SEXUAL AND REPRODUCTIVE HEALTH RIGHTS EDUCATION AND SERVICES FOR ADOLESCENT GIRLS IN LESOTHO: A FEMINIST CRITIQUE

By

Lerato RAMAILI

Supervisor: Dr Rosalie Katsande

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Abstract

Adolescence is a phase of human development that leads to adulthood. Among other things, a person's body undergoes several changes which may be difficult for him or her to understand without proper guidance. Since most of the changes are related to sexual maturity, adolescents are unlikely to obtain accurate information, whether from their teachers and school curriculum or from their parents or guardians at home as discussions about sex are forbidden in most cultures, including Lesotho. Consequently adolescents become vulnerable and make uninformed decisions which may impact negatively on their health. This period of life calls for comprehensive sexuality education (CSE) so that adolescents may have access to sufficient and correct information upon which to build their life skills and ultimately make healthy choices in relation to their sexual and reproductive health (SRH). In the same vein, they must have access to comprehensive sexuality and reproductive health services which are adolescent-friendly to enable them to access and use these services in an environment that upholds their privacy and confidentiality. Sexual and reproductive health rights (SRHRs) are fundamental human rights which must be upheld to ensure that every individual, irrespective of age and gender, attains a safe standard of health. Introducing comprehensive sexuality education and services for adolescents can go a long way to reducing the spread of HIV/AIDS, unplanned pregnancies, unsafe abortions and other sexually transmitted infections (STIs) amongst adolescents in countries such as Lesotho where these conditions are prevalent. In order for real empowerment to happen on the ground there must be corresponding implementation strategies such as capacity building for various stakeholders responsible for delivering information and services.

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Declaration

I, Lerato Ramaili, declare that this dissertation is my own work and has not been submitted to any other university.

Signature…….

Date…….

Dedication

To my beloved family; my husband, Motlatsi and my angels, Kananelo and Kamohelo Ramoholi. It was not easy leaving you guys behind to study and I know it was not easy for you guys to let me go either, but the love we have for each other has always been the pillar of our strength and has kept our hearts forever connected.

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List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CGPU	Child and Gender Protection Unit
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CPWA	Children's Protection and Welfare Act, 2006
CSE	Comprehensive Sexuality Education
CHAL	Christian Health Association of Lesotho
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population Development
CRC	Convention on the Rights of the Child
CPWA	Children's Welfare and Protection Act
FGD	Focus group discussion
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
IPPF	International Planned Parenthood Federation
LBSE	Life Skills Based Sexuality Education
LPPA	Lesotho Planned Parenthood Association
MDG	Millennium Development Goal
NCDC	National Curriculum Development Centre
NGO	Non-governmental organisation
NUL	National University of Lesotho
PSS	Personal Spiritual and Social
RCC	Roman Catholic Church
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHR/s	Sexual and Reproductive Health Right/s
STI	Sexually Transmitted Infection
WHO	World Health Organization

List of human rights instruments

African Charter on the Rights and Welfare of the Child (1990)

Beijing Platform of Action (1996)

Convention on the Elimination of all Forms of Discrimination against Women (1981)

Convention on the Rights of the Child (1990)

Committee on the Convention on the Rights of the Child, General Recommendation No. 4

International Covenant on Civil and Political Rights (1976)

International Covenant Economic, Social and Cultural Rights (1976)

Committee on Economic, Social and Cultural Rights, General Recommendation No. 14

International Conference on Population Development Platform of Action (1995)

Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa (2003) (the African Women's Rights Protocol) (the Maputo Protocol)

List of local legislation

Children's Protection and Welfare Act, 2006 (CPWA)

Constitution of Lesotho, 1993

Education Act, 2010

Penal Code, 2010

List of local policies

Curriculum and Assessment Policy, 2009

National Adolescent Policy, 2006

National Minimum Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services, 2013

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Executive summary

The writer of this research is a lawyer and co-founder of a young women and girls' organisation in Lesotho called Development and Leadership Centre. She conducted this research to find out the nature of information that adolescent girls in Lesotho are receiving in relation to their sexual and reproductive health rights and to find out the kind of barriers that adolescent girls in Lesotho encounter in relation to their access and use of sexual and reproductive health services. She was concerned about the high rates of teenage pregnancies, unsafe abortions and the rate of sexually transmitted infections such as HIV/AIDS among young people in the country. It had come to her attention during various interactions with these young people that they were not aware that they have sexual and reproductive health rights which include the right to access comprehensive sexuality education and services such as family planning. This, coupled with her own childhood and adolescent experiences of not receiving appropriate sexuality education, was the inspiration behind her research.

Accordingly she sought to find out the role of the government and other stakeholders towards guaranteeing comprehensive sexuality education and services for adolescents. She considered it a paradox that whereas there are laws and policies that seek to protect and promote the adolescent girls' sexual and reproductive health rights, the reality on the ground revealed otherwise. The right to comprehensive sexuality education and services is still not understood and appreciated by many, especially in the context of adolescents who are culturally expected to remain abstinent until marriage.

The women's law approach was the over-arching research methodology adopted in the research to gather the lived realities of adolescent girls through focus group discussions that were held with them. Moreover since sexual and reproductive health is a human rights issue, the human rights approach was very instrumental throughout the research. Lesotho is party to several international human rights instruments that seek to promote and protect these rights at the domestic level of state parties. Other key methodologies that she adopted were the gender and sex analysis and the actors and structures approach which among others reflected the impact of the social constructions of gender on adolescent sexuality and how various stakeholders continued to be influenced by these cultural interpretations and stereotypes in the implementation process. Individual interviews were conducted with the service providers and the parents. It was through these interviews that she was able to understand the reasons

behind adolescent girls' continued failure to enjoy their sexual and reproductive health rights as reflected by the lived realities of adolescent girls on the ground. The fact that she was further able to inspect the school curricula on sexuality education proved very useful as it gave an insight into the nature of the content of sexuality education delivered in schools.

The main findings of the research revealed that there is Life Skills education also known as Life Skills Based Sexuality Education at the primary and secondary school level. However the curriculum was revised in 2012 at both levels in order to address challenges such as lack of comprehensiveness and implementation identified in the previous curriculum. Unfortunately, a thorough scrutiny of the curriculum revealed that the primary school level curriculum is still not comprehensive enough. Amongst others it is premised on the assumption that all adolescents in primary school ought to be abstinent hence for instance the right to information and access to family planning has been vaguely addressed. Conversely the secondary school level curriculum is very detailed and could go a long way towards empowering adolescents on these rights. Furthermore the problem of implementation remains a huge barrier at all levels. The personnel responsible for educating the adolescents have no capacity to effectively carry out the implementation and the government has no clear implementation strategies in place.

Moreover she found out that adolescent girls are still not receiving sexuality education beyond the school from their families and other institutions due to the cultural and religious convictions which continue to be a huge barrier towards effective implementation. In relation to services she found out that adolescent girls are not aware that they have a right to sexual and reproductive health services like the right to family planning. For those that are aware, they are reluctant to access them due to the fear of being stigmatised. Further the lack of adolescent-friendly institutions in Maseru especially those belonging to the government, poses a major barrier to access and overburdens the few non-governmental intuitions offering these services for adolescents. Consequently most adolescents do not have the correct information on the services being offered. Subsequently adolescent girls end up at a higher risk of becoming infected with sexually transmitted infections like HIV/AIDS over and above becoming pregnant due to lack of education and services related to these rights.

She accordingly draws the following conclusions:

- That the government of Lesotho through the Ministry of Education has taken a huge step by revising the primary and secondary school curricula on sexuality education. However that on the ground, adolescents are still likely to continue not receiving comprehensive sexuality education in accordance with the Children's Welfare and Protection Act (CPWA), 2011, in that the content, especially at the primary school level, is still not comprehensive enough. Outside the school environment, there is still a huge problem because it seems the stakeholders are also not delivering comprehensive sexuality education to the adolescents.

- That the cultural and the religious convictions on the part of the parents and the teachers are and will continue to be a stumbling block as there is no clear training plan to extensively educate them on comprehensive sexuality education. Pushing for the curriculum to be compulsory and examinable without investing in capacity building for the implementers is a futile exercise.

- That in Maseru, the availability of appropriate adolescent friendly institutions is a huge challenge. There is not sufficient awareness-raising about the few that are available hence adolescent girls remain in the dark as to where they can access these services without the risk of falling victim to discrimination and stigma. The Roman Catholic schools and hospitals pose a huge challenge to the realization of these rights as they are against the education of adolescents on family planning and do not offer these services in their clinics.

- That adolescents still think it is socially unacceptable for them to access and use services related to sexual and reproductive health before marriage. Moreover that it is generally accepted that while boys can access and use condoms, this is not the case for girls as they are often stigmatized if they do.

- Adolescent girls are at a higher risk than their male counterparts of contracting HIV and other sexually transmitted infections over and above becoming pregnant due to lack of appropriate information and access to services.
- Finally that the implementation of comprehensive sexuality education by qualified personnel and improved service delivery on sexual and reproductive health would go a long way towards ensuring informed decision making by adolescent girls about their sexual health, building their life skills, encouraging responsible behaviour and advancing their human rights.

She therefore recommends as follows:

- That the National Curriculum Development Centre should further improve the content of the curricula especially at primary school level to ensure that it captures issues in a more comprehensive manner so as to not only consider the age of the adolescents only but also their evolving capacities. In that way the link between gender and sexuality can be highlighted to come up with a rights based approach to sexual and reproductive health that considers issues of sexual orientation, family planning and even post abortion services as fundamental.

- That the Ministry of Education should devise a clear implementation strategy in relation to selection criteria of persons who are expected to teach the Life Skills curriculum in schools as it is not feasible for effective implementation to force every teacher to be a sexuality education teacher. The Ministry must allocate resources towards extensive training of the potential sexuality education teachers for effective implementation of the curriculum. The Ministry may also consider engaging expert sexuality education teachers from outside the schools though this may turn out to be costlier than the first option.

- That parents should be thoroughly sensitized on comprehensive sexuality education so that they can be able to open up to their adolescent girls and teach them facts about their sexuality. This can be done through inviting

parents at school to be addressed by an expert on sexuality education and public gatherings within communities.

- That the current move by the Ministry of Health to sensitize service providers in hospitals and clinics across the country to mainstream comprehensive sexuality services in these institutions is a step in the right direction but should not be considered an end. The Ministry of Health should revive adolescent corners. To this end there are no government owned specific adolescent-friendly institutions in Maseru. In order for the adolescents to be able to utilize sexual and reproductive health rights services, they must be adolescent-friendly in all possible ways to be able break all the barriers that inhibit access such as stigmatization of adolescents who seek these services. Efforts must be made to make adolescent girls aware of other non-governmental institutions like Lesotho Planned Parenthood Association which also provide these services to adolescent girls.

- That people within the communities must be thoroughly sensitized on sexuality education and corresponding services and why they are specifically important for adolescent girls to reduce unplanned pregnancies and sexually transmitted infections.

CHAPTER ONE

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

The government of Lesotho has adopted the World Health Organization (WHO) definition of adolescents as people in the 10-19 year old age group and this is the same definition that was adopted by the National Adolescent Policy of 2006. According to the Lesotho Planned Parenthood Association (LPPA), young people in Lesotho aged 10-24 years old make up 34% of the total population (LPPA Strategic Plan 2010-2014)[1] and this category of the population faces various problems which impinge on their general well-being. The most critical problem centres on their sexual and reproductive health (SRH) which can be the overriding determinant of their entire future. In 2002 premarital sex for those in the 12-19 age group was 34.9% for males and 28.2% for females. Despite this evidence of high sexual activity among young people, contraceptive prevalence is still very low at 16.3% (LPPA Strategic Plan 2010-2014). According to Kimane (2015), by the age of 17, 50% of adolescents are already sexually active in Lesotho and this is notwithstanding the fact that HIV prevalence in the country is very high at 23% for those in the 15-49 age group (LPPA Strategic Plan 2010-2014). The percentage of young people within this age group who have already begun child bearing is consequently very high, ranging from 3% to 39.6%, respectively. These statistics clearly indicate that Lesotho needs to invest in the sexual and reproductive health of its young people, as its failure to do so has already had and will continue to have negative consequences on their health and life in general.

1.2 Background to the study

1.2.1 The theoretical conceptualization of sexual and reproductive health rights (SRHRs) discourse

SRH is inextricably tied to the sex of human beings and there is no possibility of discussing SRH without discussing sex. Sex is a natural part of human life hence it is a subject that cannot be avoided. According to Jansen (2007), sex goes to the very basis of our very existence, not only for its biological and procreational importance but also because of its connection to our deepest sense of self. However, discussions around sex continue to be

[1] The Population and Housing Census of 2006 indicates that the total population of Lesotho stands at 1,876,633 though this may vary as the national census will soon be held in May this year.

wrapped up in secrecy and taboos which make it very difficult to understand or embrace as part of human sexuality. Rubin (1989) identifies sex negativity as one of the important ideological formations that has reinforced stereotypes around the topic as it postulates sex as dangerous, destructive and inherently sinful unless it is performed within the ambit of marriage with the primary reason being procreation. Modern societies accordingly appraise sex acts according to their hierarchical system of sexual value such that if the act is not marital and reproductive it is not respected and valued (Rubin, 1989). For example, sex acts that take place between unmarried couples or homosexuals attract little or no protection from the law because they do not take place within marriage or for the purpose of procreation.

SRH is a combination of two concepts with the common dominator being sex, that is, sexuality which is broader and reproductive health which is narrower. According to International Planned Parenthood Federation (2011), sexuality is how people experience and express themselves as sexual beings. It includes sexual behaviour, gender identities, gender roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. However, these elements are not always experienced or expressed due to biological, social, cultural, economic, environmental and contextual factors which contribute to people's sexual behaviours, relationships, feelings, identity, desires, and attitudes. Therefore, each person experiences and expresses their sexuality in a unique way (International Planned Parenthood Federation, 2011). Paragraph 7.3 of the International Conference on Population Development (ICPD) Platform of Action defines sexual health as relating to the enhancement of life and personal relations beyond counselling and care related to reproduction and sexually transmitted infections (STIs). Reproductive health on the other hand is defined as:

> 'a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant' (ICPD Platform of Action Chap 7A).

The Beijing Platform of Action (1996) which came a year later further affirmed the above definition and went further to state that:

> 'the human rights of women include their right to have control over their fertility and decide freely and responsibly on matters related to their sexuality, including sexual reproductive health, free of coercion, discrimination and violence.'

Therefore whereas *sexual rights* refer to human rights that relate to a person's sexuality, sexual health, sexual orientation and sexual identity, *reproductive health* refers to human rights that relate to a person's fertility, reproduction and reproductive health (International Planned Parenthood Federation, 2011). However despite the fact that choice must ideally form the basis of sexual and reproductive health rights (SRHR), it appears that in practice there exists no such freedom especially when it comes to women. In most cases when it comes to sex, women's bodies are primarily regulated by law. For example, the kind of clothes that women wear, laws on abortion and access to contraceptives are usually strictly regulated yet these issues hardly ever affect men. Women do not have control or enjoy privacy in relation to their sexuality. In most cases it is usually the state that is in control. According to Jansen (2007), this treatment of women and their sexuality fits within a historical pattern in which a woman's sexuality was not hers to make decisions about since across various cultures, her sexuality belonged to her family. SRHR in relation to women therefore seeks to change the status quo to ensure that women of all ages have autonomy and power over their bodies including access to health services that cater for their unique bodies and experiences as women.

Mackinnon (1989) sees in sexuality what Marxism sees in work. In Marxist theory, as the organized expropriation of the work of some (workers) for the benefit of others defines class, so the organized expropriation of sexuality of some for the use of others defines sex. In the first place heterosexuality is its social structure, desire its internal dynamic, gender and family its congealed forms, sex roles its qualities generalized to social persona, reproduction a consequence, and control its issue. Accordingly, Mackinnon (1989) defines sexuality as:

> 'the social process through which social relations and gender are created, organized, expressed, and directed, creating the social beings we know as women and men, as their relations create society.'

Given this background it becomes understandable why it has been so difficult for women to win their struggle for their sexual liberalization. In the first place many women are not aware of the fact that female sexuality is socially constructed but instead regard it as innate and natural. For the few that seek to challenge the status quo, they are met by many barriers as in so doing they challenge male dominance. In her dominance theory, MacKinnon (1989) indicates that women play a significant role in men's struggle for control by supporting the idea that men and women are fundamentally different and therefore accepting femininity as a valid view of who women are and how they are supposed to be. The women cannot be accorded similar sexual traits to those accorded to men such as being sexually aggressive or predatory because this would challenge the idea of unique male sexuality as a basis for male solidarity, competition and dominance (Mackinnon, 1989).

Therefore from a feminist point of view the promotion of abstinence-only until marriage is an attempt to perpetuate patriarchal notions in relation to female purity and the confinement of female sexuality within a hetero-normative marital and coital framework (Twesiime-Kirya, 2008). When women fight for control of women's fertility through for example access to medicalised or safe abortion or access to contraceptives, appeal is made to moral ethics by using religion as a tool to scare them off and in the eyes of society such women are viewed as radical. In some societies[2] the practice of female genital mutilation (FGM) or cutting is performed as one of the ways to control or curb women's sexual desire. Any movement towards the advancement of SRHR is usually viewed with suspicion unless the activists focus more on the reproductive rights especially in the context of married couple with specific emphasis on maternal and infant health. For as long as female sexuality is seen as something negative to be controlled and contained, rather than something to be acknowledged, managed through informed choice and enjoyed, gender equality cannot be achieved. Hence abstinence-only until marriage is nothing but an extension of patriarchal values to keep a tight reign on female sexuality (Twesiime-Kirya, 2008).

Consequently despite the controversial and hidden nature of human sexuality, the emergence of diseases such as HIV/AIDS and issues such as sexual violence pushed the discussions around SRHR to the public debates as human rights issues due to their health implications for the victims. In their express provisions or within the body of the two fundamental human

[2] These include some tribes in countries like Kenya and Tanzania.

rights treaties, there is no mention of SRHR. The right to the highest attainable standard of health is protected under article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR). In relation to the rights specific to women it included the protection of reproductive health rights in the context of mother and child health through focusing on maternal and infant mortality as well as protection from diseases under articles 12(2), (1) and (3). The International Covenant on Civil and Political Rights (ICCPR) does not have provisions directly related to health although it can be implied from other rights such as the right to life under article 6. The reproductive role of women together with the fact that in most cases they are the ones who suffer sexual harm meant that they became exposed to unwanted pregnancies and STIs and therefore needed protection. Accordingly addressing SRHR .under the broad umbrella of the right to health is limiting due to their unique, broad nature and the fact that they do not affect women and men in the same way.

