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Comprehensive sexuality education in six Southern African Countries: Perspectives from learners and teachers

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Abstract

Comprehensive sexuality education (CSE) promotes young people's healthy sexual decisions. This study assessed the level of provision of CSE in schools in ten sites in six Southern African countries from the perspectives of learners and teachers. The data was from a needs assessment preceding the baseline evaluation of the SRHR-HIV Knows no Borders Project conducted in ten sites in six Southern African countries. A total of 161 learners from 10 schools and 96 teachers from 96 schools were interviewed. Among the teachers, 82.3% reported CSE was part of the school curriculum. Although basic education policies in Southern African countries are in tandem with international, regional and national policies, complete implementation of the policies remains unfulfilled owing to conflicting policies and socio-cultural values of diverse stakeholders. Awareness campaigns and trainings may help to promote positive perceptions among stakeholders about sensitive CSE topics and the distribution of SRH commodities in schools. *(Afr J Reprod Health 2021; 25[3]: 60-71).*

Keywords: Adolescent health, sexual health, reproductive health commodities, school health

Résumé

L'éducation sexuelle complète (CSE) encourage les jeunes à prendre des décisions sexuelles saines. Cette étude a évalué le niveau de fourniture d'ESI dans les écoles de dix sites dans six pays d'Afrique australe du point de vue des apprenants et des enseignants. Les données provenaient d'une évaluation des besoins précédant l'évaluation de base du projet SRHR-HIV Knows no Borders mené dans dix sites dans six pays d'Afrique australe. Au total, 161 apprenants de 10 écoles et 96 enseignants de 96 écoles ont été interrogés. Parmi les enseignants, 82,3% ont déclaré que l'ESC faisait partie du programme scolaire. Bien que les politiques d'éducation de base dans les pays d'Afrique australe soient en tandem avec les politiques internationales, régionales et nationales, la mise en œuvre complète des politiques reste inachevée en raison des politiques contradictoires et des valeurs socioculturelles des diverses parties prenantes. Les campagnes de sensibilisation et les formations peuvent aider à promouvoir des perceptions positives parmi les parties prenantes sur les sujets sensibles de l'ESC et la distribution de produits de SSR dans les écoles. *(Afr J Reprod Health 2021; 25[3]: 60-71).*

Mots-clés: Santé des adolescents, sante sexuelle, produits de sante reproductive, sante scolaire

Introduction

Adolescence is a transitional period into adulthood when young people aged 10 to 19 years typically initiate their first romantic and sexual relationships, indulge in sexual risk-taking behaviour and experience heightened peer pressure[1,2]. In Sub-Saharan Africa (SSA), 23% of the population are adolescents and they face the highest risk of HIV infection, sexually transmitted diseases, unintended pregnancy, child marriages, low education attainment, and school dropout[2–5]. Consequently, CSE was introduced as a response to the adverse sexual and reproductive health outcomes for adolescents. CSE is a curriculum-based method of teaching and learning about sexuality, human development, reproductive health, contraception use, diversity, and sexually transmitted infections[6,7]. Adolescent sexual and reproductive health (ASRH) has been recognised as an important public health issue in both developing and developed worlds. Provision of CSE at educational institutions ensures that adolescents are equipped with correct knowledge, skills, attitudes and values

required to make healthy informed choices about their sexual lives and relationships[6–13]. The provision of CSE promotes positive healthy behaviour among adolescents thereby contributing to an increase in abstinence, responsible sexual behaviours including condom use and a reduction in teenage childbearing, unsafe abortion, sexual violence and HIV infections[5,9,14].

Internationally, there are supportive policies, framework and bodies that promote implementation of CSE. These include the Convention on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination Against Women (CEDAW). In addition, the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 supported the right of all children and adolescents to receive sexual and reproductive health information, education and services that fulfil the specific needs[2,14]. In Africa, the Maputo Plan of Action, and the African Youth Charter further emphasised the need for education on reproductive health, HIV and gender for adolescents[2].

