religion		
D6	Are the topics in Comprehensive Sexuality education appropriate with your religion? a. Yes b. No	[ ] [ ]
D.7	Which topics are appropriate with your religion? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.8	Which topics are not appropriate with your religion? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
CSE and Culture		
D.9	Are there topics that are a taboo in your culture? a. Yes b. No c. I don't know	[ ] [ ] [ ]
D.10	Which topics are a taboo in your culture? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
D.11	Which topics are not a taboo in your culture? a. 1…… b. 2…… c. 3…… d. 4…… e. I am not sure……	
CSE and Sexuality		
D12	Are you comfortable discussing safe sex after learning about CSE in school? a. Yes b. No	
D.13	If yes, with whom do you discuss safe sex after learning about CSE in school? a. Parents/Guardians b. Grandmother	[ ] [ ]

	c. Grandfather d. Aunty e. Uncle f. Male Teacher g. Female Teacher h. Guidance and Counseling teacher i. Other, please specify……	
D.14	If no, why are you not comfortable discussing safe sex after learning about CSE in school? …… …… ……	
D15	Are you able to discuss sexuality and reproductive health after learning about CSE in school? a. Yes b. No	
D.16	If yes, with whom do you discuss sexuality and reproductive health after learning about CSE in school? a. Parents/Guardians b. Grandmother c. Grandfather d. Aunty e. Uncle f. Male Teacher g. Female Teacher h. Guidance and Counseling teacher i. Other, please specify……	
D17	If no, why are you not comfortable discussing sexuality and reproductive health after learning about CSE in school …… …… ……	
SECTION E: Effect of Comprehensive Sexuality Education on the Social-Emotional development of adolescents		
E1.	Do you know what sexual risk behaviour is? Yes No I don't know	
E.2	Do adolescent school learners engage in sexual risk behaviours after learning about CSE? a. Yes b. No c. I don't know	[ ] [ ] [ ]
E.3	What sexual risk behaviours do adolescents engage in? a. 1…… b. 2…… c. 3……	

	d. 4…… e. I don't know……	
E4	Why do adolescents engage in sexual risk behaviour …… …… …….. …… ……	
E.5	After learning about CSE, are you comfortable discussing your feelings towards the opposite sex? a. Yes b. No	[ ] [ ]
E.6	If yes, with whom are you comfortable discussing your feelings towards the opposite sex? a. Parents/Guardians b. Grandmother c. Grandfather d. Aunty e. Uncle f. Male Teacher g. Female Teacher h. Guidance and Counseling teacher i. Other, please specify……	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
E.7	Please explain your answer …… …… …… ……	
E.8	Are you comfortable discussing relationships after learning about CSE? a. Yes b. No	[ ] [ ]
E.9	If yes, with whom are you comfortable discussing about relationships? a. Parents/Guardians b. Grandmother c. Grandfather d. Aunty e. Uncle f. Male Teacher g. Female Teacher h. Guidance and Counseling teacher i. Other, please specify……	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
E.10	Please explain your answer …… …… ……	
E.11	Are you comfortable to talk about your body? a. Yes b. No	[ ] [ ]
E.12	With whom are you comfortable discussing your body? Please select all that apply.	[ ]

	a. Parents/Guardians b. Grandmother c. Grandfather d. Aunty e. Uncle f. Male Teacher g. Female Teacher h. Guidance and Counseling teacher i. Other, please specify……	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
E.13	Please explain your answer …… …… …… ……	
	SECTION F: School Related Gender-Based Violence (SRGBV)	
F.1	Is there violence targeted at girls/boy in the school? a. Yes b. No	 [ ] [ ]
F.2	What forms of violence are targeted towards the girls/boys in school? Please select all that apply. a. Bullying b. Physical fighting c. Sexual harassment d. Sexual acts in exchange for good grades or for the paying of school fees e. Seduction or sexual harassment of learners by a teacher	 [ ] [ ] [ ] [ ] [ ]
F.3	Which forms of violence **mostly** affects the girls/boys only? Please select all that apply. a. Bullying b. Physical fighting c. Sexual harassment d. Sexual acts in exchange for good grades or for the paying of school fees e. Seduction or sexual harassment of learners by a teacher	 [ ] [ ] [ ] [ ] [ ]
F.4	Please explain how the violence mentioned above, affect girls/boys? …… …… …… ……	
F.8	a. How does the school address violence that is targeted at the pupils? Please select all that apply. Establishment of safe spaces in schools b. Introduction of clubs c. School committees d. Any other, please specify…….	[ ] [ ] [ ] [ ]
F.9	Have these approaches helped in addressing Gender Based violence experienced by boys/girls in schools? a. Yes b. No c. I don't know	[ ] [ ] [ ]
F.10	How has the approach helped the girls? ……	