Unfortunately even women themselves are not a homogeneous group. Within the huge group of women, we have girls, young women and even elderly women, yet it seems reproductive health receives protection due to its procreative nature to ensure the wellbeing of the mother and child while also giving families the autonomy to decide on the number of children and spacing. Accordingly the extent to which these frameworks also envisaged the sexual and reproductive health rights of the other categories of women such as young women and girls who may be unmarried and may be engaging in sexual intercourse for pleasure and not procreation becomes questionable. These were criticized for placing too much emphasis on sex as a biological function thereby restricting reproductive health to procreation (Jansen, 2007).[3] Even the national Constitutions of most states that sought to domesticate these instruments merely focused on the limited scope of reproductive health in the context of maternal and infant mortality. A good example is section 26 of the Constitution of Lesotho. However the work of treaty bodies of these instruments and other international and other regional instruments that emerged later on have built up a very comprehensive jurisprudence on these rights, in particular, the recognition of sexual rights including those of previously unrecognized groups such as adolescents has been a huge milestone.

[3] The same approach was seen in the Millennium Development Goals which only recognized maternal mortality and infant mortality as essential components of sexual and reproductive health leaving out other key aspects of these rights which are not purely focused on reproduction. For example, the issue of access to information and services such as family planning for adolescents was not covered.

1.2.2 The controversies surrounding adolescent girls' SRHRs

Adolescent SRHRs are surrounded by several controversies except in those rare cases where the issue is sexual assault where adolescents, especially adolescent girls, are passive victims of a crime. In these cases the government usually recognizes their right to acquire reproductive health services such as medicalised abortion, post exposure prophylaxis or even the morning after pill to prevent unwanted pregnancy because they are considered victims of a crime. What happens where sexual intercourse is voluntary and what are the implications for the parties involved? That is the girl and the boy? We still live in times in which sexual hierarchies as postulated by Rubin (1984) still matter. According to Rubin, sexual hierarchy resembles a class system in which different sexual practices, expressions, identities, and communities are ranked, from the most normative and socially approved to the most stigmatized and despised. It is therefore not surprising that on the ground adolescents are not aware that they have SRHR and that this is worsened by the use of phrases such as family planning which still continue to be used in the discourse notwithstanding that it does not essentially apply to all women or all couples that are engaging in sexual intercourse.

Sexual hierarchy therefore becomes an important analytic device for identifying how a culture evaluates sexual behaviours, relationships, and expressions as its practical value lies in the way it lays bare the rules evaluating what is considered legitimate and illegitimate sexuality, thereby laying them bare for evaluation from the human rights perspective (Miller and Vance, 2004). As an adolescent I never received sexuality education nor did I know comprehensively of the services available for adolescent girls in relation to their SRH nor where these services could be accessed. The general information that I had which I remember very vividly from my mother which was later reinforced during my interaction with the elders within the society and at school was that I must avoid any relationship of any kind with boys as they will destroy my future. Even though I was able to conform for a larger part of my life, when I got to tertiary I began dating and this was not to spite my mother or to be intentionally rebellious but simply because I felt ready. The feelings of affection that I had felt for boys all along could no longer be suppressed any further.

Unfortunately even though I thought I was completely ready and sufficiently mature to engage in sexual intercourse, I did not have sufficient information on how to protect myself against unplanned pregnancy and was very ignorant of the reality of STIs. Since my boyfriend (husband) was older than me I was reassured when he told me he was very good at

withdrawal as a natural method of prevention. In so trusting in him, not only did I expose myself to STIs, like HIV, but I also became pregnant and married at the age of 21. Even though I received support from him and my family and continued with my education, this is often not the case for many young people in similar situations. Most of them become confused and with little or no support, they end up resorting to unsafe abortions[4] which are usually backstreet abortions which maybe cheap but are unsafe and hazardous to their health. Others may be so frustrated that they underperform in their studies, drop out of school to take care of their new born child or may be expelled from school because of having fallen pregnant. According to Tambiah (1995), what I experienced as an adolescent was inevitable as the continued contradictions and forced ignorance of the girl child's sexuality can result in serious consequences in that, a girl or young woman who is curious about her body and who wants to express her erotic desire with a male partner but who, having little knowledge about the consequences of heterosexual intercourse, engages in sex without appropriate protection, may risk pregnancy or infection with a STI. Though I did not get infected with an STI, this is exactly what I went through.

Consequently while girl children are particularly vulnerable to constraints upon the development of their sexuality, adult women face a series of choices and challenges with regard to exercising an informed autonomous choice about their sexual activity (Tambiah, 1995). It is not surprising therefore that most articles of the International Conventions do not explicitly make provision for the protection of sexual activity, whether of the self or freely consenting partners as those that expressly provide for that right do so in the context of marriage (Tambiah, 1995). The recognition of the adolescent girl's sexual reproductive health rights is as a result of the work of various treaty monitoring bodies through the interpretative mandate of provisions relating to the right to health, privacy, dignity and integrity to name but a few. This explains the reason why adolescent girls are still lagging behind when it comes to the enjoyment of SRHR. The Human Rights Committee (HRC) in its Concluding Observations has interpreted the right to non-discrimination under article 3 and the right to privacy provisions under article 26 of the ICCPR to mean that states must adopt all necessary legislative and other measures to assist women, and particularly adolescent girls, confronted with the problem of unwanted pregnancies to obtain access to adequate health and education

[4] Section 45 of the Penal Code, 2010 criminalizes abortions to terminate unplanned pregnancies. Backstreet abortions are very common at the National University of Lesotho as most young people do not use condoms and information as to how and where to obtain assistance is often obtained from peers.

facilities under paragraph 11. Similarly the Committee has interpreted article 19(2) of the ICCPR to mean that governments must introduce sexuality education into the public school curriculum (Centre for Reproductive Law and Policy, 2002).

However at the regional level, the Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa, 2003 (the African Women's Rights Protocol) (the Maputo Protocol) expressly recognizes the sexual reproductive rights or girls. Article 14 protects their right to control their fertility, to choose any method of contraception, self-protection and to be protected from sexually transmitted diseases, their right to family planning education, provision of adequate, affordable health services which include information and education and communication and the authorization of abortion including cases where continued pregnancy endangers the mental and physical health of the mother or foetus. Thus the African Women's Rights Protocol became the first instrument at international level to recognize the right to medical abortion and explicitly prohibit FGM. In the same vein, the 2030 Development Agenda referred to as Sustainable Development Goals (SDGs), is more encompassing in its targets and indicators unlike the Millennium Development Goals (MDGs) which recognized SRH within the narrow context of maternal and infant mortality. Goal 3 of the SDGs is committed to ensuring healthy lives and to promoting the well-being of people of all ages while Goal 5 targets achieving gender equality and empowering all women and girls. Implicit in these Goals is the guaranteeing of access to information and services related to SRH through the removal of barriers such as gender discrimination in making decisions related to the health of all women.

Since the international standards set the minimum standards for state parties to uphold the human rights of its citizens, various states are working very hard at the domestic level to ensure compliance. Obviously the international community is very aware that the realization of SRHR for adolescent girls at the national level is likely to be hindered by the cultural and religious norms thereby highly jeopardizing their health especially due to their specific needs on the right to health. The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the African Women's Rights Protocol vehemently call upon states to illuminate all forms of discrimination against women. In particular Article 1(g) of the African Women's Rights Protocol defines discrimination against women as:

> ‘any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or exercise by women regardless of their marital status, of human rights and fundamental freedoms in all spheres of life.’

Lesotho follows a dualist tradition which means that for international law to be applicable in the country, it must first of all be domesticated into law by parliament. The government of Lesotho enacted the Children’s Protection and Welfare Act (CPWA) 2011 which provides, under section 11(6), that children must be provided with sexuality education that is age-appropriate. The SRHRs of adolescents are thereafter catered for under various policies such as the National Adolescent Policy, 2006 which also makes provision for access to SRH services in an adolescent-friendly environment. The SRHRs therefore also fall squarely within the right to health under Chapter III of the Constitution of Lesotho 1993. Unfortunately this right is non-justiciable as it is falls under Principles of State Policy which are enforceable subject to the availability of resources in the country. This means that it could take forever for these rights to be realized as the state may have no resources to fulfil them or it may simply divert them to other projects which are thought to be more important.

1.2.3 Comprehensive SRH education and services framework

UNESCO (2009) defines effective sexuality education as one that provides young people with age-appropriate, culturally relevant and scientifically accurate information in a way that includes structured opportunities for young people to explore their attitudes and values, and practice decision making and other life skills they need to enable them to make informed choices about their sexual lives. Moreover not only is effective sexuality education a vital part of HIV prevention but it is also essential to achieving a universal target for HIV prevention, treatment, care and support (UNESCO, 2009). However this is not to suggest that education alone will eliminate all problems associated with SRH in the context of adolescents but it can certainly reduce the dangers involved. This is because without such information young people are vulnerable.

According to International Planned Parenthood Federation (2010), a rights based approach to Comprehensive Sexuality Education (CSE) seeks to equip young people with the knowledge, skills, attitudes and values that they will need to determine and to enjoy their sexuality physically and emotionally, individually and in relationships. That is, it views sexuality holistically and within the context of emotional and social development. Moreover it

recognizes that information alone is not enough hence young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values (International Planned Parenthood Federation, 2010). Generally the information on sexuality education must be able to help the young people to: firstly, acquire accurate information on SRHR and give information to dispel myths; secondly, it must help to develop skills such as critical thinking, communication, negotiation, self-development and decision making skills, sense of self, confidence, assertiveness, ability to take responsibility as well as ability to ask questions and seek help and empathy and finally, to nurture positive attitudes and values which include self-worth or self-esteem and a positive attitude toward SRH (International Planned Parenthood Federation, 2010).

Moreover, CSE from the outset of schooling and through the educational process will enable individuals to look after their own health responsibly and respectfully, allowing men and women to claim their reproductive rights and respect other persons' reproductive rights. CSE will also consider and challenge stereotypical gender roles. It will not only look into women's issues, but will also involve men, who can benefit from less rigid roles and more egalitarian relationships (United Nations, 2014). Furthermore, teaching methodologies must take the differences between boys and girls into account. Sexuality education is extremely important in view of the threat of HIV/AIDS and STIs, especially for vulnerable groups, such as women and girls exposed to sexual violence and children living on the street. Enjoyment of the right to sexuality education plays a crucial preventive role and may be a question of life or death (United Nations, 2014).

Moreover research shows that these programmes can help young people to abstain from or delay the debut of sexual relations, reduce the frequency of unprotected sexual activity and the number of sexual partners. They can also help to increase the use of protection against unintended pregnancy and STIs during sexual intercourse (UNESCO, 2009). However some of these results can only be achieved if there is proportional access to comprehensive sexual and reproductive health care services where adolescents have decided to engage in sexual activities. According to UNFPA (2014), comprehensive SRH services in the context of adolescents refers to a holistic youth-friendly health-care package of services such as: universal access to accurate SRHR information, a range of safe and affordable contraceptive methods, sensitive counselling, quality obstetric and ante natal care for all pregnant women and girls and the prevention and management of sexually transmitted infections, including

HIV. Lesotho signed the Eastern and Southern African Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health services for Adolescents and Young People (ESA) in 2013 thereby making a commitment to ensure, among other things, that adolescents will receive CSE and SRH services which are youth-friendly. In particular, paragraph 3.4 of the National Adolescent Policy, 2006 provides for universal access to adolescent friendly health services which have characteristics such as availability of health care packages, accessibility to health facilities, acceptability and quality in relation to the commodities offered.

1.3 Statement of the problem

The nature of information that adolescents girls in Lesotho are receiving is not comprehensive enough to enable them to make informed decisions and seek appropriate services concerning their SRH. According to UNESCO (2010), we have a choice to make. Do we leave children to find their own way through the clouds of partial information, misinformation and outright exploitation that they will find in the media, on the internet, from their peers and the unscrupulous? Or, should we instead face up to the challenge of providing them with clear, well-informed and scientifically-grounded sexuality education based on the universal values of respect and human rights?

The failure to educate young people comprehensively in sexual issues affects their health and leaves them vulnerable to exploitation, unplanned pregnancies and STIs. According to UNAIDS's (2010) key findings, globally comprehensive and correct knowledge about HIV among young men and young women has increased slightly since 2008[5] but only to 34%. The number of young people with this comprehensive knowledge is barely one third of the UNGASS target of 95%. In Lesotho HIV prevalence among young women is high, sitting at 14% while for their male counterparts it is 4% (Kimane, 2015). The LPPA Strategic Plan 2010-2014 indicates that in 2000, 12% of new AIDS cases reported were among young people in the age group of 10-24 and girls accounted for 10% and boys, 2%. This pattern suggests intergenerational sex which means that younger girls are having sexual intercourse with older men.

[5] The UNAIDS Global Report 2008 on the AIDS Epidemic reported that only 40% of young people aged 15-24 had accurate information about HIV and how it is transmitted.

Moreover adolescent girls who are sexually active are left with no option but to consider backstreet abortions where they become pregnant after having unprotected sexual intercourse. These abortions are administered by unqualified personnel in most cases and they become hazardous to the girl's health as they usually result in severe pain, uncontrollable bleeding and sometimes result in sterility or death. The LPPA Strategic Plan (2010-2014) further indicates that in 1994, the gynecology ward report at Queen Mamohato Hospital revealed that 54.6% of females below 24 years old admitted to the ward were cases of incomplete abortion and that 16.8% of all hospital deaths for females aged 14 years were due to abortion complications and finally that 13% of all abortion cases attended were adolescents.[6] In Lesotho, sexual activity starts as early as the age of 12 for males and 14 for females (National Adolescent Health Policy, 2006), however, despite this reality on the ground, not enough is done to solve these problems.[7]

Finally, adolescents spend most of their time either at home or at school and these are the two most fundamental places in a child's life as that is where socialization and most of their learning takes place. Consequently parents and teachers play a significant role in children's development that cannot be overlooked. In order for adolescents to enjoy their SRHRs, parents and teachers are some of the most important players. It therefore becomes imperative to critique the role played by these actors in ensuring that adolescents do have comprehensive information to enable them to exercise their SRHRs. This is because what is happening on the ground may be a reflection of what is going on within these two structures, i.e., the family and the school. More importantly, how is the state helping to ensure that these actors perform their responsibilities?

1.4 Objectives of the study

The research sought to find out the role played by the government and other non-governmental institutions towards guaranteeing the right to CSE and services to adolescent girls in Lesotho, to promote informed decision making and healthy choices concerning their SRH.

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[6] The recent trend is that those who can afford to do so cross the border into the Republic of South Africa where they can access safe legal abortions as abortion is legal in that country; the majority of Basotho women, especially adolescent girls, do not, however, enjoy such a luxury.

[7] In Lesotho, post abortion care is available, yet not much is done to address the structural issues leading to unsafe abortion in the first place. If safe abortion were legal and affordable in Lesotho would there be any need for post abortion care in the first place?

1.5 Research assumptions

1. Adolescent girls in Lesotho do not receive sexual and reproductive health education in accordance with section 11(6) of the Children's Protection and Welfare Act, 2011 which provides that a child has the right to sexual and reproductive health information and education appropriate to his or her age.

2. The cultural and religious convictions of teachers and parents are a barrier against effective implementation of the revised curricula on sexuality education in Lesotho.

3. Adolescent girls in Lesotho are not aware of the existence of adolescent friendly institutions such as adolescent corners in hospitals or at the Lesotho Planned Parenthood Association (LPPA) where they can receive education and services on sexual reproductive health in accordance with their evolving capacities.

4. There is a lot of stigma that surrounds issues of sexual and reproductive health rights in the context of adolescent girls which makes them reluctant to seek contraceptives or information about them.

5. Adolescent girls are at a higher risk than their male counterparts of contracting sexually transmitted diseases such as HIV over and above becoming pregnant due to lack of comprehensive sexuality information and failure to access services on their sexual and reproductive health.

6. The implementation of CSE by qualified personnel and improved service delivery on SRH would go a long way towards ensuring informed decision making for adolescent girls on their sexual health as well as build their life skills, increase responsible behaviour and advance their human rights.

1.6 Research questions

1. Do adolescent girls in Lesotho receive sexual and reproductive health education in accordance with section 11(6) of the Children's Protection and Welfare Act, 2011

which provides that a child has the right to sexual and reproductive health information and education appropriate to his or her age?

2. Are the cultural and religious convictions of teachers and parents are a barrier against effective implementation of the revised curricula on sexuality education in Lesotho?
3. Are adolescent girls in Lesotho aware of the existence of adolescent friendly institutions such as adolescent corners in hospitals or at the Lesotho Planned Parenthood Association (LPPA) where they can receive education and services on sexual reproductive health in accordance with their evolving capacities?

4. Is there a lot of stigma that surrounds issues of sexual and reproductive health rights in the context of adolescent girls which makes them reluctant to seek contraceptives or information about them?

5. Are adolescent girls at a higher risk than their male counterparts of contracting sexually transmitted diseases such as HIV over and above becoming pregnant due to lack of comprehensive sexuality information and failure to access services on their sexual and reproductive health?

6. Would the implementation of CSE by qualified personnel and improved service delivery on SRH go a long way towards ensuring informed decision making for adolescent girls on their sexual health as well as build their life skills, increase responsible behaviour and advance their human rights?

1.7 Conclusion

The chapter has given a picture of the ideal situation in relation to the SRHRs of adolescent girls as provided for by the literature and legal frameworks as well as the challenges that these young people are likely to encounter in reality. The research assumptions and questions formulated directed me towards identifying and exploring the barriers against the enjoyment of SRHRs by adolescent girls in Lesotho and urged me to come up with possible interventions. The next chapter outlines the methodological frameworks adopted in this research in order to gather information pertaining to adolescent girls' SRHR education and services and why they were particularly relevant in this study.