As part of the global response to the HIV epidemic, progress has been made towards institutionalisation of CSE within countries' educational systems in Africa. However, adoption and implementation of CSE by schools has been slow and variable between countries and between schools within countries[2,5,15,16]. This is partly attributed to policies in many African countries that prohibit distribution of SRH commodities in schools and teaching of sexual orientation, homosexuality in particular and pregnancy termination which, according to UNESCO (2013), should be incorporated into CSE[2,5,17–22]. In addition to restrictive policies, topics on sexual orientation and pregnancy termination face resistance from teachers and parents as they believe these topics encourage sexual activity among their children[23,24]. As a result, teachers find it difficult to reconcile their personal beliefs with professional duties. For example, teachers found talking about sexual activity, diversity, condom use and masturbation as illicit within their culture and religious beliefs[25–27]. Thus, teachers found it easier to discuss non-sensitive topics around relationships and personal skills while shunning topics which are perceived to be sensitive[25,27]. Thus, partial adoption and implementation of CSE in schools is attributed to cultural and religious beliefs that regard discussions about sexuality as a taboo in sub-Saharan Africa[28]. This fact makes many schools' curricula fall short of basic information on certain topics which are perceived to be against cultural and religious norms[15,16,25,27–30]. The affected topics include information on key aspects of sexual health, abortion, information about condom use and contraception, gender diversity and human rights[2,5,16,25–27].

In addition, in many sub Saharan African countries it has been reported that parents feel uncomfortable openly discussing sexual issues with their children and the visibility of sex in the society through media and public health discourses has also been met with resistance[23,30–33]. The discussions about sexuality between parents and children were found to be authoritative, top down discussions with parents warning their children in a negative way rather than having open, positive and participatory dialogues[28,34–36]. As a result, parents were found to have negative perceptions and attitude toward schools that provide condoms to learners[25,35]. On the other hand, children resist having discussions with their parents concerning sexuality as they perceive discussions to be an invasion of their privacy and a sign of disrespect to their parents[34,35]. Furthermore, adolescents suggested that perceived traditional values held by parents were a barrier to open discussions about HIV[34].

In 2013, Eastern and Southern African (ESA) countries including South Africa, Zambia, Lesotho, Kingdom of Eswatini, Malawi and Mozambique signed a declaration committing to scale-up comprehensive rights-based sexuality education starting from primary school level[37]. Most ESA countries have developed CSE curriculum i.e. integrated into the mainstream curriculum. However, sexuality education remains controversial among stakeholders and there is a lack of collaboration between schools and health

facilities in the provision of sexual and reproductive health (SRH) information and commodities[37]. This paper explores the content and delivery of CSE, and SRH commodity provision in schools from the perspectives of learners and teachers in ten sites in six Southern Africa countries.

Methods

The data analysed in this paper is from a needs assessment conducted in ten sites in six Southern African countries that preceded the baseline evaluation of the SRHR-HIV Knows no Borders Project. The project is a collaboration of the International Organization for Migration (IOM), Save the Children Netherlands (SCNL) and University of the Witwatersrand's School of Public Health (WSPH) consortium partners and was conducted in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa, and Zambia. The aim of the project was to improve the sexual and reproductive health and rights, and HIV (SRHR-HIV) related outcomes among adolescents & young people (AYP), sex workers (SW) as well as others living in 10 high migration communities in the selected countries. The CSE component of the project focused on determining the topics covered in the curriculum and the commodities being provided in schools.

The assessment was conducted in the high migration communities of Hhohho (Kingdom of Eswatini), Maputsoe (Lesotho), Mchinji and Mwanza (Malawi), Chifunde and Ressano Garcia (Mozambique), Ekurhuleni and Nkomazi (South Africa), Chipata and Katete (Zambia). The sites are transport and labour migration corridors characterised by high mobility of people within the countries and from other countries[38].

The study population comprised of learners aged 10 to 14 years (boys and girls) and teachers in charge of CSE/life orientation or selected by school heads in selected schools. The teachers responded on behalf of selected schools. The target was to obtain information from 10 schools per site and 20 (10 boys and 10 girls) learners from one school randomly selected out of the 10. In sites where schools were 10 or less, all schools in the sites were enlisted and in sites with more than 10, a random sample of 10 was selected. In total, 161 learners from 10 schools and 96 teachers representing the 96 schools participated in the assessment.