	…… …… ……	
F.11	How has the approach helped the boys? …… …… …… ……..	
	SECTION G: Sources of adolescent sexual reproductive health services	
G.1	Do You have access to sexual reproductive health services? a. Yes b. No	 [ ] [ ]
G.2	Who provides sexual reproductive health services? Please select all that apply. a. The school b. The Healthcare facilities c. The community members d. Any other, please specify……	 [ ] [ ] [ ] [ ]
G.3	What sexual and reproductive health services are provided by schools for adolescents? a. 1…… b. 2…….. c. 3…… d. 4……	
G.4	Are the sexual reproductive health services provided in schools appropriate for adolescents? a. Yes b. No	 [ ] [ ]
G.5	Please explain your answer …… …… ……..	
G.6	Are the sexual and reproductive health services provided in schools appropriate for: a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	 [ ] [ ] [ ] [ ] [ ]
G.7	Please explain why the services provided in schools are appropriate …… …… ……..	
G.8	What sexual and reproductive health services do the healthcare facilities provide for adolescents? a. 1……	

	b. 2…….. c. 3……. d. 4……. e. I don't know	
G.9	Have you accessed the sexual reproductive health services at the healthcare facilities after learning about CSE? a. Yes b. No	 [ ] [ ]
G.10	If yes, please explain what services you accessed at the healthcare facility …… …… ……..	
G11	If no, please explain why you haven't accessed sexual reproductive health services at the healthcare facilities after learning about CSE in school …… …… ……..	
G.12	Sexual and reproductive health services provided by the healthcare facilities are appropriate for: a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	 [ ] [ ] [ ] [ ] [ ]
G.13	Please explain your answer ……. …… ……..	
G.14	Are there NGOs that provide sexual reproductive health services to adolescents? a. Yes [ ] b. No [ ] c. I don't Know	
G.15	If, yes, what sexual reproductive health services do NGOs provide for adolescents? a. 1……. b. 2…….. c. 3……. d. 4…….	
G.16	Are the sexual reproductive health services provided by the NGOs appropriate for adolescents? a. Yes b. No	 [ ] [ ]
G.17	Please explain your answer …….	

	………	
G.18	Sexual and reproductive health services provided by the NGOs appropriate for: a. Girls only b. Boys only c. Boys and girls d. Adults e. None of the above	 [ ] [ ] [ ] [ ] [ ]
G.19	Do you have access to information on Sexual Reproductive Health? a. Yes b. No	 [ ] [ ]
G.20	Where do you get information on sexual reproductive health? Please select all that apply. a. The radio b. Television c. Male teachers d. Female teachers e. Guidance and Counseling f. Traditional teachers g. Friends h. Teachers i. Mother j. Father k. Brother l. Sister m. Magazines n. Books o. Movies p. Any other, please specify…………	 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
G.21	Which sources provide information that is appropriate for adolescents? Please select all that apply. a. The radio b. Television c. Male teachers d. Female teachers e. Guidance and Counseling f. Traditional teachers g. Friends h. Teachers i. Mother j. Father k. Brother l. Sister m. Magazines n. Books o. Movies p. Any other, please specify…………	 [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
G.22	Explain your answer	

	…… …… …… …… ……	
G.23	Do you have challenges in accessing sexual reproductive health information at School? a. Yes b. No	
G.24	Please explain your answer …… …… …… …… ……	
G.25	Do you have challenges in accessing sexual reproductive health services at the healthcare facilities? a. Yes b. No	
G.26	Please explain your answer …… …… …… …… ……	
G.27	Do you have challenges in accessing sexual reproductive health services from the NGOs? a. Yes b. No	
G28	Which of the following sources are a challenge to obtain information on sexual reproductive health? Please select all that apply. a. Male teachers b. Female teachers c. Guidance and Counseling d. Traditional teachers e. Friends f. Teachers g. Mother h. Father i. Brother j. Sister k. Any other, please specify……	
G.29	Which Sources would you prefer to obtain information on sexual reproductive health for adolescents? Please select all that apply. a. The radio b. Television c. Male teachers d. Nurses e. Doctors c. Female teachers	

	d. Guidance and Counseling e. Traditional teachers f. Friends g. Teachers h. Mother i. Father j. Brother k. Sister l. Magazines m. Books n. Movies f. Any other, please specify……	
G.30	Please explain your answer. ……..……..……..……..……..……..……..……..…… ……. ……..……..……..……..……..……..……..……..…… ……..……..……..……..……..……..……..……..…… ……	