CHAPTER TWO

2.0 METHODOLOGY AND DATA COLLECTION METHODS

2.1 Introduction

This chapter highlights my journey in collecting data on adolescent girls' SRHR education and services. Conducting research around the area of sexuality in the African context is not an easy task as anything around sex is often treated as taboo and is rarely discussed. Lesotho is no different from the rest of the continent and as a young person researching around this subject was not easy, especially when it came to talking to older people as they are still very conservative. Consequently I had to choose my methodologies and methods very carefully to be able to 'unearth invisible, silenced and repressed knowledge' around adolescent girls' sexuality (Tamale, 201l).

2.2 Methodological framework

2.2.1 The human rights approach to adolescent girls' SRHRs

A human rights-based approach is a conceptual and analytical framework that integrates human rights norms, standards and principles into all development work (United Nations, 2014). Due to their broad nature, sexual and reproductive rights are incorporated in various international human rights instruments whether in the form of convention, declaration and/or consensus documents. The International Conference on Population Development (ICPD) Programme of Action gave a comprehensive definition on SRHR which built on the right to achieve the highest attainable standard of health incorporated in various conventions including article 12 of the ICESR.

There are also specific instruments which provide for women's rights both at the international and regional level which have gone the extra mile to outline the specific needs of women in relation to reproduction. For instance articles 12 and 16 of CEDAW make provision for the right to access health care services including those related to pregnancy, family planning and the spacing of children. At the regional level, article 14 of the African Women's Rights Protocol provides for the right to sexual and reproductive health rights for women and girls.

Accordingly, these instruments when coupled with the concluding observations and general comments of various treaty bodies establish a very strong foundation that guides states on

how to effectively implement SRHR. Since these rights have previously been considered in the context of married couples and more specifically married women, establishing a clear and equal right for an adolescent girl appeared to be a great challenge but adopting the human rights based approach made it easier because it mandates that the marginalized and excluded groups in society be of paramount consideration. In any research that has a developmental goal such as this one which advocates for investing in the health of adolescents or young people as they are the future generation, this approach becomes in evitable. This is because amongst others it provides an analytical lens to understand the complexity of development problems, including the identification of underlying and root causes of problems, in order to put in place more integral policy and programming responses. In the area of SRH, for instance, it can contribute to more integral multi-sectoral responses beyond a health sector approach and vertical programming interventions such as in the areas of maternal health or family planning (United Nations, 2014).

2.2.2 The lived experiences of adolescent girls in relation to sexuality and reproductive health

In order to get a true reflection of the lived realities of adolescent girls in relation to issues of sex and reproduction and the impact they have on their health, I had to go into the field and interact with these girls. The nature of information that these young people had as major beneficiaries of effective SRHR helped me to identify the gaps and to think about the possible solutions as they went further and explained their understanding of the reasons for not accessing these services and how this impacts on their lives. The women's law approach became useful because it relies on empirical data collected on the ground focusing on women's lived realities and experiences as a starting point for the analysis of the position of women in law and society (Bentzon *et al.*, 1998).

When I began my journey into the field, I had hoped to find no change in the assumptions I had drafted because the statistics that had informed my assumptions were very high in that I had actually assumed the situation was completely the same as when I was an adolescent. One of my assumptions was that there is no curriculum in either primary or secondary school that effectively promotes and protects adolescent girls' sexual and reproductive rights. To my surprise I found that the curriculum on Life Skills that includes sexual and reproductive health rights and HIV/AIDS education was introduced as early as 2006 and revised again in 2012, yet it appeared, the problem still persisted. There were apparently other underlying

structural issues that needed to be interrogated including those which constitute a barrier to the exercise of SRHR and I was able to adjust my assumptions accordingly as this methodology is highly flexible.

This then helped me to shift my focus toward considering the nature of the content of the curricula as well as the implementation strategy that has been put in place by the Ministry of Education and Training. On paper, it appeared that the laws and policies in relation to promoting the SRHR of adolescents were ideal yet the legal pluralistic nature of the law seemed to pose a serious problem towards implementation. For example, the school curriculum sought to provide sexuality education in accordance with the provisions of the Children's Protection and Welfare Act, 2011 yet the delivery of sexuality education to adolescents as demanded by international human rights was greatly hampered by the cultural and religious norms which do not recognize such rights, especially in the context of adolescent girls. Consequently in order to link theory with practice and to understand the realities of adolescent girls in relation to sexuality, I also had to consider their position in law and society concurrently with the plural systems of the laws that have a bearing on their daily life from the beginning to the end of the research.

2.2.3 The connection between sexuality and gender and how they continue to maintain existing power relations between girls and boys

To be able to understand the relationship between men and women and boys and girls and how this has a bearing on their sexuality I had to consider the relationship between sex and gender as this is how males and females receive their identities within the societies they live in. According to Tamale (2011), sexuality and gender go hand in hand as they are both creatures of culture and society and both play a central and crucial role in maintaining power relations in our societies. Therefore gender provides the critical analytical lens through which any data on sexuality must logically be interpreted. Women have been socialized to believe they are asexual from when they were small girls while men (boys) have been raised to believe they have a natural sexual urge that comes with being male, hence it is acceptable within society that they can explore sexually. This has been astutely observed by Tambiah (1995) as follows:

> 'Socialization of the girl child is determined by the expectation that she will become a co-operative member of the society that is generally organized to

> ensure normative heterosexual behaviour. In order to ensure such behaviour, a society does not impose equal expectations (or restrictions) on both its female and male constituents. Male sexual desire and its satisfaction are frequently considered natural, legitimate and privileged while female sexual desire and its satisfaction are just as frequently considered unnatural, problematic, and fearful.'

Unfortunately this is learned behaviour and girls are often confronted by serious challenges when their hormones start to rage, yet society expects them to remain virgins until married. Masculine cultural forms cannot be abstracted from sexuality, which is an essential dimension of gender. Sexuality has been leeched out of much of the literature on masculinity under the assumption that sexuality is pre-social, that is, a natural force belonging to the realm of biology. But while sexuality addresses the body, it is itself a social practice and constitutive of the social world (Connell, 2005).

The analysis of gender was therefore helpful to my research because I was able to identify the gaps that have been caused by the stereotypical interpretations of gender and how they further translate into human sexuality. For example, while interacting with adolescents on the ground it became clear why the girls are disproportionately affected by lack of Comprehensive Sexuality Education (CSE) and lack of access to related services. I came to appreciate the reason why in most cases boys would be the ones found in possession of condoms and why they felt they could use the condoms if necessary, whereas the majority of girls regarded condoms as dirty and a sign of promiscuity. Most importantly it is this analysis that actually informed the assumption that adolescent girls are disproportionately affected by lack of access to sexuality education and services. This assumption was therefore not challenged because the stereotypical interpretations of gender and sex continue to exist on the ground.

2.2.4 The role played by key stakeholders towards the realization of SRHRs for adolescent girls

In order for adolescents to effectively exercise their SRHR there are certain structures that are charged with the responsibility of ensuring that they support adolescents in the enjoyment of these rights. The actors and structures perspective enables us to start out with women's experiences in the process of life management and look at the normative structures that impinge on their lives (Bentzon *et al.*, 1998). The structures that I engaged with include the governmental structures of the National Curriculum Development Centre (NCDC), the Ministry of Education, Ministry of Health, and Ministry of Gender, Youth Sports and

Recreation as well as other non-governmental bodies like the family and civil society organizations. Since it was clear that these structures do actually exist in Lesotho but the adolescents on the ground are not aware that they have SRHR and do not know how to claim these rights, I had to go further to engage with various actors within these structures to determine whether the problem emanates from the structures or from the actors within these structures.

Moreover, the process of changing cultural practices and how men and women relate in the society will often result in new practices and new gender standards.

> 'There is a constant state of flux between the actors and the structures as new knowledge changes the actors' perception of reality, and in turn their acceptance of the normative structure or the belief system which informs their perception of the relationship between themselves and others…Thus even if there is new knowledge and change in living conditions people may change their practices without consciously adjusting their ideas' (Bentzon *et al.*, 1998).

Whereas in the past things were mostly done according to the customary law or traditional way of doing things which used to coincide perfectly well with the how men and women related to each other on the ground, today things are somewhat different. In the past the girl child would be legally married under the customary law as soon as it was ascertained that she had reached puberty but these days child marriages are highly discouraged and illegal in some jurisdictions because such marriages not only interfere with the rights of young girls to education but also to their SRHR. Consequently this implies that girls will marry later on in their lives and during the time in between they may be tempted to engage in sexual intercourse. Unfortunately on the ground the actors who may have to intervene may not be ready to deal with the reality that they have to talk to children about sex outside of marriage and introduce means of safe sex. So whereas the practice may have evolved, the ideas may remain unadjusted or vice versa and negatively impact on implementation. Consequently my last assumption was adjusted to fit this reality that it is actually the implementation of these rights by qualified personnel which can translate into healthy sexual lives for adolescent girls.

2.3 The research sample

The details of the respondents involved in this research are reflected in Table 1.

Table 1: Details of research respondents

Respondents	Male	Female	Total
Key informants	3	7	10
10 Focus group discussions (FGDs) (Adolescents & young women)	28	44	72
Teachers	5	16	21
Parents	10	20	30
Total	**46**	**87**	**133**

2.4 Data collection methods

2.4.1 Interviews with key informants

Selecting key informants working around area of SRH especially in the context of adolescents was a bit challenging mainly because there are hardly any institutions whose main focus is promoting and advocating SRH in Lesotho. In most institutions SRHR is usually a mini-project under a huge project that may seek to promote women's rights in relation to mother and child care under antenatal or postnatal care programmes. The Lesotho Planned Parenthood Association (LPPA) was one institution that I identified knowing that it offers SRH services to young people, mainly from my own experience, though I only started accessing its services after I was married because before then I did not clearly understand its mandate.

I then identified the Ministry of Gender, Ministry of Health and the Ministry of Education purposively as they have a direct role to play either through giving information to these young people or offering them services. Talking to the Curriculum Developer at the NCDC also helped a lot because I was able to gather all the information I needed in relation to the sexuality education curricula in the country. Kick for Life was also very relevant as it offers

life skills training to young people. My major aim here was to critique the role played by these officials in supporting adolescent girls in their exercise of their SRHR.

2.4.2 Focus group discussions (FGDs)

I interviewed the adolescents and young women using focus group discussions (FGDs). These groups were mostly formed randomly at school during break or lunch times and even after school in some cases. Other groups were formed with young women who went to access services related to SRH at LPPA. This method proved very effective especially because the respondents were already in one place for specific tasks and purposes. For example, in relation to the students, they were already in the school environment and could relate to the Life Skills subject and could easily discuss issues around its content especially because they were grouped according to the Grade they were in. I separated the groups in accordance with the sex of the participants because I observed that generally girls talked more freely when they were not among boys. Moreover talking to adolescents individually would not have enabled me to get as much information as I was able to acquire when I interacted with them in groups. The reason is that I found that on their own they tended to be very shy which made me feel as though I was putting them on the spot; but in a group they seemed to feel encouraged by their peers who were very open and they joined in the flow of the exchanges.

In relation to ethical considerations, since most of the young people in these groups were minors, I had to obtain consent from the school principal before interviewing them. The principal went through the questions that were to be discussed with the adolescents to ensure they were not prejudicial to them The principal and the minors involved were reassured that the research was in the best interests of the adolescent minors and therefore that their safety, rights and interests would be protected at all times throughout the research.

2.4.3 Individual interviews

Individual interviews were conducted with parents and teachers. The parents were selected randomly and their data categorized in accordance with their gender, age, educational and religious background and whether or not they had children, while the teachers who were interviewed were the ones who teach the Life Skills course at primary and secondary school level as well as the principals. Some teachers were interviewed in their capacity as parents. The reason for conducting open ended interviews with these respondents was so that they

could express themselves as freely as possible in relation to what they thought about the course and to determine their overall role in educating their children about these issues.

This method proved highly effective especially for parents as they were able to share concrete stories about their experiences with their children in relation to sexuality. Most mothers were able for example to disclose that they had occasionally found condoms and erotic magazines in their sons' rooms. Since the issues relating to sex are hidden, the individual interview method provided a safe space for sharing without fear of being judged. Similarly, teachers do not share same views in relation to communicating to students openly on issues involving sex hence I was able to get individual views.

2.4.4 Inspection of documents (school curricula)

In order to be able to critique the nature of information that the adolescent girls are obtaining at school it was important to for me to scrutinize the content of its curriculum. In so doing I was able to determine whether it is comprehensive enough through determining whether it provides information that could help adolescent girls to delay the start of their sexual life while at the same time equipping them with effective tools to assist them in decision making should they still nevertheless want to do so. That is, does the curriculum give them enough information to enable them to protect themselves against sexually transmitted diseases like HIV/AIDS and unplanned pregnancies? This question could only be answered through an analysis of the curriculum.

2.5 Limitation of the study

The study was based in Maseru and the schools visited were around the city. The parents interviewed were from an area called Khubetsoana which is just a few kilometres from town. The findings of the research therefore may not reflect the entire situation in relation to SRHR education and services for adolescent girls in Lesotho. However since the research took place within the capital city it also gives some idea of the situation outside the city and in the districts because in most cases development usually starts from the city and then goes beyond it and into the districts. It is worth mentioning here that in paragraph 32 of its Concluding Observations to Lesotho the Committee on CEDAW stated in relation to health, that it was

very concerned with the women's limited access to quality SRH services especially in the rural and remote areas.[8]

2.6 Conclusion

The choice of methodological frameworks in this research was very helpful because I was able to get information on barriers to the enjoyment of SRHR for adolescent girls. The next chapter covers the findings in relation to the nature of education that adolescent girls receive from various stakeholders to determine whether it is comprehensive enough to enable them to make informed decisions concerning their health. Accordingly the role of the government, the schools and the parents or guardians will be scrutinized.

[8] The situation in the rural areas is far worse in terms of both education and services on SRH. In 2014 I employed a housemaid who informed me that she ended up HIV positive just because there was a shortage of condoms in the clinic near her village. Even though she suspected that her husband could be HIV positive, she had to give in and have intercourse with him without a condom.

CHAPTER THREE

3.0 RESEARCH FINDINGS ON THE QUALITY AND DELIVERY OF COMPREHENSIVE SEXUALITY EDUCATION (CSE) TO ADOLESCENT GIRLS

3.1 Introduction

This chapter comprises the findings on the nature of information that adolescent girls are receiving whether in schools, at home or through other government institutions or independent organizations. In particular it critiques the content of the curriculum on sexuality education and considers the implementation strategies put in place to ensure that adolescents obtain Comprehensive Sexuality Education (CSE) in Lesotho.

3.2 Education on SRHRs in Lesotho

3.2.1 An overview of the Life Skills curricula in primary and secondary schools on sexuality education in Lesotho

According to Edward (2013), a curriculum refers to the means and materials with which the students will interact for the purpose of achieving identified education outcomes. Accordingly the reason behind including sexuality education in the school curriculum is so that it can reach almost every child in Lesotho as issues of SRH are critical to the wellbeing and healthy development of every child. In Lesotho basic or primary education is free and compulsory in public schools in accordance with section 3(a) of the Education Act, 2010. This means that there is a good chance that the curriculum on sexuality education can reach many young people across the country while they are still young. At secondary and high school level education is not free but the government has tried to subsidize fees and generally the majority of the children are able to continue schooling after their primary school education.

Sexuality education in Lesotho was introduced into primary and secondary schools in 2006 under the auspices of Life Skills. According to the Curriculum Development Officer at the National Curriculum Development Centre (NCDC), Life Skills was introduced into primary and secondary school levels in response to the HIV/AIDS pandemic in Lesotho to teach young people about the virus and how they could protect themselves whilst also touching on other life skills issues like healthy relationships, human rights, drug abuse and gender. In

2012 however the curriculum was revised upon the realization that it was failing to assist young people on health and social issues. It appeared that young people were becoming infected with STIs more than ever before. The key concerns with the old curriculum were basically twofold. In the first place it appeared that it was too shallow in content as most of the topics were not covered comprehensively. Secondly the implementation of the curriculum in schools remained a huge challenge and it was believed this was caused by the fact that the subject was not compulsory and examinable. The Curriculum Development Officer expressed this as follows:

> 'Stakeholders or the agents such as the teachers and principals were not convinced on the relevance of Life Skills as a subject or the need for its incorporation in the curriculum and saw it as a waste of time.'[9]

According to the views of the lecturer at the National University of Lesotho (NUL) who has represented the university since 2009 in relation to matters related to the Life Skills subject at the NCDC, one of the greatest challenges that was then facing Life Skills as a subject related mostly to its implementation over and above the issue of its shallow content:

> 'The ministry wanted ordinary teachers to teach this subject as an independent course over and above the workload they already had. For example, English and Geography plus Life Skills as a third subject and this became a challenge as there were no resources hence it would be taught after school or in morning hours by those willing or passionate enough. In some schools it was taught by the principal who you find would be very busy and often absent from school hence it was there in the time-table but not taught' (Lecturer at NUL).[10]

Lesotho introduced the new curriculum at primary school level and referred to it as the Integrated Primary Curriculum in 2013 which was developed and introduced in accordance with the Curriculum and Assessment Policy of 2009. The curriculum sought to impart skills that enable the learners to face the challenges of the modern world we live in, whilst at the same time upholding the fundamental values and uniqueness of Basotho culture and society. In this way the curriculum intends to strike a balance between these two competing claims which could be a very difficult exercise considering that culture should be dynamic and evolve with the changing times. The primary school curriculum has since been in pilot testing in 70 schools from 2013 and this year the pilot is at Grade 7 and will be rolled-out to the rest

[9] Interview held at Maseru at the National Curriculum Development Centre on 23 October 2015.
[10] Interview held in Roma at the National University of Lesotho on 5 February 2016.

of the schools in 2017. This means that by 2017 all schools will be expected to be teaching this new curriculum.

For Grades 1 to 4 the curriculum is divided into Units and some components of sexuality education can be traced to Unit One and Two referred to as Knowing Oneself and Relating With Others and My health and Safety Unit, respectively. For Grades 5 to 7 the curriculum is divided into various learning areas and sexuality education is found in the Personal Spiritual and Social Learning Area (PSS).