Data was collected between April and December 2018 in the six countries using checklists (leaners' and schools'). The schools' checklist explored the CSE topics that are covered in the school curriculum while the learners' checklist was an enquiry on their perception of CSE topics that are taught in school, their preferred mode of learning concepts taught and their access to SRH commodities during and after school. The checklists were distributed to the appointed/selected teachers by the school and were self-administered by the teachers. For the administration of the learners checklist, all learners in a school were put together in a classroom and a teacher (at times two) take/guide them through the content (item by item) of the checklist and ask them to tick their desired response on the checklist distributed to them. The University of Witwatersrand monitored the data collection process in all the countries. Data was analysed using STATA 15 and ethical approval was obtained in each of the six countries. Permission to conduct the study at the project sites was also obtained from the provincial authorities as well as Ministries of Education and Health and the schools. Written consent was obtained from all participants and written consent for learners below the age of 18 to participate was obtained from their parents. Only learners whose parents or guardian signed written consents participated in the interviews.

Results

Demographic characteristics of the study population

In all countries a total of 161 learners from 10 schools and 96 teachers were interviewed in 96 schools across the 10 sites. The median age of the learners was 13 years, 46% of them were males and 27.3% were in Grade 6. Majority of the schools were government schools (96.9 %) and 63.5% of the participating schools were at primary level.

Table 1: Characteristics of the learners and schools from the six countries

Learners	Kingdom of Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Median age (range)	11 (10-13)	13 (12-14)	12 (10-14)	13 (11-14)	13 (11-14)	13 (11-14)	13 (10-14)
Gender							
Male	2(16.7)	6(66.7)	22(52.4)	18(55.6)	7(26.9)	19(48.7)	74(46.0)
Female	10(83.3)	3(33.3)	20(47.6)	15(45.5)	19(73.1)	20(51.3)	87(54.0)
Learner grade							
3	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	2(5.1)	2(1.2)
4	1(8.3)	0(0.0)	5(11.9)	0(0.0)	0(0.0)	0.(0.0)	6(3.7)
5	2(16.7)	0(0.0)	5(11.9)	3(9.1)	0(0.0)	1(2.6)	11(6.8)
6	9(75.0)	2(22.2)	10(23.8)	6(18.2)	13(50.0)	4(10.3)	44(27.3)
7	0(0.0)	4(44.4)	13(31.0)	14(42.4)	0(0.0)	7(18.0)	38(23.6)
8	0(0.0)	2(22.2)	8(19.1)	10(30.3)	3(11.5)	13(33.3)	36(22.4)
9	0(0.0)	1(11.1)	0(0.0)	0(0.0)	10(38.5)	9(23.1)	20(12.4)
10	0(0.0)	0(0.0)	1(2.4)	0(0.0)	0(0.0)	3(7.7)	4(2.5)
Schools							
School type							
Government	9(100.0)	8(80.0)	20(100.0)	19(100.0)	18(100.0)	19(95.0)	93(96.9)
Private	0(0.0)	2(20.0)	0(0.0)	0(0.0)	0(0.0)	1(5.0)	3(3.1)
School level							
Primary	4(44.4)	5(50.0)	18(90.0)	18(94.7)	7(38.9)	9(45.0)	61(63.5)
Junior/middle	0(0.0)	0(0.0)	1(5.0)	0(0.0)	2(11.1)	2(10.0)	5(5.2)
Secondary/high	3(33.3)	5(50.0)	1(5.0)	1(5.3)	9(50.0)	9(45.0)	28(29.2)
Missing	2(22.2)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	2(2.1)