THIS IS THE END OF THE QUESTIONNAIRE

THANK YOU

Annex III: Interview guides

AN ASSESSMENT OF THE IMPACT OF THE IMPLEMENTATION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) IN ZAMBIA

Key informant interview guide – DRCC

Purpose: *The overall purpose of the study is to assess the impact of the implementation of CSE in Zambia since it was introduced in Zambia as well as examine what gaps still exist and investigate reasons why numbers of teenage pregnancies continue increasing regarding the country implementing CSE and make recommendations on what has to be done going forward.*

Geographic Location:
Interview date:
Name of Interviewer:
Name of Committee:
Name (optional):
Place of interview:
Method of interview (e.g. phone, WhatsApp etc.):

Introduction

1. Thank the participant(s) for the interview
2. Explain the objectives and expectations of the interview
3. Outline the amount of time interview will take
4. Obtain the informant's informed consent to record / write notes from the interview.

Sex of key informant:
Position of the informant:

A. General information

1. How long have you lived in this community? *Probe: How long have you been in this position?*
2. How many schools are in the district? *Probe: Primary? Secondary? Basic schools?*
3. How many schools in the district are implementing CSE? *Probe: Primary? Secondary? Basic schools*
4. How many teachers have been trained in the district to deliver CSE? *Probe: Males/females?*
   I. When did they attend the training?
   II. Who provided the training?
   III. What was the duration of the training?

B. Implementation of CSE

1. Does the district have the resources to implement CSE in the schools?
2. What additional resources do you require to effectively implement CSE in the schools?
3. Before implementing CSE in the school were the needs of the learners considered? *Probe: Why? Why?*
4. Delivery of CSE:
   I. Is the pedagogical approach effective in implementing CSE in the schools?
   II. Are the subjects appropriate in delivering CSE in the schools?
   III. What are the gaps in implementing CSE in the schools? *Probe: How can these gaps be addressed?*

IV. What are the challenges in implementing CSE in the schools? *Probe: How can these challenges be addressed*

5. CSE and age, culture, religion and language:
   I. Is CSE appropriate for the age groups in the schools? *Probe: Why? Why not?*
   II. Is CSE appropriate with the culture of the learners and the teachers? *Probe: Why? Why not?*
   III. Is CSE appropriate with the religion of the learners and teachers delivering it in the schools? *Probe: Why? Why not?*
   IV. Is the language appropriate for learners and teachers? *Probe: Why? Why not?*

C. Successes in implementing CSE

The question below is seeking information about the success and positive outcome of the implementation of the program. We don't yet know if the outcome is positive, it is advisable to restructure the question as follows:

1. What has been the successes in implementing CSE at this schools?
2. How do you assess the impact of CSE on students' knowledge and behavior related to sexual and reproductive health?
3. What factors have contributed to the successes in implementing CSE in the schools?

D. CSE and Coordination

6. Are the schools working with the healthcare facilities in strengthening the implementation of CSE? *Probe: Why? Why?*
7. What has been the challenges in working with the healthcare facilities in the implementation of CSE in the schools?
8. What can be done to address the challenges?
9. What has been the successes?
10. In the Ministry of education working with any NGOs in strengthening the implementation of CSE in the school? *Probe: Why? Why not?*
11. Which NGOs is the Ministry working with? Probe: How are you working with the NGOs? When did you start working with the NGOs?
12. What has been the challenge in working with the NGOs in implementing CSE in the schools?
13. What can be done to address the challenges?
14. What has been the successes?

Parents are part of the main stakeholders in the CSE coordination, they are responsible in shaping their children sexuality and relationships. The following question needs to be included:

What role do parents or guardians play in CSE delivery?