At the primary school level sexuality education is referred to as Life Skills, while at secondary school level it is referred to as Life Skills Based Sexuality Education (LBSE). In Grade 7, Life Skills is an independent learning area that is taught and assessed independently unlike in the lower streams, but generally Life Skills is said to be compulsory at the primary school level as it forms part of the integrated curriculum. At the secondary school level LBSE will be a stand-alone subject with similar status to other courses or subjects. In 2015 the Form A curriculum was in the pilot phase in 100 schools where 100 teachers from these schools were trained in the curriculum and it is supposed to be rolled out to the rest of the schools across the country so that the Form B curriculum follows the next year following the same procedure until the Form C level is piloted in 2017. The high school curriculum on sexuality education however at this stage has not yet been developed.

Consequently in this study one of my greatest areas of concern is finding out whether the content of the revised curriculum is comprehensive enough to promote healthy decision making among adolescent girls and how the Ministry of Education has planned to tackle the problems that were identified in the earlier curriculum such as poor implementation to ensure sustainability of the curriculum in schools and effective knowledge of sexuality education amongst adolescent girls.

3.3 Analysis of the revised curricula on sexuality education at primary and secondary school levels

3.3.1 The presumed age of the adolescent as the standard for determining the content of sexuality education

Generally the curricula at all levels is divided into key thematic areas, like: knowing oneself and relating to others, human rights, gender norms and equality, sexual and reproductive health rights, HIV/AIDS and STIs as well as drugs, alcohol and substance abuse. These are further categorised into: learning outcomes, concepts, skill, values, attitudes, suggested learning experiences, method of assessment and teaching learning resources. However, the learning outcomes in each theme gives a general idea of the content each learner is expected to gain at the end of the lessons on the theme. The dilemma that becomes apparent while perusing the expected learning outcomes of the syllabi from Grades 4 to 7[11] (Appendix 1) is finding out what it means to give a child comprehensive information which will build her life skills as well as enable them to make informed choices in relation to issues of sex.

The learning outcomes on the theme of SRH for example from Grades 4 to 7 gives the impression that the information is purely abstinence based. One would expect that as the syllabus progressed through the higher Grades its content would include information on contraceptives in a clear and unambiguous manner. For example, the Grade 6 syllabus which asks learners to describe the consequences of engaging in unprotected sex and the consequences of pregnancy for the teenage mother and how it can be prevented, only goes further in the syllabus to show the negative aspects of engaging in unprotected sex and indicates that the learners must learn refusal mechanisms and exercise self-control as values and attitudes to ensure abstinence. Nowhere does it mention contraceptives and condoms except to link avoiding unprotected sex with detailed information on abstinence. In Grade 7, while there is still that ambiguity, there is at least mention of condoms and contraceptives which is an improvement because they were also omitted in the previous Grade 7 syllabus. It goes even further to advise the teacher to invite an expert speaker from the health sector to talk about the pros and cons of using contraceptives and condoms.

[11] The average age of a child in primary school ranges from 6 years to 12 years old. That is, from Grades 1 to 7, the ages are 6, 7, 8, 9, 10, 11 and 12 years, respectively, which means that the content is developed in accordance with this expectation.

Therefore while there is the need to encourage delaying the commencement of sexual activity in children and to promote abstinence at all costs, it is equally important to balance this information by giving them sufficient information about contraception, as it is possible that not everyone will abstain. According to Jones and Movahed (2008), abstinence-only programmes are fatal for young people as they are not only ineffective in causing them to remain abstinent, but they also tend to misinform them by dwelling on the need to avoid pregnancy and sexually transmitted diseases while banning discussions on contraceptives or permitting them only to show how ineffective contraceptives are. CSE generally emphasizes the benefits of abstinence while also teaching about contraception and disease-prevention methods, including condom and contraceptive use. On the other hand, abstinence-only programs only focus on teaching abstinence from all sexual activity as the only appropriate option for unmarried people and little or no information is provided on the use of contraception for the prevention of STIs and unintended pregnancies (Collins and Alagiri, 2002). So whereas comprehensive sexuality education acknowledges that many teenagers will become sexually active, abstinence-only teachings do not acknowledge that many teenagers will become sexually active (Collins and Alagiri, 2002).

Furthermore, the respondents from both UNESCO and NCDC indicated that in determining what content is to be taught in what year, the standard age of a child in each year was the guiding tool. Therefore the question of what constitutes age appropriate information coupled with using age as the only criteria for determining the content poses a great challenge. Section 11(6) of the CPWA provides that every child has a right to age-appropriate SRH information and education. This means that the content of the school curriculum is set in accordance with the age of the child, meaning that it is assumed that every child in Grade 1 is six years old and every child in Grade 7 is twelve years old. However this ideal situation in relation to age prescriptions per grade in reality does not hold. In almost all the focus group discussions held with the students, not all were within the expected age limits for the grades they were in. In each group some were beyond the expected age limits, especially in Grades 5 to 7. This means that there is a risk of under-informing them when it comes to the content of sexuality education that is incorporated for these grades as they would have envisaged that every adolescent fits within the ideal age for that particular grade. As pointed out by some of the teachers, some of the contributing factors to having different age groups in a particular grade include: starting school late, repeating a grade or dropping out of school due to

pregnancy or marriage as well as being orphaned and having the responsibility of taking care of the family in child-headed families.

This stance needs to be assessed against the provisions of relevant legislation and human rights instruments. Part II of the CPWA provides for the fundamental principles guiding children's rights under the Act and these are the best interest of the child (section 4) and the evolving capacity of the child (section 5). These principles have their roots in the Convention on the Rights of the Child (CRC) which provides for the best interests of the child (article 3) and article 5 which states that the evolving capacity of the child shall be of paramount consideration in matters concerning a child. General Recommendation No. 4 of the Committee on CRC has stated that it is in the best interest of the child to have appropriate information in relation to health issues. Therefore considering age as the only standard in fixing the content of the curriculum could be very misleading as age does not necessarily symbolize maturity for most children. The criteria must therefore be flexible enough to cater for other principles in order to guarantee what is in the best interest of the child.

In Lesotho sexuality education starts from Grade 4 because it is assumed that a child in this grade will be 9 years old and have more understanding about these issues. This is very misleading because a person's sexuality is part of them from the moment they are born. Even children at nursery school are already curious about their bodies and they must be oriented as early as possible and not wait for a specific age. However the content could be deepened as the child grows up. In this way the teachers can focus on the individual needs of the child in addition to their age and determine what is appropriate for the child and at what level. Considering age on its own can therefore be very misleading and counter-productive. It is accordingly not surprising why the curriculum at primary school level tends to insist on abstinence since culturally such children are regarded as being too young to be taught about sex or anything sexual or to even engage in sexual activities. Yet it is a well-known fact that sometimes when the children play house one of them plays mother and the other father and sometimes they play sex. One parent even asked me whether there are any chances of HIV infection in such cases. Giving serious consideration to the level of maturity of a child is a very helpful indicator in designing a syllabus because relevant information and appropriate guidance can be given timeously. This explains the reason why culturally in order to determine whether a girl was ready for marriage the criterion was usually her level of maturity in terms of whether she had reached puberty and not her age. She was then married

off as it was presumed that any delay meant her running the risk of an unplanned pregnancy outside wedlock which would bring disgrace upon her family.

3.3.2 The evolving capacities of the adolescent as an additional standard for determining the content of sexuality education

The International Planned Parenthood Federation (2011) defines evolving capacity as:

> 'a concept recognizing that young people, as individuals, gradually develop the ability to take full responsibility for their actions and decisions. This happens at a different pace for different young people. In practice this means looking at the capacity of young people rather than their age when trying to strike a balance between protection and autonomy. Therefore it is necessary to approach young people's sexual rights in a progressive way, respecting their diversities and ensuring they are both empowered to exercise their rights on their behalf while also being protected and guided with their best interests.'

It is not clear how the curriculum has taken the principle of evolving capacity of adolescents into consideration. Incorporating sexuality education into the school curriculum means it may be taught in different slots for different grades, for example allowing a Grade 5 pupil to attend a Grade 7 session considering their level of maturity, may be difficult if not impossible. This is also further complicated by the fact that the curriculum is examinable which means the learner is likely to be confused. The developers of the curriculum were very inclined to make the curriculum compulsory and examinable in order to ensure implementation without considering the fact that in some instances the learners may be prejudiced. This is because ultimately the concern is not on assessment but on building the life skills of the concerned adolescents. Hence a balancing act must be done to also take into account the pace of each child for best results.

A closer look in the secondary school level syllabus on LBSE reveals something very different (Appendix 2). The themes are more detailed with information both in relation to abstinence and other available options such as family planning. It is stated in very clear terms that the adolescents have SRHRs which include the right to access contraceptives, the right to privacy and the right to life which includes the right to be protected from harm. There is mention of abortion, sexual orientation (making specific reference to transgendered people) and a clear link is drawn between abuse of alcohol, drugs and substances and the negative impact on SRHRs. The secondary curriculum has tried as much as possible to balance the

information towards ensuring delaying sexual debut with sufficient information on condoms and general contraceptive use for those who may already be engaging in sexual activities or who may be in future. However there seems to be a huge gap between the information that the learners are getting at the primary school level with that provided at secondary school level from Form A. The information on contraceptives and SRHR is very detailed at form A and even goes further to cover issues such as on abortion. Despite the illegality of abortion in the country adolescents need awareness raising on the health consequences of unsafe abortion that appears to be so common in the country. They should be made aware of the existence of post abortion care services available in clinics to reduce adverse effects of unsafe abortion.

The gap between the Grade 7 and the Form A curriculum presupposes that there is a huge age difference between the two. According to a Form A teacher at Lesotho High School, some of the topics ought to have been introduced in Grade 7 so that the Form A curriculum just builds up on the foundation already established instead of appearing as a whole new subject altogether. For example he stated that contraceptives, especially condom use, ought to be introduced in primary school in more detail and before many children become sexually active. However the respondents behind the development of the curriculum stated that talking to the children about these issues in more detail at primary school may encourage them to explore their sexuality unlike at the secondary school level which poses a difficult time for adolescents. They stated therefore that it is at the secondary school level when adolescents need this information more than ever due to the fact that they are at in the teenage years of their life and in a new school environment.

The risk of over-informing the child leading to further confusion or giving the child information too late becomes inevitable. Furthermore issues such as sexual orientation are also missing at primary school level, yet some children may already be inquisitive about their identities at this level and may already be suffering discrimination because of their sexual orientation. For sexuality education to be effective it is better to introduce it while the children are still young rather than wait until they are at risk. For example the secondary school syllabi only mentions the demonstration of condom use as late as Form C, whereas I was informed that primary school students in Grades 6 and 7 are already carrying around condoms. If they are using them, one wonders where they received information on how to correctly use them.

In these modern days young people are becoming sexually mature and active at an increasingly earlier age, yet they are also marrying later, thereby extending the period of time from sexual maturity until marriage (UNESCO, 2011). There is a common misconception that young people are not, or should not, be sexual beings with the exception of certain groups, such as married young people or young people above a certain age, but sexuality is a central aspect of being human during all phases of every person's life. Accordingly, all young people are sexual beings whether or not they are sexually active. Sexuality is a central part of being human for young people of all ages across the world (International Planned Parenthood Federation, 2011). It is therefore incorrect to think that sex education is only necessary for children approaching puberty or during a particular age because a person's sexuality is with them from birth to death. This means that the need for knowledge has to continuously evolve with a child's age and capacity, especially because new information about sexuality is being found all the time (Darvill and Powell, 1995).

It has been argued that critics of early marriage are hypocritical for promoting promiscuity through sex education and reproductive health while condemning early marriage (Bunting, 2005). Whereas marriage brings with it certain undesired expectations like expecting a wife (in this case a child) to drop out of school in order to have children which she must raise and care for whilst she has not properly matured physically and mentally to do so, sexuality education merely highlights that marriage is not a solution for children who may be sexually active due to the adverse effects it has on their health and overall development. Acknowledging that one of the primary reasons for engaging in consensual sexual intercourse may be the pleasure it brings is the starting point rather than seeing sexual intercourse as mainly for procreation. If the former were the case I guess it would not be much of an issue if children married each other but using contraceptives as there would be no procreation and other societal expectations that come with being a wife. In that case both can continue with their lives provided they have the means to sustain their livelihoods. This is because if the girl is sexually active it does not mean that she will stop having sex just because she has been told to abstain but instead not giving her information on contraceptives puts her life at risk which is why she needs skills to protect herself whether or not she is married. Unfortunately the problem of intergenerational sex will still persist whether or not a child is married but if she has the right skills to protect herself, the risks involved can be minimized. Therefore in a HIV-stricken country like Lesotho failure to introduce and implement CSE by taking into account both the age *and* evolving capacities could prove fatal for these young people.

The primary school syllabus has tried to include the issues around violence in a broad way under three themes of gender, human rights and sexual and reproductive rights. It makes reference to gender based violence, sexual violence, trafficking in persons, homophobia (though it is silent on sexual orientation) and even child marriages. It also promotes a discussion on where young people can report violence so that perpetrators can be apprehended. However the syllabus omits relevant information that is critical to their health especially in the event of sexual abuse. Reporting a sexual offence is not only important to be able to apprehend the perpetrator but also for purposes of timeously accessing medication like post-exposure prophylaxis to prevent HIV transmission or emergency contraception in case of an unwanted pregnancy for the victim provided they are taken within 72 hours. If all this information is provided, it is likely to induce the girls who are victims of these crimes to report due to the potential health benefits. More interestingly the syllabus at primary level, whilst mentioning offences that are criminal in nature, makes absolutely no mention of sexual harassment within the school environment yet it is taking place and there are generally no sexual harassment policies guiding either the learners or the school on how to handle this problem. When it does occur, the perpetrator usually escapes punishment. The curriculum presented a good platform for raising awareness of this problem at all school levels. However, it is only as late as in Form C that the syllabus at the secondary school level mentions sexual harassment at school, at home or in the community for the first time under the human rights theme.

It is very crucial to teach adolescent girls about sexual harm because they are disproportionately affected by sexual violence since it impacts so negatively on their sexual health. Unfortunately, the curriculum tends to discuss these issues in a stereotypical manner which assumes that children will always be helpless victims of sexual harm. While it is good to empower adolescent girls on these issues, emphasizing only the negative aspects without also considering scenarios in which, e.g., the girl initiates or consents to having sex is disempowering and does not help these girls. Sooner or later they will learn on their own the positive aspects of sex like sexual pleasure and when that happens they are unlikely to be equipped with sufficient information to protect themselves.

3.3.3 Linking rights, gender and sexuality in the curriculum

Sexuality education is mainly a discussion about gender, sexuality and rights. These components should come out without difficulty from the content of the curriculum. It should

be clear from the curriculum on sexuality education that adolescents have the right to attain the highest attainable standard of health as in accordance with the article 24 of the CRC which includes the right to receive comprehensive information and services such as family planning services where they have freely consented to sexual intercourse. This gives the adolescents certain power that enables them to possess negotiating skills and ensures that every sexual encounter is planned rather than accidental.

> 'Unfortunately, the first time many young people actually think about whether they want to be sexually active is when they are sexually aroused and have to make a decision then and there! In this situations sex "just happens", without planning. This is one reason why so many young people do not practise safe sex the first time they have sex' (Darvill and Powell, 1995).

One of the essential CSE components is sexual rights and sexual citizenship which primarily includes adopting a rights based approach to sexual and reproductive health and these encompass choice, protection, negotiation skills, consent and the right to have sex when one feels ready as well as the right to freely express and explore one's sexuality in a safe, healthy and pleasurable way (International Planned Parenthood Federation, 2010). The secondary school curriculum on the other hand has attempted to adopt a rights based approach to SRH by interrogating various SRHRs that allow adolescents to lead health lives.

Most of the adolescents with whom I engaged in the focus group discussions were surprised when I mentioned that adolescents have SRHRs as they had never before heard of such rights and wanted me to explain what they were. Soon after our discussion they understood and agreed that these rights are indeed important and must be embraced. According to the UNESCO respondent, when the primary school curriculum on sexuality education was developed, the plan was to have it as a stand-alone subject throughout the grades. Unfortunately the NCDC had already developed an integrated curriculum which was soon to be piloted. The new curriculum eliminated independent subjects but combined them under thematic areas as earlier stated. This meant they had to improvise and make decisions on what content to include in or exclude from the curriculum in order to fit it into the integrated curriculum as otherwise it would be too bulky. Consequently this may have watered down some of the key issues of sexuality education at the primary school level. However it is not clear why the content of the Grade 7 syllabus is not as strong as expected in view of the fact that it will be an independent learning area that will be taught and assessed independently.

Finally, it is a bit worrying that under the syllabi at both primary and secondary school level, the theme on gender has failed to make or establish a link between gender and sexuality even though it is simply impossible to think about sexuality or address problems on sexuality without making reference to gender. The only hint of this link can be traced to a reference in the Form A syllabus that mentions gender identity and sexual orientation under these themes. Under these concepts the syllabi get their learners to interrogate what it means for a person to be a girl, boy or a transgendered individual in his or her community. In this manner the syllabus does indeed recognize diversity in sexuality. In the rest of the grades, however, gender has been depicted in a stereotypical way of being either boy or girl without considering the possible reality that there are people in our communities who are intersex or who identify as either gays or lesbians but whose identities have been stolen in the mist of the social construction of gender. The fact is that gender informs sexuality and this has not been explained. Therefore, it becomes a futile exercise to try and bring solutions to problems about sexuality without understanding the role the social construction of gender has played. Ultimately, it is futile to talk about gender without sexuality and vice versa. In the socialization process one is assigned a gender which brings with it associated gender roles, then society further ascribes one a sexuality depending on whether one is labelled a man or woman, boy or girl. In its broadest definition, sexuality also refers to socialization (Tamale, 2011).