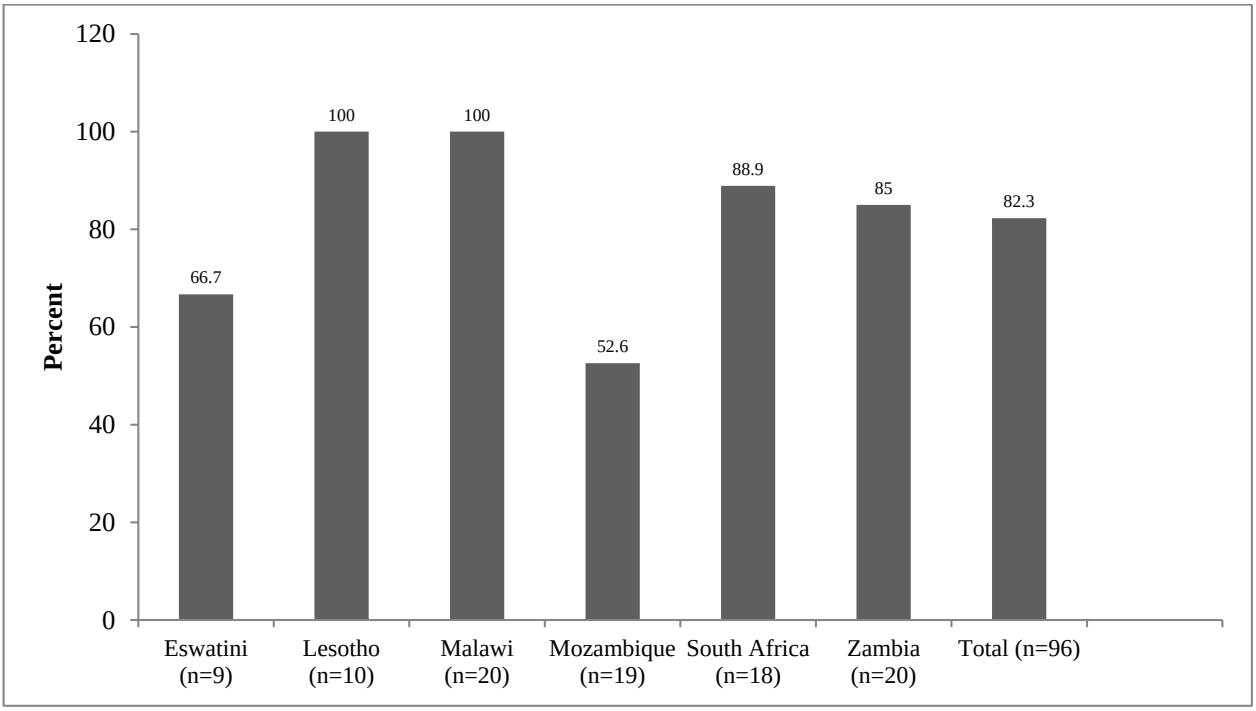

Figure 1: Percentage of schools providing CSE in the six Southern African countries

Table 2: The most covered CSE topics in the six countries as reported by teachers and learners

Topics covered	Teachers (N=96) % of schools covering the topics	Learners (N=161) % of leaners reporting the topics covered
HIV & AIDS	81.3	97.2
Substance abuse	80.2	91.1
Abstinence	79.2	-
Puberty	78.1	93.1
Adolescence	77.1	-
Reproduction	75.0	-
STDs	-	92.5
Human rights	-	91.1
Gender equality and gender roles		89.8

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

Provision of comprehensive sexuality education in schools

Of the 96 schools that were surveyed in the six Southern African countries, 82.3% provide CSE as shown in Figure 1. In the schools where CSE is not taught, the reasons reported by teachers for not providing CSE include: its contradiction with the teachers' religious beliefs, teachers discomfort with teaching CSE and the belief that CSE encourages learners to be sexually active.

Comprehensive sexuality education topics provided in schools as reported by the teachers and learners

Both teachers and learners reported HIV/AIDS, substance abuse and puberty among the CSE topics covered in all the countries. In addition, teachers indicated abstinence, adolescence and reproduction while the learners added STDs, human rights and gender equality and gender roles to their top six list of topics (Table 2). More detailed results by country are presented in Appendices 1 and 2.

Comprehensive sexuality education teaching methods

The CSE teaching methods used across the six countries as reported by the teachers and learners are shown in Table 3. The four main teaching methods reported by the teachers are face to face (70.8 %), textbooks/teaching guide (70.8 %), use of peer educators (37.5 %) and information pamphlets (33.3%). In all the countries, learners prefer CSE to be taught face to face (53.2%), textbook/teacher's guide (34.2%), videos (27.3%) and information pamphlets (10.6%). More detailed results by country are presented in Appendices 3 and 4.