H. Pregnancies in the schools

15. Have there been cases of teenage pregnancies in the school districts?
16. What are the age groups and grades?
17. How many cases have been reported in the last five (5) years?

18. Have the cases increased or decreased after the school started implementing CSE? Why? Why?

It is important to find out what are the key factors that contribute high rates of pregnancy and child marriage as perceived by key informants. Including the following question shades more insight into the problem.

19. In your opinion, despite the implementation of CSE, what are the key factors contributing to the sustained high rates of teenage pregnancies and child marriages in Zambia?
20. What measures/strategies should be put in place to address teenage pregnancies in the schools?

Closing the interview

1. **"Are there any other issues that have not been discussed that you would like to discuss?"**
2. Ask the interviewee if they have any **questions** about the discussion.
3. **Thank the interviewee** for their participation in the discussion.
4. Ask the interviewee if the information provided can be used in the rapid assessment. Clarify that all information will be summarized and that the rapid assessment will not identify any participants by name.

AN ASSESSMENT OF THE IMPACT OF THE IMPLEMENTATION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) IN ZAMBIA

In-depth interview guide – Healthcare facility

Purpose: *The overall purpose of the study is to assess the impact of the implementation of CSE in Zambia since it was introduced in Zambia as well as examine what gaps still exist and investigate reasons why numbers of teenage pregnancies continue increasing regarding the country implementing CSE and make recommendations on what has to be done going forward.*

Geographic Location:
Interview date:
Name of Interviewer:
Name of Committee:
Name (optional):
Place of interview:
Method of interview (e.g. phone, WhatsApp etc.):

Introduction

5. Thank the participant(s) for the interview
6. Explain the objectives and expectations of the interview
7. Outline the amount of time interview will take
8. Obtain the informant's informed consent to record / write notes from the interview

Sex of key informant:
Position of the informant:
Name of the healthcare facility:
The facility has a youth friendly corner? Yes [ ] No [ ]

A. General information

5. How long have you lived in this community? *Probe: How long have you been in this position?*
6. Population in the catchment areas? *Probe: Adult males? Adult females? Adolescents/ youths?*
7. Do you work with the adolescents and youths? *Probe: From Primary? Secondary? Basic schools*

B. Sexual Reproductive Health services

21. Does the facility provide SRH services to adolescents and youths? Probe: Why? Why not?
22. When did you start providing the services?
23. Do the male and female adolescents and youths access the SRH services?
24. What services do they ask for? Why? Why not?

Since the problem at hand is highly ethically sensitive, the issue of confidentiality is of utmost importance, it is reasonable to include the following question:

1. How do you ensure confidentiality and privacy when providing SRH services to young people?

C. Successes and challenges in providing SRH services

25. What has been the successes in providing SRH services to the male and female adolescents and youths?
26. What factors have contributed to the successes?
27. What have been the challenges in the providing SRH services to the male and female adolescents and youths?
28. What can be done to address the challenges?

D. Coordination with the Schools

29. Are the schools working with the healthcare facilities in strengthening the implementation of CSE? *Probe: Why? Why?*
30. What has been the challenges in working with the schools in the implementation of CSE in the schools?
31. What can be done to address the challenges?
32. What has been the successes?
33. Is the healthcare facility working with any NGOs in strengthening the implementation of CSE in the schools? *Probe: Why? Why not?*
34. Which NGOs is the Healthcare facility working with? Probe: How are you working with the NGOs? When did you start working with the NGOs?
35. What has been the challenge in working with the NGOs in providing SRH services to the adolescents and youths?
36. What can be done to address the challenges?
37. What has been the successes?

H. Pregnancies among teenagers

38. Have there been cases of teenage pregnancies reported at the healthcare facility?
39. What are the age groups and grades?
40. How many cases have been reported in the last five (5) years?
41. Have the cases increased or decreased after you introduced SRH services? Why? Why?
42. What factors are contributing to teenage pregnancies in the schools?
43. What measures/strategies should be put in place to address teenage pregnancies in the schools?

Closing the interview

5. **"Are there any other issues that have not been discussed that you would like to discuss?"**
6. Ask the interviewee if they have any **questions** about the discussion.
7. **Thank the interviewee** for their participation in the discussion.
8. Ask the interviewee if the information provided can be used in the rapid assessment. Clarify that all information will be summarized and that the rapid assessment will not identify any participants by name.