The main reason why a case is made for CSE that is mainstreamed in the school curriculum where boys and girls equally benefit becomes apparent even though at the end the girls are the ones who will benefit the most. As long as the information is delivered in a correct and satisfactory manner there is no need for a specific curriculum addressing the specific needs of girl's sexuality independently from the boy's sexuality because the two cannot be understood separately. In the same manner it is equally difficult or impossible to attempt to change one without the other as they are binaries constructed within societies in which they live. The social construction of sexuality gives boys sexual power over girls and renders the latter passive. The classroom presents a good platform to deconstruct the myths on female sexuality which ultimately renders them victims of sexual violence and this can be a perfect place to target the boys while they are still young before actually adapting to these stereotypes. For example:

> ‘Societies that construct the institution of marriage as the only legitimate venue for sexual intimacy de-legitimize other choices of many women actually make about their sexual lives, irrespective of whether or not such sexual activity outside marriage is carried out in socially respectable way. For instance, a woman who chooses to cohabit with a male partner without marriage may be subjected to disparaging treatment by her community, and face graver risks than her partner because of the association between female sexual behaviour and female honor, and by extension the honor of her family and community in relation to the rest of the society’ (Tambiah, 1995).

This does not mean that the woman’s troubles in relation to sexuality are solved once she is married. A woman within marriage may continue to lack the capacity or power to negotiate sexual activity including suggesting a means for safe sex or use of preventive methods like a condom. Any attempts to do this may be defeated by violence from her spouse and in other extreme cases, women are subjected to marital rape which they endure without any legal recourse[12] simply because it is usually presumed, especially in the African context, that a man has automatic rights to sexual activity with his wife by virtue of marriage.[13] It is only through the re-socialization of the up-coming generation and with the help of parents and teachers that these stereotypes can be dismantled.

Therefore, whereas there have been significant improvements in the sexuality education curriculum since it was first introduced within the subject of Life Skills, it seems there is still much that still needs to be done, especially at the primary school level. However, there is a lot that the revised curriculum can achieve in preventing unwanted pregnancies and protecting young people from STIs like HIV provided it is implemented by well trained and supported educators as they will be able to detect loopholes that go beyond the limits of the curriculum. This is because at the end of the day, the curriculum is nothing but a guideline and without effective implementation it becomes a useless tool. Ultimately implementation is what matters because while the curriculum could be flawless, without effective implementation it will remain worthless. The sexuality education syllabus needs to appreciate, recognise and harness the potential of teachers who remain trusted sources of

[12] In some countries the law does not recognize marital rape. However even in countries like Lesotho where the Sexual Offences Act, 2003 explicitly criminalizes marital rape, this law in most cases does not benefit women. While some may not be aware of the existence of such a law, others may not be willing to sue their husbands and drag their family name through the mud. In some cases the husband is the sole breadwinner, which means that his family will go hungry if he is put in jail and he stops working.

[13] The fact that a husband has paid the bride price for his wife when he marries her is usually interpreted to mean that she becomes his property and that he has the right to exercise all control and power over her.

knowledge and skills in all education systems. They are a highly valued resource in the education sector's response to AIDS (UNESCO, 2009).

3.4 Barriers against effective implementation of the revised curriculum in schools

3.4.1 Lack of specific criteria for the teachers to implement the subject

I had an opportunity to communicate with various teachers who are already teaching the subject of Life Skills at the primary and secondary school level. At primary school level if a teacher is allocated to teach a certain grade then they are expected to teach everything in relation to that grade. At the secondary school level, however, the criteria as to who is to teach Life Skills is not very clear. In some schools it is a class teacher of a particular class, in other classes it is any teacher who has interest in Life Skills or is thought to relate well with the students. As has been illustrated above, this has caused serious implementation challenges. For example, in some schools Life Skills was not offered as a subject mainly because of the lack of human resources as there was no teacher willing to take on the extra-work load of teaching the subject. At St James High School this was exactly what happened. The subject has never been offered there due to a lack of human resources as no teacher is willing to take it. As a result, the school is relying on out of school interventions by inviting organizations such as Kick for Life to assist and this depends on the willingness and availability of funding within the organisation. The principal therefore stated that if the government were to provide teachers for the subject, they would definitely offer the subject in the future.

The St. James High School principal stated further that the only time she would ever talk about life skills issues herself would perhaps be during, say, a class on Literature if they were studying a text in which a girl has an unplanned pregnancy or if a student falls pregnant at school. In such cases she said she would reprimand the students especially the girls and tell them that such are the consequences of not listening to their elders who urge them to abstain and stay clear of boys at all costs. At Mmabathoana High School the principal stated that she never understood what the Life Skills curriculum was about and therefore that they never offered it. She said they used to hold sessions with students once in a while when they would talk to them about how to conduct themselves and what is expected of them. The girls would be told of the advantages of abstinence. The sessions were carried out in groups in which

male teachers would talk to male students and female teachers to female students and these would usually happen following some 'strange occurrence' such as where a girl has fallen pregnant. However she said there are chances that this year it will be offered as their school is one of the 100 schools that are piloting the secondary school curriculum on Life Skills. She stated that they selected one teacher who has always had interest in building the students' life skills over the years and who has a good relationship with students. At Lesotho High School Life skills is taught by class teachers.

The government and the persons behind the introduction of CSE need to consider the fact that it is not every teacher who is passionate and interested in Life Skills as they seem to assume. When a Form A teacher at Lesotho High School was informed that the revised secondary school curriculum that was being piloted required teachers to talk openly about abstinence and contraceptive use as one of the fundamental sexual reproductive rights of adolescents, including the fact that ultimately adolescents have a choice whether or not to have sexual intercourse, he said that he did not agree with the content. He added that personally, he did not wish to attend any training for such a course.

> 'I would not want to be a life skills teacher because I already have too much on my plate. I really have no interest on it whatsoever because the course it is also not even taken seriously in the system' (Form A Teacher).[14]

The same views were further supported by the two Grade 7 teachers from Mejametalana Primary School who both said they did not wish to attend any training on sexuality education and that if it possible they wished to be excused, unless that means losing their jobs. They clearly stated that they would have to be strong and compelling reasons for them to do so, otherwise they said they were not interested as they preferred to teach their existing subjects. What will be the result of forcing every teacher to teach life skills?

An approach adopted by the National University of Lesotho (NUL) may actually be a step in the right direction even though respondents like the UNESCO officer and the lecturer who will be teaching the course later this year seem to think it is a set-back. Whereas at the Lesotho College of Education, the subject of Life Skills Education is compulsory for all trainee teachers, at NUL it has turned out quite differently. The course will only be offered in

[14] Interview held in Maseru at Lesotho High School on 26 October 2015.

fourth year as an elective and as a semester course starting in the forthcoming academic year for 2016/2017 in August. I think this can actually be a positive move. Making it an elective means that we are sure that every trainee teacher who opts for the course has a passion for it and will be in the position to implement more effectively than someone who is compelled to do train for the course and teach it. The outcomes are likely to differ.

The other Form A and B teachers at Lesotho High School stated that the school is one of the 100 pilot schools and that she has attended several government workshops on sexuality education. She is also currently enrolled with an online course on CSE which aims to equip teachers with a comprehensive knowledge of the course so that they can effectively implement the new curriculum which is very extensive and requires understanding. The teacher informed me that she ended up being the only one on the training course because she had displayed an interest in the subject when it was first introduced and therefore had a greater opportunity to attend more workshops on Life Skills education than other teachers. Lack of a clear guideline on what category of teachers are expected to teach the Life Skills course will result in a shortage of teachers for this subject because at the end of the day teachers will not be forced to teach the course if they do not want to. Most importantly such an approach will not do justice to the subject, the teachers or the students.

3.4.2 Implications of the cultural and religious convictions of teachers for the implementation of the curriculum

It appeared from the interviews that most teachers and even some schools were not too keen on the revised curriculum that requires the schools and teachers to accept that children and adolescents have SRHR which include receiving information on family planning, accessing family planning services and even talking openly about masturbation and the rights of sexual minorities. The content clearly contradicts the culture and most importantly the religion of the churches like the Roman Catholic Church. In one Roman Catholic Church school one of the Life Skills teachers who is also a Sister in the church explained that the school will only implement the curriculum on LBSE to the extent that it does not violate the fundamental principles and rules of the church. This means that they will not teach anything that goes beyond abstinence as it would simply mean that they would be condoning premarital sex. The UNESCO officer stated that they have developed the materials to educate or sensitize the school boards (especially in church owned schools) on CSE and stated that they will also keep negotiating with them until certain compromises can be achieved. He said that what is

essential is that the aim of the course is that the child should have complete information so that they can make their own choice; its aim is not to encourage the child to have sex. He said that this seemed to be a point that was misinterpreted.

On the other hand, upon talking to three teachers whose schools are piloting the curriculum at the secondary school level, I found that they were very confident in wanting to teach the students after a series of workshops they had attended. Even though one of the teachers teaches in the Roman Catholic school she said that for her issues of sexuality are a matter of life and death and that they determine the kind of future that a child will lead. Therefore she said she could never withhold information from her students as long as she knows it will help them. She gave the example of the fact that children are usually never taught about emergency contraception and end up carrying unplanned pregnancies to full term which may negatively impact their health, especially if they resort to backstreet abortions. She said it is her duty as a teacher to help these children and that she is prepared to do so. She further stated that early pregnancy may cause health problems to the child as her body has not fully matured and that this also accounts for the country's high maternal mortality rate. She added that if this could be avoided by giving information on abstinence and contraceptives to protect a child against unplanned pregnancy if she decides to have sex, it could really save her life. Whereas some teachers can be naturally compassionate, others need to be sensitised to the grounded realities surrounding the subject in order to fully appreciate SRH issues in the context of children.

Upon talking with teachers at the primary school level, I found that some teachers still have an attitude towards the Life Skills subject especially as far as it relates to communicating about sex with the learners. The two Grade 7 teachers that I interviewed at Mejametalana Primary School revealed that they are not comfortable teaching the course and that they do not remember the last time they taught it. One of the teachers said the major problem is that the children are already just too knowledgeable as a result of their exposure to the media to which they have limitless access and she feels that they will not respect her if she talks about such issues. She said that even when she teaches health science she does not go into great detail about the topic of reproduction and contraceptives because the learners usually giggle or get excited and do not listen. The other teacher said that Life Skills teaching is simply in conflict with her religious beliefs as a Roman Catholic and that she does not see how talking about condoms to children is necessary or helpful to them. She pointed out that adults are

also failing to use condoms and that it is therefore impossible to expect the children to do so. Of course there are many reasons why adults are failing to use condoms. One of them could be the fact that condoms were either introduced too late to them or they were introduced to them in a negative way and it is such things we wish to change with the next generation.

Generally teachers do not think it is proper to talk about contraceptives or condoms with learners at primary school level as they regard them to be too young and therefore that if they found them in possession of condoms, they would discourage them. In one example, a Grade 5 teacher was teaching about HIV/AIDS and rightfully mentioned that pupils may use condoms in order to protect themselves against STIs such as HIV. The next day she received a report in class that one of the learners while at home with the elders told them that they can also use condoms, citing her as the source and that the people were terrified. The teacher said she had to 'correct' the learner there and then in class by indicating that condoms are only for grown-ups not for children like them. This is a similar lesson to the one the Grade 6 teacher said he gives to his class. When one of the teachers at Lesotho High School was asked whether he talks about condoms and other contraceptives with students, he replied as follows:

> 'I never mention condoms because I regard them as kids and in doing so I would be crossing the boundaries. To me talking about condoms is equal to giving them permission to engage in sexual activities. If I were to find any one of them in possession of a condom I would ask two questions, "What are you doing with this? Why are you carrying it around?" I would not go further to discuss the pros and cons of using condoms because I believe they should not use them in the first place as those are for adults' (Form A male teacher).[15]

Some teachers are really willing to talk to the children about these issues but unfortunately they are still doing so in a stereotypical way as they do not understand that it is the very information that excludes contraceptive use and where to obtain such services that the CSE standard deems insufficient and even inappropriate. The Form B teacher from Lesotho High School said she is really not sure what the curriculum on Life Skills is about and that when she desires to know more about some of its issues, she consults her other female colleague who has been taking several courses on Life Skills. Therefore she said she just continues talking about things that she thinks may help the students in life. She stated further that she has never communicated about condoms or contraceptives in class though there is evidence that the students do engage in sexual activities. However she concluded by indicating that she

[15] Interview held in Maseru at Lesotho High School on 26 October 2015.

would not have a problem teaching the Life Skills subject as long as she is well trained and all the materials are available to assist her.

The principals who were interviewed at the primary school level said they support the teachers who do not talk about condom use to the learners because they said that is encouraging the use of condoms. Some said they understand that the teacher may not personally be comfortable discussing such issues as they require experts to do so, whom they are not. They said they do invite resource persons like officers from the Child and Gender Protection Unit (CGPU) to talk about child abuse and where they can report abuse or the LPPA and Kick for Life where possible.

Further, over and above these prevailing circumstances, I discovered that the girls who become pregnant in schools are expelled from school to preserve the reputation of the school. It is assumed that allowing them to continue gives an impression that others can also become pregnant and continue attending that school and that in due course almost every girl will be pregnant. If they do not leave school, it gives the impression that pregnancy is acceptable. In this way the school is able to reinforce abstinence as the only way to go. Section 11(4) of the CPWA clearly provides that pregnancy shall not be a reason for a girl child to stop attending school. The Committee on the CRC in its Concluding Observations to Lesotho in 2001 urged Lesotho (paragraph 54) to ensure that pregnant girls are permitted to continue attending school both during and after pregnancy. Unfortunately this practice is still continuing on the ground and what is worse is that the boy who may have impregnated still continues with his education as though nothing has happened because once he denies fatherhood, no one pursues him any further.

During the interview with one of the Grade 6 teachers whose school is also part of the pilot project, she said that she does talk to the children about everything including how best to protect themselves. She also indicated that since they are still young, they must try as much as possible to abstain because even the contraceptives are not 100% safe, meaning that they may still end up pregnant or catching an STI. The Grade 6 curriculum was on pilot last year and this year it will be rolled out to the rest of the schools throughout the country. I was able to interview one teacher from Sekamaneng High School who will be teaching Grade 6 this year and who also attended the training programme earlier this year which started in the Berea district. Unfortunately, the training is not specifically on the revised curriculum on Life

Skills but on the entire integrated curriculum, specifically on the new modes of assessment, planning and scheming. I was given the impression that the training during the roll-out will be mainly on Life Skills but this turned out not to be the case. This was a one week training course and the teacher said they were divided into groups and each group was assigned a different topic in the broad content of the curriculum. She said in her group they never dealt with sexuality education but she heard some mention of the subject from the other groups during their presentations. Unfortunately this appears to be the only training that the Ministry has on the revised curriculum on sexuality education at the primary school level throughout the country.

As to how the Ministry of Education intends to make the Life Skills and LBSE compulsory without or before ascertaining whether the intended teachers have the required skills to implement the curriculum remains a dilemma. Unlike at the primary school level where Life Skills is integrated in the curriculum, at secondary school level the situation is worse as it will be a stand-alone subject. In answering the question on challenges facing implementation at the secondary school level (like the issue of shortage and lack of skills of the teachers and challenges posed by culture and religion), the NCDC Curriculum Development Officer stated that it is not surprising to find a shortage of teachers to teach a particular subject in schools and it will simply not be taught in that particular year if there is no teacher. She completely pretended not to be aware of the peculiar circumstances underlying the implementation of Life Skills which make it very different from other subjects and the fact that the percentage of schools that may not be able to implement may be just too high. As far as religion and culture are concerned, she said they will just continue with the awareness programmes. But clearly this will take a while as it requires resources.

It becomes clear that the government invested in the shaping of the curriculum without a clear strategy on implementation. There is no clear training plan for the rest of the teachers and it is just impossible to expect them to implement the curriculum bearing in mind the cultural and religious convictions that they have. The question whether there is political will on the part of the government therefore becomes an issue. It seems there is no budget for training the teachers across the country yet on paper the government says it will provide in-service training for the teachers in the system. According to the Director of Teachers Service Department, within the primary education sector there are 11,167 teachers and 1,477 schools with each grade having to be assigned an independent Life Skills teacher. Similarly in

secondary education sector there are 15,367 teachers and 339 schools. She stated further that Lesotho was under pressure to introduce comprehensive sexuality education as the international community was alarmed at the high rates of new HIV infections among young people. All efforts were then invested in the development of the curriculum to try and make it comprehensive and the issue of implementation was ignored. This is most unfortunate as law reform on paper or improving people's rights on paper does not mean such efforts will be automatically translated into reality. Additional efforts must be made to equip qualified personnel to educate and inform the beneficiaries of such legal reforms. It is only once the beneficiaries are able to exercise and do exercise their rights as provided for in the improved curriculum that it will be able to be said that such legal reform has been successful.

3.4.3 Lack of a budget for capacitating the teachers on CSE

The Curriculum Development Officer informed me that unfortunately the online course with extensive training and materials for teachers on CSE at the secondary school level that is offered over and above the government training will only be free with respect to those teachers who are already representing teachers in the pilot schools. She stated that when the curriculum is rolled out to other schools, the teachers there are expected to enrol for the course at their own cost as the government does not have money to pay for every teacher. These extend to other teachers within the pilot schools who were not part of the training during the piloting of the subject. She said that it is actually to the advantage of the teachers to do the course as this will help them to get other jobs in CSE. In the meantime these are the qualified teachers who already have expertise in certain areas or fields, which means that from their point of view it is actually easy to forgo taking the course as it is demanding. This is because there is also no extra pay for taking the Life Skills course over and above the other courses that the teachers are already teaching due to a lack of resources. As has already been discussed above, if some teachers find the content of the subject so disturbing, how can the government be sure that they will be willing to use their own money to enrol for training on this course?

The training of teachers at the government's roll-out phase is roughly one weeks time. With the nature of the content and the scope of the revised curriculum at the secondary school level from A, it is almost impossible to expect that the teachers (who have hardly any background training on issues of gender, human rights and even sexuality) to understand the content and be able to pass it on to the learners. The extra online modules offered for the 100 teachers

could have been a good way to ensure that at least teachers are given a certain background, especially because most of them do not even understand their own sexuality and the course would present a good opportunity for them to unlearn most of the stereotypes that they have blindly and uncritically accepted as 'truths' and relearn in accordance with reality. Moreover since the pilot has taken only one teacher from each school it means that this is the teacher with all the knowledge and who could assist other teachers within his or her school, but what if this teacher leaves this school? At the secondary school level the LBSE will be a standalone subject but the feasibility of implementation remains a huge challenge. This is worsened by the fact that the course is online which means one must have computer literacy skills. Clearly there is insufficient political will to ensure the thorough implementation of sexuality education in Lesotho in the absence of resources allocated towards building the capacity of teacher as primary implementers of the curriculum.