CSE providers and learners preferred providers

In most schools, life orientation teachers (42.5%) and class teachers (40.5%) were reported to be common providers of CSE (Table 4). Generally, the learners preferred to receive CSE from various stakeholders, including teachers (55.9%), parent/guardian (43.5%), and peer educators (18.6%) – Table 4. More detailed results by country are presented in Appendices 5 and 6.

Provision of CSE commodities in the six countries

Of the 96 schools that were surveyed, only 7.2% provided condoms. None of the schools in the Kingdom of Eswatini, Lesotho and Malawi distributed condoms. Contraceptive pills were reported to be provided in some schools in Mozambique and South Africa only. Sanitary pads are provided in all the countries but in less than half of the schools surveyed (Table 5). The SRH commodities that teachers reported are required which were either not provided or else the provision was not sufficient included sanitary pads, condoms, contraceptive pills, CSE materials, pregnancy testing kits and HIV testing and treatment. More detailed results of the required SRH commodities by country are presented in Appendices 7 and 8. Table 6 shows that besides obtaining SRH commodities at school, learners would want the commodities to be provided at home (90.3%), at the clinic/hospital (85.7%), at youth clubs and in the community (75.9%).

Table 3: CSE teaching methods and Learners preferred medium of learning

CSE Teaching methods (teachers)	Frequency (%)	Learners preferred teaching methods	Frequency (%)
Face to Face	68/96 (70.8)	Face to Face	86/161 (53.2)
Textbook/teacher's guide	68/96 (70.8)	Textbooks/teacher's guide	55/161 (34.2)
Videos (Lesotho, Mozambique & Zambia)	6/96 (6.3)	Videos	44/161 (27.3)
Information pamphlets	32/96 (33.3)	Information pamphlets	17/161 (10.6)
Peer educators	36/96 (37.5)	Tests & homework (South Africa)	4/161 (2.5)
		Radio (Lesotho & Malawi)	2/161 (1.2)
		Magazine (Zambia)	1/161 (0.6)
		Text messages (Zambia)	1/161 (0.6)

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

Table 4: CSE providers/instructors reported by learners in the six countries

CSE teacher (Learners)	Frequency n (%) N=153	Learners' Preferred CSE teachers	Frequency n (%) N=161
Life orientation teacher	65 (42.5)	Teacher	90 (55.9)
Class teacher	62(40.5)	Parent/guardian	70 (43.5)
Health education teacher	16(10.5)	Peer educator	30 (18.6)
Principal/ headmaster	7(4.6)	Health worker	13 (8.1)
Social worker	2(1.3)	Elders/grandparents	10 (6.2)
Save the children	1(0.7)	Aunt	4 (2.5)
		Pastor/Priest	4 (2.5)
		Counsellor	2 (1.2)
		Police	1 (0.6)
		Social Worker	1 (0.6)

*There were 8 missing values [+]Percentages do not add up to 100 as multiple responses were allowed

Table 5: SRH commodities provided at schools reported by teachers

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

Table 6: Places learners would want to receive SRH commodities other than at school

Places	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Home	7(100.0)	3(100.0)	8(88.9)	19(100.0)	7(53.9)	21(100.0)	65(90.3)
Youth club		1(100.0)	20(95.2)		0(0.0)	1(100.0)	22(75.9)
Radio/Television		1(100.0)	8(88.9)		0(0.0)		9(56.3)
Church			1(50.0)		8(57.1)	8(100.0)	17(70.8)
Clinic/hospital	2(100.0)	4(100.0)	1(50.0)	15(100.0)	7(53.9)	13(100.0)	42(85.7)
Groups			1(50.0)		0(0.0)		1(12.5)
Friends			5(83.3)		0(0.0)	3(100.0)	8(53.3)
Community	2(100.0)	3(100.0)	0(0.0)		3(33.3)	14(100.0)	22(75.9)
Chief's office		2(100.0)	0(0.0)		0(0.0)		2(22.2)
Council		1(100.0)	0(0.0)		0(0.0)		1(12.5)