AN ASSESSMENT OF THE IMPACT OF THE IMPLEMENTATION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) IN ZAMBIA

In-depth Interview – School headteachers and CSE/Guidance teachers

Purpose: *The overall purpose of the study is to assess the impact of the implementation of CSE in Zambia since it was introduced in Zambia as well as examine what gaps still exist and investigate reasons why numbers of teenage pregnancies continue increasing regarding the country implementing CSE and make recommendations on what has to be done going forward.*

Geographic Location:
Interview date:
Name of Interviewer:
Name of Committee:
Name (optional):
Place of interview:
Method of interview (e.g. phone, WhatsApp etc.):

Introduction

1. Thank the participant(s) for the interview
2. Explain the objectives and expectations of the interview
3. Outline the amount of time interview will take
4. Obtain the informant's informed consent to record / write notes from the interview

Sex of key informant:
Position of the informant:

A. General information

1. How long have you lived in this community? *Probe: How long have you been in this position?*
2. When did you start implementing CSE at this school?
   I. Are there teachers that have been trained? How many? Males/female?
   II. When did they attend the training?
   III. Who provided the training?
   IV. What was the duration of the training?

B. Implementation of CSE

1. How is CSE delivered in your school?
2. How often is CSE taught in your school?
3. Were any adjustments made to the delivery of CSE based on student feedback or other factors?
4. Who teaches CSE?
5. Which grades receive CSE at this school? Why? Why not?
6. Do you have the resources to implement CSE in the school?
7. What additional resources do you require to effectively implement CSE in the school?
8. Before you started implementing CSE in the school were the needs of the learners considered? Why? Why?
9. Delivery of CSE:
   I. Is the pedagogical approach effective in implementing CSE in the schools?
   II. Are the subjects appropriate in delivering CSE in the schools?

III. What are the gaps in implementing CSE in the school? Probe: How can these gaps be addressed?
IV. What are the challenges in implementing CSE in the school? Probe: How can these challenges be addressed

10. CSE and age, culture, religion and language:
    I. Is CSE appropriate for the age groups in the schools? Why? Why not?
    II. Is CSE appropriate with the culture of the learners and the teachers? Why? Why not?
    III. Is CSE appropriate with the religion of the learners and teachers delivering it in the schools? Why? Why not?
    IV. Is the language appropriate for learners and teachers? Why? Why not?

C. Successes in implementing CSE

11. What has been the successes in implementing CSE at this school?
12. What factors have contributed to the successes in implementing CSE in the school?
13. What has been the impact of CSE in the school? Positive? Negative?
14. Do you think CSE has been effective in reducing teenage pregnancies and child marriages in your school?
15. Are there any best practices you have identified in the implementation of CSE in your school?
16. Have you noticed any changes in student behavior or attitudes since the implementation of CSE?
17. Have there been any changes in the number of teenage pregnancies or STIs among students since the implementation of CSE?
18. Have you received any feedback from parents or community members about the impact of CSE on students?

D. CSE and Coordination

19. As a school do you work with the healthcare facilities in strengthening the implementation of CSE? Why? Why? How are you working with the healthcare facilities?
20. What has been the challenges in working with the healthcare facilities in the implementation of CSE in the schools?
21. What can be done to address the challenges?
22. What has been the successes?
23. Are you working with any NGOs in strengthening the implementation of CSE in the school? Why? Why not?
24. Which NGOs are you working with? Probe: How are you working with the NGOs? When did you start working with the NGOs?
25. What has been the challenge in working with the NGOs in implementing CSE in the schools?
26. What can be done to address the challenges?
27. What has been the successes?

As the problem is a complex issue that requires a multi-sectoral and multi-disciplinary approach. Addressing this challenge will require a sustained coordination effort between the government of Zambia, civil society organizations, communities, and other stakeholders. Hence it reasonable to include the following questions:

1. How is the coordination between the school, the Ministry of Education and other stakeholders in the implementation of CSE?
2. How is feedback and data on CSE delivery and impact shared among stakeholders?

[This section is for the teachers trained in CSE/Guidance]

H. Pregnancies in the schools

1. Have there been cases of teenage pregnancies in the schools?
2. What are the age groups and grades?
3. How many cases have been reported in the last five (5) years?
4. Have the cases increased or decreased after the school started implementing CSE? Why? Why?
5. What factors are contributing to teenage pregnancies in the schools?
6. What measures/strategies should be put in place to address teenage pregnancies in the schools?