3.5 The nature of information adolescent girls receive beyond the school curriculum

3.5.1 The role of the family

The interviews that I conducted with the adolescents and the parents gave me an insight into the nature of relationship that exists between parents and their children especially in relation to sexuality and reproduction issues. The family is the fundamental institution of each and every society and nation. Article 23(1) of the ICCPR provides that the family is the natural and fundamental group unit of the society and is entitled to protection by society and the state. When a child is born, he or she learns about almost everything from this unit whether it is walking, talking or any other behaviour and this is further built up by the society in which he or she grows. Accordingly depending on whether one is born male or female certain roles are ascribed to each sex depending on whether they are born male or female so that they grow up to be men or women who portray the traits that come with each gender. The ultimate goal of raising a boy or a girl is so that they eventually marry and have children whom they will also socialize according to how they were brought up. This then becomes a tradition that is passed down from one generation to the next. Not only does this guarantee certainty but it also helps maintain the social order.

On the ground while talking to the parents about the relationship they have with their children, the majority were very emotional and frustrated stating that the children these days

were just way too fast, that they think they know it all and do not listen. A single mother who was in her early 60s claimed:

> 'While my daughters were growing up, I had repeatedly told them not to eat things like eggs and animal intestines but they never listened but during my time when we were told that by our elders, we always obeyed. You could hardly hear any stories in my village of a girl becoming pregnant outside of the wedlock because the girls back then respected themselves and eventually got married. But these days it is very common for most households to have unmarried girl children who also have children of their own.'[16]

Whereas adolescent girls in the past hardly went to school or even completed primary school, in recent years it is very rare to have children who have not completed basic education. Hence unlike in the past, they now have various ways of acquiring information such that even in class they could have been informed that proteins are body building foods and they must eat them as their bodies are still growing. To just tell them to stop eating eggs seems unfair on their part, yet in the past, the parents and elders used to be their only source of information so they would just give false explanations. What is surprising is the fact that these double standards did not apply to boys. If the rationale was that such foods cause the girls' bodies to mature faster than their age, then it ought to equally apply to the boys. The mother said she decided to leave them because she was not comfortable discussing the issue further. The topic around sex is so sensitive that she could not bring herself to furnish reasons because sooner or later it would lead to talking about sex which was culturally unacceptable in the context of children who are unmarried or not preparing to be married. The grip that culture has on the grown-ups is so tight many find it hard to go against it:

> 'It is not easy, that is not the way I was raised and my duty as a mother was to follow similar principles so that my children could grow up like other children' (The mother of three girls).[17]

Generally the way in which the girl child is brought up is different from how the boy child is brought up. Girls are not expected to know much about sexual issues because this is a sign that they are good and well behaved. Their male counterparts, however, are given some liberty to explore these matters and this is a sign of their manhood. Unfortunately this expression of liberty is not accompanied by appropriate discipline or guidance and it is shared

[16] Interview conducted in Maseru at Khubetsoana Ha Rankhala on 5 January 2016.
[17] Interview held in Maseru at Khubetsoana Ha Rankhala village on 5 January 2016.

in a very stereotypical manner that undermines female sexuality. Since these boys are expected to explore sexually with the boys at the end, they could be given proper guidance and education that girls are also sexual beings and that they need to be protected in the same way that boys need protection. Instead young men who do not conform to the norms of sexual supremacy are often ridiculed and their masculinity is brought into question. This is why today the majority of HIV infected women are from monogamous relationships, often with their first sexual partner and in Sub-Saharan Africa more women than men are infected with HIV (Ampofo and Boateng, 2011).

In most cases I found that the mothers were still the ones trusted and vested with the duty to socialize the children due to their reproductive role because it was assumed that it is her natural role. Moreover in some of the families the mothers raised the children single-handedly as the fathers were working on the South African mines. I had an opportunity to interview three male respondents who have had the experience of raising their children because in one case the mother was working full-time and the father was unemployed; in another case the mother had passed on and the grandfather was raising the children and in the other the mother was attending school in the Republic of South Africa full time. Only one father said he would be free to talk about everything with his children. His daughter was only six years old and his son was two. He said he listens to the radio a lot and feels that his children need to know about everything and that he has tried to build a very strong bond with them so that they can also open up to him.

The grandfather said he can never be in a position to talk to the children about issues relating to sexuality because that is not the way he was raised and therefore it would be very uncomfortable. Since the grandmother had also passed on he said he would rather ask female relatives to intervene because it is more natural for them to discuss such issues than for a man. However he said it would do the children much good if they were taught about these issues in more detail at school. In the last case the father said he used to be very close to the children and talk about everything but since their mother had come back from school there was now a huge distance between them. The mother is the one who does the talking and his role is just to observe the behaviour and report to their mother if they needed to be disciplined. He also explained that since the children are now in their adolescent stage, the culture does not allow him to be very open about such matters especially in relation to the girl child. He could only step in when things got out of hand. I then asked if he was waiting for

the child to get pregnant before he would talk because by then it would certainly be too late, but he said he does tell them to focus on their studies and have a settled future first before they should start dating.

The parents, whether male or female, are not comfortable discussing contraceptives with their children and this extends to those few who are very close to their children to the point of discussing relationships. They say they feel like they are encouraging them to have sexual intercourse. In fact many parents demonstrate many fears like: they think the child is still young, talking about sex will make them wild, I will just hear from them when they are ready as they will behave differently or that if I tell them anything they will share with everyone. Unfortunately all these are major setbacks to parents helping their children. Comprehensive, age-appropriate sexuality education from both home and school has many life-long benefits. It will help prepare children for the physical and emotional changes they will experience as they grow. Consequently your children will see their bodies in a positive way, and welcome these changes as a normal part of growing up (Darvill and Powell, 1995). It does not matter about the level of education of the parents since, at the end of the day, the cultural beliefs are predominant. Children must not engage in sex and parents must do all in their power to ensure that they conform.

The adolescents who were interviewed indicated that they have never received information about contraceptives from their parents nor have they discussed relationships. In the same manner parents indicated that they are either uncomfortable talking to their children about contraceptives or that they do not see how talking about contraceptives will help their children, except to render them sexually active. Adolescent girls stated that they would never carry around condoms because should anyone especially the parents see them they would be in serious trouble. The boys also shared the same views but said that they are very clever in how they keep them so that parents do not see them but that at the end of the day it is very stressful to not have privacy. Article 10 of the African Charter on the Rights and Welfare of the Child upholds children's right to privacy subject to a reasonable level of parental supervision, but on the ground parents do not have limits, they are in total control. When the parents do talk about condoms or other contraceptives they present them in a very negative light so that the children ultimately see that they have no option but to abstain. Generally adolescents get information about sexuality from friends, relatives and the media. There are three separate incidents where the boy children were found in possession of condoms. In the

first case the boy was still in primary school and the mother found a condom in his pocket. She was so furious and took him to his school to tell the teachers that the child is sleeping around and that they must intervene. A meeting was then convened at the school for the Grade 7 learners and their parents to address the behaviour of the learners and mainly to reinforce that rushing into sex will rush them to their graves.

In the second case the son clearly told the mother not to do his laundry any more or clean his room as he said he felt mature enough to assume such responsibilities for himself. The mother nonetheless continued and one day she found condoms under the son's bed and immediately confronted him. The child was about 15 years of age then and the mother said he should stop such behaviour as he will end up with babies everywhere or catching STIs like HIV. This is very similar to what happened in the third case where the mother disclosed the fact that the behaviour of her 18 year old son is really getting out of hand. She also found condoms several times in her son's bedroom and is still worried her that her son does not want to stop this behaviour as it will reduce his chances of a better and successful future. How does the behaviour of the parents help in these cases except to bring the children negative consequences?

Some parents claimed that when their sons have reached puberty they may possibly talk about condoms to them but will also try as much as possible to ensure that they do not use them as it is not in their best interests to follow that kind of lifestyle at their age. Clearly these adolescent boys are not receiving correct information from their parents and their parents are instead actually pushing them towards engaging in risky behaviour. Parental discipline that prevents adolescents from seeking and obtaining methods of protection and information rarely prevents sexual activity altogether. This increases the health risks to the child and it is in direct conflict with the principle of the best interests of the child (Centre for Reproductive Law and Policy, 2002). As far as the girls were concerned, I encountered only two mothers who said that they had discussed the issue of condoms with their children. One said she did so mainly to encourage her child to test her HIV status so she always reminds her how the virus is transmitted. The other mother said she was exposed to contraceptives as a young girl by her friend who was a nurse and because she understands a lot about the behaviour of young women she felt that her children should know about them as they also helped her a lot. One father who used to work for the National AIDS Commission stated that he would be happy to see condoms in his daughter's room as it is a good indication that she is protecting

herself. Surprisingly, none of the parents said that they regulated what their children watched on television and parents of children who have cell phones are simply not able to regulate their use effectively. Only one parent said he told his son not to watch music programmes as they show explicit nudity but he did not give any further explanation.

The evolving capacities of the child standard becomes particularly relevant at this point as it informs the discussion concerning the conflict between the child's right to health and the parental decision making authority. The standard is particularly relevant when determining the adolescent's right to make decisions about their reproductive life because it implies that there is a point at which an adolescent should take responsibility for their own decisions (above). Accordingly adolescents who actively seek out services on contraception are acting in their best interests to prevent any potential harm that may occur should they behave in an unprotected manner. The same dilemma is faced by some adolescent girls whose parents forcibly take them to family planning services because they say that their child is already sexually active and they do not want her to become pregnant. In such instances the adolescent is not given any prior counselling including education on the methods available which would enable her to make a choice; instead the decision-making process takes place entirely between the girl's mother and the nurse. The mother will closely monitor her daughter to ensure that what was given is compatible. But how will she really know?

In some extreme cases girls are not even told that they are being taken to family planning services as it is assumed that if they were to be informed they would believe that they would not be able to fall pregnant. This is clearly being done in the best interests of mothers who want to avoid being 'humiliated' by their daughters who may fall pregnant out of wedlock. Clearly these actions violate the child's right to freedom from interference in reproductive decision making which directly violates their rights such as the right to dignity and integrity, the right to liberty and security of the child as well as their right to privacy all of which are clearly protected by the CRC. Unfortunately, in practice it is very difficult for children to exercise their rights due to the long-standing legal tradition that parents exercise their so-called rightful power and control over their children. Hence the child remains totally dependent and helpless while their parents are all-powerful and controlling. However, even though article 1 of the CRC defines a child as anyone below the age of 18, it does not recognize exclusive autonomous decision-making power on the part of the child or parent. Rather the Convention seeks to attain a balance between the decision making rights of the

adolescents and those of the parent in applying the evolving capacity of the child and the best interest of the child standards (Centre for Reproductive Law and Policy, 2002).

In the light of the above, it seems that the parents are still reluctant to open up to their children on matters relating to sexuality and reproduction due to their culture as well as their religion which dictate that discussions on sex and reproduction remain the sole domain of a married couple. Children are therefore expected to abstain at all costs and the information that they get from their parents is very inaccurate, given as it is under the false impression that they will abstain. Since we start our lives within families and our parents are of supreme importance during the early years of our childhood, it is a fact that they exercise enormous power and influence over their children within the privacy of the family (Rodman *et al.*, 1984). Accordingly parents are major key players in the realization of effective sexuality education for adolescent girls which is why we need to evaluate their practices in socializing and communicating with their children. Most of the teachers in schools are or will be parents themselves at some point in their lives and therefore it is in the home where it all begins.

3.5.2 The role of other relevant government ministries and civil society organizations

I conducted individual interviews with two respondents from the Ministry of Gender and one from Kick for Life non-governmental organisation (NGO). The former institution generally promotes women's empowerment in all fields including health and HIV and AIDS related issues through the office of the HIV/AIDS Co-ordinator and Gender Department. The latter institution empowers young people in life skills as a way to prevent HIV infections in young people and to promote HIV/AIDS testing to offer care and support for those infected.

The HIV/AIDS Co-ordinator at the Ministry of Gender indicated that there are programmes dedicated to adolescents and young people which seek to help them to avoid risky behaviour which may lead to HIV infection and to assist those who are infected and affected with the care, treatment and support of people living with HIV. She stated that most of the programmes that they carry out are dedicated towards social behavioural change as they believe it is through the change of certain attitudes and perceptions that women can achieve true equality and live in a just and healthy society. However when asked whether she encourages or educates young people and adolescents about the use of contraceptives especially condoms whenever they wish to engage in sexual intercourse, she related the following:

> ‘During empowerment forums with young people I still strongly encourage them to abstain. Preaching these foreign concepts like family planning causes resistance as these are foreign concepts to our culture. I strongly believe the indigenous ways of intervention such as encouraging abstinence is still ideal and must be emphasized. Otherwise too much advocacy on contraceptives appears as if we are saying it is okay for them to have sex, whereas having sex especially at their age is actually what puts them in health risks’ (HIV/AIDS Coordinator).[18]

Clearly there is no way in which young people are going to receive CSE if this is the attitude. Also there is a huge contradiction between what the office seeks to achieve (which is to change social attitudes and behaviour that lead to inequality and discrimination between men and women) and what the officer is saying. One of the social attitudes that should be changed here is the very belief that young people are asexual as this is one of the greatest barriers against accepting and receiving comprehensive information and services, like contraceptives and condoms. Whereas the structure maybe clear as to its mandate, it would seem that the actor in charge of implementing the mandate is not clear, thereby leading to an adverse impact on adolescents who are relying on the office to deliver accurate information. The officer also stated that they also have programmes aimed at equipping herd boys with CSE. Whereas this could have been a good initiative on the part of the government and stakeholders to ensure that those who are not attending school receive equal access to sexuality education which is mainstreamed in the school curriculum, it is doubtful whether such education will be as ‘comprehensive’ as is ideally intended. Moreover there was no mention of a similar programme for adolescent girls, for example, those who have dropped out of school for various reasons, thereby rendering them even more vulnerable.

The Co-ordinator also mentioned that there is an upcoming programme in partnership with the Ministry of Health and supported by UNAIDS which will be implemented in tertiary education institutions. This programme came about after they realized that most of the adolescents and young people are HIV negative when they join tertiary institutions but acquire the disease during their period of attendance in them. The programme will therefore offer support to the students through counselling which is intended to assist them to maintain their negative status because most students during this time are usually away from the support and guidance of their families.

[18] Interview held in Maseru at the Ministry of Gender on 1 February 2016.

Moreover the Principal Gender Officer who was interviewed stated that they often have programmes aimed at empowering adolescents in many areas including SRHR. However she said they encounter serious barriers when it comes to delivering CSE because culturally they (the programme's staff) are still expected to talk about abstinence when talking to the adolescents as it is safe and acceptable in their context. She said she remembers one time during a programme for empowering adolescent girls, who were school drop-outs, on life skills when the officer who was allocated to talk about SRH completely refused to continue saying she could not talk about sex with children. The slot was then given to a young male volunteer who did not understand the issues and kept talking about abstinence and no one intervened. There is a serious barrier to implementation in this case that is caused by the actors within the structures that are setup to promote non-discrimination and equality to all human beings. Most of the actors are told that they must run programmes on comprehensive sexuality education, yet they themselves do not understand their own sexuality, and the result is that their delivery of the programme becomes highly problematic. We therefore cannot shy away from the reality that weak institutional frameworks which do not invest in capacity building of their agents for change have a negative outcome on the reform process.

As far as Kick for Life is concerned, the focus is on building life skills in young people and promoting HIV and AIDS prevention as well as care, support and treatment for those that are infected with the virus. The organisation encourages young people to be involved in sports such as soccer and their main mobilization strategy is sports. An adolescent here is generally someone between the ages of 12 and 20. There is a counselling unit that has coaches who offer HIV education which encourages young people to find out about their HIV/AIDS status through taking a test. Those found to be HIV positive would then be referred to clinics and there are regular check-ups made with them to make sure they cope as best they can with the disease. One strategy to encouraged these young people to test their HIV status involved a campaign called Test For Your Team where they would go to various villages and mobilize young people, divide them into teams (boys in one team and girls in another). They would play various games, be given various life skills and those who were willing to be tested would be tested for HIV and the team with the most members who had agreed to be tested became the winning team. It was found that in most cases infection rates amongst the girls were higher than the boys.

Unfortunately, Kick for Life still encourages abstinence as the only way to prevent HIV and AIDS and even for those who are sexually active they encourage secondary abstinence.

> 'For life skills we touched on good relationships and good decision making while under prevention we mainly preached abstinence, though we still talked about using of condoms and how that can be done. Condom use education was only for those above 18. In most cases for those under 18 we did not talk about sex but abstinence. Sometimes we just do not go deeper because those who are not sexually active get bored' (Kick for Life officer).[19]

It is true that most of the programmes are ultimately controlled by the nature of their funding, but how, after all this effort, is the information that these adolescents are receiving is actually able to help them, considering the times in which we live? This, in the truest sense of the word, is a very serious violation of these young people's rights: they are continually being asked by the authorities to test for their HIV status, yet hardly anything is being done by these same authorities to give them the essential information they need in order to make appropriate decisions to protect themselves from becoming infected with HIV/AIDS. True, testing for their HIV status is a healthy move because they will be able to get treatment in time, but surely the numbers of those becoming infected will simply keep on growing because those who are HIV negative are so inadequately supported in the maintenance of their status because information on condom use is omitted. Since they are naturally sexual beings, they will not know what to do or how to effectively protect themselves when their first sexual encounter arrives. Also there seems to be a false assumption that adolescents should only receive information about contraceptives when they are married but by then it may be too late for such information which means the marriage can still pose a serious health risk for them. This gives the impression that once married, young people will not need information on contraceptives and this is simply not true.

3.6 Conclusion

Paragraph 7.47 of the ICPD Programme of Action provides for programmes for adolescents in areas such as family planning practice and reproductive health. In like manner, paragraph 107(e) of the Beijing Platform of Action emphasises the importance of the dissemination of information to ensure that adolescent girls have access to SRH. The findings in this chapter show that the government clearly still has a lot to do to ensure that service providers are

[19] Interview held in Maseru at Kick for Life offices on 13 January 2016.

equipped with extensive knowledge of CSE because without implementation of effective sexuality education, we cannot say that adolescent girls are actually receiving the kind of appropriate information they need to help them gain access to services related to sexual reproductive health or to acquire the skills they need to protect themselves. It is clear at this point that the outstanding barrier against the effective realization of adolescent girls' SRHRs is largely the agents of implementation who seem to lack adequate training to teach CSE to adolescents. The next chapter is an analysis on the findings in relation to the services on SRH for adolescent girls in Lesotho.