*Multiple responses permitted

Discussion

This study documents the level of comprehensive sexuality education (CSE) provision in schools in ten high migration areas of six Southern Africa countries and the perspectives of learners and teachers in the provision of CSE. CSE is provided in about 82% of the schools surveyed in the six countries. However, there is variability across the countries with respect to percentage of schools

offering CSE, content, mode of delivery and the people that are delivering it. The challenges identified by teachers in providing CSE included socio-religious factors, and educators not being comfortable with providing CSE. Similar findings have been reported in some studies conducted in Eastern and Southern African countries namely Kenya, Lesotho, Malawi, South Africa and Zambia studies[2,5,15,16,24,25,30,36].

In this study, HIV & AIDS, substance abuse, abstinence, puberty, adolescent and reproduction were the main topics taught in schools as reported by the teachers. The learners added STDs, human rights and gender equality and gender roles to the list. The discrepancy could be due to the fact that all learners were selected from one school within each of the ten sites. It is also possible that there were differences in the terms used in teaching CSE between the schools and in learners understanding of the concepts taught. On the other hand, termination of pregnancy, source of SRH commodities, romantic relationships, condom use, pregnancy and prenatal care and physical assault were the least covered topics as reported by the teachers and learners. Consistent with previous findings from studies in Ghana, Malawi, South Africa, Kenya and Zambia, the findings show that teaching of CSE is selective, with some topics being excluded owing to cultural and religious norms[5,8,15,26,27]. For instance, findings in 10 Eastern and Southern African countries, showed that topics on sex and sexual health, information about condoms and contraception were not taught[2]. This is attributed to CSE being regarded as taboo for example within the Basotho communities, Malawian, the Kingdom of Eswatini and Zambian traditions[2,17,27,30,39]. Further, in a study conducted in South Africa teachers reported that topics such as condom use and masturbation were taboo within their culture or according to their religious beliefs[25,33]. Several studies have also attributed omission of selected CSE topics to conflicting cultural and religious beliefs of various stakeholders including parents, teachers and religious leaders[25,32–35].

In this study, the main teaching methods as reported by the teachers were face-to face and textbooks/teaching guides. This is consistent with a review of CSE education conducted in Eastern and Southern Africa where it was found that the main CSE teaching methods were teaching guides and face to face teaching which made learner-centred methodologies such as role play difficult to practice [5,29]. Videos, information pamphlets and use of peer educators are not widely used in teaching CSE although their importance have been highlighted by previous studies[5,16,29]. Consistent with other studies' findings, learners reported that CSE is mainly taught by the life orientation teacher or a general class teacher[5,30]. Learners also indicated that they would prefer to be taught CSE by their parent/guardian, elders/grandparents and aunties. This brings to the fore, the role and importance of the family in the provision of CSE[39].

Access to sexual health commodities and services is very important for the well-being of adolescents and improved use of contraceptives and condoms provided by school-based health programs have been documented[40]. In this study only schools in Mozambique, South Africa and Zambia reported that they provided condoms and contraceptive pills while none of the schools in the Kingdom of Eswatini, Lesotho and Malawi provided condoms or contraceptive pills. This can be attributed to the basic educational policies which prohibits distribution of condoms in schools in the Kingdom of Eswatini, Lesotho and Malawi[5,30]. Sanitary pads are provided in all the countries but in less than half of the schools surveyed. All the national policies, frameworks and strategies in the six countries studied support the distribution of contraception in health facilities, community health delivery points and health clubs. However, the policies do not mention schools as part of contraception distribution points[19,29,39,41,42]. In Mozambique, literature has shown that condoms are provided in secondary schools and the country aims to reach 90% to 100% of schools providing contraceptive methods by 2021[43]. The South African government policies including the 2007 Children's Act grants individual schools the authority to decide whether to distribute condoms[44]. However, owing to contradictory government policies and public pronouncements regarding

provision of condoms in South African public schools, few schools are providing condoms in South Africa[44].

Limitations

Since the study focussed on high migration communities, the study sites were purposively selected within each of the six countries. Learners were chosen from one randomly selected school in each site. The non-random selection at community level meant that there was no measure of the variability between schools within each site. In addition, although the teachers were trained in administering the tool, we cannot ascertain how well they interpreted and communicated its content to the learners. In addition the study is subject to social desirability bias because the information collected was self-reported.