Adequate teachers training and knowledge of the CSE curriculum is critical to the delivery of the program in schools. It essential to assess teachers' capacity in terms of their awareness, education knowledge and commitment towards the delivery of the CSE program. Hence the following questions are believed to shade more insight into their current status:

1. Have you received any training or guidance on Comprehensive Sexuality Education?
2. How comfortable are you discussing sexuality and sexual health with your students?
3. Do you think Comprehensive Sexuality Education should be taught in schools?
4. What topics related to sexuality and sexual health do you think should be included in Comprehensive Sexuality Education?
5. What resources or support do you need to effectively teach Comprehensive Sexuality Education?
6. How do you handle sensitive or controversial topics related to sexuality and sexual health in the classroom?
7. Have you ever faced any resistance or pushback from parents or community members regarding Comprehensive Sexuality Education? If so, how did you handle it?
8. Do you feel confident in your ability to answer questions or provide information on sexuality and sexual health to your students?
9. Do you think Comprehensive Sexuality Education can help prevent sexually transmitted infections and unwanted pregnancies?
10. What strategies do you use to create a safe and non-judgmental learning environment for your students when teaching Comprehensive Sexuality Education?

Closing the interview

9. **"Are there any other issues that have not been discussed that you would like to discuss?"**
10. Ask the interviewee if they have any **questions** about the discussion.
11. **Thank the interviewee** for their participation in the discussion.

12. Ask the interviewee if the information provided can be used in the rapid assessment. Clarify that all information will be summarized and that the rapid assessment will not identify any participants by name.

Annex IV: Focus group Discussion Guide

AN ASSESSMENT OF THE IMPACT OF THE IMPLEMENTATION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) IN ZAMBIA

Focus group discussion guide – Learners (12 – 19 years)

Purpose: *The overall purpose of the study is to assess the impact of the implementation of CSE in Zambia since it was introduced in Zambia as well as examine what gaps still exist and investigate reasons why numbers of teenage pregnancies continue increasing regarding the country implementing CSE and make recommendations on what has to be done going forward.*

Geographic Location: **Name (optional):**
Discussion date: **Place of the discussion:**
Name of Facilitator: **Method of discussion:**
Name of the school:

Introduction

9. Thank the participants) for the discussion
10. Explain the objectives and expectations of the discussion
11. Outline the amount of time the discussion will take
12. Obtain the participants' informed consent to record / write notes from the discussion.

Sex of participants:
Grade of the participants:
Age of the participants:

A. General information

8. How long have you lived in this community? *Probe: Who do you live with?*
9. When did you start learning CSE at this school?

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B. Comprehensive Sexuality Education

1. What is your understanding of comprehensive sexuality education? *Probe: How do you define it?*
2. When did you start learning Comprehensive Sexuality Education? *Probe: When is it taught? Who teaches Comprehensive Sexuality Education? How many days in a week are you taught CSE? Is the time allocated adequate? Why/why not?*
3. What topics are covered in CSE? *Probe: Which topics do you like the most? Which topics do you like the least? Why/why not? Which topics are relevant to you/ Why? Which topics are not relevant? Why?*
4. Has CSE helped you? *Probe for the before and after? The practices. The behavior and knowledge. Have the changes happened at home or at schools? Why?*

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Discussion on Relationship between culture and comprehensive Sexuality Education

1. What cultural/traditional practices do you know? Probe: How did you know about the cultural practices? Have you participated in any of the traditional practices? What are the expected norms for adolescent females/adolescent males?
2. What traditional practices are harmful to the adolescent male/female pupils? Probe: Why/Why not?
3. Is CSE appropriate with your traditional cultures? Probe: Why/why not? Are there topics that are in conflict with your norms? Values and beliefs? Are there topics that are considered as taboos? Why/why not?

4. What language is used when teaching CSE? Probe: Is the language appropriate in the delivery of CSE? What language is appropriate and which topics? Why/why not? Which topics are not appropriate for the language used/Why/why not?
5. Who do you discuss issues to do with sexuality? Probe: Why/why not?
6. Are you able to discuss sexuality and reproductive health with your parents? Probe: Why/why not? Are you able to discuss with the teachers? Male/female teachers? Why/why not?
7. Are there cultural factors that affect the learning of sexuality and reproductive health in the classroom? Probe: Why/why not?
8. Are there religious factors that affect the learning of sexuality and reproductive health in the classroom? Probe: Why/why not?
9. What rights do adolescent male/female have in this community?