CHAPTER FOUR

4.0 RESEARCH FINDINGS ON THE NATURE AND DELIVERY OF SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES FOR ADOLESCENT GIRLS

4.1 Introduction

Efforts to improve CSE for adolescent girls must be proportional to those taken to ensure comprehensive sexuality services for this group of people. Where sexuality education is properly administered young people will be informed of various services related to their SRH and where these can be obtained at their best possible convenience. This chapter critiques the nature of the services that are that are available in Lesotho in relation to the adolescent girls' SRH as it is through access and use of these services that they can ultimately lead healthy SRH lives free from diseases and infections.

4.2 SRH services for adolescent girls in Lesotho

4.2.1 Overview of comprehensive SRH sservices for adolescents in Lesotho

Implicit in the definition of SRHRs in the ICPD Platform of Action (in terms of paragraph 7.3) is the right of all persons including adolescent girls to attain the highest standard of sexual and reproductive health which includes securing a safe and satisfying sex life. The right to the highest standard of SRH comprises access to a comprehensive package of health services including voluntary family planning, abortion (where it is not against the law), post abortion care, ante- and postnatal care, for both mother and child, and prevention and treatment for STIs, including HIV/AIDS (United Nations, 2014). What this means is that these services must be truly available to all, including marginalized and vulnerable groups who are also the groups most likely to have their reproductive health threatened (United Nations, 2014).

The Committee on CRC noted in its Concluding Observations in relation to adolescent health and HIV/AIDS in Lesotho (paragraph 45) that it is extremely concerned at the alarming high incidence and increasing prevalence of HIV/AIDS in particular amongst teenage girls and the high instance of teenage pregnancy and STIs. It further urged Lesotho to take measures, including the allocation of adequate human and financial resources to develop youth-friendly counselling care and rehabilitation services which will be accessible to them without parental

consent. There is currently no legal requirement for parental consent for children to access these services in Lesotho. The Ministry of Health and the LPPA are largely responsible for offering SRH services in the country. According to the National Adolescent Policy 2006, adolescent-focused programmes were initiated on a pilot basis in three districts in 1998, in response to evidence of poor health among adolescents. The aim was to introduce adolescent friendly services in one unit where adolescents could feel free and comfortable to share their health concerns. The major services offered in these corners include counselling on SRH, family planning and screening for STIs and treatment. Unfortunately in Maseru there is currently no adolescent corner as the one that existed in Queen Mamohato Hospital closed down in 2012 when the hospital was shut down and it to date has not been re-established despite the fact that the hospital is now functional once again. Whereas adolescent corners could have solved many problems encountered by young people, on the ground they were met with many challenges which continue to prevent them from operating effectively.

4.2.2 Access to SRH services for adolescent girls in government hospitals

The information that I obtained from the focus group discussions conducted with the adolescent girls revealed that they associated SRH services with married people or young people who are promiscuous. Therefore most of them felt they would only access these services if they were or once they were married because it is acceptable within society to do so. Almost all the adolescents interviewed did not have accurate information on what constitutes reproductive health services including accurate facts about the various methods of family planning. According to the nurse who worked in the adolescent corner in Maseru, as part of the procedure before assisting adolescents who came for services they would carry out 'health talks'. This was when they gave them information on the various services offered and life skills education. However during one-on-one consultations with nurses, specific information was given depending on the needs of each adolescent. The age group that used to access the services was mostly those from the age 13 and upwards and most of them needed prenatal related services. Those aged 10 or 11 were usually rare and in most cases they involved sexual offences.

Clearly one of the major reasons why the adolescents in the focus group discussion did not have accurate SRH information could have been attributed to the fact that there are no adolescent corners in Maseru. However the information gathered from the nurse who used to work in the corner in Maseru was not of the view that if the corner had still been in existence,

adolescents would have been able to protect themselves from unplanned pregnancies and STIs. According to her, the main aim of the adolescent corners was to prevent unplanned pregnancies in adolescent girls yet it seemed the only service that was popular then with adolescents was the antenatal service for pregnant adolescents and this was not just in Maseru. This was supported by the Adolescent Health Officer who stated that in those areas where adolescent corners were established, they encountered various challenges which were both social and financial. But the officer said that the major problem related to implementation. Young people continued to encounter unplanned pregnancies and only became aware of the corners when they wanted to access antenatal services. She stated that that was the reason why adolescent corners were failing dismally to protect and safeguard their best interests. Socially some of the corners were turned into Antiretroviral Treatment (ART) corners where people who are HIV positive could access their medication and most adolescents stopped going as they did not want to be associated with the HIV/AIDS stigma.

Moreover the officer and the nurse stated that financially these corners were under-staffed and had little resources and they could hardly do any outreach activities hence they were restricted to town areas. Even though they did raise awareness through the media, they mainly emphasized accepted services like mother and child health, education on life skills testing for STIs but hardly mentioned the various contraceptives offered. The nurse further stated that there were only two of them in the office and sometimes they would get an invitation to visit certain schools with high rates of pregnancies or abortions but they would not be able to go because of the workload at the clinic. The adolescent respondents knew very little about where they could access contraceptives but most of them said they thought they would be available at the clinics. None of them said they themselves could go to the clinic to access them, though they mentioned that maybe they would do so after they were married. One parent who was a father who is retired from the National AIDS Commission stated that when his two children were teenagers he took them to this adolescent corner counselling on SRH issues. He said years later the children thanked him very much as the counselling sessions helped them a lot. Therefore the effectiveness of these corners sometimes depended on the support of the parents and their knowledge of the services they offer as they could easily refer their children in these corners for counselling.

Unfortunately instead of working towards solving these problems, the Ministry of Health has decided to abandon these corners on the grounds that they are expensive to maintain. The

Ministry is currently training service providers like nurses and assistant nurses in the provision of friendly SRH services for adolescents in accordance with the National Minimum Standards and Implementation Guide for Provision of Adolescent Friendly Health Services, 2013. Evidence has shown that in order for adolescents to be able to receive and access adolescent friendly services, the services must be provided in an adolescent friendly environment by well qualified health personnel because it is not every nurse for example who is able to provide this services effectively and efficiently. The training or orientation is said to take a few hours and the adolescents are expected to access these services with adults who often stigmatize them in normal hospital settings. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights (paragraph 23) obligates states to provide adolescents with youth-friendly care which respects confidentiality and privacy and includes sexual and reproductive health.

The health services in Lesotho are provided by the government of Lesotho and the Christian Health Association of Lesotho (CHAL) and the RCC own more of the health facilities than any other faith-based organizations. According to Kimane (2015), there are 372 health facilities in Lesotho and 38% of the health centres and the same proportion of 38% of the hospitals are owned by CHAL. Unfortunately the RCC hospitals do not offer family planning as they believe in natural methods of prevention. This means that they are not able to help out in this crisis. Therefore the duty to provide these services rests solely on the government hospitals and a few other faith based organizations that are not Catholic.

4.2.3 Access to SRH services for adolescent girls in non-governmental institutions

The other sexual and reproductive health services provider in Lesotho is the LPPA which has a specific corner (Thakaneng) which is reserved for dealing with the adolescents of Lesotho. Whereas the LPPA is also available in other districts of the country, this corner is only available in Maseru due to limited funding. This division serves young people aged 10-24 years of age. The LPPA provides all services that relate to sexual and reproductive health including counselling services. According to the respondent at LPPA very few young people in this age group come for these services. In most cases it is usually those who are 20 years old and above. This is not surprising because even though the adolescents that I interviewed said that they knew about the organisation, most of them associated it with married people. One adolescent boy from Lesotho High School said he could only go with his girlfriend to access these services if she was a steady girlfriend and he was planning on marrying her. The

fact that the organization in its outreach activities targets tertiary institutions could be one of the reasons why young people do not have accurate information on the services provided nor that they could access these services unconditionally. The nurse interviewed indicated that they focus on tertiary institutions because that is where the greatest risk occurs. He said at primary and secondary or high school level the risk is still at its lowest. The result of this move is fatal as lack of awareness by adolescents means they will not access services when they need them even in future. However he also stated that in the lower institutions of learning there are several restrictions including the fact that they (the providers) may not talk about contraceptives so they find it a self-defeating exercise. Hence, they usually visit tertiary institutions.

Moreover the nurse said they have realized that in most cases since the organisation has other activities where they usually engage the adolescents who come for services to be involved in theatre and other plays to raise awareness on SRH issues, the adolescents who are past the age of 24 are reluctant to join the adult services but keep coming to the corner due to incentives which are given for their participation. As a result they sometimes sit around all day doing nothing and their presence may threaten new adolescents who may be interested in joining and even accessing the service for the first time. Even the young women that I interviewed at the corner in a focus group discussion who had come to access the services were above 20 years of age and they said they heard about the services offered through friends. The office operates week days from 8.00 a.m. to 4.30 p.m. but on Fridays they close at 12.00 p.m. Obviously, these operational times are not suitable for adolescents as this is the time of day when they are at school and they also have to travel to access these services. On Fridays most schools break at 12.00 p.m. to 1.00 p.m. yet the office closes at 12.00 p.m. Clearly the office is not friendly to the adolescents who are at primary, secondary and high school level. Moreover the services are not entirely free which means that if adolescents do not have money they may not be able to go. This is particularly problematic because some adolescents may not want their parents to know which means this may be a barrier to access.

Moreover the LPPA has introduced an antenatal clinic for these young people within this corner and the pregnant girls come in great numbers especially on Wednesdays. There is only one nurse who attends to these young expectant mothers in addition to the other young people who come for daily services like accessing family planning services. These young people take almost the whole day waiting for service since each person takes one to two hours in the

consultation room. These hours may be normal since even where an adolescent has not come for an antenatal check-up, they usually take a long time due to the counselling sessions involved. While talking with young women in a focus group discussion they said that they try their best to avoid Wednesdays as they queue becomes unbearable. It is not clear why the adolescent friendly institutions are not able to attract larger numbers of adolescents to access SRH services before they become pregnant so that they can access family planning. But obviously this can be linked to a lack of awareness-raising campaigns and the stigma surrounding unmarried adolescent girls who access these services.

Further, awareness-raising campaigns do not emphasis family planning in relation to the youth as this may be resisted by the public who are likely to construe them as promoting premarital sex. What I also found, which directly corresponds with these findings, is that once a girl has had a child everybody is willing to give her information on contraceptives but they do not so beforehand. Therefore targeting and reaching adolescent girls before they become pregnant remains a huge challenge. The revised curriculum indicates that the resource persons shall from time to time be invited to talk to students about the services available in relation to SHR. Although this could go a long way towards promoting knowledge about these services, implementation could be difficult. In the first place, whether or not a resource person is invited lies within the discretion of the teacher involved and, secondly, taking into account the scarce human and financial resources in these institutions there may not be sufficient resource personnel available or have the time (given their busy work schedule) to provide such a service.

4.2.4 The social restrictions preventing access to SRH services for adolescent girls

When the adolescent girls were whether they would go out of their way to buy a condom or insist that their partner uses a condom, their response was that they could not buy one over the counter as they were too shy to do so and were afraid people would think they were sexually active. Conversely the boys said they would actually go and buy a condom or even send someone older to do so if they felt they needed to have sexual intercourse. One adolescent girl stated that she would insist that the boy goes to the shop to get the condom because at the end of the day he was the one who wanted to have sexual intercourse and when asked whether she meant girls could never initiate sex, she was too shy to answer. In another case, an adolescent girl at primary school level indicated that sex is for boys and men because

when performing sex, they are the only ones who enjoy the act, while women normally worry about falling pregnant.

> 'All the girls or women will ever get from a relationship with a male partner is nothing but a baby. There can never be true love outside of marriage, boys only want to taste you and move on to the next girl so it is important for girls to always keep their legs closed and not listen to their lies' (Grade 6 pupil from Phethahatso English Medium Primary School).[20]

This kind of information is very misleading for girls as it does not explain why so many girls or women fall victim to this prey if there is no pleasure in sex for females. Consequently, it renders them ill-prepared to take the right precautions when their hormones are raging and telling their bodies that they are in need of sex. Through the correct use of dual methods of contraceptives like using a pill or an injectible contraceptive plus a condom, a woman or girl can enjoy safe and pleasurable sex free from the fear of falling pregnant or being infected by STIs. Pretending, however, that women or girls do not have sexual agency is detrimental to their health. The girls interviewed said they would rather opt for free condoms in the toilet malls, though some said they are still problematic because they are usually put in an open area where everyone can easily see who is taking them. They said that it then becomes stressful because you have to wait for everyone to leave (before helping yourself), so you feel like you are hanging around waiting to steal them when you should feel entitled to use them freely. Hence they suggested that these condoms should be put in individual cubicles in the toilets so that they can be taken and put away safely in private and without feeling stressed. This is not problematic for male adolescents who regard helping oneself to a condom in public is a source of pride especially when witnessed by others of about their own age.

The common problem for adolescent boys and girls would then be about where they will keep the condoms at home so that their parents do not see them. Also, most adolescents interviewed did not have information on the emergency contraceptive pill and for those that knew about it, they feel threatened to access it from pharmacies which are visited by many adults. Some mentioned that they would not have the courage to go to pharmacies even if they had to for fear of coming face to face to the service providers; in such a situation they said that their boyfriends could go on their behalf. Given this information, it is not surprising that there are so many cases of unsafe abortion amongst these young people as they regard it

[20] Interview held in Maseru at Phethahatso English Medium Primary School on 10 November 2015.

as comparatively convenient answer to unplanned pregnancy. The adolescents interviewed indicated that they are not aware of pre- or post-exposure prophylaxis which are administered for HIV prevention, nor about the conditions under which they are given.

The above explains why there are such high rates of HIV infection amongst adolescent girls and why it is so difficult to control unplanned pregnancies and STIs among young people. The social expectations (that adolescent girls must remain abstinent) have a strong hold over these adolescents and put them in a very risky position. Consequently, adolescent girls are not accessing information on services related to contraceptives. No one is willing to open up to them and tell them that it is actually all right for them to access these services. As a result they are overcome by constant fear, even to the point of even stigmatising themselves. I asked the parents, teachers and other stakeholders what they thought about condom distribution in schools to solve the barriers to access especially for the girl child. All of them literally thought I was crazy. One respondent from UNICEF stated that the actual aim of sexuality education is to delay the beginning of sexual activity in young people as much as it possibly can, but that bringing in condoms would actually contradict this aim as it would actually mean that we are acknowledging that they can also have sex. The respondent from UNESCO said he thinks it would be a very bad move at this stage because they are still struggling to have the schools, the parents and the communities support sexuality education and that bringing in condoms at this stage would bring confusion. One secondary teacher said:

> 'I think it would be the worst idea to distribute condoms at school. It is almost similar to opening a bar in the school campus and not expecting students to buy or consume the alcohol. How do we discipline a child in such instances?' (Lesotho High School Form A Teacher).[21]

In my opinion using condoms is not comparable to consuming alcohol because condoms promote and protect the health of the user. So long as we do not regard sex as a natural part of human existence, we will not appreciate the need to have a wide distribution of condoms wherever we find people, including young people. Our problem seems to be that we have always restricted adolescents them to places where we find adults who treat adolescents as asexual beings or even worse, we force adolescents to access SRH services in places where they are discriminated against and stigmatized. Restricting or banning the use of condoms is

[21] Interview held in Maseru at Lesotho High School on 26 October 2015.

like having an emergency kit without protective cloves especially in this era where HIV/AIDS is rife. Where learners have been properly taught sexuality education there is no need to fear that they will sleep around with every one, as they will be able to exercise their judgment correctly. What happened in the past was that condoms would just be used without any sensitization whatsoever and it was not surprising that many interpreted that to mean they could have sex all the time. This will not happen when proper sexuality education is in place.

4.3 Conclusion

It is evident that adolescent girls are still confronted with serious obstacles that prevent them from accessing available services on SRH. Beyond the fact that there are a few adolescent-friendly institutions in the country, the cultural and religious barriers continue to take their toll. In the final chapter I will draw conclusions as the position of SRHR education and services for adolescent girls in Lesotho and provide possible recommendations.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides conclusions and recommendations based on the findings and the analysis of the data collected in the field. It accordingly presents solutions to my research questions which I sought to answer at the beginning of the research.

5.1 Conclusions

From the research findings the following conclusions are drawn:

1. That the government of Lesotho through the Ministry of Education has taken a huge step by revising the primary and secondary school curriculum on sexuality education. On the ground adolescents are still unlikely to continue not receiving CSE in accordance with the CPWA 2011, due to the fact that the content of the curriculum especially at the primary school level is still not comprehensive enough. Outside the school environment, there is still a huge problem because it seems the stakeholders are also not delivering CSE to the adolescents.

2. That the cultural and religious convictions of parents and teachers are and will continue to be a stumbling block as there are no clear training plans to extensively educate them on CSE. Pushing for the curriculum to be compulsory and examinable without investing on capacity building for the implementers is a futile exercise.

3. That In Maseru, the availability of appropriate adolescent friendly institutions is a huge challenge. There is not sufficient awareness-raising of the few that are available, hence adolescent girls remain in the dark on where they can access these services without suffering discrimination or stigma. Roman Catholic schools and hospitals pose a huge challenge to the realization of these rights as they are against the education of adolescents on family planning and do not offer these services in their clinics.

4. That adolescents still think it is socially unacceptable for them to access and use SRH services before marriage. Also that it is generally accepted that boys can access and use condoms than is the case for girls, as they are often stigmatized if they do.

5. That adolescent girls are at a higher risk than their male counterparts of contracting HIV and other STIs over and above becoming pregnant due to the lack of appropriate information and access to services.

6. Finally that implementation of CSE by qualified personnel and improved service delivery on sexual and reproductive health would go a long way towards ensuring informed decision making on their sexual health as well as build their life skills, increase responsible behaviour and advance their human rights.