Recommendations and conclusion

Comprehensive sexuality education (CSE) equips adolescents and young people with an understanding of sexual health and rights and the knowledge they need to make informed decisions about their sexuality. The common providers of CSE reported in most schools in this study were life orientation and class teachers. However, the teachers' cultural and religious beliefs were reported to limit their delivery of the CSE curriculum. In-depth teacher training should be conducted especially in areas regarding sexuality and gender diversity to assist teachers to overcome their own commonly held cultural beliefs. This CSE training will not necessarily change the teachers' beliefs but will rather help them to reconcile their personal and professional values.

In addition to class teachers, learners reported preference for CSE to be taught by their parents/guardian and peer educators. Informal out of school CSE learning should be strengthened by training parents and peers in CSE so that they can provide correct information about sexuality education to their children and peers. The main teaching methods in schools are textbooks/teaching guide and face to face which can be described as authoritative and teacher centred. It is crucial to develop learner-centred or learner focused initiatives, for example, role-plays/drama where active dialogue and learner participation is encouraged. This would ensure that learners take control and ownership of their sexuality education and enhance stories and experiences to be shared in a non-judgmental way. There is a need to link and promote collaboration between the education systems, health care systems and community initiatives regarding provision of age-specific and appropriate SRH services and referrals.

Contribution of authors

Study conceptualisation and design: Latifat Ibisomi and Jonathan Levin; data collection: the SRHR-HIV knows no Borders Project; supervision of data collection: Christine Chawhanda, Temitope Ogunlela, Relebogile Mapuroma, Jonathan Levin and Latifat Ibisomi; data analysis: Christine Chawhanda; manuscript preparation: Christine Chawhanda, Oludoyinmola Ojifinni; manuscript editing and approval: all authors.

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Appendices

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

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

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

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

Top six topics covered (leaners)	Eswatini n(%)	Lesotho n(%)	Malawi n(%)	Mozambique n(%)	South Africa n(%)	Zambia n(%)	Total n(%)
HIV & AIDS	11(100.0)	7(100.0)	38(95.0)	28(100.0)	26(100.0)	30(93.8)	140(97.2)
Puberty	10(90.9)	7(87.5)	34(81.0)	26(100.0)	26(100.0)	31(100.0)	134(93.1)
STDs	10(90.9)	8(100.0)	34(81.0)	16(100.0)	23(95.8)	32(100.0)	123(92.5)
Substance abuse	9(81.8)	7(87.5)	37(88.1)	18(100.0)	24(96.0)	28(90.3)	123(91.1)
Human rights	8(72.7)	6(75.0)	37(88.1)	29(100.0)	24(96.0)	29(93.6)	133(91.1)
Gender equality and gender roles	6(54.6)	6(75.0)	40(97.6)	11(100.0)	24(96.0)	27(87.1)	114(89.8)

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

Appendix 3: CSE mode of delivery reported by the teachers by country

Mode of delivery (Teachers)	Eswatini n (%) N=9	Lesotho n (%) N=10	Malawi n (%) N=20	Mozambique n (%) N=19	South Africa n (%) N=18	Zambia n (%) N=20	Total n (%) N=96
Face to face	5 (55.6)	9(90.0)	19 (95.0)	10 (52.6)	13 (72.2)	17 (85.0)	73 (76.0)
Videos/movies	0(0.0)	1 (10.0)	0(0.0)	2(10.5)	0(0.0)	4 (20.0)	7 (7.3)
Textbooks/teaching guide	6 (66.7)	6 (60.0)	18 (90.0)	9(47.4)	17(94.4)	18(90.0)	74 (77.1)
Information pamphlets	2(22.2)	5(50.0)	4(20.0)	5(26.3)	7(38.9)	12(60.0)	35(36.5)
Peer educators	3(33.3)	2(20.0)	4(20.0)	4(21.1)	10(55.6)	13(65.0)	40(41.7)