Discussion on the effects of Comprehensive Sexuality Education on the Social-Emotional Development of adolescents

1. Do adolescents engage in risky sexual behaviors? Probe: the types of risky sexual behaviours? Why do they engage in these behaviors?
2. Do you talk about your feelings with your parents/teachers? Probe: Who are you comfortable talking to? Why/why not?
3. Do you talk about your sexual feelings? Probe: Who are you comfortable talking to? Why/Why not?
4. Are you comfortable talking about your body as a male/female? Probe: Why/Whynot?
5. What challenges do the adolescent male/female pupils face in discussing sexual feelings?

Discussion School related Gender Based Violence

1. Do you know what school related Gender -Based violence is? Probe: What are the forms of SRGBV? Which ones are targeted towards adolescent girls/ boys? What the causes?
2. Where does the violence happen? *Probe: Are there places in the school that are not safe for male/female adolescents? Why/why not?*
3. *What are the effects of SRGBV? Probe: How does each SRGBV affect the adolescent girls/boys?*
4. How do pupils react to SRGBV survivors? To perpetrators? How do communities react to SRGBV survivors? To perpetrators? How does the school react to SRGBV survivors? To perpetrators*? Probe: Is there someone you can go to if you feel scared, threatened, or experience abuse of any kind [friend, nurse, teacher, police]? Where do the female pupils get help if they were raped? How do communities react to someone who has been raped? How do adolescents cope with violence against their male and female adolescent pupils? What do the teachers do to prevent SRGBV and help survivors?*
5. What does the school do to help adolescent boys and girls who are at-risk of school gender-based violence or who have experienced SRGBV? *Probe: Who does the school provide services to? What services does the school provide? What challenges do the SRGBV survivors face?*
6. *Does the school address the SRGBV? Probe: How? Do pupils report the cases? Who they report to? Are there challenges for adolescents to report the cases? Why/why not?*
7. Have you received training as a change agent regarding SRGBV and early child marriage and other harmful traditional practices*? If you have, can you please describe the nature of the training? Probe: What type of information did you receive? Who trained you? What did you find useful about the training? What didn't you like about the training?*
8. What are your responsibilities as an adolescent? Please provide an example of you how use the information in your everyday life. *Probe: Are there clubs that have been formed to address SRGBV? How frequently do you hold discussions, individual talks, or lead activities related to SRGBV? How frequently do you meet, for how much time in each meeting, and over what period of time? Who leads the group sessions? What do you talk about? What challenges are there to sustaining the club?*
9. *How have you changed the way you communicate with your parents, peers, teachers and community members?*

10. What more can be done to prevent abuse and violence in the schools to make it a safer place to live? *Probe: What can be done by the school, NGOs and the government to prevent and respond to SRGBV? What are the best ways to involve adolescent male and female pupils in preventing SRGBV?*

Transformative Adolescent Sexual Reproductive Health services

1. Do the male and female adolescent pupils have access to sexual reproductive health services? Probe: Who provides the services? What services are available for the male and female adolescents in schools? Are the services appropriate for adolescent female and male pupils?
2. Do the male and female adolescent pupils have access to information on sexual and reproductive health? Probe: Where do the adolescents access the information that is gender appropriate? Where adolescents access information that age appropriate?
3. What challenges do the male and female adolescent pupils face in accessing information on sexual and reproductive health?
4. Which sources are ideal for the male and female adolescents to access information on sexual and reproductive health? Probe? Why/why not?

Pregnancies in the schools

1. Have there been cases of teenage pregnancies in the schools among the learners?
2. What factors are contributing to teenage pregnancies in the schools?
3. What measures/strategies should be put in place to address teenage pregnancies in the schools?

Closing the interview

13. **"Are there any other issues that have not been discussed that you would like to discuss?"**
14. Ask the interviewee if they have any **questions** about the discussion.
15. **Thank the interviewee** for their participation in the discussion.
16. Ask the interviewee if the information provided can be used in the rapid assessment. Clarify that all information will be summarized and that the rapid assessment will not identify any participants by name.

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