5.3 Recommendations

From the above conclusions the following recommendations are made:

1. The NCDC should further improve the content of the curriculum especially at the primary school level to ensure that it captures issues in a more comprehensive manner so as to not only consider the age of the adolescents but also their evolving capacities. In that way the link between gender and sexuality can be emphasised to come up with a rights based approach to sexual and reproductive health that considers issues of sexual orientation, family planning and even post-abortion services as fundamental.

2. The Ministry of Education should devise a clear implementation strategy in relation to drafting clear selection criteria for persons who are expected to teach the Life Skills curriculum in schools. As has been shown it is not every person who can effectively teach CSE. The qualities of the educators can have a huge impact on the effectiveness of the curriculum. Those who deliver curricula should be selected through a transparent process that identifies relevant and desirable characteristics. These include: an interest in teaching the curriculum; personal comfort discussing sexuality; ability to communicate with students; and skill in the use of participatory learning methodologies (UNESCO, 2009). Also it could consider training teachers who are already teaching sciences like Health Science or Biology as these subjects have much

in common with the content offered in CSE. Those without this background should prove that they have an interest in the subject and essential characteristics as a prerequisite. This can be very cost effective and not compromise the content delivered to students.

Moreover the Ministry must allocate resources towards the extensive training of the potential teachers on sexuality education for the effective implementation of the curriculum and not expect the teachers to pay out of their own pockets in order to qualify to teach CSE because the primary beneficiaries are adolescents not the teachers. It must also consider the feasibility of online training in CSE especially for the teachers who live in rural areas where access to the internet and computer literacy may be a challenge. We cannot proudly say that there is compulsory and examinable curriculum in sexuality education in Lesotho when teachers do not possess the skills to implement such a curriculum.

To this end the teachers are still not receiving specialized training by experienced and knowledgeable trainers. This is also the case with other stakeholders especially the Ministry of Gender and the Ministry of Health as there are no specialized adolescent corners within government hospitals and clinics in Maseru. According to UNESCO (2009), the training should be able to assist the educators to distinguish between personal values and the health of the learners and must run long enough to cover the content of the entire curriculum especially at the primary school level where some of the issues are not comprehensively covered.

Further the Ministry could consider using the services of expert sexuality education teachers from outside the schools although this may prove very expensive and costlier than its first option. According to UNESCO (2009) the advantage of engaging such people include the fact that they can freely and strategically address sensitive topics and they are always conversant with new developments and are aware of various places where the services can be accessed.

3. The parents should be thoroughly sensitized on what constitutes CSE so that they can open up to their adolescent girls and teach them facts about their sexuality. This can be done through inviting parents at school to be addressed by an expert on CSE or

through public gatherings within their communities. Parents and teachers stated during interviews that it is the joint responsibility of the teacher and the parent to help adolescent girls to enjoy their SRHR. Teachers can also provide student homework assignments to increase parent to child communication about sexuality (UNESCO, 2009).

4. The Ministry of Health should revive adolescent corners since there are no specific adolescent-friendly government-owned institutions in Maseru. In order for adolescents to be able to utilize sexual and reproductive health rights services, they must be adolescent-friendly in all possible ways in order to break all the barriers that inhibit access through stigmatizing adolescents who seek these services. Efforts must be made to make adolescent girls aware of other non-governmental institutions like the LPPA which also provides these services to adolescent girls.

5. People within communities must be thoroughly sensitized to CSE and its corresponding services and that they are specifically important for adolescent girls to reduce and ultimately eliminate the stigma that is attached to adolescent girls who seek and use these services.

Bibliography

Ampofo, A. and Boateng, J. (2011), "Multiple Meanings of Manhood among Boys in Ghana." In: Tamale, S. (ed), African Sexualities: A Reader. Cape Town, Pambazuka Press.

Bentzon A.W et al. (1998). Pursuing Grounded Theory in Law. South-North Experiences in Developing Women's Law. Tano- Aschehoug, Oslo and Mond Books, Harare.

Bunting, A. (2005), "Stages of Development: Marriage of Girls and Teens as an International Human Rights Issue."Social and Legal Studies,Volume 14(1),Canada, York University.

Collins, C. et. al. (2002), Abstinence Only vs. Comprehensive Sexuality Education. What are the Argument? What is the Evidence? Policy Monograph Series, San Francisco, AIDS Research Institute. Available online at: http://www2.gsu.edu/~wwwche/Sex%20ed%20class/abstinence.pdf (Accessed 03/05/2016).

Center for Reproductive Law and Policy and Child and Law Foundation, (2002), State of Denial: Adolescent Reproductive Health Rights in Zimbabwe. Harare, Child and Law Foundation.

Connell, R.W. (2005). The Social Organization of Masculinity. Cambridge, Polity Press.

Darvill, W. and Powell, K. (1995), What Shall We Tell the Children? A Guide for Parents and Teachers. Rydalmere, NSW: Hodder and Stoughton.

Edward, S.E. et.al. (2013). Curriculum Definition. Available Online at: http://www.education.com/reference/article/curriculum-definition/ (Accessed 30/03/2016)

Jansen, Y. (2007),"The Right to Freely Have Sex? Beyond Biology: Reproductive Rights and Sexual Self Determination."Akron Law Review, Volume 40 Issue 2. Available Online at: http://ideaexchange.uakron.edu/cgi/viewcontent.cgi?article=1230&context=akronlawreview (Accessed 09/03/2016).

Jones B.S. and Movahed M. (2008), Lesson One: Your Gender is Your Destiny -The Constitutionality of Teaching Sex Stereotypes in Abstinence-Only Programs. Washington

College of Law, American Constitution Society for Law and Policy. Available online at:http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Jones%20-%20Movahed%20Issue%20Brief.pdf (Accessed 02/02/2016)

Kimane, I. (2015), Updated Situation Analysis (SitAn) for Adolescents and Young People's Health in Lesotho: Final Report. Maseru, Lesotho Ministry of Health.

International Planned Parenthood Federation, (2010),International Planned Parenthood Federation Framework for Comprehensive Sexuality Education (CSE). London, IPPF Adolescent Team. Available online at: http://www.International Planned Parenthood Federation.org/system/files/International Planned Parenthood Federation_framework_for_comprehensive_sexuality_education.pdf(Accessed 01/02/16).

International Planned Parenthood Federation, (2011),Exclaim! Young People's Guide to 'Sexual Rights: An International Planned Parenthood FederationDeclaration.'IPPF. Available online at: http://www.International Planned Parenthood Federation.org/sites/default/files/International Planned Parenthood Federation_exclaim_lores.pdf(Accessed 20/12/2015)

MacKinnon, C. A. (1989), Toward a Feminist Theory of the State. Cambridge Mass: Harvard University Press.

Miller A. M and Vance C. S (2004), "Sexuality, Human Rights and Health."Health and Human Rights: An International Journal, Volume 7(2).

Rodman, H. et al. (1984), The Sexual Rights of Adolescents: Competence, Vulnerability and Parental Control. New York,Columbia University Press.

Rubin, G. (1984), "Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality" In: Vance C. S. (ed), Pleasure and Danger: Exploring Female Sexuality. Boston: Routledge.

Tamale, S. (2011), "Researching and Theorising Sexualities in Africa." In: Tamale, S. (ed), African Sexualities: A Reader. Cape Town,Pambazuka Press.

Twesiime-Kirya, M. (2008), "Until Marriage" or "Until Graduation:" Abstinence-only Strategies and their Impact on University Students in Uganda and Kenya. Faculty of Law, Makerere University.

Tambiah, Y. (1995). "Sexuality and Human Rights." In: Schuler, M.A. (ed), From Basic Needs to Basic Rights; Women's Claim to Human Rights. Washington. Women Law and Development International.

U.N Committee on the Elimination of Discrimination against Women. (2011), Concluding Observations of the Committee on the Elimination of Discrimination against Women. Lesotho: CEDAW/C/LSO/CO/1-4. Fiftieth Session, Geneva. Available online at: http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-LSO-CO-1-4.pdf (Accessed 13/02/2016)

U.N Committee on the Rights of the Child. (2001), Concluding Observations of the Committee on the Rights of the Child, Lesotho: U.N. Doc. CRC/C/15/Add.147. Twenty Sixth Session. Available online at: http://www1.umn.edu/humanrts/crc/lesotho2001.html (Accessed 10/03/2016)

UNAIDS, (2010), Report on the Global AIDS Epidemic. Available online at http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf (Accessed 02/03/2016)

UNESCO, (2009), International Technical Guidance on Sexuality Education: An Evidence Based Approach for schools, teachers and health educators. UNESCO.Available online at:http://unesdoc.unesco.org/images/0018/001832/183281e.pdf(Accessed 12/01/2016)

UNFPA, (2014), Adolescent Sexual and Reproductive Health. UNFPA.Available online at: http://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health (Accessed 15/03/2016)

United Nations, (2014), Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions. United Nations. Available online at: http://www.ohchr.org/Documents/Publications/NHRIHandbook.pdf (Accessed 14/02/2016)

Appendices

Appendix 1: Primary School Curriculum

Themes & Expected Learning Outcomes

GRADE	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
4	1. Greet formally, informally and use social graces appropriately. 2. Demonstrate unique personal attributes and express positive feelings about themselves. 3. Talk about how they feel. 4. Suggest ways in which they can build healthy relationships.	1. Demonstrate understanding of children's rights and responsibilities. 2. Engage in rights promoting behaviour and reject behaviour that violates rights.	1. Explain that the differences in the ability of girls and boys are more cultural than biological. 2. Resist negative effects of gender socialization on their self-image.	1. Identify changes in males and females at puberty. 2. Explain the importance of keeping their sexual parts clean. 3. Recognize inappropriate touching regardless of who does it. 4. Protect oneself from sexual abuse.	1. Reject myths relating to the mode of HIV transmission. 2. Support each other in making healthy choices in relation to HIV/AIDS.	Nothing.
GRADE	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
5	1. Demonstrate the understanding of love.	1. Describe the effects of violation of human rights. 2. Identify various forms of abuse and violence against children. 3. Describe effects and precautions on human trafficking.	1. Demonstrate understanding of how gender stereotypes promote gender roles and gender boundaries.	1. Demonstrate understanding of how one can avoid being forced into risky behaviour.	1. Describe ways of avoiding situations and behaviour leading to a risk of STIs, including HIV/AIDS.	1.Apply assertiveness and refusal strategies to avoid abuse o drugs and substances.

GRADE	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
6	Nothing	1. Apply ways of minimizing gender based violence and discrimination to boys and girls.	1. Describe impacts of gender discrimination on boys and girls.	1. State the emotional and psycho-social changes at puberty. 2. Describe consequences of engaging in unprotected sex. 2. Describe consequences of pregnancy on the teen mother and how it can be prevented.	1. Needs and challenges of people living with HIV and care, support and treatment of STIs and HIV/AIDS.	Nothing.
GRADE	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
7	1. Demonstrate skills to deal with their emotions. 2. Demonstrate ability to set their personal goals. 3. Choose friends who will be likely to contribute to the achievement of their set goals.	1. Differentiate between traditional norms and practices that promote children's rights and those that violate them. 2. Identify norms of violence that children may be subjected to in the community. 3. Act to reduce violence against children.	1. Recognise consequences of negative gender norms & practices on girls & boys. 2. Reject gender practices and norms that are harmful to their rights & well-being. 3. Report incidences of Gender Based Violence (GBV) to trusted individuals & organizations at home, school & community. 4. Display skills of sound decision making & critical thinking. 5. Espouse values of respect & compassion for those around them.	1. Assess the effects of external agents on sexual decisions made by adolescent girls & boys. 2. Demonstrate intentions to abstain even when confronted with romantic & sexual feelings. 3. Identify various forms of sexual violence & consequences of such. 4. Avoid situations & behaviour that may put them at risk of sexual abuse & violence.	1. Explain the impact of HIV/AIDS on the individual & in society in Lesotho. 2. Resist pressure to engage in risky behaviour. 3. Understand the importance of regular testing & timely treatment of STIs & HIV. 4. Propose ways that those infected with & affected by HIV/AIDS may live positively in society.	1. Differentia between myth facts relating drug abuse. 2. Resist peer pressure to indulge in abuse of drug substances 3. Identify available serv in the commu for the rehabilitation drug & substance abusers.

Appendix 2: Secondary School Curriculum

Themes & Expected Learning Outcomes

FORM	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
A	1. Express positive feelings about themselves as unique individuals. 2. Clarify their own personal values and why they are important. 3. Suggest ways in which they can build healthy relationships. 4. Demonstrate skills for avoiding unhealthy relationships.	1. Describe the concept of human rights for all and the application of rights to adolescents. 2. Understand that the exercise of human rights include reciprocal responsibilities. 3. Differentiate between positive and negative norms that facilitate or hinder the fulfilment of the rights of adolescents. 4. Explain the importance of non-discrimination and respect for diversity. 5. Apply essential life skills in the promotion of their human rights and those of others.	1. Differentiate between sex and gender identities and roles and sexual orientation. 2. Describe how gender identities and roles are socially constructed and are changeable. 3. Explain how gender inequality is driven by culture and society. 4. Identify the manifestations and consequences of gender inequality. 5. Exhibit skills that facilitate protection against gender-based violence.	1. Recognise that puberty is an essential and natural stage in human development. 2. Explain the relationship between puberty and changes that characterise adolescence. 3. Understand that sexuality is expressed in different ways across the life cycle. 4. Identify key risk & protective factors associated with sexually risk behaviour. 5. Exercise their sexual and reproductive rights. 6. Employ skills acquired to realise their rights. 7. Describe common sexual behaviour. 8. Identify the signs of pregnancy, stages of fetal development & childbirth. 9. Describe effective methods for preventing unintended pregnancy. 10. Explain the likelihood of pregnancy if having unprotected sex. 11. Identify key responsibilities of	1. Describe STIs, HIV and AIDS and their prevalence in Lesotho. 2. Explain the relationship between STIs and HIV and how they are transmitted, prevented and treated. 3. Adopt behaviour and attitudes that will protect them against HIV and STIs infection. 4. Describe challenges that people living with HIV face. 5. Describe where to seek help for HIV and STI testing and treatment. 6. Practice skills and attitudes for healthier lifestyles.	1. Explain the differences between various types of drugs and substances and their use and abuse. 2. Identify the risk and protective factors relating to drug and substance use and abuse. 3. Resist pressure to abuse drugs and substances. 4. Identity and implement actions for the creation of a drug-free school

				long-term commitments & marriage.		
FORM	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
B	1. Critically assess themselves and identify how values influence their behaviour. 2. Demonstrate ability to set their personal goals and limits and adhere to them. 3. Appreciate values of healthy relationships and demonstrate skills of escaping from unhealthy relationships.	1. Critically examine the enjoyment of their sexual and reproductive rights and positively resolve any conflicts that these rights may have in the exercise of other rights. 2. Describe various forms of violence against adolescents, and explain why these are violations of one's human rights. 3. Protect themselves against violence, and the violation of their rights.	1. Critically analyse positive and negative gender norms and practices in the school setting and how it shapes their gender identity and capabilities. 2. Identify positive peer norms, values and beliefs and reject gender practices and norms that are harmful to their rights and well-being. 3. Act against gender-based violence and abuse.	1. Critically assess the veracity of information that they receive from various sources regarding puberty and adolescence, sex and sexuality. 2. Appreciate that sexual relationships can put you at risk of unintended pregnancy and HIV/STIs depending on your sexual behaviour. 3. Identify sexually protective and risky behaviour and the consequences of engaging in these. 4. Avoid situations and sexual behaviour that may put them at risk of unintended pregnancy or HIV/STIs. 5. Apply knowledge and skills in the exercise of their sexual and reproductive health rights. 6. Describe the signs of pregnancy, stages of foetal development and childbirth. 7. Understand the different types of contraceptive methods for preventing unintended pregnancy. 8. Identify	1. Explain the relationship between risky behaviour, STIs, HIV and AIDS and a weakened immune system. 2. Critically examine their behaviour and identify situations and influences that may put them at risk of STIs and HIV. 3. Adopt risk reducing attitudes and behaviour. 4. Positively support adolescents and other people living with HIV to exercise their rights and responsibilities.	1. Make informed decisions regarding drug use and abuse. 2. Resist external pressures to indulge in the abuse of drugs and substances. 3. Actively contribute to the creation and maintenance of drug free spaces in school. 4. Identify available services in the community for the rehabilitation of drug and substance abusers.

				implications of long-term commitments and marriage.		
FORM	Knowing Oneself	Human Rights	Gender	Sexual & Reproductive Health (SRH)	HIV/AIDS & STIs	Drug Abuse
C	1. Express a positive self-image and confidence in their abilities to act against abuse. 2. Critically assess their own behaviour and recognize how one's actions may be influenced by others. Apply essential life skills to improving their relationship with themselves and others.	1. Apply skills that they need to make responsible choices related to the exercise of their rights, including and those of others. 2. Reduce risk of violence by utilizing anger management techniques. 3. Explain national policies and laws that protect adolescent rights and apply these in their daily lives.	1. Critically assess media messages and how these construct their image of self as a girl, boy or transgendered individual. 2. Reject gender practices and norms that are harmful to their rights and well-being. 3. Take concrete steps to help those who are at risk of being trafficked and whose rights are being violated.	1. Describe the sexual and reproductive capacity of males and females over the life cycle. 2. Understand that during adolescence boys and girls become more aware of their sexual responses. 3. Assess the effects of external agents on sexual behaviour of male and female adolescent. 4. Explain how to behave in ways that are consistent with one's own values. 5. Recognize various forms of sexual violence and why they are violations of their rights. 6. Act to protect themselves from risky situations and risky sexual behaviour. 7. Describe personal benefits and risks of available contraception and where to access contraception. 8. Demonstrate how to use a condom correctly. 9. Negotiate contraceptive/condom use. 10. Identify key physical, emotional, economic and	1. Explain the impact of HIV and AIDS on the individual and society in Lesotho. 2. Assess a range of risk reduction strategies for effectiveness and personal preference. 3. Demonstrate effective communication and decision-making skills to avoid risky situations and adopt sexual protective behaviour. 4. Propose ways that those infected and affected by HIV and AIDS may live positively in society. 5. Describe stigma and discrimination in relation to people living with HIV.	1. Take informed decisions relating to their use of drugs and substances. 2. Act on the knowledge to practice safe drug use behaviour. 3. Identify available services in the community for the rehabilitation of drug and substance abusers.

				educational needs of children and the required responsibilities of parents.		