Appendix 4: Learner's preferred method of CSE teaching by country

Mode of delivery	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Textbooks/teacher's guide	3(75.0)	5(83.3)	34(100.0)	1(20)	7(43.8)	5(45.5)	55(72.4)
Face to face	9(90.0)	3(75.0)	32(100.0)	15(79.0)	12(57.1)	11(71.4)	86(80.4)
Videos	0(0.0)	2(66.8)	13(100.0)	14(77.8)	3(25.0)	12(66.8)	44(67.7)
Magazine	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(14.3)	1(4.6)
Information pamphlet	0(0.0)	1(50.0)	2(100.0)	0(0.0)	6(40.0)	8(57.1)	17(44.7)
Radio	0(0.0)	1(50.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	2(8.7)
Tests & Homework	0(0.0)	0(0.0)	0(0.0)	0(0.0)	4(30.8)	0(0.0)	4(16.0)
Text messages	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(14.3)	1(4.6)

Appendix 5: CSE providers/instructors reported by learners in the six countries

CSE teacher (Learners)	Eswatini n (%) N=11	Lesotho n (%) N=8	Malawi n (%) N=42	Mozambique n (%) N=33	South Africa n (%) N=26	Zambia n (%) N=33	Total n (%) N=153
Life orientation teacher	1(9.1)	4(50.0)	0(0.0)	24(72.7)	26 (100.0)	10 (30.3)	65 (42.5)
Health education teacher	0(0.0)	3(37.5)	1(2.4)	2(6.1)	0(0.0)	10(30.3)	16(10.5)
Principal/ headmaster		0(0.0)	1(2.4)	5(15.2)	0(0.0)	1(3.0)	7(4.6)
Social worker	0(0.0)	0(0.0)	0(0.0)	2(6.1)	0(0.0)	0(0.0)	2(1.3)
Class teacher	9(81.8)	1(12.5)	40(95.2)	0(0.0)	0(0.0)	12(36.4)	62(40.5)
Save the children	1(9.1)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(0.7)

Appendix 6: Preferred CSE Provider by country as reported by learners

Preferred provider	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Parent/guardian	9(75.0)	5(55.5)	10(23.8)	18(54.6)	11(42.3)	17(43.6)	70(43.5)
Aunt	0(0.0)	0(0.0)	0(0.0)	1(3.03)	3(11.5)	0(0.0)	4(2.5)
Peer educator	1(8.3)	1(11.1)	9(21.4)	0(0.0)	9(34.6)	10(25.6)	30(18.6)
Elders/grandparents	0(0.0)	1(11.1)	0(0.0)	0(0.0)	4(15.4)	5(12.8)	10(6.2)
Teacher	2(16.7)	3(33.3)	34(81.0)	10(30.3)	17(65.4)	24(61.5)	90(55.9)
Health worker	1(8.3)	4(44.4)	0(0.0)	0(0.0)	1(3.9)	7(18.0)	13(8.1)
Pastor/Priest	0(0.0)	0(0.0)	0(0.0)	0(0.0)	3(11.5)	1(2.6)	4(2.5)
Counsellor	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(3.9)	1(2.6)	2(1.2)
Police	0(0.0)	1(11.1)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(0.6)
Social Worker		0(0.0)	0(0.0)	0(0.0)	1(3.9)	0(0.0)	1(0.6)

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

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

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

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

Commodities	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Toiletries	4(80.0)		15(100.0)	0(0.0)	0(0.0)	2(100.0)	21(55.3)
CSE materials	0(0.0)		17(100.0)	6(50.0)	0(0.0)	6(100.0)	29(63.3)
Sanitary pads & panty liners	5(83.3)		5(100.0)	0(0.0)	5(33.3)	11(100.0)	26(60.5)
Soccer balls	0(0.0)	1(100.0)		0(0.0)	0(0.0)	2(100.0)	3(15.0)
Condoms	0(0.0)	1(100.0)		6(50.0)	1(9.1)	7(100.0)	15(46.9)
HIV testing material	0(0.0)	1(100.0)		0(0.0)	4(28.6)		5(22.7)
Contraceptive pills	0(0.0)		1(100.0)	0(0.0)	1(9.1)		2(10.5)
Pregnancy test kits		1(100.0)					1(100.0)

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